

Quality of life and better than Well: a mixed method study of long term (post 5 years) recovery and recovery capital

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Abstract

Purpose: To compare quality of life scores in a long term recovery population group (post 5 years) with a general population group and to explore how any differences might be explained by recovering individuals themselves in a small number of follow up qualitative interviews.

Design: A sequential explanatory mixed method design combining quantitative Quality of Life measure (WHOQOL-Bref, WHO 1996) and six subsequent semi-structured individual interviews. The Quality of Life measure compared long term recovery scores (post 5 years) with the general population group. The subsequent qualitative semi-structured interviews explored what the participants themselves said about their recovery.

Findings: The quantitative data provides evidence of a significant difference in Quality of Life (WHOQoL-BREF) in two domains. The long term recovery group (5 or more years into recovery) scored higher in both the environment and psychological domains than the general population group. Of the long term recovery group 17 people who still accessed mutual aid scored higher in all four domains than those 23 people who did not. The interviews provide evidence of the this difference as result of growth in psychological elements of recovery such as developing perspective, improvement in self-esteem, spirituality, as well as contributing as part of wider social involvement.

Research implications: This study provides support for the Quality of Life measure as useful in recovery research. The empirical data supports the concept of recovery involving improvements in many areas of life and potentially beyond the norm, termed 'better than well' (Best & Lublam 2012, Valentine, 2011). (Hibbert & Best, 2011).

Originality/value: One of small number of studies using with participants who have experienced long term (post five years) recovery, also using Quality of Life measure (WHOQOL-Bref, WHO 1996) with this population.

keywords: Recovery capital, Quality of Life, Public Health, Better than Well

Background Literature

The National Treatment Agency (drugs and alcohol) in the UK became part of Public Health England in 2013 and aims to provide local commissioners, including public health specialists, with information to support and share best practice in relation to services, treatment and recovery and emphasises a recovery-oriented approach (UK Drug Strategy 2010). The use of the term recovery in both policy and research literature 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 (White & Cloud 2008, Best et al. 2017).

Recovery is complex and may take years (White and Kurtz 2005); it may take 5-7 years for heroin users (White and Kurts, 2005) and 4-5 years for alcohol drinkers (Edwards 2000). It is characterised as a process of 'voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society' (UK Drug Policy Commission 2008 p.6). In 2011, a review of literature on personal recovery identified five common processes that underpin successful recovery; connectedness, hope, identity, meaning in life and empowerment (Leamy, Bird, Le Boutillier, Williams, Slade 2011).

One way in which the process of recovery has been represented in the substance field is as a process of building and sustaining recovery capital (Granfield and Cloud 1999). The term recovery capital draws on a long history of use of the concept of social capital in sociology (Bourdieu 1980) and also in public health (Wilkinson 2002). Granfield & Cloud (2001) suggested recovery capital is a conceptual extension of social capital referring to the aggregate of personal and social environmental resources that substance dependent people possess and can be supported to develop in recovery. Recovery capital can be drawn upon to help overcome addiction and sustain a substance free life. Recovery capital encapsulates both internal and external resources (Granfield & Cloud, 1999, 2004), such as having somewhere to live, maintaining a property, rebuilding family relations, improving health and body image, training, education and employment.

Granfield and Cloud (2009) outline four elements of recovery capital, social, cultural, physical and human capital. Physical capital can be understood as 'tangible assets' providing both buffers and resources supporting recovery (Cloud and Granfield 2008). Social capital via group/social network membership and the resources such membership confers provides a key concept in understanding differences in access to many important relational resources supporting health and wellbeing and recovery (Cloud and Granfield 2008). Human capital emerges from and relates to social capital (Coleman 1988). Relationships provide a space and place for interactions which support capacity and growth in individuals to think about themselves differently and to take different actions. The process of recovery from addiction has many elements one of which can be framed in terms of the gains in human capital, within wider recovery capital concept (Fitzgerald 2018). Granfield and Cloud's model (2001) provides a framework for understanding the recovery process as one in which recovery is obstructed by negative elements and supported by strengths. Strengths in the four types of recovery capital are proposed as likely predictors of long term change (White and Cloud 2008). This approach moves away from pathology to develop a socially situated model where available resources i.e. recovery capital, result in differential capacity and opportunity for overcoming

problems (Cloud and Granfield 2008). The proposed model requires further research in terms of how to capture and measure growth, strengths and resources over time (White and Cloud 2008).

