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Recovery capital pathways: Modelling the components of recovery wellbeing

Ivan Cano[a,*], David Best[a], Michael Edwards[a], John Lehman[b]

[a] Helena Kennedy Centre for International Justice, Department of Law and Criminology, Development and Society, Sheffield Hallam University, Collegiate Crescent, Sheffield, S10 2BQ, United Kingdom

[b] CEO/Board Chair, Florida Association of Recovery Residences, United States

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ABSTRACT

Background: In recent years, there has been recognition that recovery is a journey that involves the growth of recovery capital. Thus, recovery capital has become a commonly used term in addiction treatment and research yet its operationalization and measurement has been limited. Due to these limitations, there is little understanding of long-term recovery pathways and their clinical application.

Methods: We used the data of 546 participants from eight different recovery residences spread across Florida, USA. We calculated internal consistency for recovery capital and wellbeing, then assessed their factor structure via confirmatory factor analysis. The relationships between time, recovery barriers and strengths, wellbeing and recovery capital, as well as the moderating effect of gender, were estimated using structural equations modelling.

Results: The proposed model obtained an acceptable fit (χ^2 (141, N = 546) = 533.642, p < 0.001; CMIN/DF = 3.785; CFI = 0.915; TLI = 0.896; RMSEA = 0.071). Findings indicate a pathway to recovery capital that involves greater time in residence ('retention'), linked to an increase in meaningful activities and a reduction in barriers to recovery and unmet needs that, in turn, promote recovery capital and positive wellbeing. Gender differences were observed.

Conclusions: We tested the pathways to recovery for residents in the recovery housing population. Our results have implications not only for retention as a predictor of sustained recovery and wellbeing but also for the importance of meaningful activities in promoting recovery capital and wellbeing.

1. Introduction

In recent years, there has been a gradual transition from an exclusively clinical definition of addiction recovery to something broader, incorporating not only control over substance use but also global health and active participation in communities (Betty Ford Institute Consensus Panel, 2007; UK Drug Policy and Commission, 2008). Following mental health recovery, there has also been increasing interest in differentiating between observable changes (substance use, offending, etc.) and experiential processes (such as changes in identity, quality of life and a sense of hope and belonging; Slade, 2010). Further, there is recognition that recovery is a journey and not an event, and that it takes around five years before recovery can be regarded as self-sustaining (Dennis et al.,2005). This concept of a journey was originally considered in terms of reduced likelihood of relapse (White, 2009) but has been reframed as involving the growth of recovery capital (Granfield and Cloud, 2001), defined as the sum of resources that an individual can draw on to support their recovery pathway. As individuals progress through their recovery journey, so recovery capital should increase, which is likely to augment the chances of ongoing remission (Kelly and Hoeppner, 2015). Best and Laudet (2010) have argued that there are three domains for recovery capital – personal capital (qualities such as self-esteem and resilience), social capital (based on the networks and supports that the individual can draw on) and community capital (referring to the resources from the local community that can be accessed such as reasonable housing, training and employment opportunities).

This has prompted an increased interest in the idea of operationalising recovery capital. In 2013, based on extensive piloting in Scotland and England, Groshkova et al. published a paper reporting on the psychometrics of the Assessment of Recovery Capital (ARC). The 50-item instrument showed strong internal properties and correlated well with measures of quality of life and wellbeing.

However, there are limitations with the ARC as a standalone measure – it does not account for the community recovery capital domain

* Corresponding author.
E-mail address: ivan.cano@shu.ac.uk (I. Cano).

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that Best and Laudet (2010) identified as central to understanding long-term recovery pathways and it also offers little direction to addiction treatment professionals or peer recovery champions identifying the next stages of an individual's recovery journey, and so its application in treatment and recovery community organisations has been limited. For this reason, Best et al. (2016a; see also Best et al., 2016b) have developed the REC-CAP as a recovery capital battery of measures to create a more holistic assessment of recovery barriers and strengths, and that creates a profile that informs subsequent recovery care planning.

A critical question involves how this recovery intervention is designed to generate lasting effects (see Walton, 2014; Wilson, 2011) that become embedded in the structure of people's lives (see Kenthirarajah and Walton, 2015). Prior research has shown that retention in recovery residences contributes to continued abstinence (French et al., 1993), albeit with gender differences (Brady and Ashley, 2005; Marsh et al., 2004), and also creates the conditions to gain useful employment skills (Gómez et al., 2014), which in turn is a favourable factor in continued remission (Platt, 1995). In other words, retention in recovery residences provides residents with opportunities to redevelop purpose and identity that benefits their selves and (re)connects them to the world beyond the self (see Burrow and Hill, 2011; Damon et al., 2003; Yeager and Bundick, 2009; Yeager et al., 2012). Building on Lewin (1943) field-theory analysis, the present study argues that recovery is initiated by first targeting people's meaningful activities (identified in the REC-CAP as employment, education and volunteering) yet we also appreciate that multiple, interrelated forces influence the individual within a force field at any moment. Therefore, a lasting change will be the consequence of an equilibrium of forces between meaningful activities and context-specific barriers and needs.

