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Emerging consensus on measuring addiction recovery: Findings from a multi-stakeholder consultation exercise

Joanne Neale^{1,2}, Daria Panebianco¹, Emily Finch^{1,3}, John Marsden¹, Luke Mitcheson^{1,4}, Diana Rose⁵, John Strang^{1*}, and Til Wykes^{6*}

¹Addictions Department, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK, ²Centre for Social Research in Health, University of New South Wales, Sydney, NSW, Australia, ³South London and Maudsley NHS Foundation Trust, Blackfriars Road Community Drug and Alcohol Team, London, UK, ⁴South London and Maudsley NHS Foundation Trust, Lambeth Drug and Alcohol Service, London, UK, ⁵Service User Research Enterprise (SURE), Health Services and Population Research Department, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK, and ⁶Department of Psychology, Institute of Psychiatry, Psychology and Neuroscience, King's College London, De Crespigny Park, London, UK

Abstract

Aim: To identify indicators that diverse stakeholders believe are important when measuring recovery from addiction. **Methods:** Our previous work with service users had generated 28 indicators of recovery. Using Delphi group methodology (three rounds), we assessed the extent to which stakeholders working in the addictions field agreed that the 28 indicators were important on a scale of 1–10. Participants included 146 individuals with diverse job roles in 124 organisations across the British Isles. **Findings:** Round 1 scores were high. There was evidence of greater scoring consensus in Round 2, but this trend was less certain in Round 3. Participants scored 27/28 indicators $\geq 7/10$ in Round 3, so confirming their importance. The only Round 3 indicator with a mean score <7 was “experiencing cravings”. There were statistical differences between the Round 3 indicator scores of some sub-groups of participants, but absolute differences were small (never more than 1 point for any indicator). **Conclusions:** We have identified 27 recovery indicators that stakeholders working within the addiction field in the British Isles consistently ranked as important. Replicating our methods in other countries, and with additional stakeholder groups, will provide greater clarity on the term “recovery”, its relevance and value, and how it can best be measured.

Keywords

Delphi group, measurement, recovery, service users, stakeholder consultation

History

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Introduction

The word “recovery” has been embedded within drug and alcohol policy and practice for a number of years and is now recognised across specialist and non-specialist services and features in lay terminology internationally (Center for Substance Abuse Treatment, 2006; Clark, 2008; Duke, Herring, Thickett, & Thom, 2013; Laudet, 2007, 2009; Scott & Dennis, 2002; White, 1996). Despite this, there is still no clear consensus on what the term means, whether it is a good thing, or how it should be measured (Neale et al., 2014, 2015). Recovery was once almost exclusively associated with 12-step fellowships and abstinence (Laudet, 2009), but there is increasing acceptance that its meaning encompasses benefits achieved in a wide range of life areas, including housing, health, employment, relationships, self-care, use of time, community participation and general well-being (Advisory Council on the Misuse of Drugs, 2013; HM

Government, 2010; Neale, Pickering, & Nettleton, 2012; Scottish Government, 2008). Furthermore, recovery can be supported by appropriately prescribed medications (Recovery Orientated Drug Treatment Expert Group, 2012).

Whilst some believe that a discourse of recovery presents a positive opportunity to raise individuals’ treatment aspirations, others argue that it can undermine services operating within a harm reduction framework or even cause harm by encouraging people into detoxification and abstinence programmes prematurely (Neale, Nettleton, & Pickering, 2011, 2013). Such divergence of opinion is compounded when recovery is considered in an international context. In the UK, the rise of a “recovery agenda” has now been endorsed at multiple levels including government strategies, publications by think tanks, speeches by politicians, substantial grassroots activity, changes to commissioning practices and service delivery and altered funding structures (Duke et al., 2013; Home Office, 2012; Thurgood, Crosby, Raistrick, & Tober, 2014). In contrast, in other countries – such as Australia – recovery has been constituted as problematic, politicised, disruptive and destabilising (Lancaster, Duke, & Ritter, 2015).

Whilst there are undoubtedly many people in the UK who remain uncertain about, or even actively critical of, the

*These authors contributed equally to this work.

Correspondence: Joanne Neale, Addictions Department, Institute of Psychiatry, Psychology and Neuroscience, King's College London, Denmark Hill, 4 Windsor Walk, London SE5 8AF, UK and Centre for Social Research in Health, University of New South Wales, Sydney, NSW 2052, Australia. E-mail: joanne.neale@kcl.ac.uk

concept of recovery, there is little opportunity to “opt out” of the recovery agenda on moral, political or ideological grounds. Without due reference to aspirations of recovery, services in the UK struggle to be funded and drug and alcohol users can find it difficult to access support. It therefore seems incumbent upon those working in the UK addiction field to find a way of conceptualizing recovery such that it is deployed positively to optimise treatment, minimize harm, and best support those who want and need services. To some, this may seem like “selling out” or capitulation. Indeed, in other contexts, it might perhaps be better to resist the term recovery altogether and to defend the treatment *status quo*. On the other hand, sensitive deconstruction and exploration of the meaning of recovery may reveal goals, aspirations and measurable indicators of change that people experiencing addiction share with the professionals working with them. If so, that will provide a stronger platform for recovery-oriented services in the UK, but might also provide valuable insights in other contexts where recovery does not currently dominate.

In the United States, where there has also been a strong recovery movement, Laudet (2009) identified a “critical” need for an addiction recovery measure that would capture the multi-dimensional nature of recovery and the views of multiple stakeholder groups, including service users, providers and funders. She argued that a dedicated measure would foster accountability in the delivery of recovery-oriented services, help to monitor and improve the quality of provision, assist with the identification of appropriate support for individual clients as their needs and circumstances changed and provide researchers with a suitable tool to plot and understand recovery processes. Laudet conducted a broad review of extant recovery measures, but identified no addiction specific instrument, despite an evident demand from the field. Instead, her review found that addiction professionals were using measures designed to assess the performance of services (e.g. the Client Assessment Inventory – CAI) or broader measures of health and wellbeing developed in other fields (e.g. WHOQOL) (2009).