Within public health literature, there is a shift away from exclusively clinical measures to see health not just as the absence of disease or infirmity, but including wider aspects of positive health and wellbeing (WHO 1993, Tulloch 2005), and is reflected in the concept of Quality of Life (Pennacchini, Bertolaso, Elvira & De Marinis MGare 2011). The World Health Organisation identifies Quality of Life as a multifaceted concept reflecting physical and psychological health, social relationships as well as salient aspects of the wider environment (WHOQOL Group 1996). The WHOQOL-Bref is one of the best known instruments that has been developed for cross-cultural comparisons of quality of life and is available in more than 40 languages (Vahedi 2010). The Quality of Life concept and measure can be a useful addition to drug and alcohol research as it describes peoples' experiences in aspects of functioning that are important to them, but are not captured by traditional symptom assessments such as the Addiction Severity Index (Donovan et al; 2005). This wider approach and focus on health and wellbeing is also implicit in the current UK recovery-orientated treatment policy of 2010 (UK Drug Strategy 2010). However, the addiction field lags far behind other mental health and biomedical disciplines in embracing Quality of Life as an essential outcome (Laudet 2011).

There are a small number of studies aiming to examine Quality of Life in relation to early recovery, however few address stable (or long term) recovery which is defined as over 5 or more years (Betty Ford Institute Consensus Panel, 2007). Laudet and White's 2008 study in New York on a sample of 312 people in recovery examined four recovery stages: less than 6 months, 6-18 months, 18-36 months and over 3 years. This study concluded that Quality of Life was related to recovery length. Quality of Life has also been identified as being related to enhancing the likelihood of long term remission (Laudet and White 2009).

A study in Glasgow (Best, Gow, Knox, Groshkova, White 2012) found that higher Quality of Life scores were associated with longer duration of recovery. One further study in Birmingham (Hibbert and Best, 2011) of 53 recovering drinkers reported higher scores in the social and environmental elements of their Quality of Life measurement and proposed these scores may exceed those in the general population. These studies contributed to recovery being conceived as less a return to 'normal', but more as a process towards higher levels of appreciation and fulfilment of quality of life. The Better Than Well (White, & Kurtz 2005, Hibbert, & Best 2011) approach to understanding recovery provides a framework to understand how some individuals in long term recovery may come to appreciate their lives, compared to the adversity and negative experiences in their time whilst actively engaging in drugs or alcohol. It also helps us to understand how they transcend their addiction to play vibrant roles in their communities. Both the concept of quality of life and better than well, frame recovery less as symptom reduction and pathology and more as a

process with the potential for positive elements and outcomes. The aim of this research is to add to the relatively small amount of literature on long term recovery in the UK (where long-term recovery in this study refers to post 5 years).

Methodology

The aim in this mixed methods design is to provide multiple perspectives on the area of study (Cresswell 2007), namely long term recovery. This mixed-method approach combines elements of quantitative and qualitative in a convergent parallel mixed method design to attempt begin to explore and understand aspects of long term recovery (Creswell & Clark, 2011). A quality of life measure compared long term recovery scores (post 5 years) with a general population group and Research into psychosocial measures using QoL within recovery remains limited (Smith & Larson 2003) yet the measure provides the potential to explore systematically the importance of building recovery capital. subsequent qualitative semi-structured interviews explored what participants themselves identified as important in their lived experience of long term recovery

The quantitative phase of the study compared quality of life scores between a group of 40 people in long term recovery (5 years and over) and a group termed general population. The quantitative phase used the WHOQOL-Bref as a measure of quality of life (WHO 1996). Long term recovery participants were recruited by 'snowballing', i.e. using existing social contacts and social media groups known to the researcher. The long term recovery group consisted of 30 men and 10 women. The people in the sample were aged between 36 and 66 years old. Three participants reported five years recovery, six reported six years recovery, two reported seven years recovery, three reported eight years recovery, two reported nine years recovery and 24 reported 10 years.

