

Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

Citation: White, W. & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor*, 9(5), 22-27. Posted at www.williamwhitepapers.com

Recovery Capital: A Primer for Addictions Professionals

William L. White, MA and William Cloud, PhD

From Pathology to Resiliency and Recovery

The history of addiction treatment in America contains within it a history of key ideas that have transformed service philosophies and practices. In the early history of modern treatment, for example, *chemical dependency* emerged as a core idea that helped integrate what were then two separate fields: one focused on alcoholism, the other on drug addiction. Other concepts, such as *codependency*, *dual diagnosis*, *gender-specific*, *developmental appropriateness*, *cultural competence*, *trauma-informed*, *evidence-based*, *stages of change*, *motivational enhancement*, *recovery management*, and *recovery coaching* helped, or are now helping, transform addiction treatment into a more person-centered, holistic, family-centered, and recovery-focused system of care.

Addiction professionals across America are witnessing the field's paradigmatic shift from a pathology and intervention focus to a recovery focus (White, 2004, 2005). Attention on the lived solution to alcohol and other drug (AOD) problems is reflected in the growing interest in defining recovery, conducting recovery prevalence surveys, illuminating the varieties of recovery experiences, and mapping the patterns, processes, and stages of long-term recovery (Betty Ford Institute Consensus Panel, 2007; White & Kurtz, 2006).

One of the key ideas at the core of this shift is that of *recovery capital*. This article defines recovery capital and explores how attention to recovery capital can be integrated into the service practices of front-line addiction professionals.

Recovery Capital Defined

Recovery capital (RC) is the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from severe AOD problems (Granfield & Cloud, 1999; Cloud & Granfield, 2004). Recovery capital is conceptually linked to natural recovery, solution-focused therapy, strengths-based case management, recovery management, resilience and protective factors, and the ideas of hardiness, wellness, and global health. There are three types of recovery capital that can be influenced by addictions professionals.

Personal recovery capital can be divided into physical and human capital. A client's physical recovery capital includes physical health, financial assets, health insurance, safe and recovery-conducive shelter, clothing, food, and access to transportation. Human recovery capital includes a client's values, knowledge, educational/vocational skills and credentials, problem solving capacities, self-awareness, self-esteem, self-efficacy (self-confidence in

managing high risk situations), hopefulness/optimism, perception of one's past/present/future, sense of meaning and purpose in life, and interpersonal skills.

Family/social recovery capital encompasses intimate relationships, family and kinship relationships (defined here non-traditionally, i.e., family of choice), and social relationships that are supportive of recovery efforts. Family/social recovery capital is indicated by the willingness of intimate partners and family members to participate in treatment, the presence of others in recovery within the family and social network, access to sober outlets for sobriety-based fellowship/leisure, and relational connections to conventional institutions (school, workplace, church, and other mainstream community organizations).

Community recovery capital encompasses community attitudes/policies/resources related to addiction and recovery that promote the resolution of alcohol and other drug problems. Community recovery capital includes:

- active efforts to reduce addiction/recovery-related stigma,
- visible and diverse local recovery role models,
- a full continuum of addiction treatment resources,
- recovery mutual aid resources that are accessible and diverse,
- local recovery community support institutions (recovery centers / clubhouses, treatment alumni associations, recovery homes, recovery schools, recovery industries, recovery ministries/churches), and
- sources of sustained recovery support and early re-intervention (e.g., recovery checkups through treatment programs, employee assistance programs, professional assistance programs, drug courts, or recovery community organizations).

Cultural capital is a form of community capital. It constitutes the local availability of culturally-prescribed pathways of recovery that resonate with particular individuals and families.

Examples of such potential resonance include Native Americans recovering through the "Indianization of AA" or the "Red Road," or African Americans recovering within a faith-based recovery ministry or within an Afrocentric therapeutic orientation (Coyhis & White, 2006; White & Sanders, in press).

In total, recovery capital constitutes the potential antidote for the problems that have long plagued recovery efforts: insufficient motivation to change AOD use, emotional distress, pressure to use within intimate and social relationships, interpersonal conflict, and other situations that pose risks for relapse.

