Inter Rater Reliability of Recovery Capital: Assessment of a Clinician Rated Measure

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This thesis is presented in partial fulfilment of the requirements for the degree of Bachelor of Arts (Honours), Murdoch University, 2012
I declare that this thesis is my own account of my research and contains as its main content work which has not previously been submitted for a degree at any tertiary educational institution.

Ben May .......................................................... (signature)
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Full Name of Degree: Bachelor of Arts in Psychology with Honours

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Abstract

This study investigated the inter rater reliability for the Clinician Recovery Capital Measure as a tool to assess recovery capital for clients with alcohol and other drug problems. The sample consisted of 15 women \((M = 40.07\) years, \(SD = 10.79\) years) and 6 men \((M = 47.83\) years, \(SD = 13.57\) years), who had at least a three year degree or equivalent in a relevant field plus professional/practical experience with mental health clients. Assessment of inter rater reliability required participants to code standardised case notes using the Clinician Recovery Capital Measure. Data were analysed for total recovery capital as well as the subcategories of social, human, cultural and physical capital. Use of the Intra Class Correlation Coefficient (ICC) demonstrated excellent levels of inter rater reliability for total recovery capital ICC = 0.909, social capital ICC = 0.884, human capital ICC = 0.775, cultural capital ICC = 0.857, and physical capital ICC = 0.975. These ICC results demonstrate that the Clinician Recovery Capital Measure can be reliably coded by a range of mental health practitioners in an Australian clinical context. This study is an important step in the development of the clinician recovery capital measure and the process of operationalising recovery.

**Keywords:** AOD, Australian, clinician, inter rater reliability, intra class correlation, recovery capital, substance misuse, CRCM
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Inter Rater Reliability of Recovery Capital: Assessment of a Clinician Rated Measure

Alcohol and Other Drug (AOD) dependence has been identified as an important mental health concern in contemporary Australian society, with the National Survey of Mental Health and Wellbeing identifying that over 800,000 Australians met the criteria for a diagnosis of substance use disorder (Australian Bureau of Statistics, 2007). This prevalence rate represents a great burden on the lives of those affected individuals, their families and the community in general. For this reason, research has begun to look more closely at recovery from AOD dependence, and the resources needed to promote that recovery, also known as recovery capital.

The construct of Recovery capital can be defined as the personal resources, traits and abilities of a person that contribute to their ceasing substance misuse, and maintaining that abstinence (White & Cloud, 2008). These include such elements as self efficacy, social skills, education, attachment and cultural values (Best, 2010b). Specifically, Cloud and Granfeild (2008) define recovery capital as “the sum total of one’s resources that can be brought to bear on the initiation and maintenance of substance misuse cessation”. Bennet (2005) produced the Clinician Rated Recovery Measure (CRCM) in order to operationalise recovery capital. The purpose of this paper was to report on a study of Inter Rater Reliability (IRR) for the CRCM.

The CRCM was designed with the clinician in mind as the rater of a client’s alcohol and other drug AOD related recovery resources. Recovery capital thus operationalised, provides a valuable metric for use by clinicians and public health policy makers who wish to evaluate the outcomes of recovery orientated policies and interventions. Assessing the psychometric properties of the CRCM is an essential
step in establishing the potential value of this measure for research and clinical assessment.

**Background**

There is now a fundamental shift occurring in Australian mental health policy, from a focus on acute intervention towards a recovery focussed perspective (Department of Health and Aging, 2009). A similar shift is well documented as in many western countries (AMHOCN 2010), particularly the US (Gagne, 2007), U.K. (Home Office, 2008), Australia (AMHOCN 2010), and New Zealand (Slade, Amering, & Oades, 2008). The Australian commitment toward recovery focused policy is seen in frequent references to recovery in key mental health policy documents (Marshall, 2007). International professional organisations are likewise adopting the rhetoric and policies of recovery, including groups such as the Royal College of Psychiatrists (Wallcraft, Tew, Griffiths, & Nicholls, 2007) and the American Psychiatric Association (American Psychiatric Association, 2005).

**Recovery**

Review of the literature reveals three interpretations and uses of the term recovery, each with a different emphasis. These uses being: clinical (AMHOCN 2010), which focuses on traditional treatment approaches, personal (Slade et al., 2008), which focuses on the continued adaptation to living with the effects of mental illness, and AOD recovery (White, 2007) which focuses on the maintenance of control over substance misuse. This lack of consensus in defining recovery has a negative impact on clinical research and practice, and on communication among professionals, the public and policy makers (Laudet, 2008). This situation can only be resolved satisfactorily through the availability of psychometrically sound
measures that operationalise recovery and so provide an acceptable common metric of assessment.

**Clinical recovery.**

Traditional medical models of recovery focus on acute stabilisation, sustained remission, reduction in symptoms and improved functioning of clients in everyday life (AMHOCN 2010). This definition of recovery carries the distinct advantage of being invariant across individuals, and allowing relative ease in operationalising variables (Slade et al., 2008). These properties of clinical recovery allow for the reliable rating of variables and readily facilitate long term epidemiological prevalence studies (Slade et al., 2008).

**Personal recovery.**

The personal view of recovery stems from grass roots consumer movements. It draws on the documented experiences of people living with mental illness and emphasise learning and adaptation to ongoing life (White, 2009). The Mental Health Commission of New Zealand (2001) defined personal recovery as “the ability to live well in the presence or absence of one’s mental illness”, and described recovery as being as much a journey as a destination. Personal recovery involves an individual’s change and adaptation to a life affected by mental illness.

The emphasis of personal recovery is not on the return to a level of function or to attitudes that might mirror an affected person’s earlier life experience. Rather, personal recovery refers to finding meaning and purpose in life as a changed person, and in the presence of any ongoing residual symptoms of mental illness. This process of change and adaptation constitutes an ongoing way of life. Definitions such as these highlight the move from traditional medical and service based
interceptions of recovery, to more personal and user based definitions of the term (AMHOCN 2010).

The inherently individual nature and subjectivity of this definition carry negative implications for research, in that the objective measurement of recovery becomes problematic (White, 2007). Such shortcomings in the assessment of recovery outcomes lead to difficulties in policy and case management, and have brought many experts and leaders to call for valid, reliable measures of personal recovery (Slade et al., 2008).

AOD recovery.

Those involved in the AOD typically field hold an interpretation of recovery that sits between the clinical and personal definitions of the term. AOD recovery can be defined as an individual’s maintenance of control over substance use, in a manner facilitating their ongoing global health and social engagement (UK Drug Policy Commission, 2008).

White (2007) identified three core elements of recovery in the AOD sense. The first being remission from the substance use disorder. This factor shares the relatively clear cut nature of variables as is found in clinical interpretations of recovery. The second core element of AOD recovery is enhanced global health, and includes physical and emotional health, relationships, and life meaning or purpose. Citizenship and positive community inclusion form the third element of AOD recovery. These second and third core components include considerations that are more in keeping with the individualistic nature of personal recovery.

The challenge for those who would employ any of the above definitions of recovery is to conceptualise recovery as a measurable outcome (Groshkova & Best,
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2011; Royal Society for the Encouragement of Arts, Manufactures and Commerce [RAS], 2010; Slade et al., 2008; White, 2007). It was this challenge that led to the concept of recovery capital, and the development of relevant measures.

Objections to recovery.

The need for conceptual clarity and a dependable research base for recovery are seen in the concerns expressed by those who are critical of the recovery movement.

One such concern often raised is that research on recovery processes and outcomes is relatively limited (Best, 2010a). While it is true that data on the actual processes of recovery are limited, there is extensive documented evidence that on the whole people can in fact learn to live with their mental illness (Davidson, 2006).

Concerns over the research base specifically for AOD recovery are much the same. While there is considerable data available on the trends of drug use and related casualties, details of AOD recovery are relatively little known (White, 2008). A challenge for researchers is to investigate the implementation of current evidence based interventions as they impact on and facilitate recovery.

Such concerns can only be properly addressed through the research and understanding facilitated by the operationalisation of recovery (Best, 2010a; Davidson, 2006; White, 2008). The present study plays a part in this process by contributing to the development of the CRCM as a measure that allows this operationalisation.

Recovery Capital

Recovery capital deals with AOD issues and therefore necessarily follows an AOD interpretation of recovery. Recovery capital addresses a “strengths based” approach to recovery assessment with a focus on protective environmental factors
and psychological resilience (White & Cloud, 2008). The foundations of the recovery capital concept lie in research by Cloud and Granfield (Granfield & Cloud, 1999, 2001) into “natural recovery”, or recovery from AOD dependence problems without formal intervention or clinical treatment.