The general population participants were recruited through snowballing using existing social contacts and social media and asked to complete an online questionnaire. These participants were existing social contacts of the researcher. The general population group completed an online version of the questionnaire using Survey Monkey (Surveymonkey.com). This online version of the WHOQOL-BREF asked participants if they had ever experienced problematic drink or drug use in the past, if so the questionnaire concluded at this point and no record was kept of their attempt. In this way, these participants could be excluded from the general population group without breaking any confidentiality. This group consisted of 10 women and 30 men. The people in the sample were aged between 41 and 55 years old.

After the quantitative data had been collected six semi-structured interviews were conducted with people in long term recovery who had previously completed one of the QoL questionnaires and given their consent to be interviewed. These interviews

with the participant were recorded and then transcribed. The aim of the interviews was to provide some qualitative data to explore the way these participants talked about their recovery. The interview participants were made up of 3 men and 3 women with a number of years in recovery ranging from 6 years recovery to 10 years recovery..

The primary research in this paper was undertaken as part of a postgraduate course at Sheffield Hallam University and the research was considered and approved in line with course and institution processes. A research proposal was submitted prior to any data collection via the formal department approval processes. Long term recovery participants were not recruited via any treatment programme or service and so the proposal did not require formal ethical approval from an NHS Research Ethics Committee.

Key principles of ethical research and guidelines on good research practice developed by the Economic and Social Research Council (ESRC 2015) were followed in this research. The quality of life measure front sheet outlined the anonymity of the study and all interview participants signed a consent form. The long term recovery interviewees had been informed what the interview questions were and it was made clear they could choose not to continue at that point and that they were free to withdraw from the study at any point. If they did continue they could choose to not answer any questions as they wished. Participants were also informed what the interview entailed to ensure they were willing to discuss the areas covered. The interview participants were informed all data was anonymous and no personal details recorded or stored. Collection and storage of data followed information governance standards and all data was anonymised to ensure anonymity throughout the study. No incentives were given to participate.

Findings

Quantitative WHOQOL-BREF data comparing the long term recovery group to the general population group.

The quantitative findings of the self-report questionnaire showed that people in the long-term recovery group scored themselves higher in all four of the WHOQoL-BREF domains compared to the general population group. The WHOQoL-BREF domains are psychological, relationships, environment and physical health. Table 1 shows the scores across all 4 domains. The table shows that the long term recovery group scored higher in all four WHOQoL-BREF domains.

Table 1: Comparing long term recovery group and general population group scores across all 4 domains

Table 1 Comparing overall WHOQOL-Bref scores of long term recovery group and general population group

	Domain 1 Physical Health	Domain 2 Psychological	Domain 3 Social relationships	Domain 4 Environment
Long term recovery group	62.375	67.8	74.55	79.825
General population group	59.25	62.15	70.025	73.925

Given that the long term recovery group scored higher in all four WHOQoL-BREF domains, an independent T test was conducted to compare long term recovery subjects with the general population in each of the four WHOQoL-BREF domains. There was a significant difference ($t=2.31$, $df=78$, $p=0.01$) in mean scores in the psychological domain between the long-term recovery group ($M=67.8$, $SD=11.87$) compared to the general population group (62.15 , $SD=9.87$). The psychological domain incorporates facets relating to positive feelings, self-esteem, spirituality, personal beliefs and religion. There was also a significant difference ($t=2.01$, $df=78$, $p=0.02$) in the mean scores for the environment domain between the long-term recovery group ($M=79.8$, $SD=14.29$) and the general population group ($M=73.9$, $SD=11.91$). The environment domain incorporates home environment, financial resources, recreation/leisure services, physical safety and security. Care must be taken with interpreting these findings as the sample size is small.