Early Scientific Findings

Modern addiction science has illuminated critical factors that contribute to the onset and complicate the course of substance use disorders, e.g., a family history of AOD problems, childhood victimization, early age of unsupervised AOD use, multiple drug use, injection drug use, long delay from onset of AOD problems to first treatment, high emotional distress (co-occurring psychiatric illness), and enmeshment in an AOD-saturated social milieu (See White, in press/a for a review). But the protective factors that can offset such risk factors or increase one's odds of successful long-term addiction recovery have yet to be fully charted. The following key findings from recent scientific studies and reviews underscore the potential importance of recovery capital.

- Recovery capital—both its quantity and quality—plays a major role in determining the success or failure of natural and assisted recovery (e.g., recovery from AOD problems without or with participation in professional treatment or a recovery mutual aid society) (Granfield & Cloud, 1996, 1999; Moos & Moos, 2007; Kaskutas, Bond, & Humphreys, 2002).
- Increases in recovery capital can spark *turning points* that end addiction careers, trigger recovery initiation, elevate coping abilities, and enhance quality of life in long-term recovery (Cloud & Granfield, in press; Laudet, Morgan, & White, 2006).

- Such *turning points*, both as climactic transformations and incremental change processes, may require the accumulation of recovery capital across several years and multiple episodes of professional treatments (Dennis, Foss, & Scott, 2007).
- Elements of recovery capital vary in importance within particular stages of long-term recovery (Laudet & White, in press).
- Recovery capital is not equally distributed across individuals and social groups. Members of historically disempowered groups often seek recovery from addiction lacking assets that are taken for granted by those seeking recovery from a position of privilege (Cloud & Granfield, 2001).
- Post-treatment recovery check-ups, and, when needed, early re-intervention can help preserve the recovery capital developed through addiction treatment (Dennis, Scott, & Funk, 2003).
- Most clients with severely depleted family and community recovery capital gain little from individually-focused addiction treatment that fails to mobilize family and community resources (Moos & Moos, 2007).
- Long-term recovery outcomes for those with the most severe AOD problems may have more to do with family and community recovery capital than the attributes of individuals or a particular treatment protocol (Bromet & Moos, 1977; Humphreys, Moos, & Cohen, 1997; Mankowski, Humphreys, & Moos, 2001).

Science is confirming what front-line addiction professionals have long known: “environmental factors can augment or nullify the short-term influence of an intervention” (Moos, 2003, p. 3). This suggests that therapeutic processes in addiction treatment must encompass more than a strictly clinical intervention (Simpson, 2004). Strategies that target family and community recovery capital can elevate long-term recovery outcomes as well as elevate the quality of life of individuals

and families in long-term recovery (White, in press/b).

Recovery Capital and Clinical Practice

Heightened attention to recovery capital can significantly influence one’s service delivery practices. The following prescriptions reflect such attention.

1. Support screening and brief intervention (SBI) programs that reach people before their recovery capital is depleted and substance use disorders have become severe, complex, and chronic (Cloud & Granfield, 1994a). SBI programs are sometimes viewed as tools of case finding and induction for addiction treatment, but their greatest value is in helping people resolve AOD problems using personal, family, and community resources before specialty-sector professional treatment is needed. To achieve such a goal, we must all become students of the processes through which AOD problems in the larger community are resolved.

2. Engage people with low recovery capital through aggressive programs of community outreach. “Hitting bottom” only has meaning when there is still personally meaningful recovery capital to be lost. When recovery capital is exhausted, people will die before such a mythical bottom is reached. The obstacle to recovery under such conditions is not insufficient pain, but the absence of hope, connectedness, and potential for fulfillment. People with severely depleted RC have unfathomable capacities for physical and psychological pain. We must go get people with high problem severity and extremely low recovery capital rather than wait for their pain or coercive institutions to bring them to us. The catalytic turning point for those with depleted recovery capital is more likely to be one of seeing an achievable top than hitting bottom.