Their initial work consisted of several qualitative studies using a grounded approach to analyse interviews with informants who formerly met the diagnostic criteria set out in the DSM-IV (Association, 2000) for substance dependence. The aim and result of this work was the development of a construct capturing differences in capacity and prospects among individuals in their overcoming of substance misuse problems (Cloud & Granfeild, 2008).

Bandura (1999) refers to this work by Cloud and Granfield in terms of self efficacy, describing recovery capital as being the resources that “enable” a person to express their self efficacy as they take control of their lives. Bandura’s comments highlight the importance of a central theme running throughout the literature related to recovery capital; the building of a new life after AOD dependence is dependent on a person’s viewing their drug issues as surmountable problems (Best, 2010b).

Through developing the recovery capital construct, Cloud and Granfield (2008) refined four major forms of capital that vary among individuals and, according to those authors, bear heavily on the initiation and maintenance of recovery from AOD problems.

**Human capital.**

Human capital represents the capacity for behaviours that allow a person in recovery to function effectively and prosper in society (Cloud & Granfeild, 2008). Such individual attributes include intelligence, education, social skills, coping skills
and health (White & Cloud, 2008). Recovery involves rebuilding many aspects of life after AOD, and the capacity to do things differently and succeed is seen in human capital. According to Kadden (2011), there is a widespread acceptance in the substance abuse field that the teaching of coping skills and their subsequent application lead to a sense of mastery, which in turn leads to enhanced self efficacy. Such coping skills and self efficacy have emerged as important predictors for the initiation and maintenance of recovery from substance addiction (Bandura, 2007).

For example, a study conducted by Litt and Cooney (2003), revealed significant positive outcomes for an alcohol dependent sample, achieved through interventions aimed at increasing coping skills in situations that placed participants at risk of drinking. This effect was found to be just as strong whether the intervention was cognitive behaviour therapy or interactional therapy, suggesting that the mode of intervention was not as important as the focus on coping skills. Litt and Cooney also review a wide range of studies demonstrating the positive influence of increased coping skills for long term AOD recovery.

Social capital.

Social capital is an expression of the resources that assist an individual in recovery and are available as a result of relationships with family and acquaintances (Cloud & Granfeild, 2008). These resources include assistance such as financial and emotional support, information, and employment opportunities (Best, 2010b). As such, social capital represents a person’s actual or perceived social facilitators of AOD recovery. The significance of such facilitators can be seen in terms of social cognitive theory, which posits that a person’s change in health behaviours is a balance between their self efficacy, and outcome expectancies in terms of
impediments and facilitators of change (Bandura, 2004). Importantly, social capital also includes reciprocal obligations and commitments. These interpersonal connections potentially provide motivation and a sense of active social involvement and contribution (Cloud & Granfeild, 2008).

The significance of social capital is evident in such findings as those by McAweeney, Zucker, Fitzgerald, Puttler, and Wong (2005). Their nine year longitudinal study involving 134 participants, suggested that while the participants’ initial severity of Alcohol Use Disorder (AUD) was not a significant predictor of long term recovery, the AUD condition and social networks of their spouse was. Having a partner who is free of AUD and in possession of a large network of social support were positive predictors for long term recovery. These findings were supported in a review by Moos and Moos (2007) illustrating the importance of family, peer and social bonding and reciprocal relationships in AOD recovery.

**Cultural capital.**

Cultural capital is an expression of how the beliefs, values, and attitudes of a person in recovery “fit in” with the norms of the dominant culture (Cloud & Granfeild, 2008). Social conformity and the acceptance of cultural norms can play an important role in recovery (RAS, 2010). Those in recovery who still hold the values of a drug culture may find it difficult to prosper in mainstream society; this is even harder for those who are also from historically disadvantaged subcultures, such as many indigenous groups (White, 2009).

A series of formal mediation tests conducted by Henry (2008) found that a critical factor contributing to adolescent drug use was the disengagement from traditional cultural influences such as family and school. This effect was especially
strong when youths also demonstrated an engagement with antisocial influences, such as delinquent peers. The Henry study provided reinforcement for the findings of Guo et al (2002) in their examination of the sociodemographic, family and peer predictors for adolescent drug taking. Guo et al. found that association with antisocial influences was a major contributor to illicit drug problems in their cohort of 808 children assessed first at age 10, then again at age 21.

The issue being addressed here is not a lack of support (as in social capital), but rather the rejection of mainstream cultural values and ideals. Teruya (2010) expands on the importance of cultural capital in a review of the literature concerning turning points in people’s lives (such as marriage and parental responsibilities) and the associated effects on drug addiction. Their research provides a review of several studies that demonstrate a link between the adoption of prosocial values or cultural norms, and positive outcomes regarding substance use problems.

**Physical capital.**

Physical capital includes any property, income or financial assets that may be used by a person to assist in their recovery (Cloud & Granfeild, 2008). These assets provide access to services through health insurance, and options such as work leave, rehabilitation/detoxification, and even relocation to avoid the situations, cues and people who might impede the recovery process (Lyons, 2010). Financial resources facilitate the person’s capacity to engage in treatment and to make significant interpersonal changes. These processes are vital to AOD health behaviour change (Bandura, 2004).

**Measurement of Recovery Capital**

The field of recovery capital has developed to a stage where the need for
effective measures is being clearly expressed in studies by prominent researchers in the AOD arena (Best, 2010a; Cloud & Granfeild, 2008; White, 2008). In examining the literature, four measures were found that were designed specifically to assess recovery capital.

One short self report measure of recovery capital, simply titled “Recovery Capital Scale” is publicly available online (White, n.d.), and does not appear with any accompanying analysis of its psychometric properties. Sterling, Slusher and Weinstein (2008) also produced a study designed to assess recovery capital using several measures in combination. While they reported only modest predictive validity for patient recovery outcomes, it is important to note that the Sterling study was strongly biased toward the spiritual components of recovery capital, and assessed on an exclusively alcohol dependent sample. As pointed out by Groshkova and Best (2011) this limits the broader applicability of any findings in the assessment of recovery capital. Best and colleagues (2010b) have produced a more generally applicable, self report measure, called the Assessment of Recovery Capital (ARC). Groshkova and Best (2011) found what was described as acceptable concurrent validity for the ARC when correlated with measures for Quality of Life (QOL). These measures included the World Health Organization (The WHOQOL Group, 1998) quality of life assessment instrument and the Treatment Outcome Profile (Marsden et al., 2008). Their results also showed a moderate one week test retest reliability.

In addition to self report measures, clinician measures of recovery capital (such as the CRCM) provide an alternative perspective and flexibility, in a way similar to the Health of the Nation Outcome Scales (HoNOS) (Audin, Margison, Clark, &
Barkham, 2001). The HoNOS provides information that is routinely used for monitoring and improvement of mental health services in Australia and Britain, and provides a clinician perspective on patient clinical outcomes (Brooks, 2000). Clinician judgement may also be required in many cases to provide an assessment of recovery for individuals who are not available at the time of rating, or not in a fit state to fill in a questionnaire.

The CRCM is a clinical rated measure of recovery capital (Bennet 2005). This 100 item rating scale was the first measure designed to address recovery capital. Bennet also produced a rating guide for the CRCM, intended to increase rater consistency and accuracy while scoring cases. The CRCM is suitable for use in rating recovery capital using case notes and other records or in assessment interviews.

During an appraisal of predictive validity for the CRCM, Bennet (2005) found that recovery capital (as operationalised by the CRCM) was a better predictor of reoffending among drug offenders than other clinical or judicial variables including type of custodial sentence imposed or court mandated drug treatment. Scores on the CRCM also outperformed scores on the Level of Service Inventory-Revised (LSI-R) in predicting re-offense (Andrews & Bonta, 1995). The LSI-R is widely considered to be one of the best assessments of not only risk, but also as a guide to specific targets for intervention (Schlager & Pacheco, 2011).

These findings are important because they demonstrate the potential broader value of the recovery capital construct beyond clinical applications, as a guide to therapeutic jurisprudence. If the aim of court mandated drug treatment is the reduction of reoffending, and recovery capital is found to be a valid predictor of such
reoffending, then the potential value of recovery capital and the CRCM as a tool for the assessment of these interventions is demonstrated.

