

THE POTENTIAL OF RECOVERY CAPITAL

This paper

This short paper outlines the concept of recovery capital and discusses the impact that the accumulation of individual success has on groups and communities. It seeks to define recovery capital, to capture its flavour and principles, and to look at the intrinsically social forces that are at play in shaping change and in growing communities of recovery. It also outlines how we will be taking forward these ideas in our action research.

Forthcoming RSA papers will discuss how the ideas in this report are being operationalised, and what the lessons are to date in trying to embed recovery-oriented practice and behaviour; and will report on our recent work in West Sussex.

About the authors

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— UK Drug Policy Commission, defining recovery capital

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— Best and Laudet

INTRODUCTION

The addictions field is now overflowing with references to ‘recovery’ with service providers and workers increasingly designated as ‘recovery-focused’, although in many areas there is confusion as to what this means in practice and what needs to change. There is an increasing awareness that people do recover, but we have limited knowledge or science of what enables recovery or at what point in the journey recovery is sparked and made sustainable.

There is also the recognition that recovery is something that is grounded in the community and that it is a transition that can occur without professional input, and where professional input is involved, the extent of its role is far from clear. We are also increasingly confident that recovery is contagious and that it is a powerful force not only in transforming the lives of individuals blighted by addiction but in impacting on their families and communities as well.

WHAT DO WE MEAN BY RECOVERY AND RECOVERY CAPITAL?

Researchers and clinicians have devised the construct of ‘recovery capital’ to refer to the sum of resources necessary to initiate and sustain recovery from substance misuse. Before discussing this construct in more detail, it is first necessary to explain what we mean by recovery.

In the US, the **Betty Ford Institute Consensus Panel** (2007, p. 222) defined recovery as “a voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship”.¹ Subsequently, the **UK Drug Policy Commission** (2008, p.6) followed up this statement with a definition of recovery as “voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society”. Both of these definitions involve three primary component parts – wellbeing and quality of life, some measure of community engagement or citizenship, and some measure of sobriety.²

In contrast, the definition from mental health recovery is typically more focused on the quality of life component regardless of the others. **Deegan** (1988) has argued that “recovery refers to the lived experience of people as they accept and overcome the challenge of disability... they experience themselves as recovering a new sense of self and of purpose within and beyond the limits of the disability”.³

What is clear, however, is that the essence of recovery is a lived experience of improved life quality and a sense of empowerment; that the principles of recovery focus on the central ideas of hope, choice, freedom and aspiration that are experienced rather than diagnosed and occur in real life settings rather than in the rarefied atmosphere of clinical settings. Recovery is a process rather than an end state, with the goal being an ongoing quest for a better life.

1 Betty Ford Institute Consensus Panel (2007) ‘What is Recovery? A Working Definition from The Betty Ford Institute’, *Journal of Substance Abuse Treatment*, Vol. 33, pp221-228

2 UK Drug Policy Commission, (2008) **Recovery Consensus Statement**, www.ukdpc.org.uk/Recovery_Consensus_Statement.shtml

3 Deegan, P. E. (1988) **Recovery: the lived experience of rehabilitation**. *Psychosocial Rehabilitation Journal*, 11, 11-19.

“Those who possess larger amounts of social capital, perhaps even independently of the intensity of use, will be likely candidates for less intrusive forms of treatment”

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— Granfield and Cloud, defining recovery capital

With recovery conceptualised as a process in this way, recovery capital refers to the sum of resources that may facilitate the process. The notion of social capital initially developed in the field of sociology, where **Pierre Bourdieu** (1980) described it as one of three resource forms along with economic and cultural capital as the basic resources for power.⁴ When this concept was applied to the addictions field, **Granfield and Cloud** (2001) suggested that “Those who possess larger amounts of social capital, perhaps even independently of the intensity of use, will be likely candidates for less intrusive forms of treatment”.⁵

However, social capital in this sense does not mean only the social resources that an individual can draw upon – their parents and families, partners, friends and neighbours when times are tough. It also implies the person’s engagement and commitment to the community and their willingness to participate in its values.

Further, **Granfield and Cloud** (1999) defined recovery capital as “... the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from AOD [alcohol and other drug] problems”.⁶ In the same paper, they summarise early evidence among naturally recovering individuals (people who did not seek professional treatment or participate in mutual aid support groups) suggesting that both the quality and the quantity of recovery capital play a major role in predicting recovery success both in and out of treatment, and crucially that the growth of recovery capital can signal a ‘turning point’ in addiction careers.

White and Cloud (2008) assert that the type of interventions that will be appropriate will depend in part on the balance of recovery capital and problem severity/complexity.⁷ They represent this in a ‘quadrant model’ as shown in Table 1 below, where people can be allocated to one of four cells (although this is a shorthand for people’s overall ratings of recovery capital and problem profile). Thus, people with high recovery capital and low problem severity may be appropriate for brief interventions of various types. People with high recovery capital but also high problem severity may be appropriate for out-patient detoxification with intense community support. White and Cloud argue that people with low problem severity and low recovery capital may be appropriate for residential rehabilitation with appropriate follow-up and people with low recovery capital and high problem severity may need a combination of intensive interventions.