There was no significant difference in the scores in the long-term recovery subjects versus the general population in either the physical health domain or the social relationship domain of the WHOQoL-BREF.

Qualitative data from long term recovery (post 5 years) interview participants

The qualitative findings provide an opportunity to explore how the participants themselves talk about recovery particularly in light of the quantitative findings. Interviews were transcribed and thematically analysed. The themes emerging from the data are family, peer support/mutual aid, education & learning and acceptance & purpose.

As might be expected from the literature (Hibbert & Best, 2011, Granfield & Cloud, 2009) all participants identified aspects of social, wider environmental and psychological elements as important in their lived experience of recovery. All of the participants talked about aspects of their experience that would relate to the social domain of the WHOQOL-BREF, namely their wider family (parents, siblings, aunts/uncles and cousins) as well as, if they had them, their own children and partners as an important part of maintaining recovery. The impact of problem drug use on families is well documented and the importance of good family support is recognised as crucial from early recovery onwards (Scottish Government 2008). The need for family support is identified clearly in all six interviews. The need to repair,

rebuild or start family relationships again was central to all the participants when talking about their recovery. One participant talked about family relationships using the phrase *"inevitably they get stretched or broken"* (Participant 4).

Participants identified some elements relating to the environment domain of WHOQOL-BREF, namely employment & training and taking on board new skills. Such opportunities gave participants the chance to re-connect and engage with aspects of the social world, as opposed to their previous experience of exclusion. Education played an important role for three participants, ranging from short courses to more extended engagement with education as the following quote by illustrates. *"Once my daughter got to 12 months old I realised that I needed to do something for myself and I'd been toying with, and always known I've wanted to work with people. I did a year's maths and then I managed to get on the Level 2 Access and then Level 3 Access and then that got me into Uni. So now I'm in the second year of my degree and I honestly believe that's because I changed everything completely".* (Participant 5)

For others it was paid and voluntary work that provided this opportunity. *"Employment was a major factor particularly in my own recovery and it was through my volunteering/mentoring [that there] then came a job opportunity, on an apprenticeship basis to start off with, which then led onto become a full-time permanent position"* - (Participant 3).

Education and employment were not seen as a quick or easy solution and required timely consideration, one participant cautioned against rushing into things too soon. *"Ah, aye yes whether it's a hobby or a job, I think if you're in early recovery with a good paid job that's another hard thing you have a pocket full of money and don't know what to do with it. So that can be a bad temptation. It's back to not being in too much of a hurry – good things will happen"* - Participant 4. Finding meaningful activities such as volunteering and entering the world of work was seen by all participants as important in their long term maintenance of recovery and supporting them to where they were now.

All six participants talked about themselves and their sense of themselves and the difference in long term recovery as being about what might be termed personal growth or purpose, this theme would relate to the elements of the psychological domain of the WHOQOL-BREF. The participants talked of acceptance of the past and the need to deal with issues before starting to move forward in their recovery. Having a better perspective on life and more balance was also discussed in interviews, alongside the need to learn to enjoy recovery rather than merely endure it. This theme reflects the participants' sense of their recovery as an ongoing process, and of themselves as learning to be different, seeing things differently, being more open and having a better perspective on life. The following quote captures something of the process of beginning to reflect on yourself in order to develop: *"I found very early on in my recovery I needed to challenge myself and if I*

sort of standstill for long enough it would catch me up” - Participant 3. For others they talked more about 'trying to stay positive' and recognising the good things in their life. All six participants talked about the importance of not taking on too much and identified both positive and negative extremes as unhelpful to their recovery. They recognised the importance of self-care and responsibility to themselves & others as becoming a way of life. All participants talked about finding ways to create equilibrium in their life such as exercise, meditation, healthy relationships, therapy, meetings, eating regularly and healthy living.