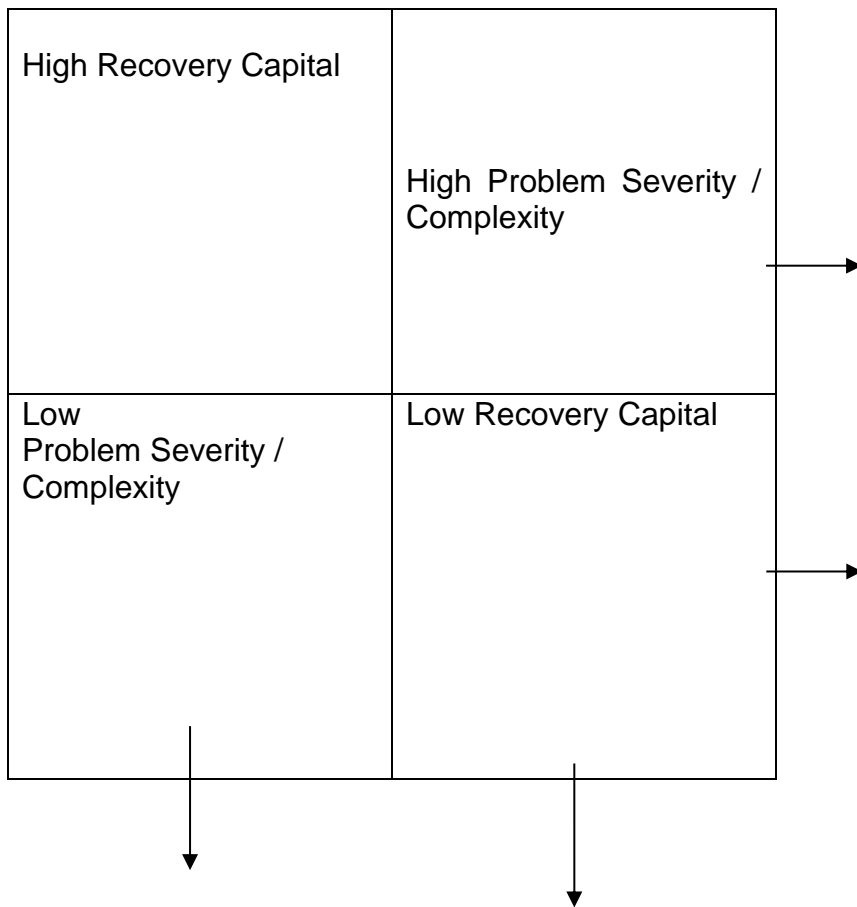
3. Assess recovery capital on an ongoing basis. Traditional assessment technologies in addiction treatment are distinctly pathology-focused. Addiction professionals have been trained to employ assessment instruments and interview protocols to generate a problems list that forms the basis of treatment planning activities. Growing evidence on the

role of recovery capital in AOD problem resolution calls for a more strengths-based approach to the assessment process. The fact that recovery capital ebbs and flows through both addiction and recovery careers also calls for a continual assessment process that can identify subtle but crucial shifts in recovery assets. The AOD cessation capacity of each individual at a particular point in time might well be thought of as the interaction between problem severity and recovery capital.

4. Use recovery capital levels to help determine level of care placement decisions.

Traditional placement models link problem severity and intensity of care. Those with high problem severity and complexity are placed in the most restrictive levels of care, e.g. inpatient and residential programs, and are provided the longest course of professional care. This formula misses the crucial influence on recovery capital. The figure below illustrates four potential interactions between problem severity/complexity and recovery capital (Figure and discussion abstracted from White, in press/a).

Figure 1: Recovery Capital / Problem Severity Matrix



Factoring in the unique combination of a client's problem severity can alter placement decisions.

- A client with moderate problem severity but high recovery capital arriving at a treatment agency in response to a positive drug test might be quite appropriate for screening and brief intervention. Such individuals often terminate addictions on their first attempt

without professional or peer assistance and without embracing an addiction/recovery-based personal identity (Granfield & Cloud, 1996; Cloud & Granfield, 1994b). They can also often be helped through non-specialty helping institutions, culturally indigenous support institutions (e.g., cultural revitalization movements), or from peer-based

recovery support groups without facing the cost, life disruption or stigma associated with addiction treatment (Cloud & Granfield, 1994a,b). This same individual with multiple risk factors (e.g., family history, early onset of use, etc.) might be appropriate for SBI followed by periodic recovery check-ups as a means of lowering the risks for future problem escalation.