Table 1: Recovery Capital / Problem Severity Matrix
(re-produced with permission from **White and Cloud**, 2008)⁸

High Recovery Capital	High Problem Severity/ Complexity
Low Problem Severity/ Complexity	Low Recovery Capital

4 Bourdieu, P. (1980) **The logic of practice.** Polity: London

5 Granfield, R. and Cloud, W. (2001) ‘Social Context and “Natural Recovery”’: The Role of Social Capital in the Resolution of Drug-Associated Problems’, **Substance Use and Misuse**, Vol. 36, pp1543-1570

6 Granfield, R. and Cloud, W. (1999) **Coming clean: Overcoming addiction without treatment.** New York: New York University Press

7 White, W. and Cloud, W. (2008) ‘Recovery Capital: A Primer for Addiction Professionals’, **Counselor**, Vol. 9, No. 5, pp22-27

8 Ibid.

Consistent with Deegan’s definition of recovery in the mental health field, this model makes no assumption that those high in addiction severity/complexity will be low in recovery capital. However, the influence of change in recovery capital (increases or decreases) on subsequent patterns of substance use and related problems remains an unanswered question.

WHAT ARE THE KEY COMPONENTS OF RECOVERY CAPITAL?

Cloud and Granfield (2009) recently revisited their initial concept and have argued that there are four components to recovery capital:⁹

- 1 **Social capital** is defined as the sum of resources that each person has as a result of their relationships, and includes both support from and obligations to groups to which they belong; thus, family membership provides supports but will also entail commitments and obligations to the other family members.
- 2 **Physical capital** is defined in terms of tangible assets such as property and money that may increase recovery options (e.g. being able to move away from existing friends/networks or to afford an expensive detox service).
- 3 **Human capital** includes skills, positive health, aspirations and hopes, and personal resources that will enable the individual to prosper. Traditionally, high educational attainment and high intelligence have been regarded as key aspects of human capital, and will help with some of the problem solving that is required on a recovery journey.
- 4 **Cultural capital** includes the values, beliefs and attitudes that link to social conformity and the ability to fit into dominant social behaviours.

Although the focus here is primarily on individual factors, it is the meshing of three of these components – social, human and cultural capital – that may be particularly important in assessing recovery capital at a group or social level.

WHAT DOES RECOVERY CAPITAL MEAN AT A COMMUNITY LEVEL?

In social epidemiology, **Christakis and Fowler** (2007) reported on the increased risk rates for obesity in up to three degrees of separation from a target individual such that a person’s odds of becoming obese increased by 57% if they had a friend who became obese, with a lower risk rate for friends of friends, lower again at three degrees of separation, and with no discernible effect at further levels of remove.¹⁰ Moreover, if the friend is perceived to be a close friend then the risk rate is increased. Repeating this social network analysis for smoking, **Christakis and Fowler** (2008) found that smoking cessation by a spouse decreased a person’s chances of smoking by 67%, while smoking cessation by a friend decreased the chances by 36%. The average risk of smoking at one degree of separation (i.e. smoking by a friend) was 61% higher, 29% higher at two degrees of separation and 11% higher at three degrees of separation.¹¹

9 Cloud, W. and Granfield, W. (2009) **Conceptualising recovery capital: Expansion of a theoretical construct, Substance Use and Misuse**, 42, 12/13, 1971-1986

10 Christakis, N. A. and Fowler, J. H. (2007) **“The Spread of Obesity in a Large Social Network Over 32 Years” New England Journal of Medicine** 357 (4): 370–379

11 Christakis, N. A. and Fowler, J. H. (2008) **“The Collective Dynamics of Smoking in a Large Social Network” New England Journal of Medicine** 358 (21): 2249–2258

In “Connected”, **Christakis and Fowler (2010)** assessed the effect of social contagion in emotions and the extent to which this reaches beyond immediate social networks, which they refer to as hyperdyadic spread.¹² Using happiness as the topic for investigation, they reported that, if a person’s friend is happy, there is a 15% increase in the chances that the target will be happy, but that even at a further degree of separation there is an increase of around 10% and at three degrees of separation, the increased likelihood of happiness is 6%. This is a critical issue in the development of interventions and policies that attempt to promote recovery as it would suggest that focusing exclusively on individuals underestimates the impact of key icons of recovery and of recovery communities. Thus, there is evidence for the social transmission of some of the key elements of recovery capital, and we do not have to conceptualise it exclusively as the property of an individual.

The development of recovery ‘champions’ as charismatic and connected community figures who are visible examples of success provides not only the opportunity for ‘social learning’ for those who claim that recovery is not possible, but also increases the waves of impact within local communities for recovery spread. Similarly, the growth of vibrant recovery groups and recovery-oriented systems of care may well provide ready-made social supports for individuals starting out on their recovery journeys (as has often been attributed to mutual aid groups, particularly Alcoholics Anonymous) while also providing the scaffolding for the development of the human and physical capital that are likely to be part of the developmental journey of recovery. In other words, recovery champions may be the key contagion that allows the ‘viral spread’ of recovery capital.

