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Recovery Capital as a Transformative Concept

The injection of a compelling, actionable, and timely new idea can overturn prevailing principles and practices within well-established fields of endeavor. Such is the case with Granfield and Cloud's introduction of the concept of *recovery capital* into the alcohol and other drug (AOD) problems arena. Since the publication of their original 1994 paper, the term "recovery capital" has appeared in the titles of more than 90 peer-reviewed scientific and medical articles and exerted a profound influence at policy, service practice, and personal recovery levels.

The AOD problems field, and more specifically the specialized addiction treatment industry, has historically featured a distinct pathology focus. This is exemplified by its preoccupation with drug psychopharmacology, medical and social harms of drug use, alarmist portrayals of drug use trends, problem-focused studies of the etiology/patterns/course of substance use disorders (SUDs), elegant schemes of clinical classification, methods of brief clinical intervention, and a fear-infused fixation on post-treatment relapse risk. The introduction of recovery capital into the field's discourse was part of the larger shift toward a recovery paradigm. This shift extended the field's vision and focus toward the successful, long-term resolution of AOD problems at personal, family, community, and cultural levels. Recovery capital writ large expanded the fields understanding of the prevalence, pathways/styles, stages, processes, and personal and social contributions related to AOD problem resolution. It is questionable whether we would have seen the rise of new grassroots recovery community organizations, international recovery-focused policy initiatives, and a dramatically expanded investment in recovery-focused research without this more solution-focused shift seeded by the concept of recovery capital.

Traditionally, addiction recovery has been viewed as a process of subtraction—deleting AOD use and its progeny of allied problems—with success measured by disordered individuals achieving a state of remission solely based on the cessation of drug use (now assessed as no longer meeting substance-specific diagnostic criteria for a substance use disorder in the past twelve months). In contrast, recovery capital proponents place great emphasis on recovery as processes of addition and multiplication—the acquisition of new assets, the achievement of global health and functioning, and the potential to thrive and flourish—to get "better than well." The concept of recovery capital suggested that the evaluation of addiction treatment and non-clinical recovery support services evolve from a singular focus on the subtraction of destructive drug use to a more holistic evaluation, including such dimensions as quality of life, citizenship (social contribution), and life meaning and purpose.

For more than two centuries, the prevailing cultural and professional portrayal of the course of addiction was one of self-accelerating severity, insanity, and death, with successful treatment and recovery being the "exception to the rule" of "Once an addict, always an addict." Recovery capital challenged this conception by suggesting that recovery from addiction was the norm, not the exception, and that most people resolved significant AOD problems drawing on both internal and external supports without involvement in either formal addiction treatment or lifelong participation in a recovery mutual aid organization. Granfield and Cloud's work on the concept of recovery capital raised significant questions about the prevalence and diversity of recovery experiences—questions that have been explored in a continuing series of landmark recovery prevalence and life in recovery research surveys. These survey findings have served as the core of subsequent addiction/treatment/recovery anti-stigma campaigns. It should also be evident that this shift in emphasis from human pathology to human potential exerted a liberating effect on individuals and families seeking recovery who through the lens of recovery capital were encouraged to shift their self-understanding from a focus on cataloguing pain and problems to an inventory of assets, hopes, and aspirations for the future.

Since its inception in the mid-nineteenth century, the specialty field of addiction treatment has based its understanding of addiction upon clinical experience treating people with the most severe, complex, and prolonged addiction histories and severely depleted recovery capital. It then applied its derived "truths" from that knowledge to the larger landscape of AOD problems. Recovery capital proponents, in contrast, suggested that AOD problems existed on a spectrum of severity, complexity, and chronicity as well as variable recovery assets and that the course and resolution strategies of these problems differ dramatically across these continua. They further posited that recovery outcomes were determined as much by internal and external assets as by traditionally assessed intrapersonal deficits and vulnerabilities. This shift in perspective exerted a significant influence on processes of clinical screening and assessment in addiction treatment, particularly on decisions on the need for professional interventions; the intensity and duration of such treatment; level of care placement and transition decisions; and the scope and duration of post-treatment monitoring and support. Increased recognition of the import of recovery capital on treatment outcomes sparked growing interest in the development and refinement of recovery capital measurement instruments.

Professional and public responses to AOD problems have had throughout history a distinctly intrapersonal focus—both in the understanding of the etiology of addiction and on the targets of intervention. Recovery capital expanded this focus by exploring the *physical and social ecology of addiction recovery*. Recovery capital, and particularly the notion of *community recovery capital,* expanded strategies of mobilizing community resources (forging *recovery spaces/landscapes* and shaping *recovery-friendly communities*). Recovery capital conceptually seeded the birth of new recovery support institutions (e.g., recovery community centers, recovery residences, recovery high schools and collegiate recovery programs, recovery cafes, recovery ministries, recovery art and music festivals, etc.). Community recovery capital implied that recovery was

contagious—could be socially transmitted, and that this contagion could be accelerated if the correct conditions were established. Recovery capital proponents argued that the prevalence of recovery within local communities could be elevated by increasing the density of *recovery carriers/champions* (people in recovery who made recovery attractive via the visibility and power of their stories and character). The contention that "recovery is contagious" offered the potential of *recovery cascades*—dramatic surges in recovery initiation and overall prevalence at neighborhood, community, and cultural levels. The concept of recovery capital exerted a significant influence on the growth of recovery advocacy organizations, a larger new recovery advocacy movement, and new recovery support roles (*recovery coaches* and other *peer recovery support specialists)* working in addiction treatment and allied health settings and in other community outreach settings. Recovery capital also provided a rationale for the birth and spread of an ecumenical (multiple pathway) *culture of recovery*. This spurred recovery cultural production in such areas as language, literature, history, art, music, film, theatre, public storytelling, sport, leisure, and public recovery celebration events.

From its inception, addiction treatment has been characterized by competing professional silos, most advocating a single pathway model of recovery—one cause, one course, one viable treatment method, one successful style of recovery maintenance. Since Granfield and Cloud's introduction of the concept of recovery capital, its proponents have illuminated the varieties of recovery experience and celebrated multiple pathways and styles of recovery, including patterns of AOD problem resolution of people who do not consciously embrace a *recovery identity* or a recovery-dominated social network. Recovery capital proponents also acknowledged people with mild to moderate AOD problems and high levels of recovery capital whose resolution pattern may involve deceleration rather than cessation of AOD use.

Given these profound influences, it is with great pleasure that we welcome the first comprehensive collection of papers authored by those who have worked on the conceptual refinement, measurement, and practical applications of the concept of recovery capital. It is our collective hope that this landmark text provides both a look back and a look forward for the future of recovery capital research and practice and will spur a deeper understanding of the resolution of AOD and related problems.

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