Today, there is still no robust, validated measure of addiction recovery anywhere within the world. Whilst there are numerous established scales of addiction, e.g. the Severity of Dependence Scale (SDS), the Addiction Severity Index (ASI), and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), these do not capture – or purport to capture – the concept of recovery. The closest scales to have been developed in the UK are (i) the Assessment of Recovery Capital (ARC) – a 50-item (10-domain) instrument that assesses the resources individuals need to initiate and sustain recovery from alcohol and other drug problems (Groshkova, Best, & White, 2013) and (ii) the Drug and Alcohol Outcomes Star – a non-validated measure that assesses 10 areas that support people in progressing towards, and maintaining, a life free from drug misuse and problem drinking (Burns & MacKeith, 2012). The quest for a dedicated psychometrically tested addiction recovery measure that is simple and easy to complete, acceptable to a wide range of stakeholders, and applicable across a range of drug and alcohol using populations continues.

Aim and theoretical approach

In this paper, we seek to make a contribution to the debates and literature on addiction recovery by identifying indicators that stakeholders, including service users, living in the British Isles routinely report as important when measuring recovery. Our work sits within the philosophical traditions of pragmatism and critical theory and is loosely informed by the German sociologist and philosopher, Habermas (1970, 1991). As such, we do not try to develop an absolute set of indicators that will be agreed at all times by all people (complete consensus or “universal truth”). Rather, our intention is to identify indicators of recovery that most stakeholders agree are important most of the time for most people (a *de facto* “working consensus”) (Neale & Strang, 2015). We have sought to achieve this by facilitating open communication (or “communicative action”) between multiple stakeholders (Habermas, 1970) over a period of 18 months. To this end, we consulted service providers, then service users, and then a much wider range of individuals working within the addictions field.

Methods

The initial stages of our work have been reported previously (Neale et al., 2014, 2015), so we only summarise them briefly here. To begin, we used online Delphi groups to ask 25 UK-based addiction psychiatrists, senior residential rehabilitation staff and senior inpatient detoxification staff how they thought we should measure recovery. This generated 76 indicators that comprised 15 broad domains (Table 1). Findings showed good agreement on the domains, but some disparity between,

Table 1. Seventy-six indicators of recovery identified by 25 service providers in three separate online Delphi groups^a.

Substance use
1. Reduced drug use
2. Using drugs safely
3. Achieving abstinence
4. Practising relapse prevention
5. Reduced cravings
Treatment/support
6. Accessing treatment
7. Accessing peer support/self help
8. Engaging in private therapy
Psychological health
9. Having good mental health
10. Being confident
11. Coping
12. Feeling in control
13. Having self-belief
14. Having self-worth
15. Being able to trust people
16. Having emotional balance
17. Achieving self-acceptance
18. Having no anxiety
19. Dealing with past trauma
20. Accepting responsibility
21. Being able to manage feelings
22. Not feeling depressed
23. Not being lonely
24. Feeling safe
Physical health
25. Having good physical health
26. Being physically active

(continued)

Table 1. Continued

27. Taking care of your appearance
28. Taking care of yourself
29. Eating healthily
30. Dealing with toothache
31. Appetite returning
32. Not feeling tired
33. Going to the toilet regularly/not being constipated
34. Periods coming back (for women)
35. Sex drive coming back
36. Putting on weight
37. Feeling energetic
38. Sleeping well
Use of time
39. Having a daily routine
40. Going to appointments
41. Having hobbies
42. Using time meaningfully
43. Not being bored
Education/training/employment
44. Participating in education or training
45. Doing voluntary work
46. Having a paid job
Income
47. Having a stable income
48. Not having debts
49. Being able to manage money
Housing
50. Having stable housing
51. Living independently
52. Keeping the house clean and tidy
Relationships
53. Having good relationships with family (including partner and children)
54. Having good relationships with peers in recovery
55. Having good relationships with non-using friends
56. Having social support
57. Being independent
58. Not having negative relationships
59. Having honest relationships
60. Supporting others
Social functioning
61. Having a role in society
62. Participating in society
63. Not causing problems to society
64. Having a good quality of life
Offending/anti-social behaviour
65. Not offending
66. Not being in contact with the criminal justice system
67. Behaving morally
Well-being
68. Not feeling shame or guilt
69. Feeling positive
70. Not feeling stigmatized
Identity/self-awareness
71. Being self-aware
72. Having a non-addict identity
Goals/aspirations
73. Having purpose
74. Having realistic plans and goals
Spirituality
75. Having hope
76. Being spiritual

^aNeale et al. (2014).

and considerable disparity within, groups on the relative importance of specific indicators (Neale et al., 2014). Next, we took the 76 service provider generated indicators to five focus groups of London-based current and former drug and alcohol service users (44 service users in total). The focus group participants identified multiple problems with the

76 indicators, with analyses suggesting that many of the indicators were irrelevant, inappropriate, contradictory or offensive (Neale et al., 2015).