- A client with high problem severity and complexity but exceptionally high recovery capital might be appropriate for outpatient detoxification and outpatient treatment despite a level of problem severity that, viewed in isolation, would justify inpatient care. Assertive linkage to recovery mutual aid groups in tandem with motivational interviewing and ongoing recovery check-ups might well serve as an alternative to inpatient or residential treatment.
- A client with low problem severity but high risk factors and extremely low recovery capital might be in greater need of residential treatment and step down care than the above profiled clients, even though he or she is likely to end up with SBI or outpatient treatment within current assessment and placement systems.
- A client with high problem severity/complexity and extremely low recovery capital requires services of high intensity, broad scope (e.g., outreach, assertive case management, and sustained recovery coaching), and long duration (Cloud & Granfield, 2001, 2004; White, in press,a). Providing such clients brief treatment isolated from their natural environment and then “graduating” them into that same environment without substantial community-based supports is a set-up for failure. Clients from historically disempowered communities are often punished (e.g., lost custody of children, incarceration) following such “failures” on the grounds that they “had their chance” (White & Sanders, in press).

5. Target all three spheres of recovery capital within professionally-directed treatment

plans and client-directed recovery plans. The question is: What resources need to be mobilized within the individual, the family/social milieu, and the community to support the long-term recovery of each client? The Native American Wellbriety movement uses the metaphor of the “healing forest” to underscore the inextricable link between personal, family, and community health. Treatment and recovery plans that reflect this understanding include interventions to elevate family and community recovery capital and assertively link clients and families to other individuals, families, and community institutions rich in recovery capital.

6. Support recovery-linked cultural revitalization and community development movements. One of the ways addiction professionals can increase the recovery capital of the individuals and families they serve is to actively support local movements aimed at increasing recovery support services and creating a community milieu within which recovery can flourish. Such support could include serving on the board of a recovery community organization, volunteering at a recovery support center, encouraging those seeking to start a new recovery support group, participating in recovery education or recovery celebration events, and providing financial contributions to help promote and conduct such events.

7. Use changes in levels of recovery capital to evaluate your program and your own professional performance. The most effective addiction treatment programs help build community recovery capital beyond their own service programs. This can be done by regularly assessing aggregate community recovery capital, issuing a periodic report card on community recovery resources, and by allocating organizational resources to support recovery community development activities. If non-treatment community recovery capital decreases in tandem with the growth of treatment services, the community is being inadvertently wounded by treatment expansion. One of the best ways to assess the impact of treatment resources is to evaluate whether they generate long-term increases or decreases in community recovery capital.

At a personal level, we tend to evaluate our effectiveness based on what is subtracted

from the lives of our clients (e.g., AOD use, criminal activity, threats to public safety, financial problems, high health care consumption, and emotional distress). But the short-term elimination or reduction of these ingredients may or may not have any linkage to the prospects of long-term recovery. A better predictor of long-term recovery may be what has been added to the lives of the individuals and families with whom we work, e.g., radically altered perceptions of alcohol and other drugs, physical and emotional health, increased coping and communication skills, improved family relationships, new family rules and rituals, safe/stable housing and employment; clean and sober friends, membership in a community of recovering people, and life meaning and purpose.

Summary

The concept of recovery capital reflects a shift in focus from the pathology of addiction to a focus on the internal and external assets required to initiate and sustain long-term recovery from alcohol and other drug problems. As this concept permeates the field, addiction treatment programs will increase their involvement with families and communities, and addiction professionals will become more involved in recovery community building activities. Recovery capital has a contagious quality. It is time we all became its carriers.

About the Authors: William White (bwhite@chestnut.org) is Senior Research Consultant at Chestnut Health Systems and author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. William Cloud is Professor at the Graduate School of Social Work, University of Denver. Much of his teaching, research, and writing has been in the areas of substance abuse cessation and substance abuse policy.