Within the addictions field, **Best and Gilman (2010)** have argued that the growth of recovery has a ripple effect that confers benefits on families but also serves to generate ‘collective recovery capital’ that provides support and hope for those in recovery and that engages people in a range of activities in the local community.¹³ This process translates into active participation in community life and ‘giving something back’ by creating a collective commitment in recovery groups to community engagement and immersion. In other words, the recovery community acts and is seen as a positive force in the local community and a resource for that community that goes beyond managing substance misuse issues.

WHAT DOES THIS MEAN FOR PROFESSIONALS AND ADDICTION AGENCIES?

As **Laub and Sampson (2003)** have reported with respect to the predictors of long-term desistance from crime, it is not direct treatment effects that will trigger the growth of recovery capital; rather, it is likely to be a range of life events and personal and interpersonal transitions:¹⁴

- attachment to a conventional person (spouse);
- stable employment;
- transformation of personal identity;
- ageing;
- inter-personal skills; and
- life and coping skills.

12 Christakis, N. A. and Fowler, J. H. (2010) **Connected: The Amazing Power of Social Networks and How They Shape Our Lives**, Harper Press: London

13 Best, D. and Gilman, M. (2010) **Recovering Happiness, Drink and Drugs News**, 15 February 2010

14 Laub, J.H. and Sampson, R.J. (2003) **Shared Beginnings, Divergent Lives: Delinquent Boys to Age 70**. Cambridge, MA: Harvard University Press

The RSA

RSA Projects put enlightened thinking to work in practical ways. We aim to discover and release untapped human potential for the common good. By researching, designing and testing new social models, we encourage a more inventive, resourceful and fulfilled society.

The RSA Commission on Illegal Drugs, Communities and Public Policy published its report, *Drugs – facing facts*, in 2007, which argued, inter alia, for a more tailored and expansive approach to drug services.

Following this report, and with our modern mission to extend our thought leadership into practical action on the ground, we are working with West Sussex Drug and Alcohol Action Team and partners to develop and test a user-centred approach to personalised recovery.

Building on this work, we have launched a new project to explore how to develop a broad recovery community

RSA Peterborough Recovery Capital Project

The RSA is working with Peterborough City Council and partners to put the ideas in this paper into practice as part of the broader **Citizen Power Programme** of work which sets out a vision for active citizenship across the City and seeks to realise it with local stakeholders.

There are strong overlaps between the notion of recovery capital and its domains, and the RSA's account of individual and collective civic health. Broadly, the latter includes being engaged in civic life; acting in an other-regarding, pro-social manner; being resilient in the face of change and shocks; having sufficient self-reliance to make change and to participate in civic life; and being resourceful and creative in problem-solving and in the face of scarcer resources.

The RSA's **Recovery Capital** project will work with current and former substance misusers to map and understand their recovery capital. We will then work with substance misusers, service providers and a wide range of other stakeholders to re-design services for recovery, foster recovery capital, and mobilise community assets to support recovery journeys and the active participation in civic life.

However, this does not mean that treatment providers or commissioners have nothing to offer – they are often best placed to act as guides to recovery communities, and they are essential in activating the basic health supports that are needed. In “Getting back into the world”, the mental health recovery group, **Rethink** (2010), argued that the starting point for a recovery journey requires three components – a safe place to live, effective control over symptoms and general health problems, and basic human rights supports.¹⁵ While not all clients are looking for recovery guides, the *sine qua non* of treatment services and workers should be to enable their clients to get to the starting blocks of the recovery journey and to enable and support recovery activities that will be community-based and socially grounded.

RECOVERY CAPITAL AS COMMUNITY ENGAGEMENT

This overview of recovery capital has focused on recovery from addictions and the increasing recognition that recovery is not only possible, it is the reported experience of many people who have (had) addiction problems. Recovery unfolds in the lived, physical community as well as in the substance misusing communities and it has significant ramifications for those wider communities. The growth of recovery capital as a collective, community concept will involve mutual empowerment, support and recovery contagion in substance misusing groups, but it will manifest itself in improved functioning for the family and the wider community. The growth of recovery capital is, as far as we currently know, idiosyncratic and personal, but its manifestation is inherently social and community-based and its impact can be measured in terms of those lived communities.

What this means is that at a systems level – the Drug Action Team in England or the Alcohol and Drug Partnership in Scotland – it is meaningful to conceptualise and measure recovery capital as the sum of resources and supports available to people starting recovery journeys. This will include the range and dynamism of recovery support groups, the local champions of recovery and the services that provide continued and ongoing care. This resource is the community asset that we should aim for as the foundation stone of recovery-oriented systems of care.

¹⁵ Ajayi, S., Billsborough, J., Bowyer, T., Brown, P., Hicks, A., Larsen, J., Mailey, P., Sayers, R., and Smith, R. (2010) **Getting Back into the world: Reflections on lived experiences of recovery.** Rethink recovery series: volume 2 www.rethink.org/intotheworld