Participants, when discussing their long-term recovery, also talked about aspects of themselves and their experience that might be perceived as spiritual. Spirituality is identified in the literature as being of potential benefit in recovery (Laudet, Morgen and White, 2006). As illustrated by the following extract, *“I can’t pinpoint it but there is something about karma and there’s something about the universe that if you put the effort in, I say the universe will pay you back” - Participant 1.*

Spirituality came up to some degree in all of the interviews sometimes explicitly in relation to religion and at other times more in the way the extract above is framed. Cloud and Grandfield (2008) in discussing the limitations of categories of capital recognise the uniqueness of people and the potential of the spirituality to play part in resources for recovery.

The participants talk about recovery reflects the complexity of the concept itself as found in the literature (White 2007). This qualitative data adds to the quantitative findings in providing patterns in the participants talk illustrating evidence of recovery involving improvements in many areas of life, in several areas of recovery capital, including social involvement and wider supportive contexts (Hibbert & Best, 2011). In this qualitative data there is a representation of a process of recovery where much internal and external elements of recovery capital (Cloud and Granfield 2009) are captured in this complex interconnected process as lived by participants.

The long term recovery group: mutual aid attendance

In the WHOQOL-BREF long term recovery group there were 17 people who still accessed mutual aid. These 17 people scored higher in all four domains of the WHOQOL-BREF than those 23 people who stated they did not attend mutual aid. Of the 17 people who currently accessed mutual aid 11 had attended rehab as part of their recovery. Of the 23 people who stated that they were not currently accessing mutual aid, 10 had never accessed mutual aid though 13 had previously

Table 2: Comparing WHOQOL-BREF scores of those who attend mutual aid with those who do not attend across all 4 domains

Table 2 Comparing overall WHOQOL-Bref scores of those in the long term recovery group attending mutual aid and those not attending

	Domain 1 Physical Health	Domain 2 Psychological	Domain 3 Social relationships	Domain 4 Environment
Attending mutual Aid	65.94	70.35	78.35	81.88
Not attending mutual Aid	59.74	65.91	71.74	78.30

Of the participants interviewed all six had at some point attended mutual aid and of these three were still actively attending. The three still attending mutual aid credit this with their ability to maintain recovery and talk positively about the way the programme of mutual support enables them to both gain insight into themselves and *'build themselves back up'* (participant 2). The importance of peer support and learning is illustrated well in the following extract. *"I totally believe that my recovery didn't come from me it came from other people, even though I'd been clean for two or three years I didn't start to really get recovery until I'd gone into a narcotics anonymous meeting my recovery came from other people really cos there was stuff that I didn't know and couldn't learn on my own"* Participant 6.

The Long term recovery group: Comparing men and women

In the long-term recovery group there were gender differences in the WHOQoL-Bref scores, with the 10 women in the sample scoring higher in all domains except physical health compared to the 30 males in the sample.

Table 3: Comparing male and female scores across all 4 domains

Table 3: Comparing overall WHOQOL-Bref scores of the men and women in the long term recovery group scores across all 4 domains

	Domain 1 Physical Health	Domain 2 Psychological	Domain 3 Social relationships	Domain 4 Environment
Men	62.87	66,37	73.53	79.5
Women	60.9	72.1	77.6	80.8

The table shows the women scores highest in the social and environmental domains. The sample was too small for meaningful statistical analysis. The difference identified was not reflected in the qualitative data. The women interviewed did not

highlight certain experiences or aspects of their lives as more significant than the men and there no difference in the kinds of things they talked about in relation to their experiences. The three women and the three men interviewed all identified complex, interwoven elements of their life and experience in their talk of their recovery. This may reflect the very small sample or may in part reflect that gender differences were not the focus of the research question yet highlight a potential future area of research in sustained recovery.

