Strengths Planning
for Building Recovery Capital

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For decades, addiction professionals have been providing screening and assessment instruments that evaluate problem severity, complexity, and chronicity, but offer little data on internal and external resources individuals and families can mobilize in resolving such problems (White & Cloud, 2008). This status is changing with a new generation of instruments that have profound implications for the future of addiction treatment and addiction counselling.

This development is consistent with a recovery movement (e.g., White, 2006; White, 2007) that is predicated on the transition from a pathology to a strengths-based model in which the pathway to sustained recovery is seen as the accrual of resources and capabilities more than the successful management of illness (White & Cloud, 2008). This model is gathering ground across domains of social care and health and includes not only addiction and mental health recovery, but positive psychology and criminology (Ronel & Segev, 2015), and a diverse range of criminal justice approaches including restorative justice (Zehr, 2002) and therapeutic jurisprudence (Wexler, 2000). These approaches are all advocating a holistic model that engages not only the protagonists but also families and communities; emphasizes relationships and community integration; and focuses on well-being and quality of life (De Maeyer, Vanderplasschen, & Broekaert, 2009).

Building on the language of social capital (Putnam, 2001), recovery capital has been defined as "the sum total of one's resources that can be brought to bear on the initiation and maintenance of substance misuse cessation" (Cloud & Granfield, 2008, p. 1972). Granfield and Cloud (2001) had previously coined the term "recovery capital" and described what they regarded as its four primary domains: social capital, physical capital, human capital, and cultural capital. Best and Laudet (2010) subsequently developed a tripartite model based on personal, social, and community recovery capital.

Although the term has been used extensively, it has remained poorly operationalized and only recently have there been systematic attempts at creating scales and measures for recovery capital. The most widely cited of these is the Assessment of Recovery Capital (ARC; Groshkova, Best, & White, 2013), a fifty-item scale that has two domains—personal recovery capital and social recovery capital—both consisting of five subscales of five items each. However, this measure has primarily been used in research studies and its application in clinical practice has been limited, meaning that recovery capital is a term that is widely deployed but poorly articulated in many addiction recovery settings.

This gap has been addressed through developing an extended version of the ARC that examines not only recovery capital but wider measures of well-being, motivation, involvement in recovery groups and social support, and barriers to recovery in the form of unmet support needs and acute substance-related and lifestyle factors. This measure, called the "REC-CAP," takes around fifteen minutes to complete and is described in a recent paper by Best and colleagues (2016a). However, what is unique about the REC-CAP is that it is a measure of recovery barriers and strengths, and provides a method for translating this evidence-based summary of needs and strengths into a recovery care planning approach. The data are drawn from a partnership between the Helena Kennedy Centre at Sheffield Hallam University and the Florida Association of Recovery Residences (FARR).

Rationale and Method

The REC-CAP is both an innovative assessment tool and a method of creating and operationalizing an evidence-based recovery care planning and review process with direct links to community engagement.

The assessment measure is designed for use across a range of contexts including specialist addiction treatment services, peer-based recovery support services (White, 2009), and as a self-completion and self-help tool for individuals in the later stages of their recovery journeys. Essentially there are four blocks to the REC-CAP:

Block One

Following basic demographic information, the first block assesses acute problems individuals have in five domains—substance use, risk taking, housing, criminal justice, and lack of meaningful activities—and assesses unmet specialist support and treatment needs across these and other areas.

Block Two

The second block assesses recovery capital, resources in the domains of personal and social capital, recovery group participation, social support, well-being, quality of life, and commitment to sobriety.

Block Three

One of the concerns of any standard instrument is that it does not allow sufficient scope for personal experiences and subjective needs. Therefore, following the structured parts of the REC-CAP, the third block is an open-ended section where individuals are encouraged to report their experiences and needs.