Analyses of the Delphi group and focus group data were next combined to produce a revised list of 33 recovery indicators. This involved three researchers rewording indicators that the focus group participants had deemed unacceptable due to terminology or language, combining these with indicators that the focus group participants had generally agreed were acceptable, and discarding indicators that the focus group participants had described as irrelevant, inappropriate or offensive. These 33 indicators were then presented to two panels of London-based current and former drug and alcohol service users. The 17 panel participants were asked to debate and rank the list of 33 recovery indicators in terms of wording, acceptability and importance, with further analyses suggesting that 30 of the 33 indicators were largely acceptable and important to everyone. Next 48 current and former service users (again all London based) rated themselves on the 30 indicators and commented on their appropriateness and usefulness. Further rewording and slight modifications occurred, one indicator was eliminated, and an indicator was re-introduced. Following this, another sample of 50 current and ex-service users rated themselves on the 30 indicators twice within a 7-day period and 111 individuals rated themselves on the indicators whilst also completing three other validated measures (the ASSIST-Lite, the WHOQOL-BREF and the ARC). Two indicators proved to be unreliable and so they were removed leaving 28 indicators.

By now, we were confident that our 28 indicators captured key aspects of recovery from the service user perspective and so we began further data collection for more advanced psychometric testing of a patient reported outcome measure (PROM) of addiction recovery. This work is ongoing and involves surveying over 500 service users and conducting more advanced statistical analyses, including exploratory and confirmatory factor analyses (these analyses will be used to validate the PROM and will be reported separately once completed). However, we still did not know the extent to which other stakeholders would agree that the 28 indicators were important. As the measures had originated from service providers, we felt that it would be instructive to take the refined list of 28 indicators back to a much wider range of stakeholders working within the addiction sector. We conceived of this as a kind of “back translation” and considered that an online Delphi group would be the best method for exploring this whilst ensuring participant anonymity, diversity and reach (Linstone & Turoff, 1975; McKenna, Keeney, & Hasson, 2011).

The Delphi method is a versatile way of structuring group communication so that the “process is effective in allowing a group of individuals, as a whole, to deal with a complex problem” (Linstone & Turoff, 1975, p.3). Although it is commonly believed that achieving consensus between participants is a defining feature of the Delphi method, the approach can also be used to determine the extent to which individuals agree or disagree about a given issue (Jones & Hunter, 1995; Mullen, 2003). Thus, consensus is not a necessary end point. Group participants are asked a series of questions and their responses are collated and analysed.

Collated responses are then fed back to the group in anonymised form. Participants are next given the opportunity to confirm or modify their responses in light of the group feedback. The process of feedback and further data collation can be repeated for a pre-determined number of “rounds” or until some other pre-specified criterion has been met (Mullen, 2003).

In our Delphi Group, we pre-specified three rounds of data collection. In Round 1, participants were asked to score each of the 28 indicators on a scale of 1–10 for importance. In Round 2, they were told the mean score of all participants in Round 1 and invited to score the indicators again. In Round 3, they were told the mean scores for all participants in Round 2 and invited to score a final time. Hypotheses were specified in advance of data collection as follows:

- *Round 1 Hypothesis:* If stakeholders were asked to score each of the 28 indicators on a scale of 1–10 for importance, scores would be high.
- *Round 2 Hypothesis:* If stakeholders were told the mean score for everyone in Round 1 and asked to score the indicators a second time, greater consensus would emerge.
- *Round 3 Hypothesis A:* If stakeholders were told the mean score for everyone in Round 2 and then asked to score the indicators for a third time, all indicators would have a mean score of ≥ 7 .¹
- *Round 3 Hypothesis B:* Round 3 scores would not vary significantly by core stakeholder characteristics, such as gender, job role or location of work.

Data collection

In March 2015, we used the online survey tool BOS (<https://www.onlinesurveys.ac.uk/>) to create an open registration form for anyone wishing to join the consultation exercise. A link to the form was disseminated through mailbases, contacts working in the UK sector and a range of social media. The first page of the registration form explained that we had identified 28 indicators of recovery that most service users felt were important and now wished to consult service providers and other key stakeholders to see whether or not they agreed. We specified that the consultation was open to anyone working directly or indirectly with people experiencing problems with drugs or alcohol, and this included (but was not limited to) frontline staff, service managers, commissioners, specialist GPs and pharmacists, independent consultants, and people working in government, policy, and think tanks. We actively welcomed paid employees and volunteers, those working full-time and part-time, and individuals from the National Health Service and third sector.

The second page of the form included details on how the Delphi group would operate, the time commitment required by participants (completion of three short online forms, each taking 10–15 min), and the overall timeframe for the work (6–9 weeks). On the third page, interested individuals were then asked to provide some basic information about themselves, including their name, whether they were personally in recovery, the organization for which they currently worked,

their job/role, their location of work, the number of years they had been working in the drug/alcohol sector and their email address. Responses to these questions were required so that we knew exactly who was registering and so that data collected in subsequent rounds could be matched back to individuals by their name and email address. Participants were, however, reassured that their personal details would not be shared with anyone and that all their responses would be kept strictly confidential to the research team.

Findings

Participating stakeholders

In total, 157 stakeholders registered, of whom 146 (93%) went on to complete at least one of the three rounds. These 146 individuals worked for 124 different organisations across England, Scotland, Wales, Ireland and the Isle of Man. They included 79 (54.1%) males and 67 (45.9%) females, and their job roles ranged from policy-makers and commissioners to front line staff and peer workers. Further participant details are shown in Table 2.

Round 1 Hypothesis: If stakeholders were asked to score each of the 28 indicators on a scale of 1–10 for importance, scores would be high

In total, 141 stakeholders completed Round 1 of the consultation exercise. Descriptive statistics relating to how they scored each of the 28 indicators are shown in Table 3.

Median scores for all indicators ranged from 7 to 10 and mean scores ranged from 6.15 (“not experiencing cravings”) to 9.43 (“coping with problems without turning to drugs/alcohol”). Modal scores for all indicators were either 8 or 10, with the exception of “not experiencing cravings” (mode = 5). The score range for all indicators was between 4 and 9

Table 2. Characteristics of stakeholders who completed at least one round.