However, in order to establish the CRCM as a measure of observer ratings it must be assessed for inter rater reliability (Forsberg, Källmén, Hermansson, Berman, & Helgason, 2007). Whatever use the CRCM might be put to, the underlying value is in its operationalising of recovery capital. Given the long term focus of recovery it cannot be reasonably expected that the same clinician will be available to assess a given client at all stages of their recovery journey. As such, operationalization of recovery capital hinges on the interchangeability of clinicians for the rating of a client at various stages of their recovery. This property of consistency across judges is assessed through inter rater reliability studies.

Bennet (2005) performed an inter rater reliability study on the CRCM that consisted of 2 raters assessing 15 cases, which resulted in a spearman’s rho of 0.9; this result can be considered as having a large effect size (Cohen, 1988). The participants for this study were recruited from the Jersey (U.K.) criminal system and comprised individuals with known drug or alcohol problems and who had been referred by a Magistrate to the Jersey Alcohol and Drug Service. The materials assessed during the rating of each participant consisted of a completed LSI-R, an alcohol and drug assessment, criminal record and 18 month criminal outcome data for the period following their initial offence. As such, the case notes for the Bennet study consisted of records quite different from those one might expect to encounter in the Australian mental health context. The present study used standardised clinical case notes in order to address these issues for the broader applicability of results.

While the above factors distinguish the present study from the assessment
performed by Bennet (2005), her finding of an IRR showing a large effect size in a U.K forensic context was the basis for this research. The question addressed in this study was; do ratings using the CRCM show a sufficient level of inter rater reliability in an Australian clinical context to justify its use in this context?

To address this question, inter rater reliability was assessed using different raters’ scoring of standardised case notes using the CRCM. The statistic used to interpret this data was the Intraclass Correlation Coefficient (ICC), for which a result of >.75 is considered excellent (Cicchetti, 1994). Given previous evidence of high inter rater reliability for the CRCM, it was hypothesised that the level of consistency among different clinicians in their scoring of patient recovery capital using the CRCM would equate to an ICC of .75 or above.

Method

Participants

The sample consisted of 15 women \( (M = 40.07\) years, \(SD = 10.79\) years) and 6 men \( (M = 47.83\) years, \(SD = 13.57\) years). A three year degree or equivalent in a relevant field plus professional/practical experience with mental health clients was considered a minimum requirement for participation. This level of qualification was sought in order to align the participants in this study as closely as practical to the wide range of practitioners that might be expected to have use for the CRCM.

The intended sample size for the study was based on the recommendations of Walter, Eliasziw, and Donner (1998). These authors suggest that a sample of 20 participants rating three cases each would be sufficient to achieve an intraclass correlation coefficient with 80% power at \( \alpha = 0.05\).

Participants were recruited by email invitation, advertisement in the Australian
Psychological Society members news magazine InPsych, and by snowball sampling through professional contacts. Invitations included the offer to enter a prize draw to win a $50 book voucher as an incentive to participate. Online access to participation allowed for interstate recruitment and a broadening of the sample beyond local practitioners (3 interstate out of 21 total participants, 14%).

The majority of participants were psychologists (57%), while mental health nurses (10%), general nurses (10%), medical doctors (10%) and occupational therapists (10%) each contributed to the sample, alongside one quality services manager (5%). A masters degree was the most common participant qualification (33%), followed by doctorate (19%), PhD (14%), undergraduate degree plus diploma, and bachelor of nursing (each 10%), with one hospital trained nurse (5%). Participants from the private sector were the most common (57%), followed by those who identified as public sector (20%) or mixed private/public (20%), and one from non government organisations (5%). The participant interaction with AOD clients was split into groups; those who saw 10+ AOD clients per week (48%), with some seeing 5 to 10 AOD/week (14%), or 3 to 5 AOD/week (14%), and those who saw less than 1 such client per week (31%).

Materials

The clinician recovery capital measure.

The focus of this study was the CRCM developed by Bennet (2005). As mentioned earlier, in order to develop criteria representing Recovery Capital, Bennet first gained access to a cohort of individuals who had been referred by a Magistrate for assessment by both the Jersey (UK) Alcohol and Drug and the Jersey Probation Service. She then conducted a theory led thematic analysis of a comprehensive data
set available on each participant. This process resulted in the design of the original 100 items that were used to construct the CRCM.

Part of this construction was the option to individually assess each of the four subcategories (social, human, cultural, physical) of total recovery capital. This allows for a closer view of the client’s strengths in different areas, and the targeting of interventions or assessment. A rating guide was also developed by Bennet for use in conjunction with the CRCM. This guide was designed to increase rater consistency and more clearly define the items of the measure.

This original form of the CRCM was modified for the present study with the intention of simplifying response requirements, reducing the time required to complete the measure, and in order make the measure relevant to local clinical populations. The changes were made in consultation with senior AOD clinicians, with the result retaining all essential elements and scoring of the original measure.

Primary changes related to wording of the items to ensure that they were applicable to Australian clinicians rather than specific to Jersey (UK), for example replacing the term “Jersey” with “local area”. In addition, the CRCM was modified by localising currency estimates (eg changing the minimum wage to an equivalent for Australia). In addition the order and presentation of items were changed to enhance ease of completion. The items in the original CRCM (Bennet 2005) were listed by subcategories of recovery capital. This order was modified to follow clinical assessment categories with grouping of items to minimise unnecessary duplication of responding. In order to clarify some of the items, content from the rating guide was incorporated into the item. These and other changes of wording were aimed to reduce the ambiguity of item meanings, and increase rater
consistency. The rating guide was also modified to balance changes made to the items of the measure. The modifications were refined through piloting of the measure and checked to ensure the scoring process was retained.

**Psychometric properties of the CRCM.**

The original author of the CRCM (Bennet 2005) performed a preliminary inter rater reliability study of this instrument involving two raters, each assessing the same 15 cases. This exercise yielded a correlation coefficient of 0.9. The main psychometric finding of the Bennet study was of predictive validity in the judicial system, with that study indicating that reoffending risk could be reliably predicted through the assessment of participant recovery capital using the CRCM. Bennet found that every extra point of Recovery Capital was associated with a 5% reduction in the risk of reoffending during the 18 months following participation. However, the reliability of the instrument has not yet been assessed in a clinical context, which is the purpose of this study.

**Case Notes.**

For the current study, I constructed three sets of standardised case notes, designed to represent the kind of data found in the Australian clinical situations. Rather than using archival material for the rating task, standardised case notes were used to improve the internal validity of the study through ensuring control over the data and the availability of a full data set. However, to maintain similarity to a real world context and to enhance external validity, the notes were based on examples of admission assessment forms used in Australian mental health services.

Case notes were constructed to ensure a variation of details (e.g. age, living circumstances, drug use, history) that would allow variability in the scores. In
addition, this variation was intended to provide raters with an acceptably representative range of the characteristics that might be encountered in a clinical context. The draft versions of the notes were repeatedly piloted with senior clinicians and assessed using the CRCM, and changes made iteratively, so as to ensure that there was sufficient detail that a full rating could be achieved by participants who were not familiar with the CRCM. An experienced, senior clinician who specialises in treating clients with AOD problems piloted the case notes and deemed them to be very realistic. By the end of piloting, the rating process using the CRCM typically required 10-15 minutes to complete.

Procedure

This study was a correlational design, and involved no experimental manipulation or assignment of participants to different conditions. The variable of interest was the ratings given by participants for the recovery capital of each of the three sets of case notes. Expressed operationally, recovery capital was the obtained score (out of 100) given by the participant using the CRCM to rate one set of case notes.

The study was conducted through the SurveyMonkey website. This method of collection assisted in meeting ethical requirements for anonymity of respondents, as well as facilitating data entry. The web based encoding and storage of psychometric data in is study is in keeping with current trends in health care systems around the world towards electronic records management (Hillestad et al. 2005). Access was provided through a web link via invitational emails and advertised on the Australian Psychological Society website. A paper version of the study was made available on request. A full copy of the task is provided in Appendix A.
Respondents consented to participate after viewing the participant information sheet. The following page contained a set of demographic questions including participant’s level of education, professional role, and experience in the AOD area. General instructions were provided before the rating task commenced (see Appendix A).

The order of presentation for the three sets of case notes was randomised using features offered by the online survey provider. Each set of case notes was followed by a copy of the CRCM, including several links to a rating guide. This guide gave clarification for many of the CRCM items to aid participants in rating the cases and so to increase rating consistency (see Appendix B).