Block Four

The fourth block is predicated on successful coding and scoring of the first two sections and is the translation of the summary of scores into a node-link map that initiates the process of recovery care planning. The data from the assessment provide a systematic way of populating the initial "Your Recovery Well-Being" map and are then broken down through two further mapping exercises—"Continuing the Journey of Recovery" and "Recovery Planning: Setting a Goal"—to help people in recovery translate their needs and strengths into an action plan based on their own subjective experiences and perceptions, and based on the evidence from the REC-CAP (as shown in the two case studies we will provide).

The online version of the assessment and care plan also provides the opportunity for direct linkage into the third part of the REC-CAP model (i.e., a method of linking into community resources and assets). Based on a strong and clear evidence base that recovery progress is significantly enhanced by spending more time with others in recovery (Longabaugh, Wirtz, Zywiak, & O'Malley, 2010) and by engaging in positive and meaningful activities (Best, Irving, Collinson, Andersson, & Edwards, 2016b), the third stage of the model offers linkage opportunities for people who do not have access to this form of recovery capital, which is most people leaving acute drug and alcohol treatment.

Based on a three-month assessment and review cycle, the REC-CAP system employs an "MPE" process to do three things:

1. **Measure:** Identify barriers to recovery and resources people have to overcome these
2. **Plan:** Use these data to create the basis for a recovery care plan that sets goals and outlines a strengths-based way to achieve these goals
3. **Engage:** Provide links to activities and groups in the local community that can help individuals achieve the goals they have set

Preliminary Findings

The findings outlined next are for one hundred of the first cases that have been collected as part of the pilot program with the Florida Association of Recovery Residences (FARR). Following this analysis and presentation of strengths and needs, two cases are analysed in more depth. Eight recovery residences in Florida participated in the project, engaged a total of 630 clients at various stages of their stay in the residences, and completed the REC-CAP assessment.

The method relies on a visualization approach that uses traffic lights for rapid recognition of areas that are strengths (in green), areas that are neither weaknesses nor strengths (in amber), and areas that require further attention (in red). The purpose of this traffic lighting system is to allow both workers and recovery residents to have an "instant and holistic" picture of where they are in their recovery journeys so they can move immediately into planning and action phases.

The presentation method provides a snapshot of overall functioning that can be used either at an individual level (as in the case studies presented later in this article) or as an aggregate across a population as shown in Figure 1 (below), where key findings are outlined for each of the domains of the REC-CAP.

In summary, the top box ("Quality of Life & Satisfaction") shows generally high levels of reported well-being, particularly around satisfaction with accommodation and social support.

In the second and third boxes ("Barriers to Recovery" and "Service Involvement & Needs"), barriers and ongoing support needs with the current sample are reported, showing some problems with ongoing substance use—including both illegal and legal substances (e.g., tobacco, alcohol, and prescribed medication)—and lack of meaningful activities as more prevalent barriers, with additional support needs most commonly identified in the areas of primary health care and family support. In sum, half of the cohort report at least one barrier, with a mean and median of two barriers each for those fifty residents.

Finally, the bottom box ("Recovery Strengths") indicates that there is strong recovery capital across the board, but particularly in the areas of recovery experience (e.g., perceived strength and confidence in recovery) and in citizenship—which is largely around community involvement and engagement—with high levels of participation in community recovery groups and activities, and in the local community. Finally, the sample typically reported very high levels of abstinence self-efficacy. Thus, this is a population who generally have the personal, social, and community recovery capital to sustain the belief that they can be the drivers of their own recovery journeys.