	N (%)
N	146
Gender	
Male	79 (54.1)
Female	67 (45.9)
Personally in recovery	
Yes	38 (26.0)
No	102 (69.9)
Do not wish to answer	6 (4.1)
Current job/role	
Non-clinical practitioner, worker or volunteer	41 (28.0)
Commissioning/policy/strategy	28 (19.2)
Clinical/medical practitioner	26 (17.8)
Non-clinical administration/management	19 (13.0)
Clinical administration/management	14 (9.6)
Campaigning/activism/advocacy	9 (6.2)
Research	9 (6.2)
Location of work	
London	33 (22.6)
Not London	113 (77.4)
Years working in the drug/alcohol sector	
Mean (SD)	12.77 (8.51)

¹ ≥ 7 was used in the first Delphi study to designate indicators as important (Neale et al., 2014).

points (interquartile range 1–3). When the range scores for all 28 indicators were summed, the total was 191 (possible range = 9–252). For each stakeholder, we also calculated a total score for all indicators (possible range = 28–280). Individuals' scores for all indicators ranged from 151 to 280 (mean = 230.80, SD = 25.65).

Round 2 Hypothesis: If stakeholders were told the mean score for everyone in Round 1 and asked to score the indicators for a second time, greater consensus would emerge

In total, 120 stakeholders completed Round 2 of the consultation exercise. This included five stakeholders who had not completed Round 1. Descriptive statistics relating to how the 120 stakeholders rescored each of the 28 indicators are shown in Table 4.

Round 2 median scores for all indicators ranged from 6 to 10 and mean scores ranged from 6.03 (“not experiencing cravings”) to 9.32 (“coping with problems without turning to drugs/alcohol”). This compared to 7–10 and 6.15–9.43 in Round 1. Round 2 modal scores for all indicators ranged from 8 to 10, with the exception of “not experiencing cravings” (mode = 5). Fewer indicators had a modal score of 10 in Round 2 than in Round 1 (6 indicators versus 12 indicators). The score range for all indicators in Round 2 was between 5 and 9 points (compared to 4 and 9 points in Round 1) and the total range score for Round 2 was 184 points (compared to 191 points in Round 1). The interquartile range was still 1–3. For each stakeholder, the total score for all 28 indicators was virtually identical to Round 1: 152–280 (mean = 229.06, SD = 22.74).

Round 3 Hypothesis A: If stakeholders were told the mean score for everyone in Round 2 and then asked to score the indicators for a third time, all indicators would have a mean score of ≥ 7

In total, 113 stakeholders completed Round 3 of the consultation exercise. This included three stakeholders who had not completed Round 1 and nine stakeholders who had not completed Round 2. No stakeholder completed Round 3 only. Descriptive statistics relating to how the 113 stakeholders rescored each of the 28 indicators are shown in Table 5.

Round 3 median scores for all indicators ranged from 7 to 10 and mean scores ranged from 6.23 (“not experiencing cravings”) to 9.29 (“coping with problems without turning to drugs/alcohol”). This was very similar to both Rounds 1 and 2. In total, 27/28 indicators had a Round 3 mean score of ≥ 7 . As in Round 2, Round 3 modal scores for all indicators ranged from 8 to 10, with the exception of “not experiencing cravings” (mode = 5), and two indicators had a modal score of 10 (compared to 12 in Round 1 and 6 in Round 2). The score range for all indicators in Round 3 was also the same as in Round 2 (between 5 and 9 points; interquartile range 1–3), although the total range score was slightly higher (193 compared to 184 in Round 2).

For each stakeholder, the total score for all 28 indicators in Round 3 ranged from 115 to 280 (mean = 227.97, SD = 22.11). In previous rounds, the lowest scores had been 151 and 152, and the mean scores had been 230.80 and 229.06. Further checks revealed that, in fact, only two stakeholders had total scores lower than 150 in Round 3 (115 and 140) and two had total scores lower than 200 (180

Table 3. Recovery indicator scores for Round 1 ($N = 141$).

Indicator	Mean	SD	Median	Mode	Min	Max	Range	IQR
1. Not drinking too much	8.65	1.96	10	10	1	10	9	2
2. Not using street drugs	8.94	1.88	10	10	1	10	9	2
3. Not experiencing cravings	6.15	2.62	7	5	1	10	9	3
4. Taking care of mental health	9.26	1.09	10	10	5	10	5	2
5. Coping with problems without turning to drugs/alcohol	9.43	0.99	10	10	5	10	5	1
6. Feeling emotionally stable and secure	8.62	1.36	9	10	5	10	5	2
7. Feeling like a worthwhile person	9.08	1.12	10	10	6	10	4	2
8. Taking care of physical health	8.30	1.45	8	8	4	10	6	3
9. Managing pains and ill-health without misusing drugs/alcohol	8.90	1.33	9	10	5	10	5	2
10. Taking care of appearance	7.26	1.81	7	8	2	10	8	2
11. Eating a good diet	7.74	1.61	8	8	3	10	7	2
12. Sleeping well	7.94	1.69	8	8	1	10	9	2
13. Getting on well with people	7.38	1.64	8	8	1	10	9	2
14. Feeling supported by people	8.43	1.41	8	10	4	10	6	2
15. Having stable housing	8.93	1.21	9	10	5	10	5	2
16. Having a regular income (from benefits, work, other legal sources)	8.65	1.46	9	10	3	10	7	2
17. Managing money well	7.85	1.50	8	8	3	10	7	2
18. Having a good daily routine	8.23	1.48	8	8	3	10	7	3
19. Going to appointments	7.94	1.70	8	8	2	10	8	2
20. Spending free time on hobbies/interest that do not involve drugs/alcohol	8.73	1.40	9	10	4	10	6	2
21. Participation in education, training or work (paid or voluntary)	7.96	1.54	8	8	3	10	7	2
22. Feeling happy with overall quality of life	7.98	1.37	8	8	3	10	7	2
23. Feeling positive	7.91	1.48	8	8	3	10	7	2
24. Having realistic hopes and goals for oneself	8.29	1.47	8	8	4	10	6	2
25. Being treated with respect and consideration by other people	8.20	1.58	8	8	3	10	7	3
26. Treating others with respect and consideration	8.50	1.38	8	10	5	10	5	2
27. Being honest and law-abiding	8.16	1.67	8	8	3	10	7	3
28. Trying to help and support other people	7.39	1.88	8	8	1	10	9	3

Table 4. Recovery indicator scores for Round 2 ($N = 120$).