Upon completion of the main exercise, participants were asked for feedback on the usability and usefulness of the CRCM and offered the opportunity to enter a prize draw to win a $50 book voucher. The final page of the study provided further information and references on recovery capital.

Being an online study, the setting for the respondents’ participation was a venue of their own choosing and was not recorded as part of the study. Participants were not grouped in any way for analysis.

**Results**

Participants were recruited over the period 30\textsuperscript{th} July 2012 until 27\textsuperscript{th} September 2012. Recruitment was ceased once the participant pool surpassed the 20 required to provide power of 80\% at $\alpha = .05$ (Walter, Eliasziw, & Donner, 1998).

**Intraclass correlation.**

The focus of data analysis was the ICC as the basis for reporting the results of this inter rater reliability study (Shrout & Fleiss, 1979). While it is common to see
inter rater reliability results expressed using product moment correlations or the kappa statistic, both these methods risk the artificial inflation of results. Such statistics fail to allow for results that correlate while showing little agreement, while the ICC statistic does assess rater agreement and correlation simultaneously (Cicchetti, 1994). Further, given the nature of the data, the kappa statistic would unnecessarily lead to a sacrifice of information and loss of statistical power due to collapsing of data into categories (Donner & Eliasziw, 1994).

It is inadvisable to calculate a Cronbach’s alpha aimed at assessing internal consistency for the CRCM using this data, given that all participants are rating the same cases. As such it is not practical to argue that the ratings are independent of each other, rendering the data unsuited to calculations of internal consistency such as the alpha (Bland, 1997).

With these considerations in mind, the SPSS analysis consisted of a two way random (model), absolute agreement (type), intraclass correlation. The single measures ICC statistic was reported in order to indicate the reliability of an individual rater, and the interchangeability of raters. This procedure results in an intraclass correlation of the type designated ICC(2,1) by Shrout and Fleiss (1979).

The ICC(2,1) is recommended by Shrout and Fleiss (1979) for cases where a sample of judges is drawn from a larger population, and each judge rates every target. This model allows the generalisation of results to single (rather than average) raters in the larger population. An ICC(2,1) was conducted to analyse the results for total recovery capital. The four subcategories of recovery capital (social, human, cultural and physical) were also assessed individually in order to allow a deeper consideration of inter rater reliability for the CRCM as a whole.
Guidelines for assessing the clinical significance of ICC statistics are provided by (1994 Cicchetti GLines ICC). These guidelines indicate that an ICC > .44 is poor, .40 to .59 is fair, .60 to .74 is good, and .75 to 1.0 is considered excellent.

**Missing data.**

Data was only included in the analysis if the participant had completed the entire rating task, and as such all items were coded and there was no missing data. Where an item was deliberately coded with the option “?Unknown”, a score of 0.5 was given akin to an intermediate score assigned to the “neutral” rating on a Likert scale of agreement.

One participant was excluded from the analysis on the grounds that their rating consisted of a disproportionately large number of “?Unknown” ratings for two sets of case notes. Throughout the rest of the data set the distribution of “?Unknown” responses for all participants appeared randomly throughout.

**Descriptive statistics.**

The range of CRCM scores for each case was relatively small, in line with ICC results (for descriptive statics, see table 1). However a clear difference can be seen between the mean ratings for the cases. This difference is in line with the original intention to provide variation in the details of the cases so to allow variability in the obtained scores.

The ICC statistic was used to assess the level of inter rater reliability for all 21 raters, each scoring the same 3 cases using the CRCM. Overall the data set was found to be normally distributed, indicating that there is a wide spread of ratings across the three cases and across all the items of the CRCM. However as might be
expected, data was less normally distributed at the finer grained level where
participants rated individual cases on the subcategories of the CRCM.

Table 1

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Standard deviation</th>
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<tr>
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<td></td>
</tr>
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<td>Case 1</td>
<td>62.92</td>
<td>5.75</td>
<td>47.00 - 71.00</td>
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<tr>
<td>Case 2</td>
<td>80.85</td>
<td>3.13</td>
<td>73.50 - 85.50</td>
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<td>Case 3</td>
<td>47.73</td>
<td>6.29</td>
<td>38.50 - 62.00</td>
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<td>1.57</td>
<td>11.00 - 18.00</td>
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<tr>
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<td>18.01</td>
<td>0.79</td>
<td>17.00 - 19.50</td>
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<tr>
<td>Case 3</td>
<td>9.88</td>
<td>1.92</td>
<td>5.50 - 13.00</td>
</tr>
<tr>
<td><strong>Human Capital</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case 1</td>
<td>26.35</td>
<td>3.04</td>
<td>20.00 - 31.00</td>
</tr>
<tr>
<td>Case 2</td>
<td>35.71</td>
<td>2.02</td>
<td>32.50 - 40.00</td>
</tr>
<tr>
<td>Case 3</td>
<td>25.31</td>
<td>3.85</td>
<td>20.00 - 34.00</td>
</tr>
<tr>
<td><strong>Cultural Capital</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case 1</td>
<td>16.04</td>
<td>1.92</td>
<td>12.00 - 19.00</td>
</tr>
<tr>
<td>Case 2</td>
<td>20.11</td>
<td>1.12</td>
<td>17.00 - 22.00</td>
</tr>
<tr>
<td>Case 3</td>
<td>12.02</td>
<td>1.77</td>
<td>9.00 - 17.00</td>
</tr>
</tbody>
</table>

The ICC statistics were all in the “excellent” range (above .75): ICC (total
recovery capital) = .909, ICC(social) = .888, ICC(human) = .775, ICC(cultural) =
.875, ICC(physical) = .975. The ICC statistics were tested against zero, with
significant results of df (2, 40), \( p < .001 \) in each case. These F tests indicate a result
significantly different from zero, and also indicate some level of correlation between
raters (2002 Coleman Estimating p.9). Results for total recovery capital, as well as four subcategories are displayed in Table 2.

Table 2

*Intraclass Correlation Statistics for CRCM Inter Rater Reliability*

<table>
<thead>
<tr>
<th>Recovery Capital</th>
<th>ICC</th>
<th>95% CI</th>
<th>F Test with True Value 0*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Recovery Capital</td>
<td>0.909</td>
<td>.714 - .997</td>
<td>269.723*</td>
</tr>
<tr>
<td>Social Capital</td>
<td>0.884</td>
<td>.656 - .997</td>
<td>223.379*</td>
</tr>
<tr>
<td>Human Capital</td>
<td>0.775</td>
<td>.459 - .993</td>
<td>90.551*</td>
</tr>
<tr>
<td>Cultural Capital</td>
<td>0.857</td>
<td>.598 - .996</td>
<td>119.431*</td>
</tr>
<tr>
<td>Physical Capital</td>
<td>0.975</td>
<td>.909 - .999</td>
<td>792.479*</td>
</tr>
</tbody>
</table>

*Note.* All F tests have degrees of freedom (2, 40), *sig < .001, ICC = intraclass correlation coefficient, CI = confidence interval.

**Participant feedback.**

When asked to rate the case note for realism on a 5 point scale from 0 = “Not realistic” to 5 = “Very realistic”, participants reported, on average, that the case reports were “Quite realistic” (*M* = 3.94, *SD* = 1.06). When asked to rate how usable participants found the CRCM on a scale from 0 = “Quite difficult to use” to 5 = “Quite simple to use”, the mean responses was “Neutral” (*M* = 3.33, *SD* = 1.08).

**Discussion**

The hypothesis for this study was that the level of consistency among different clinicians in their scoring of patient recovery capital using the CRCM would equate to an ICC of .75 or above. This hypothesis was supported. Inter rater reliability for recovery capital assessment by a wide range of clinicians using the CRCM was found to be excellent (> .750) (Cicchetti, 1994) for total scores as well as scores on the four subcategories of recovery capital. These levels were consistent with the findings of Bennet (2005) during development of the CRCM as conducted in a U.K.
forensic context, and here support the use of the CRCM as a reliable measure of recovery capital in an Australian clinical context.

Recovery capital is an expression of the personal resources, traits and abilities of a person that contribute to their ceasing substance misuse, and maintaining that abstinence (Cloud & Granfeild, 2008). As such it is a construct that may be of use for a wide variety of health practitioners, and in varied settings. In addressing this range of application for the CRCM, this study found that excellent rater consistency was maintained across a diverse sample of participants with wide ranging training, education, occupation and engagement with AOD challenged clients. This diversity is important since recovery is a long term, ongoing process that may require assessment of the same client by different practitioners at points widely separated in time (Department of Health and Aging, 2009). In order to meaningfully interpret such results it is important to establish the interchangeability of raters using the CRCM (Forsberg et al., 2007). Such interchangeability is supported by the results of this study, with the data from varied practitioners being assessed using statistics [ICC(2,1)] specifically recommended for this purpose (Shrout & Fleiss, 1979). These results are particularly encouraging when it is considered that raters received no formal training in the use of the CRCM as part of this study.