The primary purpose of the REC-CAP is around individual cases, but the point

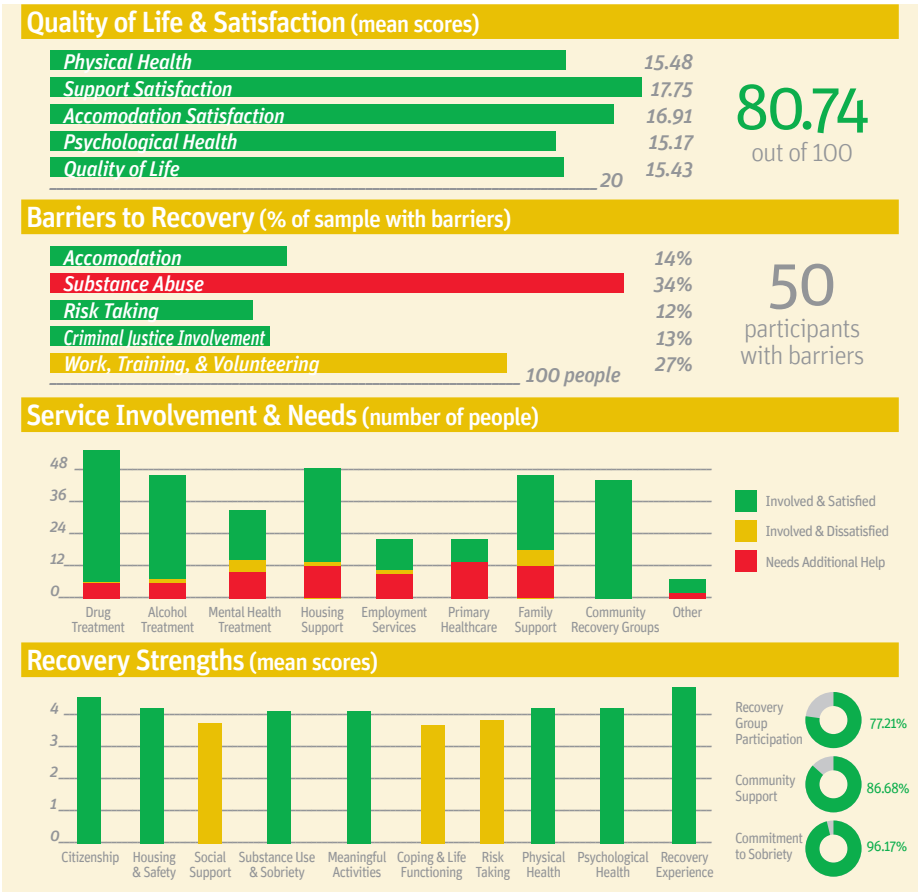

Figure 1. Overview of Recovery Capital, Barriers, and Needs for the First 100 Cases

of showing the summary dashboard in Figure 1 is to show the capability of the model as an outcome monitoring or performance management system at team or even locality levels. This can be done both for current functioning as in Figure 1 or as a measure of change over time, demonstrating where treatment centers are achieving successes and where there are blocks that need to be overcome.

Case Studies

Two case studies were selected to illustrate different phases of recovery progression and their implications for the care planning process. The first case is from a resident in early recovery.

Case Study #1: Angela

Angela has just come out of detoxification for methamphetamine dependence, although she also has a long-standing alcohol problem. She has suffered both physically and mentally as a result of her addictions and this is evident from the score profile she shows at the initial REC-CAP completion close to the start of her stay in a recovery residence. The summary page is shown in Figure 2 (below).

In Angela's case, there are several immediate barriers to the growth of recovery capital. She has both recent substance use (a meth binge prior to undertaking detox) and no involvement in any education, training, or volunteering in large part because of her physical and mental health. Furthermore, in terms of support needs, while currently receiving support in the areas of mental health, substance use, and family support, none of these is sufficient to meet her perceived needs, and it is not clear yet whether these are directly linked to her recent binge or not. Therefore there are key issues to address in acute functioning and treatment for Angela and the need for additional support in mental health, substance use, and family involvement. All of these things have to be initiated before it makes sense to focus on building recovery capital. However, that does not mean Angela does not have strengths that can be used to support her in her journey.