Indicator	Mean	SD	Median	Mode	Min	Max	Range	IQR
1. Not drinking too much	8.83	1.32	9	9	3	10	7	2
2. Not using street drugs	9.12	1.29	10	10	4	10	6	1
3. Not experiencing cravings	6.03	2.26	6	5	1	10	9	3
4. Taking care of mental health	8.93	1.05	9	10	5	10	5	2
5. Coping with problems without turning to drugs/alcohol	9.32	0.90	10	10	5	10	5	1
6. Feeling emotionally stable and secure	8.39	1.17	8	8	5	10	5	1
7. Feeling like a worthwhile person	8.58	1.29	9	8	5	10	5	2
8. Taking care of physical health	8.08	1.18	8	8	5	10	5	2
9. Managing pains and ill-health without misusing drugs/alcohol	8.90	1.26	9	9	3	10	7	2
10. Taking care of appearance	6.88	1.84	7	8	1	10	9	2
11. Eating a good diet	7.58	1.40	8	8	4	10	6	1
12. Sleeping well	7.91	1.27	8	8	4	10	6	2
13. Getting on well with people	7.33	1.50	7	8	1	10	9	1
14. Feeling supported by people	8.09	1.32	8	8	2	10	8	1
15. Having stable housing	8.92	1.16	9	10	5	10	5	2
16. Having a regular income (from benefits, work, other legal sources)	8.77	1.17	9	10	4	10	6	2
17. Managing money well	7.94	1.41	8	8	1	10	9	2
18. Having a good daily routine	8.36	1.34	8	8	5	10	5	2
19. Going to appointments	8.04	1.59	8	8	2	10	8	2
20. Spending free time on hobbies/interest that do not involve drugs/alcohol	8.72	1.25	9	10	5	10	5	2
21. Participation in education, training or work (paid or voluntary)	8.27	1.26	8	8	4	10	6	1
22. Feeling happy with overall quality of life	8.05	1.09	8	8	5	10	5	1
23. Feeling positive	7.98	1.14	8	8	5	10	5	2
24. Having realistic hopes and goals for oneself	8.31	1.06	8	8	5	10	5	1
25. Being treated with respect and consideration by other people	7.98	1.30	8	8	3	10	7	2
26. Treating others with respect and consideration	8.19	1.39	8	8	2	10	8	1
27. Being honest and law-abiding	8.08	1.57	8	8	1	10	9	2
28. Trying to help and support other people	7.49	1.66	8	8	1	10	9	3

Table 5. Recovery indicator scores for Round 3 ($N = 113$).

Indicator	Mean	SD	Median	Mode	Min	Max	Range	IQR
1. Not drinking too much	8.94	1.18	9	9	4	10	6	3
2. Not using street drugs	9.08	1.20	9	10	3	10	7	1
3. Not experiencing cravings	6.23	2.15	7	5	1	10	9	3
4. Taking care of mental health	8.89	0.95	9	9	5	10	5	2
5. Coping with problems without turning to drugs/alcohol	9.29	0.92	10	10	5	10	5	1
6. Feeling emotionally stable and secure	8.18	1.15	8	8	5	10	5	1
7. Feeling like a worthwhile person	8.58	1.10	9	8	2	10	8	1
8. Taking care of physical health	8.00	1.12	8	8	5	10	5	2
9. Managing pains and ill-health without misusing drugs/alcohol	8.81	0.95	9	9	5	10	5	2
10. Taking care of appearance	7.24	1.42	7	8	1	10	9	2
11. Eating a good diet	7.64	1.21	8	8	4	10	6	1
12. Sleeping well	7.81	1.07	8	8	3	10	7	1
13. Getting on well with people	7.04	1.41	7	7	1	10	9	2
14. Feeling supported by people	7.94	1.11	8	8	5	10	5	2
15. Having stable housing	8.85	1.06	9	9	5	10	5	2
16. Having a regular income (from benefits, work, other legal sources)	8.57	1.06	9	9	5	10	5	1
17. Managing money well	7.92	1.21	8	8	1	10	9	2
18. Having a good daily routine	8.39	1.16	8	8	5	10	5	1
19. Going to appointments	7.96	1.67	8	8	1	10	9	2
20. Spending free time on hobbies/interest that do not involve drugs/alcohol	8.69	1.16	9	9	1	10	9	1
21. Participation in education, training or work (paid or voluntary)	8.13	1.36	8	8	1	10	9	2
22. Feeling happy with overall quality of life	7.98	1.12	8	8	1	10	9	2
23. Feeling positive	7.91	1.04	8	8	5	10	5	1
24. Having realistic hopes and goals for oneself	8.25	1.14	8	8	5	10	5	2
25. Being treated with respect and consideration by other people	7.85	1.15	8	8	5	10	5	2
26. Treating others with respect and consideration	8.27	1.30	8	8	1	10	9	1
27. Being honest and law-abiding	8.21	1.30	8	8	1	10	9	1
28. Trying to help and support other people	7.32	1.69	8	8	1	10	9	2

and 195). All other 109 stakeholders had total scores of more than 200.