The results seen here play a key part in the operationalisation of recovery capital, in that all other such measures seen in the literature rely on self report. As a reliable clinician rated measure the CRCM provides a valuable stand alone measure, as well as an alternative to self report measures. Clinician rating of recovery capital may be required for use in cases where a client is not in a position to fill out a self report measure, or where assessment of case notes is required.
Findings for this study can be seen in terms of the different definitions of recovery found in the literature, and their relationship with the subcategories of recovery capital. “Clinical” definitions of recovery deal chiefly with the presence or absence of symptoms and are relatively clear in terms of operationalisation (Slade et al., 2008). Such distinct considerations are also part of AOD recovery and are expressed in recovery capital (White, 2007). A concentration of clear cut considerations is found in the subcategory physical capital.

As assessed in this study, the reliability for physical capital was particularly high (.975). This result might be explained by the fact that this part of the measure requires little interpretation. Physical capital is concerned with assets, earnings and other quite objective aspects of recovery capital, and as such this very high level of rater agreement is to be expected. This is in contrast to human capital which showed the lowest, but still excellent (.775) level of rater consistency. The qualities of human capital are by nature relatively subjective and include such considerations as attachment, coping skills, and the client’s personal insight (Cloud & Granfeild, 2008). This lower level of agreement for human capital might be suggestive of the greater level of interpretation required in rating such items.

These results for human capital are expressive of the characteristics that are seen in common with definitions of “personal” and AOD recovery (White, 2007). These characteristics involve a person’s capacity to change and adapt to life after an episode of mental illness or substance misuse, and to live with any ongoing symptoms. Given the more individual and relatively subjective considerations expressed in human capital, it might be expected that the results would contrast with those obtained for physical capital.
The results for social (.888) and cultural (.875) capital were between the above extremes. The items constituting these subcategories include questions about current family relationships, friends, employment, social support and cultural connection. As in human capital, these two subcategories of recovery capital involve the interpretation of personal strengths, self efficacy and adaptive characteristics seen in personal definitions of recovery (Bandura, 1999; Cloud & Granfeild, 2008). The overall pattern of reliability that was found across subcategories fits with the nature of recovery capital as a construct that shares characteristics of the “clinical” and “personal” definitions of recovery.

The use of the CRCM as a reliable measure in AOD treatment assessments might contribute to addressing a concern of those who are critical of the movement to a focus on recovery (Best, 2010a). This concern is over the imbalance seen between the large amount data available on drug use and the detrimental effects of that use, compared with the relatively small amount of data available on the nature of recovery from AOD dependence (White, 2007). The development of the CRCM is intended to facilitate the building of an evidence base for recovery in the AOD area of treatment. The conceptualising of recovery capital and development of its measures (such as the CRCM) provides an operationalisation of recovery as called for by leading researchers in the AOD area (Groshkova & Best, 2011; Slade et al., 2008; White, 2007). Such operationalisation is vital for the assessment and guidance of recovery orientated public health policy and clinical decision making (Laudet, 2008).

A possible criticism of this study is the use of an online platform for the investigation of a process that has traditionally been performed with pen and paper.
This web based format for encoding and archiving psychometric health data may be seen as out of place for health care professionals who are accustomed to paper based client assessments.

While it is true that hard copy forms of data collection have been used as standard practice in the health care area, this situation is undergoing rapid change (Johansen, Henriksen, Horsch, Schuster, & Berntsen 2012). The current storage of health care information on paper renders vast amounts of data difficult and time consuming to access for use in the assessment of treatment outcomes and the coordination of treatment (Hillestad et al. 2005). The usage of electronic health records provide improve efficiency of service, reduce treatment errors, and enhanced documentation in forms that facilitate data analysis (Quinn, Kats, Kleinman, Bates, Simon, 2012).

Great savings in the cost of health care provision as well as improved patient outcomes and satisfaction are predicted, and are beginning to be realised in the move to increased use of electronic forms of data collection and storage (Hillestad et al. 2005).

Presenting the CRCM in this study as a web based electronic assessment of recovery capital goes some way toward ensuring that this measure can be readily integrated into health record management systems that are rapidly changing from a paper base to an electronic form.

Limitations and future research

There were limitations to the scope of this study. The use of standardised rather than actual archival case notes allowed for the online distribution of complete data sets for rating, but this was at the expense of external validity. Real life client
INTER RATER RELIABILITY OF RECOVERY CAPITAL

Interview sessions and archival materials would have posed ethical problems and required the client’s permission for the distribution online of their highly personal information. Future investigations of inter rater reliability using archival materials or interviews might shed light on the wider applicability of the CRCM. Another potentially useful comparison might be of results from one rater using case notes, and another rating the same client from interview. The validity of inferences over recovery capital assessed using case notes might be fruitfully investigated in such a study.

This study was also limited to a small number of case notes (three). This was due to the close attention required for participants to familiarise themselves with the cases plus complete the coding. It was not reasonable to expect all the participants to concentrate closely for more than the 45 minutes required for the rating of three cases.

Although this is acceptable in terms of the statistical analysis and provided sufficient power for the results obtained, this small number of cases could be seen as less than representative of those likely to be found in clinical situations. While this study was concerned only with reliability; future investigations might build on these results through the use of fewer judges and a greater number of varied cases for rating, thus increasing external validity.

Future studies might also look at a more even spread of health professional roles in the participant demographics. This study was heavily skewed toward psychologists, with that profession representing over 50% of the participants.

 Whilst most participants rated the CRCM as “Quite” or “Fairly” simple to use, some respondents rated it as “Slightly difficult to use”. The length of the CRCM was
a specific subject of criticism in feedback on this study. While the items were restructured and revised to minimise the burden of completion, each case still took 10-15 minutes to assess. Future studies might be conducted that gather sufficient data for a statistical analysis pointing to the items that best predict total recovery capital. From this information a shorter version of the CRCM might be derived.

**Conclusion**

This study demonstrates that the CRCM can be used reliably by clinicians to rate client recovery capital in an Australian clinical context. As such, the CRCM is well placed to provide valuable balance with self report measures in the development and assessment of recovery focussed public health policy and clinical interventions. The data from the current study add to the strong results established by Bennet (2005) for the reliability and validity of this measure, and provide evidence supporting the case for clinical implementation of the CRCM in assessing recovery capital for individuals with AOD issues.
References


doi: 10.1080/10826080802289762


Appendix A

Online rating task

Evaluating the reliability of a clinician rated measure of recovery capital

1. Clinician Recovery Capital Measure

EVALUATING THE RELIABILITY OF A CLINICIAN RATED MEASURE OF RECOVERY CAPITAL
Murdoch University

Participant Information Sheet

Welcome

We invite you, as a mental health practitioner, to participate in a research study looking at the reliability of a measure designed to assess personal resources that can help a patient in recovering from alcohol and drug use. This study is being conducted by Ben May as part of an Honours degree in Psychology, supervised by Dr Helen Coriola, School of Psychology, Murdoch University.

Nature and Purpose of the Study

Recovery Capital is a description of a person’s personal, financial, social, and cultural resources that are important to help that person recover from alcohol and other drug problems. Recovery capital includes physical, mental and emotional wellbeing; employment, accommodation and financial security; education, family and social connection. This study is intended to establish the extent to which a Clinician rated measure of recovery capital produces consistent and reliable results when used by different clinicians who work in the mental health field. The study is also intended to gain feedback about the usability of the measure.

What does the study involve?

The study involves reading through 2 case notes, which are presented in a structured format, and rating them using a checklist of items that are part of the Clinician Recovery Capital Measure, as well as providing some feedback. The study should take approximately 40 minutes to complete.

Will the study benefit me?

Use of the Recovery Capital Measure may provide you with knowledge about the kind of information that has been shown to be important in the recovery from certain conditions, which may be useful in your future clinical work. At the end of the participation task, we will provide you with additional information about recovery capital and its measurement. Alternatively, please do contact the study’s authors for more information. In addition, by consenting to participate in the survey, you will have the opportunity to be placed into a draw to win a $50.00 voucher from a local or online bookseller.