Thus, the present study proposes a dose effect by which the longer the stay in recovery residences, the higher the increase in meaningful activities, and the lower the number of barriers to recovery (identified in the REC-CAP as accommodations risk, substance use, criminal justice involvement and lack of meaningful activities) and unmet needs (identified in the REC-CAP as help-seeking regarding drug treatment services, alcohol treatment services, mental health services, housing support, employment services, primary healthcare services and family relationships), resulting in increased recovery capital that may foster wellbeing. Since there are fundamental differences in pathways to recovery for men and women, with stronger effects of self-help participation on recovery for the latter (Grella et al., 2008), a second objective was to assess whether and to what extent gender was a moderating variable. Thus, the current paper examines three primary research questions:

1. What are the psychometric properties of the REC-CAP regarding its internal consistency and the relationships between observable variables and their underlying constructs (structure of recovery capital and wellbeing)?
2. In a population of participants from recovery residences, what are the effects of recovery enablers (time in residence and meaningful activities) and recovery weaknesses (barriers and unmet needs) on recovery capital and wellbeing?
3. Are there gender differences in the pathways to recovery for residents in the recovery housing population?

2. Methods

2.1. Participants

The eight recovery residences addressed in this study are spread across Florida and are all certified members of the Florida Association of Recovery Residences – FARR (USA), an accreditation body for recovery residences. FARR is an affiliate of the National Alliance for Recovery Residences (NARR), which has established a national standard for recovery residence certification. NARR's standard is built upon the Social Model of Recovery Philosophy (SMRP) and emphasises gaining experiential knowledge, connection and peer support as the basic elements to create the framework for recovery (Wright, 1990). All recruit from either community treatment or criminal justice agencies and require abstinence, mutual aid meeting attendance, the acquisition or maintenance of meaningful employment and contribution to the wellbeing and upkeep of the residence.

There are similarities, with some nuances and heterogeneity, between the residences. First, all of them require residents to remain sober during their stay in the house. Second, attendance at 12-step meetings is considered and encouraged, yet it is not always mandated. Third, stays are usually long-term (more than 30 days), with some residences establishing curfews that usually depend on the stage of recovery. While some residences rely on Intensive Outpatient Programs (e.g., Service 3), others focus on Group Therapy (e.g., Service 5) or Empowerment Models (e.g., Service 8). Likewise, there is heterogeneity within residences. For example, Service 1 offers Partial Hospitalization, Intensive Outpatient Program (IOP), Outpatient (OP), and Individual Therapy. Finally, only Service 8 offers a Veterans Program, and only Service 7 is exclusive for women.

Participants were recruited through residence unit managers and were asked to complete the survey on a single occasion on a confidential basis, either alone or as a structured research interview administered by the unit manager, depending on the agreement reached between the project team and the service. Participants in the study were 546 people resident in one of eight recovery residences and so would have already completed any acute addictions treatment that they required (e.g., detoxification), and who agreed to take part in this study. The sample, evaluated once, was made up of 427 men, 114 women, and 5 people who did not report their gender, with an age range of 17–72 (M = 33.42, SD = 11.17). About 23% of participants reported substance use within the previous three months (see Appendix A Supplementary material in for further details).

2.2. Measures

2.2.1. Demographic information

Demographic information collected included age, gender, ethnicity, time in residence, and meaningful activities. Meaningful activities, adapted from the Treatment Outcome Profile (TOP; Delgadillo et al., 2013), were assessed by four dichotomous ("Yes" or "No") items ("Are you currently working full-time?", "Are you currently working part-time?", "Are you currently at college or university or in other form of education, including on-line course work?", "Are you currently volunteering?"). A composite score was calculated (Mdn = 1), a lower score indicating less meaningful activities.

2.2.2. Barriers to recovery

A total number of five barriers, also adapted from the TOP (Delgadillo et al., 2013), were considered and measured using dichotomous ("Yes" or "No") items: (1) Accommodation risk, which was assessed by a composite of perceived risk of eviction and acute housing problems in the past 3 months; (2) any substance use in the past 90 days; (3) any risk taking (i.e., drug injecting); (4) any involvement with the criminal justice system (offending); (5) lack of meaningful activities (training or employment).

2.2.3. Services involvement and needs

This scale, which was developed for the REC-CAP and is not based on established measures, examined three themes: (a) Service involvement ("Are you currently engaged with this kind of service?"), (b) Satisfaction with the service ("If you are, are you satisfied with the service you are getting?"), (c) Unmet needs ("Do you need help or additional help in this area?"). Each theme was assessed for seven help-seeking domains ("Drug treatment services", "Alcohol treatment services", "Mental health services", "Housing support", "Employment