Round 3 Hypothesis B: Round 3 scores would not vary significantly by core stakeholder characteristics, such as gender, job role or location of work

To test for differences between the mean scores of sub-groups of stakeholders, the 113 individuals participating in Round 3 were grouped as follows: (i) male versus female; (ii) personally not in recovery versus personally in recovery; (iii) practitioner versus non-practitioner; (iv) working in London versus working outside London and (v) working in the drug/alcohol field for ≤ 10 years versus working in the drug/alcohol field for ≥ 11 years. As data for the 28 indicators were not normally distributed, analyses were conducted using the non-parametric test: Mann–Whitney *U*. This yielded 140 separate test results (28×5) (Table 6). Significant differences (at $p < 0.05$ and $p < 0.01$) were identified on 24/140 tests conducted; none of these related to gender.

Individuals in recovery rated four indicators as more important than those personally not in recovery: “not using street drugs” (9.36 vs. 9.06; $p = 0.020$); “coping with problems without turning to drugs/alcohol” (9.71 vs. 9.23; $p = 0.003$); “treating others with respect and consideration” (8.75 vs. 8.13; $p = 0.012$) and “being honest and law-abiding” (8.86 vs. 8.04; $p = 0.003$).

Non-practitioners rated six indicators as more important than practitioners: “having a regular income (from benefits, work, other legal sources)” (8.75 vs. 8.31; $p = 0.009$); “managing money well” (8.08 vs. 7.71; $p = 0.007$); “having a good daily routine” (8.54 vs. 8.19; $p = 0.02$); “participation in education, training or work (paid or voluntary)” (8.35 vs. 7.83; $p = 0.003$); “having realistic hopes and goals for oneself” (8.42 vs. 8.02; $p = 0.034$) and “trying to help and support other people” (7.58 vs. 6.96; $p = 0.004$). Individuals working in London rated “being treated with respect and consideration by other people” as more important than those working elsewhere (8.30 vs. 7.73; $p = 0.035$).

Individuals working in the drug/alcohol field for ≥ 11 years rated 13 indicators as more important than those working in the field for ≤ 10 years: “managing pains and ill-health without misusing drugs/alcohol” (8.98 vs. 8.63; $p = 0.038$); “taking care of appearance” (7.66 vs. 6.78; $p = 0.001$); “eating a good diet” (7.88 vs. 7.37; $p = 0.023$); “sleeping well” (8.03 vs. 7.57; $p = 0.024$); “getting on well with people” (7.44 vs. 6.61; $p = 0.001$); “having stable housing” (9.08 vs. 8.59; $p = 0.024$); “having a regular income (from benefits, work, other legal sources)” (8.92 vs. 8.19; $p = 0.001$); “managing money well” (8.29 vs. 7.52; $p = 0.001$); “having a good daily routine” (8.63 vs. 8.13; $p = 0.036$); “participation in education, training or work (paid or voluntary)” (8.41 vs. 7.83; $p = 0.032$); “treating others with respect and consideration” (8.58 vs. 7.93; $p = 0.011$); “being honest and law-abiding” (8.54 vs. 7.85; $p = 0.007$); and “trying to help and support other people” (7.78 vs. 6.81; $p = 0.003$).

Discussion

Our prior work had generated a list of 28 indicators that seemed to capture the multi-dimensional nature of recovery

(Laudet, 2009). Three indicators were explicitly about drugs/alcohol: “not drinking too much”, “not using street drugs” and “not experiencing cravings”. A further three were indirectly related to drugs/alcohol: “coping with problems without turning to drugs/alcohol”, “managing pains and ill-health without misusing drugs/alcohol” and “spending free time on hobbies/interests that do not involve drugs/alcohol”. In addition, the indicator “attending appointments” is meaningful within the context of addiction recovery, but probably has little significance for the general population. The remaining 21 indicators might reasonably be described as markers of general wellbeing or quality of life.

Analyses of the data confirmed our *Round 1 Hypothesis*: when stakeholders were asked to score each of the 28 indicators on a scale of 1–10 for importance, scores were high. This was evident in the Round 1 median, mean and mode scores. Furthermore, the lowest total score for all indicators in Round 1 was 151/280, revealing that no individual consistently scored all indicators low. The only exception to the relatively high scores was the indicator: “experiencing cravings”, which had a Round 1 mean score of 6.15 (reducing to 6.03 in Round 2 and increasing to 6.23 in Round 3). Our data cannot explain why “experiencing cravings” scored lower than the other indicators. However, one potential explanation is that cravings persist long after substance use has decreased or stopped and they are therefore perceived as relatively “recovery insensitive”. A second possible explanation is that cravings are deemed beyond personal control and therefore on-going cravings are not seen as reflecting the effort that an individual may be making “to recover” (Neale et al., 2015). Third, it is conceivable that a negative construct, such as cravings, is generally difficult to reconcile with the positive concept of recovery.

In terms of our *Round 2 Hypothesis* (if stakeholders were told the mean score for everyone in Round 1 and asked to score the indicators a second time, greater consensus would emerge), the narrowing total range score between Rounds 1 and 2 (191 points to 184 points) provided some confirmatory evidence. Meanwhile, an overall trend to consensus seemed to be further supported by summing the interquartile range scores for all indicators separately for each Round (61 points in Round 1, 48 points in Round 2 and 46 points in Round 3). Increasing consensus was not, however, certain across the three rounds, since a small number of individuals scored indicators significantly lower in Round 3 than in previous rounds and the total range score increased at Round 3. From this we might argue that the Delphi method facilitated some, but not complete, consensus.