As a result, while it is not surprising to see low levels of recovery capital, particularly in the domain of personal recovery capital, there are areas to work on. Each subscale is scored between zero to five, with higher scores representing better functioning and red-colored scores (zero or one) indicating little resource in this area. For this individual, there is only one area (around housing and security) that is a genuine recovery resource, but this feeling of safety about living in the recovery residence provides a strength on which to build. For the other domains measured, only motivation—measured on the "Commitment to Sobriety" scale—would suggest a real recovery asset. However, on overall well-being, Angela has scored high on feelings of physical well-being (in spite of ongoing health symptoms, and probably indicative of recent improvements), accommodation, and support, so these are also included in the asset list. The evidence from the scale would suggest that there are acute treatment and lifestyle issues that need to be addressed and only Angela's motivation, health, support, and secure accommodation represent real recovery strengths. This is then translated into the recovery well-being map.

The recovery well-being map is a visualization map (Dansereau, 2005), and to make its impact greater and for continuity with the rationale for the presentation of data findings, areas that are strengths are depicted in green, neutral areas of functioning in amber, and areas to be addressed in red. Angela's own subjective experiences and goals—personal recovery beliefs are central to any recovery model—are inserted into the central bottom box to ensure that there is a marriage between the scoring of the scale and what residents perceive their needs to be. As would frequently be the case with people early in recovery, the aspirations are ambitious and long term. Peer recovery navigators and residents will then use this overview to assess how it fits with clients' subjective experiences, review what has gone on, and plan the next stages of recovery activity moving forward. The subsequent maps will attempt to break down these long-term goals and to use the strengths identified to help individuals take steps towards achieving them. The aim for Angela is to keep her sober, get her fit and healthy, and build on her growing social supports to create the space

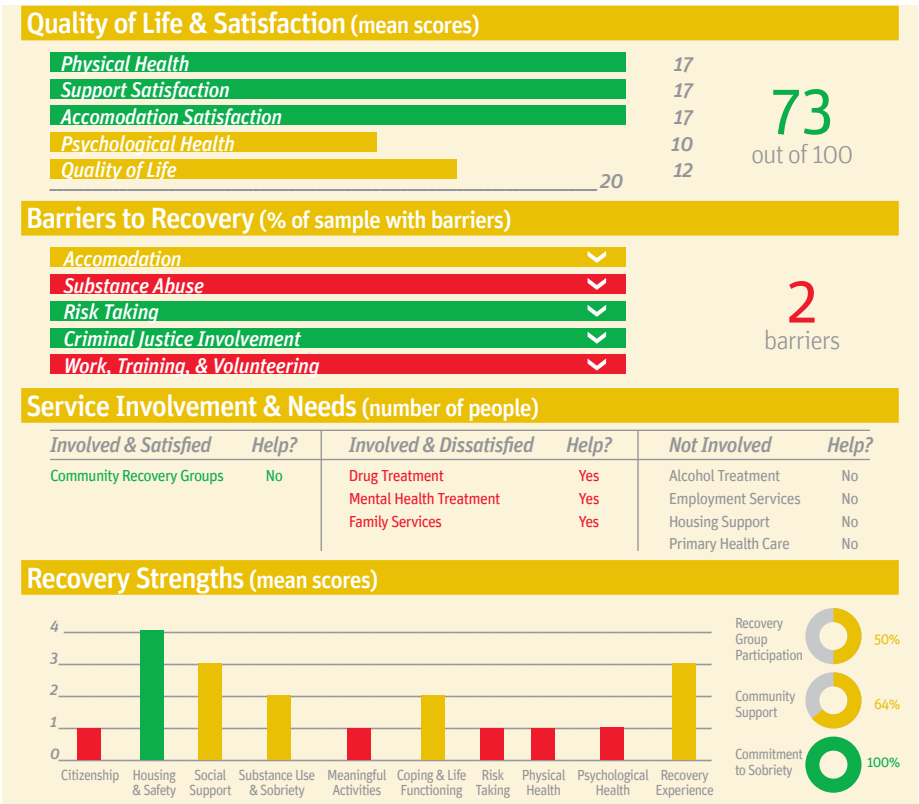

Figure 2. Angela: An Early Recovery Resident Case Summary

to build the personal and social capital that will allow her to engage in the community and have the self-determination and assets to achieve her goals.