Discussion

The quantitative data provides evidence of a significant difference in Quality of Life (WHOQoL-BREF) in two domains. The long term recovery group (5 or more years into recovery) scored higher in both the environment and psychological domains than the general population group. Care must be taken with these findings as the sample size is small. This study provides support for the Quality of Life measure usefulness in recovery research. Such evidence supports notions of recovery involving improvements in many areas of life and potentially beyond the norm, termed 'better than well' (Best & Lublam 2012, Valentine, 2011). The empirical data provides evidence of the significance of psychological facets relating to positive feelings, self-esteem, spirituality, and adds to the already existing research evidence for social involvement and to the supportive wider environmental context (Hibbert & Best, 2011). The 17 people who still accessed mutual aid scored higher in all four domains of the quality of life measure than those 23 people who did not, and females (only a small sample of ten out of the forty individuals in long term) recovery scored higher in all four domains than men. Neither sample was large enough to provide clear evidence but both raise potentially interesting areas for further research.

This leads us to argue on a theoretical level, backed by empirical data, that gains in human capital (Cloud and Granfield 2009, Coleman 1988) one sub element of recovery capital (Cloud and Granfield 2009) provide an important aspect for consideration in understanding long term recovery.

The qualitative data provides a richer understanding of the range and interaction of the different elements in the participant's own experience of recovery. The participants themselves identify many key aspects of the process towards the establishment of a stable long-term recovery. These include family or peer support (mutual aid), education, acceptance and purpose or spirituality. This reflects the conceptualisation of recovery as a process of growth and change (White and Kurtz 2005). The qualitative interviews provide some richer understanding of the ways the participants themselves frame both the internal and external resources supporting their own recovery process (Granfield & Cloud, 2009).

Both the quantitative and qualitative data supports the view that growing strengths (as opposed to getting rid of pathology) provides a useful framing of recovery from drug and alcohol problems (White and Cloud 2008). Overall the findings support the

idea that recovery is linked to gains psychological growth, social connectedness and meaningful social activity (Mawson et al 2015) and adds weight to the emerging literature relating to 'better than well' (Best & Lublam 2012, Valentine, 2011) . In addition this research adds to a small amount of literature relevant to exploring long term recovery, in this instance post 5 years.

The research has some methodological limitations that need to be taken into account. Snowballing using existing social contacts means that the representativeness of the 40 people in the long-term recovery group may reflect the people the primary researcher has contact with rather than be a representative sample. This highlights difficulties in the drugs field in the visibility of those who are in stable recovery in terms of accessing subjects. Equally, the same limitations could apply to the general population group. The study takes a snapshot of recovery post 5 years and the interviews involve people looking back at their recovery. This may therefore not be as robust as it could be in terms of adding to what can ultimately predict successful recovery.

The current study has some evidence that both women and those attending mutual aid perceive they now have a better quality of life, but the sample size in this study is too small to draw any meaningful conclusions.

This study was not commissioned but was part of public health practitioner continuing professional development and submitted as part of a postgraduate course in public health. It therefore lacks the resources that full time research might have available to it. Despite its limitations it is important for public health and substance practitioners to undertake and understand research projects in terms of developing practitioner roles for both commissioning and evaluating services in the UK and for increasing their understanding of the theoretical and methodological framing of substance services and policies. Although UK drug policy emphasises recovery there is limited evidence on what supports those outside of early recovery (Humphreys and Lembke 2014) and what recovery means outside of treatment. Public health practitioners and policy makers are not able to commission recovery, but what they can do is work with partners and agencies to ensure that there is much more work, not just treatment focused, addressing the wider social & environmental context to support individuals recovering from alcohol and drugs over the longer term. 'Better than well' (Best & Lublam 2012, Valentine, 2011) and the findings here in this study support the importance of adopting a strengths based approach and raising the visibility of recovery and recovery communities in terms of the benefit they may bring in making recovery more visible and challenging social isolation and stigma. Further this adds to the discussion about recovery happening in the context of the community rather than the clinic (Best 2017).

Within the public health domain the concepts of recovery capital and 'better than well', alongside social determinants of health and a social model of health (Dalgren & Whitehead 1991) provide a public health perspective that recognises positive

changes in health, in this case recovery, as shaped by the context in which people live, work and age. This wider social determinants of health perspective (Wilkinson and Marmot 2003, Dalgren & Whitehead 1991) can provide a framing of recovery within the broader health inequalities work across the lifespan both locally and nationally.

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