Will the study involve any discomfort for me?

The case notes are designed to be typical of people being treated within a psychiatric setting, and are consistent with this type of clinical work, so it is not anticipated that participation will cause distress. If you do have any concerns, please feel free to contact the supervisor of the study, Dr Helen Coriola.

Can I withdraw from the study?

Your participation is entirely voluntary and you are not at all obliged to be involved. If you do participate you can withdraw at any time without giving any reason and without consequence.

Privacy

Your privacy is very important. The information that you provide will be kept confidential and all information will be de-identified before analysing the results of the study.

What if I require further information?
Evaluating the reliability of a clinician rated measure of recovery capital

If you would like to discuss any aspect of the study please feel free to contact either Ben May, via email on 31812946@student.murdoch.edu.au or Dr Helen Corneia (08 9360 2290 or H.Corneia@murdoch.edu.au). Either of us would be happy to discuss any aspect of the research with you.

What if I have a complaint?

This study has been approved by the Murdoch University Human Research Ethics Committee (Approval 2012/147). If you have any reservation or complaint about the ethical conduct of this research, and wish to talk with an independent person, you may contact Murdoch University’s Research Ethics Office (Tel. 08 9360 6677 for overseas studies. +61 8 9360 6677) or e-mail ethics@murdoch.edu

*Your informed consent to participate in this study will be inferred by your clicking the “Yes I consent” button below.

☐ Yes I consent
☐ No I do not consent
Evaluating the reliability of a clinician rated measure of recovery capital

2. Demographics

It is hoped that this measure might be useful for a variety of practitioners assessing client needs indifferent areas. As such, it would help to know a bit about the background of practitioners participating in this study through the questions below.

Age
Please enter your age

Gender
- Male
- Female

Role
- Psychologist
- Clinical Psychologist
- Psychiatrist
- Medical Doctor
- Nurse
- Mental Health Nurse
- Drug and Alcohol Counsellor
- Other:

Other

Educational Qualifications

- Undergraduate degree (please specify below)
- Masters
- Doctorate
- PhD
- Other:

Other
Evaluating the reliability of a clinician rated measure of recovery capital

**Sector**

- [ ] Public
- [ ] Private
- [ ] NGO/Community Managed Organisation
- [ ] Other:
  
  Other (please specify):

**In which state/territory do you currently practice?**

- [ ] ACT
- [ ] NSW
- [ ] NT
- [ ] QLD
- [ ] SA
- [ ] VIC
- [ ] WA

Other (please specify):

**Approximately how many years of professional experience do you have working with clients with alcohol and other drug issues?**


**Approximately how many clients/patients with an Alcohol or Other Drug problem would you see per week?**

- [ ] Less than one per week
- [ ] 1-2 per week
- [ ] 3-5 per week
- [ ] 5-10 per week
- [ ] 10+ per week
### Evaluating the reliability of a clinician rated measure of recovery capital

#### 3. Instructions

Thank you for taking time to participate in our study. As part of this study you will be presented with a set of notes for each case followed by a checklist. Please use the checklist to assess each of the case notes supplied.

There are three cases in total. By clicking the link provided at the beginning of each case you can print or view the notes in separate browser.

Please note:

- The case notes are presented as a "final impression" from an initial interview, rather than a full clinical assessment of the client.
- Based on the information provided, please complete the checklist as fully as possible. If you feel that there is insufficient information to answer any items simply click the question mark button: "? Unknown"
- Note that items followed by a number (e.g., 123) have a corresponding explanation available in the Rating Guide link. Use this guide if the question is unclear.
### Evaluating the reliability of a clinician rated measure of recovery capital

#### 4. Mr. F. Smith - AGE: 28

<table>
<thead>
<tr>
<th>Presenting problem:</th>
<th>Mr Smith presented with concerns and distress about his recent charges of cannabis cultivation and possession.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living arrangements:</td>
<td>Lives alone in a rented house in a Southern suburb of 'Capital City A1', after relocating to this address 4 years ago to be closer to work.</td>
</tr>
<tr>
<td>Education:</td>
<td>Attended suburban primary school and high school near his childhood home in a northern suburb of 'Capital City A1'. He left after Year 11 to work as a labourer, reporting that he was 'OK at school' but was often bored, easily distractible, and was frequently truant.</td>
</tr>
<tr>
<td>Occupation/Employment:</td>
<td>Mr Smith reported that he secured full-time employment 5 years ago working in a warehouse, where he now has some managing duties, earning $46,000pa. Prior to this his past alcohol issues led him to have patchy employment. He reports enjoying the job, feels confident in his employment and financially secure, and has been slowly saving some money in the hope to buy a property.</td>
</tr>
<tr>
<td>Family history/childhood:</td>
<td>He noted that he was born in a Northern suburb of 'Capital City A1', and has a sister 2 years younger than him. He described his childhood as 'ordinary' with a mother who worried too much and a father who was 'strict and drank a lot'. His parents separated when Mr Smith was 19 years. He describes a childhood marked by little affection or warmth, and few positive memories with his family. He reported enjoying his adolescence more as he gained freedom to 'drink as much as I wanted, when I wanted', and engage in a range of risk taking behaviours.</td>
</tr>
<tr>
<td>Family/relationships/social networks:</td>
<td>Has never been married, is currently single, and has no children. Has little contact with his mother, who has moved overseas following divorce from Mr Smith's father. He reports a civil relationship with his sister, but does not see her often. Mr Smith has a good relationship with his father, who continues to drink excessively. He describes himself as socially isolated, with few warm, close relationships. He reports being more vary and sensitive in interpersonal relationships than most people, and tends to withdraw from social situations. His interpersonal style may be described as somewhat cold, and he indicated that others have accused him of being hostile, unable to display affection, and having little commitment to personal relationships. He reports having few friends, with little intention of creating any.</td>
</tr>
<tr>
<td>Daily activities: leisure, recreation etc:</td>
<td>Spends approx. 1 hr/day playing computer games. Reports some interest in sport (Soccer, Cricket), which he watches on TV. Reports no other interests or engagement in community activities.</td>
</tr>
<tr>
<td>Personality and Functioning:</td>
<td>He was initially reserved, but became engaged and cooperative during the interview process. He was occasionally distracted, but maintained focus for most of the interview and was able to report historic details without any problems. Whilst he portrayed himself as cold, unfriendly, and reportedly hostile to others, his self-perception was also marked by intense self-criticism, self-doubt, and negative self-evaluation. He reports resentment and regret of many of his past actions, and what he describes as past failures, which he attributes to a history of impulsivity and risk-taking. Although he reports not being physically violent...</td>
</tr>
</tbody>
</table>
### Evaluating the reliability of a clinician rated measure of recovery capital

**Substance Use/Abuse History:** Mr Smith reported that he drank alcohol excessively throughout his late teens and early twenties, primarily binge drinking on weekends, which often resulted in alcohol related amnesias. He would also drink with his father throughout the week. He noted that for most of that time he financially “lived from week to week” as he would spend most of his disposable income on maintaining his supply of alcohol. His drinking habits had resulted in being dismissed from several jobs as a labourer when he arrived at work still intoxicated.

He also reported that he had been using cannabis since age 17 years as a recreational, non-dependent user, which primarily began in social settings. However, as a result of the impact of his drinking on his employment, he decided four years ago to attempt to change his lifestyle, by taking a job in a warehouse located in the southern suburbs of “Capital City A.” and reducing contact with drinking and drug using friends. Since making this change four years ago, he reported that he had successfully reduced his alcohol use and developed a good relationship with his boss who he described as a supportive and positive role model.

**Drug/other Convictions/Comments:** Although he had successfully restrained his alcohol use, he reported that he continued to use cannabis and had been growing cannabis plants for his own personal use. Recently he was charged with cannabis cultivation by the police, resulting in a fine. He noted that he was “caught out” by a change in the laws. He reported considerable distress and regret about this as he had been making clear attempts to change and until this time had avoided criminal involvement.

**Previous history of mental health issues/treatment:** He has never been diagnosed with any mental health issues in the past, and reports no previous psychiatric or drug/alcohol treatment. Currently reports symptoms of mild depression.

**Previous history of medical issues/treatment:** He reports being moderately asthmatic since early childhood.

---

Please use the following Check-List to rate Mr Smith for Recovery Capital.