Case Study #2: JoAnne

The second case study is for a resident who is much more established in recovery. JoAnne had a long-standing battle with alcoholism that has seen her enter treatment and recovery services on a number of occasions over the course of twenty years. However, she has completed treatment, has become established in the recovery residence, and has made progress on various fronts. In her case there are no acute risks or unmet service needs, evidenced by the lack of red flags in the barriers to recovery section. All of the well-being indicators are positive and, very unusually, JoAnne scores a maximum on the ARC. She is also committed to sobriety, has good community support, and is well engaged in recovery groups in the community (see Figure 3 below).

What this means, translating those assets to the recovery well-being map, is that there is a very positive story for JoAnne and her peer recovery navigator to tell around progress and achievement with only some concerns about accommodation emerging from the summary data. And a core part of the navigator's role is celebrating success and building strengths and capital from success. The strong recovery resources reported reflect considerable recovery assets to deploy in meeting the two subjectively set goals around parenting and completing nursing school, although the recovery coach or worker may well want to discuss mental health support needs as well. Thus, the task in the subsequent maps is to break down those objectives into more manageable units and tasks and to deploy those support systems and personal resources to achieve these goals. JoAnne has done well and the recovery capital she has developed is key both to preventing relapse and to achieving these big, longer-term life goals.

Overview and Future Directions

The data presented in this article is part of the development of a new method for measuring and mapping recovery capital that builds on established research scales, but does so in a way that is accessible and applicable to both recovery care planning and self-monitoring. The REC-CAP yields a single page summary of scores that address barriers and needs, but also (and critically) identifies strengths across a range of domains of personal, social, and community recovery capital (Best & Laudet, 2010). The data can be presented as a single-page summary at both case and aggregate levels and crucially this can be translated into visualization maps that can initiate a structured process of recovery planning, as is shown in the two case studies. What is new about the REC-CAP is that it is a strengths-based assessment and review measure that directly informs recovery care planning and affords access to community resources to help individuals achieve their goals through the MPE process. It is an ongoing model of strengths building that is predicated on tapping into social supports and community resources as a way of achieving goals and building personal recovery strengths.

Across the entire sample of one hundred cases presented in this study, there is strong recovery capital and well-being, although there is considerable variation in well-being within the sample. As Figure 1 illustrated, there are residual barriers to recovery in parts of the population and additional treatment and support needs. The assumption made in this model is that recovery is a process of building strengths over time. But the recovery journey is not linear and the gradual accrual of recovery resources requires the monitoring and management of setbacks related not only to substance use, but other key life domains as well.

Additionally, the model assumes, as evidenced in the data, that while there are likely to be a series of ongoing support needs from professional services for some people in their recovery journey, it is necessary to monitor whether the support received is sufficient in addressing barriers to stable recovery. While both barriers and additional needs applied to relatively small subsamples, they are crucial to flag in developing recovery reviews and planning models.