References

Betty Ford Institute Consensus Panel (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of*

Substance Abuse Treatment, 33, 221-228.

- Bromet, E., & Moos, R. (1977). Environmental resources and the posttreatment functioning of alcoholic patients. *Journal of Health & Social Behavior*, 18, 326-338.
- Cloud, W., & Granfield, R. (1994a). Natural recovery from addictions: Treatment implications. *Addictions Nursing*, 6, 112-116.
- Cloud, W., & Granfield, R. (1994b). Terminating addiction naturally: Post-addict identity and the avoidance of treatment. *Clinical Sociology Review*, 12, 159-174.
- Cloud, W., & Granfield, R. (2001). Natural recovery from substance dependency: Lessons for treatment providers. *Journal of Social Work Practice in the Addictions*, 1(1), 83-104.
- Cloud, W., & Granfield, R. (2004). A life course perspective on exiting addiction: The relevance of recovery capital in treatment. *NAD Publication* (Nordic Council for Alcohol and Drug Research) 44, 185-202.
- Cloud, W., & Granfield, R. (in press) Conceptualizing recovery capital: Expansion of a theoretical concept. *Substance Use and Misuse*.
- Coyhis, D., & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery-The truth about the lie*. Colorado Springs, CO: White Bison, Inc.
- Dennis, M.L., Foss, M.A., & Scott, C.K. (2007). An eight-year perspective on the relationship between the duration of abstinence and other aspects of recovery. *Evaluation Review*, 31(6), 585-612.
- Dennis, M. L., Scott, C. K., & Funk, R. (2003). An experimental evaluation of recovery management checkups (RMC) for people with chronic substance use disorders. *Evaluation and Program Planning*, 26(3), 339-352.
- Granfield, R., & Cloud, W. (1996). The elephant that no one sees: Natural recovery among middle-class addicts. *Journal of Drug Issues*, 26(1), 45-61.
- Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without*

- treatment*. New York: New York University Press.
- Humphreys, K., Moos, R. J., & Cohen, C. (1997). Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol*, 58(3), 231-238.
- Kaskutas, L. A., Bond, J., & Humphreys, K. (2002). Social networks as mediators of the effects of Alcoholics Anonymous. *Addiction*, 97(7), 891-900.
- Laudet, A, Morgen, K., & White, W. (2006). The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality of life satisfaction among individuals in recovery from alcohol and drug use. *Alcoholism Treatment Quarterly*, 24(102), 33-73.
- Laudet, A.B., & White, W.L. (in press). Recovery capital as prospective predictor of sustained recovery, life satisfaction and stress among former poly-substance users. *Substance Use and Misuse*.
- Mankowski, E.S., & Humphreys, K., & Moos, R. (2001). Individual and contextual predictors of involvement in twelve-step self-help groups following substance abuse treatment. *American Journal of Community Psychology*, 29, 537-563.
- Moos, R.H. (2003). Addictive disorders in context: Principles and puzzles of effective treatment and recovery. *Psychology of Addictive Behaviors*, 17, 3-12.
- Moos, R.H., & Moos, B.S. (2007). Protective resources and long-term recovery from alcohol use disorders. *Drug and Alcohol Dependence*, 86, 46-54.
- Simpson, D.D. (2004). A conceptual framework for drug treatment process and outcomes. *Journal of Substance Abuse Treatment*, 27, 99-121.
- White, W. (2004). Recovery: The next frontier. *Counselor*, 5(1), 18-21.
- White, W. (2005). Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly*, 23(1), 3-15.
- White, W. (in press, a). Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Northeast Addiction Technology Transfer Center, and Philadelphia Department of Behavioral Health & Mental Retardation Services
- White, W. (in press,b). "With a Little Help from my Friends": The development and mobilization of community resources for the initiation and maintenance of addiction recovery. *Journal of Substance Abuse Treatment*.
- White, W., & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care*, 3(1-2), 21-61.
- White, W., & Sanders, M. (in press). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*.