- *Note that items followed by a number (eg. (1)) have a corresponding explanation available in the Rating Guide*

| CRCM for Mr F. Smith |

<table>
<thead>
<tr>
<th>Level of housing: Mr Smith</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is homeless</td>
</tr>
<tr>
<td>Lives hostel / crashing with friends etc.</td>
</tr>
<tr>
<td>Temporary / shared accommodation</td>
</tr>
<tr>
<td>Lives in long term rental</td>
</tr>
<tr>
<td>Lives in house owned by them</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stability of housing: Mr Smith</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent history of unstable accommodation (1)</td>
</tr>
<tr>
<td>Is currently living/staying away from primary place of residence (eg. Mark “Yes” if Fly-in-Fly-out, tourist etc) (2)</td>
</tr>
</tbody>
</table>

(See Rating Guide)
### Evaluating the reliability of a clinician rated measure of recovery capital

**Local connections: Mr Smith**

- Lived in "local area" less than 6 months
- Lived in "local area" 6+ months
- Lived in "local area" 3+ years
- Lived in "local area" 20+ years (or whole life)
- ? (Unknown)

* "Local Area" refers to the area that the person considers their "home" or primary place of residence. This being the entire metropolitan area in large cities, or the local region / township if in regional and rural areas.

**Language: Mr Smith**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>?Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is literate (3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English is first language (4)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(See Rating Guide)

**Educational issues: Mr Smith**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>?Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exhibited behavioral problems at school (5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educated in &quot;local area&quot; 1+ years</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(See Rating Guide)

**Highest level of high school education: Mr Smith**

- Did not complete primary education
- Completed primary education
- Completed Year 10
- Completed Year 12
- ? (Unknown)

**Post-Secondary education : Mr Smith**

- Participated in formal education after school (not completed) (8)
- Completed formal education after school (7)
- None

(See Rating Guide)

**Stability of employment: Mr Smith**

- Not currently employed
- Current job held less than 6 months
- Current job held more than 6 months
- Current job held more than 12 months
- ? (Unknown)
### Evaluating the reliability of a clinician rated measure of recovery capital

**Stability of employment cont: Mr Smith**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>?Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequently unemployed in past work-history (6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interested / committed to current job (9)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has reputation of being reliable worker / no major recent history (within 5yrs) workplace problems (10)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed in local area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has smooth work relationships (11)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(See Rating Guide)

**Income: Mr Smith**

- Earns less than $18,000 (or living on Social Benefits)
- $18,000 - $29,999
- $30,000 - $55,000
- Earns more than $55,000
- ? (Unknown)

(See Rating Guide)

**Financial: Mr Smith**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>?Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has serious financial problems (debts) (12)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reliant on welfare / social benefits (13)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has savings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently manages finances effectively (14)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owns house</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owns business / own company</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(See Rating Guide)

**Childhood History: Mr Smith**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>?Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Born in ‘local area’</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stable Childhood (15)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experienced physical / sexual abuse as a child (16)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had rewarding parental relationship (17)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had rewarding other relationship (eg sibling, aunt) etc., if not stated assume No (18)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(See Rating Guide)

**Family support / network (Family of Origin – person’s parents, siblings, aunts, uncles etc): Mr Smith**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>?Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular contact with member of family of origin (relationship is rewarding) (19)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Views family of origin positively (20)</td>
<td></td>
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</tr>
<tr>
<td>Member of family of origin lives in ‘local area’ (relationship is rewarding)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family of origin reinforce problematic lifestyle (21)</td>
<td></td>
<td></td>
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(See Rating Guide)
### Evaluating the reliability of a clinician rated measure of recovery capital

**Family of Procreation - i.e. partner and/or children: Mr Smith**

- Currently dissatisfied with relational circumstance (e.g. relationship strife) (22)
- Acrimonious separation in last 6 months
- Spouse has criminal involvement (23)
- Has children (including partner’s children)
- Has dependant offspring (e.g. <18 years) (24)
- Has children who live in ‘local area’
- Lives in a family unit with children (including partner’s children) (25)
- Indication of poor functioning in family of procreation (e.g. family services involved, DV)

**Social support / network: Mr Smith**

- Is socially isolated (26)
- Has stable support network (3+ stable people) (27)
- Has adult networks in ‘local area’ (28)
- Death / chronic illness of significant other (if mentioned) (29)
- Has capacity to form functional adult attachments (sibling, partner, colleagues)
- Maintains long term attachments (1+y) past or present (long standing partner, friend, acquaintance)
- Has current partner in ‘local area’

**Personality and Functioning: Mr Smith**

- Been assessed as having low level of mental functioning (low IQ, possible brain damage) (30)
- Has insight into their problems (31)
- Is able to set goals commensurate with own capacity (32)
- Able to manage every-day problems (33)
- Engages in organised local activities (34)
- Has constructive leisure pursuits (35)
- Has a good self presentation (sociably oriented and communicative) (36)
- Copes well with stress / frustration (has coping strategies other than aggression, substance use)
- Has empathy for others (37)
- Significant history of aggression (38)
- Frequently engages in recklessness, risk taking and impulsive behaviour (irrespective of intoxication)

See Rating Guide
### Evaluating the reliability of a clinician rated measure of recovery capital

#### *Diagnosis and Treatment / Interventions: Mr Smith*

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<th>Condition</th>
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#### *Traumatic events and risk assessments: Mr Smith*

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#### *Use and dependence: Mr Smith*

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#### *Impact: Mr Smith*

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<td>Has been incarcerated</td>
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<tr>
<td>Is a user/dealer (Subsidises the cost of their habit through selling drugs)</td>
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(See *Rating Guide*
Evaluating the reliability of a clinician rated measure of recovery capital

<table>
<thead>
<tr>
<th>*Connections: Mr Smith</th>
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<th>Unknown</th>
</tr>
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<tr>
<td>Seems to associate with illegal drug users (speed, heroin) (53)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Socialises almost exclusively with substance users (54)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Has a long standing connection with drug users in local area (3+ years) (55)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Appears to have criminal acquaintances (56)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Appears to have criminal friends (57)</td>
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(See Rating Guide)
## Evaluating the reliability of a clinician rated measure of recovery capital

### 5. Mr. P. Jones - AGE: 41

Please read the following set of case notes. You can click on the link below to open the case notes in a separate window while answering the questions. Please feel free to print these notes or open them separately in your browser for ease of reference while completing the study.

**Case Notes for Mr Jones: click here**

**Mr. P. Jones**

**GENDER:** Male, **DOB:** 09/03/1971, **AGE:** 41

### Presenting problem:
Mr. Jones presented with concerns and distress about his recent difficulties with methamphetamine use.

### Living arrangements:
Currently lives in his own home in suburban "Capital City A1", which he purchased 2 years ago.

### Education:
Attended a Primary School in a regional area before he moved to "Capital City A1" with his parents where he then attended high school. Mr. Jones achieved marks sufficient to gain entry into an engineering degree at university, but indicated that, soon after starting, he lost interest and withdrew from his studies.

### Occupation/employment:
Since withdrawing from university, Mr. Jones indicated that he worked in his father's business in the home construction industry. He reported thoroughly enjoying the work, and now has management responsibilities across construction projects in the small company. He reported that fluctuations in the market mean that he is at times concerned about his future income, but still feels secure earning around $80,000pa and he has some savings and investments to help manage periods of the year when work is slow. He is looking to take over the business when his father retires in several years.

### Family history/childhood:
He describes his childhood in "Regional Area" very positively, indicating that he has fond memories of various family outings and holidays. His mother was someone who was always caring and his father was supportive and family oriented, although he could be strict and controlling at times.

He described a positive experience of primary school, enjoying his classes and was good at sports. His high school years, however, were marked with some incidents of bullying from one offender in particular. The bullying eased as the offender left the school, and Mr. Jones was able to resume more positive relationships with his peers in later high school. He reported that in his efforts to "fit in" this also included associating with peers who were keen to experiment with drugs, some of whom he continues to associate with.

### Family/relationships/social networks:
Mr. Jones reports a positive relationship with his parents, who he describes as always being supportive, particularly during his recent difficulties with methamphetamine use. He has an older brother who lives overseas, but he maintains regular contact with him over the internet and has visited him on several occasions.

He reports a broad range of social connections and feels comfortable in social settings, describing himself as socially confident and "leading the way" in social situations. His social connections include his "party friends", whom he has known over many years of being on the "club scene", many of whom share his pattern of substance use. He does, however, report that he has solid friendships with a separate group of friends who he has worked with in the building industry, with whom he has positive, mutually supportive, relationships.