At the core of this approach is the assumption that it is the recovery capital

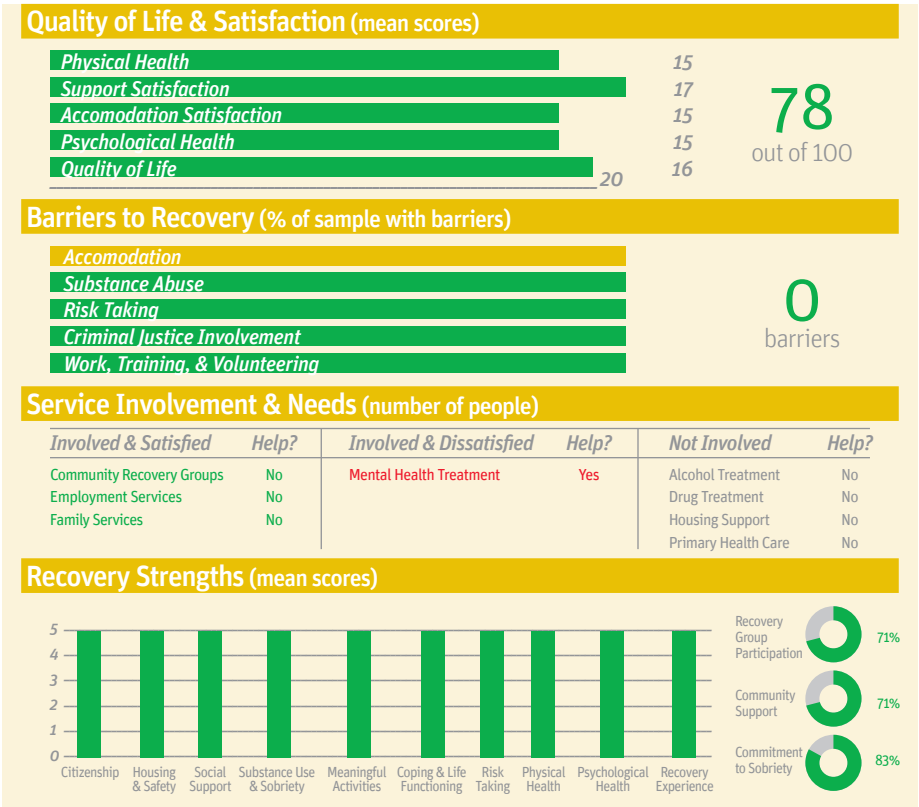

Figure 3. JoAnne: An Established Recovery Resident Case Summary

individuals have access to that is the starting point in addressing barriers and in building ongoing recovery capital—this means not only personal skills and strengths but social supports and community resources that individuals are linked into. Those resources may include professionals, but the initial resources are more likely to be embedded in peers, families, and communities, and the REC-CAP is designed to plan for recovery based on active engagement in activities and positive networks. The model and approach were well received by both clients and staff in the participating recovery residences and had face validity in terms of both completion of the measures and the underlying model behind the tool based on a single day of training.

It is important to point out that this is a work in progress in three different areas:

1. We are currently working on an electronic version of the REC-CAP (i.e., the e-REC-CAP) that will automatically populate the initial screen of the recovery plan, which will have significant implications for the speed of feedback and its utilization in the therapeutic, review, and planning process.

2. The e-REC-CAP will be piloted in the next phase of the partnership with the recovery residences in Florida, allowing us also to test the extent to which the care plans are acceptable and engaging for both treatment staff and clients.

3. We are going to have a repeated assessment with a sample of FARR services so that instead of the "static" presentation reported here, we can map change and growth in recovery capital over time and the associated visualizations associated with that change.

This work is developing an application of the principles of recovery systems and recovery capital as a mechanism for supporting and empowering recovery growth by utilizing simple, accessible, and strengths-based measurement tools that use evidence-based models. This work will contribute to the ongoing emergence of a strong and coherent research base for recovery communities, services, and the lived experiences of recovery advocates and champions.

Conclusion and Next Steps

The assessment of internal and external assets to support recovery maintenance has major clinical import for addiction professionals in the following areas:

- Identifying people who may resolve alcohol and drug problems without professional intervention
- Determining level of care placement
- Formulating counseling strategies
- Identifying the scope of needed ancillary services
- Constructing personal-, family-, and community-influenced plans for posttreatment monitoring and recovery support

Future efforts will focus on an expanded menu of sophisticated instruments capable of a more rigorous assessment of family and community recovery capital—tools that will also be of great value to addiction professionals and other recovery support specialists.

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