In contrast, there was strong support for *Round 3 Hypothesis A*. Of the 28 indicators, 27 scored ≥ 7 in Round 3. This provided good evidence that the indicators were considered to be important by a wide range of stakeholders. *Round 3 Hypothesis B* (that Round 3 scores would not vary significantly by core stakeholder characteristics) was confirmed on 116/140 occasions. Nonetheless, there were some statistically significant differences (at the 95% and 99% confidence levels), with those who had worked in the sector for longer, non-practitioners and those who were themselves in recovery rating some indicators higher than those who had worked in the sector for less time, were practitioners or did

Table 6. Mann–Whitney U tests comparing Round 3 scores by stakeholder characteristics (N = 113).

Indicator	Gender (N)		Personally in recovery (N) ^a		Current job/role (N)		Location of work (N)		Years in addiction field (N)	
	Male (60) Mean (SD)	Female (53) Mean (SD)	No (82) Mean (SD)	Yes (28) Mean (SD)	Practitioner (48) Mean (SD)	Other (65) Mean (SD)	London (23) Mean (SD)	Other (90) Mean (SD)	≤10 years (54) Mean (SD)	≥11 years (59) Mean (SD)
1. Not drinking too much	9.07 (1.11)	8.79 (1.24)	9.07 (0.85)	8.82 (1.41)	9.04 (1.05)	8.86 (1.27)	9.04 (0.76)	8.91 (1.26)	8.93 (1.28)	8.95 (1.09)
2. Not using street drugs	9.27 (1.03)	8.87 (1.34)	9.06 (1.05)*	9.36 (1.25)	9.10 (0.92)	9.06 (1.37)	8.96 (0.92)	9.11 (1.26)	8.83 (1.46)	9.31 (0.85)
3. Not experiencing cravings	6.02 (2.18)	6.47 (2.10)	6.40 (1.98)	5.93 (2.35)	6.04 (2.22)	6.37 (2.10)	6.17 (1.64)	6.24 (2.27)	5.78 (2.38)	6.64 (1.83)
4. Taking care of mental health	8.87 (1.06)	8.92 (0.82)	8.94 (0.80)	8.89 (1.10)	8.94 (0.86)	8.86 (1.02)	8.87 (0.62)	8.90 (1.02)	8.83 (1.12)	8.95 (0.77)
5. Coping with problems without drugs/alcohol	9.33 (0.89)	9.25 (0.95)	9.23 (0.80)**	9.71 (0.53)	9.40 (0.79)	9.22 (1.00)	9.13 (0.81)	9.33 (0.94)	9.28 (1.01)	9.31 (0.83)
6. Feeling emotionally stable and secure	8.28 (1.07)	8.06 (1.23)	8.20 (1.04)	8.18 (1.33)	8.35 (1.12)	8.05 (1.16)	8.13 (1.01)	8.19 (1.14)	8.02 (1.28)	8.32 (1.00)
7. Feeling like a worthwhile person	8.60 (1.22)	8.55 (0.97)	8.61 (0.84)	8.43 (1.68)	8.52 (0.94)	8.62 (1.22)	8.57 (0.89)	8.58 (1.16)	8.35 (1.30)	8.78 (0.85)
8. Taking care of physical health	7.92 (1.07)	8.09 (1.18)	7.99 (1.08)	8.11 (1.16)	8.04 (1.07)	7.97 (1.17)	8.04 (1.06)	7.99 (1.14)	7.80 (1.21)	8.19 (1.00)
9. Managing pains/fill-health without drugs/alcohol	8.77 (1.01)	8.87 (0.90)	8.89 (0.78)	8.79 (1.03)	8.73 (0.89)	8.88 (1.00)	8.91 (0.79)	8.79 (1.00)	8.63 (0.99)*	8.98 (0.90)
10. Taking care of appearance	7.30 (1.51)	7.17 (1.34)	7.18 (1.33)	7.57 (1.20)	7.17 (1.19)	7.29 (1.58)	7.22 (0.99)	7.24 (1.52)	6.78 (1.62)**	7.66 (1.07)
11. Eating a good diet	7.60 (1.19)	7.68 (1.23)	7.54 (1.11)	8.00 (1.38)	7.75 (1.10)	7.55 (1.28)	7.48 (1.12)	7.68 (1.23)	7.37 (1.29)*	7.88 (1.08)
12. Sleeping well	7.80 (0.97)	7.83 (1.18)	7.79 (1.02)	7.96 (1.13)	8.00 (0.89)	7.68 (1.17)	7.74 (1.01)	7.83 (1.09)	7.57 (1.23)*	8.03 (0.85)
13. Getting on well with people	6.97 (1.39)	7.13 (1.45)	7.18 (1.30)	6.89 (1.31)	6.98 (1.17)	7.09 (1.57)	7.17 (1.23)	7.01 (1.46)	6.61 (1.60)**	7.44 (1.08)
14. Feeling supported by people	7.75 (1.18)	8.15 (0.98)	8.06 (0.98)	7.68 (1.30)	7.85 (1.09)	8.00 (1.13)	8.13 (1.01)	7.89 (1.13)	7.78 (1.09)	8.08 (1.11)
15. Having stable housing	8.77 (1.12)	8.94 (0.98)	8.84 (0.92)	8.96 (1.23)	8.83 (1.03)	8.86 (1.08)	8.87 (0.92)	8.84 (1.10)	8.59 (1.19)*	9.08 (0.87)
16. Having a regular income	8.48 (1.14)	8.66 (0.96)	8.65 (0.89)	8.43 (1.31)	8.31 (0.99)**	8.75 (1.07)	8.61 (1.07)	8.56 (1.06)	8.19 (1.15)**	8.92 (0.83)
17. Managing money well	7.83 (1.16)	8.02 (1.15)	8.00 (0.93)	8.00 (1.24)	7.71 (0.98)**	8.08 (1.33)	8.13 (1.05)	7.87 (1.24)	7.52 (1.41)**	8.29 (0.85)
18. Having a good daily routine	8.33 (1.21)	8.45 (1.11)	8.49 (1.05)	8.21 (1.34)	8.19 (0.96)*	8.54 (1.28)	8.57 (0.89)	8.34 (1.22)	8.13 (1.15)*	8.63 (1.14)
19. Going to appointments	7.73 (1.86)	8.23 (1.39)	8.09 (1.50)	7.86 (1.69)	8.27 (1.12)	7.74 (1.96)	8.17 (0.88)	7.91 (1.82)	7.74 (1.93)	8.17 (1.37)
20. Spending time on hobbies without drugs/alcohol	8.60 (1.38)	8.79 (0.86)	8.78 (0.86)	8.71 (1.08)	8.52 (0.98)	8.82 (1.27)	8.83 (0.98)	8.66 (1.21)	8.54 (1.39)	8.83 (0.89)
21. Participation in education, training or work	8.17 (1.50)	8.09 (1.18)	8.23 (1.13)	8.14 (1.29)	7.83 (1.03)**	8.35 (1.52)	8.09 (1.41)	8.14 (1.35)	7.83 (1.48)*	8.41 (1.17)
22. Feeling happy with overall quality of life	7.92 (1.29)	8.06 (0.90)	8.10 (0.84)	7.89 (1.10)	7.90 (0.92)	8.05 (1.25)	8.22 (0.95)	7.92 (1.16)	7.76 (1.35)	8.19 (0.81)
23. Feeling positive	7.95 (1.03)	7.87 (1.05)	7.91 (0.91)	8.00 (1.24)	7.83 (1.05)	7.97 (1.03)	7.70 (0.97)	7.97 (1.05)	7.83 (1.12)	7.98 (0.95)
24. Having realistic hopes and goals for oneself	8.20 (1.07)	8.30 (1.23)	8.17 (1.08)	8.29 (1.24)	8.02 (1.13)*	8.42 (1.13)	8.26 (0.96)	8.24 (1.19)	8.11 (1.23)	8.37 (1.04)
25. Being treated with respect/consideration by people	7.77 (1.18)	7.94 (1.13)	7.93 (1.02)	7.75 (1.137)	7.88 (1.06)	7.83 (1.23)	8.30 (0.87)*	7.73 (1.19)	7.67 (1.22)	8.02 (1.07)
26. Treating others with respect/consideration	8.32 (1.17)	8.21 (1.45)	8.13 (1.29)*	8.75 (1.17)	8.10 (1.07)	8.38 (1.45)	8.39 (1.07)	8.23 (1.36)	7.93 (1.46)*	8.58 (1.07)
27. Being honest and law-abiding	8.36 (1.16)	8.06 (1.44)	8.04 (1.28)**	8.86 (1.07)	8.17 (1.20)	8.25 (1.38)	8.26 (0.86)	8.20 (1.40)	7.85 (1.49)**	8.54 (1.00)
28. Trying to help and support other people	7.53 (1.72)	7.08 (1.63)	7.27 (1.54)	7.79 (1.77)	6.96 (1.41)**	7.58 (1.83)	7.52 (1.31)	7.27 (1.77)	6.81 (1.86)**	7.78 (1.36)

*p < 0.05; **p < 0.01.

^aThree participants responded “Do not wish to answer”.

not report that they were in recovery. Despite this, mean scores for most sub-groups were still ≥ 7 and no sub-group scored any indicator (except “experiencing cravings”) lower than 6.61. Furthermore, absolute differences between mean indicator scores for high and low scoring sub-groups were consistently small (never more than 1 point for any indicator), suggesting that further analyses would have little real world significance.

Strengths and limitations

Our consultation exercise inevitably has both strengths and weaknesses. A key strength is that all 28 indicators had been identified following extensive consultation and testing with service users and we were confident that they captured the views of a very wide range of individuals in treatment and recovery. In addition, we engaged a diverse sample of 146 individuals working within the addictions sector, with good participation in all three rounds (141, 120 and 113 individuals, respectively). Despite this, participants only came from the British Isles and did not include those working in non-specialist services or others with a personal or lay interest in recovery. Furthermore, many of the broader well-being and quality of life indicators might be critiqued for (i) implying that drug and alcohol users are not responsible, productive members of society unless and until they “recover” and (ii) perpetuating normative judgments about how people should live their lives (Lancaster et al., 2015). In this regard, we must remain vigilant to the fact that (even well-intentioned) endeavours to define constructs are never value free. Moreover, unless we simultaneously address the various complex personal, social and structural barriers to recovery that people experiencing addiction often encounter, any attempt to measure recovery may have the unintended consequence of further excluding those citizens who are already most vulnerable and marginalized (Keane, 2012; Lancaster et al., 2015).

Conclusions

Through extensive consultation, we have identified 27 recovery indicators that a diverse group of stakeholders working within the addiction field consistently rank as important. Whilst we have not achieved total consensus, this was not the intention. Our stated aim was to identify recovery indicators that most stakeholders would agree are important most of the time for most people (c.f. Neale & Strang, 2015). Our findings show that the concept of recovery has the potential to be measured in a meaningful way. Indeed, the degree of consensus achieved is a notable advance on the results of our first Delphi group exercise involving 25 service providers, which found considerable disagreement between professionals on the importance of individual indicators (Neale et al., 2014). Our current work is, however, still limited in scope and scale. Further clarity on what is meant by the term recovery, its relevance and value, and how we can best measure it will therefore be achieved by replicating our methods (or a variation of them) in other countries, including larger numbers of participants and additional stakeholder groups, such as politicians, journalists, family members and the general public.

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