He recently started a significant romantic relationship with a previous associate in the building industry, which he reports he is keen to maintain.
Evaluating the reliability of a clinician rated measure of recovery capital

**Daily activities: leisure, recreation etc:** Other than the ‘club scene’, he also reports an interest in off road driving and camping, which he does regularly throughout the year. He also occasionally attends soccer games with his father and family friends.

**Personality and Functioning:** Mr Jones was engaged and cooperative throughout the interview, reporting his memory of events with sufficient detail. He was articulate and presented with confidence, though he was hesitant to disclose his occasional feelings of self-doubt and anxiety. He describes himself as goal oriented and effective at solving problems, although he admits that he is struggling to manage his current methylamphetamine use.

He is able to connect well with friends and family, although he is sensitive to challenges to his confidence and sense of authority. Whilst he is not impulsive across all areas of his life, he notes that when he attends clubs and other party venues he has difficulty controlling his substance use as he is ‘taken by the mood’.

**Substance Use/Abuse History:** He noted that his school friends introduced him to cannabis in his first year of high school, but he did not find the experience particularly enjoyable. However, once they began attending clubs after high school, they soon experimented with other drugs, such as ecstasy, and it became a regular social event. He describes his use of drugs throughout his 20’s and early 30’s as recreational, and there would be periods of months when he would be absent from clubs and would restrict his use of drugs. In the past few years, however, he and his friends began using Methamphetamine, and recently he has noticed increasing difficulties in his capacity to limit his use. He was hesitant throughout the interview to discuss these difficulties, but he did report that a recent discussion with his current partner, who had noticed a change in his behaviour, prompted him to seek assistance.

**Drug/other Convictions/Comments:** He indicates that he has no current convictions or criminal offences.

**Previous history of mental health issues/treatment:** None reported.

**Previous history of medical issues/treatment:** None reported.

Please use the following Check-List to rate Mr Smith for Recovery Capital.

- Note that items followed by a number [eg. (12)] have a corresponding explanation available in the Rating Guide.

**CROM for Mr P. Jones**

**Level of housing: Mr Jones**

- [ ] Is homeless
- [ ] Lives hostel / crashing with friends etc.
- [ ] Temporary / shared accommodation
- [ ] Lives in long term rental
- [ ] Lives in house owned by them
- [ ] Unknown

**Stability of housing: Mr Jones**

<table>
<thead>
<tr>
<th>Recent history of unstable accommodation (1)</th>
<th>Yes</th>
<th>No</th>
<th>?Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is currently living/staying away from primary place of residence (eg ‘fly-in-fly-out, tourist etc) (2)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(See Rating Guide)
### Evaluating the reliability of a clinician rated measure of recovery capital

**Local connections: Mr Jones**
- Lived in "local area" less than 6 months
- Lived in "local area" 6+ months
- Lived in "local area" 3+ years
- Lived in "local area" 20+ years (or whole life)
- ? (Unknown)

* "Local Area" refers to the area that the person considers their 'home' or primary place of residence. This being the entire metropolitan area in large cities, or the local region / township if in regional and rural areas.

**Language: Mr Jones**

<table>
<thead>
<tr>
<th>Is literate (3)</th>
<th>Yes</th>
<th>No</th>
<th>?Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>English is first language (4)</td>
<td>Yes</td>
<td>No</td>
<td>?Unknown</td>
</tr>
</tbody>
</table>

(See Rating Guide)

**Educational issues: Mr Jones**

| Exhibited behavioral problems at school (5) | Yes | No | ?Unknown |
| Educated in 'local area' 1+ years | Yes | No | ?Unknown |

(See Rating Guide)

**Highest level of high school education: Mr Jones**

- Did not complete primary education
- Completed primary education
- Completed Year 10
- Completed Year 12
- ? (Unknown)

**Post-Secondary education: Mr Jones**

- Participated in formal education after school (not completed) (6)
- Completed formal education after school (7)
- None

(See Rating Guide)

**Stability of employment: Mr Jones**

- Not currently employed
- Current job held less than 6 months
- Current job held more than 6 months
- Current job held more than 12 months
- ? (Unknown)
### Evaluating the reliability of a clinician rated measure of recovery capital

#### *Stability of employment cont.: Mr Jones*

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>?Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequently unemployed in past work-history (8)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interested / committed to current job (9)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has reputation of being reliable worker / no major recent history (within 5yrs) workplace problems (10)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed in local area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has smooth work relationships (11)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*(See Rating Guide)*

#### *Income: Mr Jones*

- Earns less than $18,000 (or living on Social Benefits)
- $18,000 - $29,999
- $30,000 - $55,000
- Earns more than $55,000
- ? (Unknown)

#### *Financial: Mr Jones*

- Has serious financial problems (debts) (12)
- Reliant on welfare / social benefits (13)
- Has savings
- Currently manages finances effectively (14)
- Owns house
- Owns business / own company

*(See Rating Guide)*

#### *Childhood History: Mr Jones*

- Born in 'local area'
- Stable Childhood (15)
- Experienced physical / sexual abuse as a child (16)
- Had rewarding parental relationship (17)
- Had rewarding other relationship (eg sibling, auntly etc., if not stated assume No) (18)

*(See Rating Guide)*

#### *Family support / network (Family of Origin – person’s parents, siblings, aunts, uncles etc.): Mr Jones*

- Regular contact with member of family of origin (relationship is rewarding) (19)
- Views family of origin positively (20)
- Member of family of origin lives in 'local area' (relationship is rewarding)
- Family of origin reinforce problematic lifestyle (21)
**Evaluating the reliability of a clinician rated measure of recovery capital**

(See Rating Guide)

**Family of Procreation - i.e. partner and/or children: Mr Jones**

Currently dissatisfied with relational circumstance (e.g. relationship strife) (22)

- [ ] Yes
- [ ] No
- [ ] ?Unknown

Anonymous separation in last 6 months

- [ ] Yes
- [ ] No
- [ ] ?Unknown

Spouse has criminal involvement (23)

- [ ] Yes
- [ ] No
- [ ] ?Unknown

Has children (including partner’s children)

- [ ] Yes
- [ ] No
- [ ] ?Unknown

Has dependent offspring (e.g. <18 years) (24)

- [ ] Yes
- [ ] No
- [ ] ?Unknown

Has children who live in ‘local area’

- [ ] Yes
- [ ] No
- [ ] ?Unknown

Lives in a family unit with children (including partner’s children) (25)

- [ ] Yes
- [ ] No
- [ ] ?Unknown

Indication of poor functioning in family of procreation (e.g. family services involved, DV)

- [ ] Yes
- [ ] No
- [ ] ?Unknown

(See Rating Guide)

**Social support / network: Mr Jones**

Is socially isolated (26)

- [ ] Yes
- [ ] No
- [ ] ?Unknown

Has stable support network (3+ stable people) (27)

- [ ] Yes
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Has adult networks in ‘local area’ (28)

- [ ] Yes
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Death / chronic illness of significant other (if mentioned) (29)

- [ ] Yes
- [ ] No
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Has capacity to form functional adult attachments (sibling, partner, colleagues)

- [ ] Yes
- [ ] No
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Maintains long term attachments (1+ years) past or present (long standing partner, friend, acquaintance)

- [ ] Yes
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Has current partner in ‘local area’

- [ ] Yes
- [ ] No
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(See Rating Guide)

**Personality and Functioning: Mr Jones**

Has been assessed as having low level of mental functioning (low IQ, possible brain damage) (30)

- [ ] Yes
- [ ] No
- [ ] ?Unknown

Has insight into their problems (31)

- [ ] Yes
- [ ] No
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Is able to set goals commensurate with own capacity (32)

- [ ] Yes
- [ ] No
- [ ] ?Unknown

Able to manage every-day problems (33)

- [ ] Yes
- [ ] No
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Engages in organised local activities (34)

- [ ] Yes
- [ ] No
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Has constructive leisure pursuits (36)

- [ ] Yes
- [ ] No
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Has a good self presentation (socially oriented and communicative) (36)

- [ ] Yes
- [ ] No
- [ ] ?Unknown

Copes well with stress / frustration (has coping strategies other than aggression, substance use)

- [ ] Yes
- [ ] No
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Has empathy for others (37)

- [ ] Yes
- [ ] No
- [ ] ?Unknown

Significant history of aggression (38)

- [ ] Yes
- [ ] No
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Frequently engages in recklessness, risk taking and impulsive behaviour (irrespective of intoxication)

- [ ] Yes
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(See Rating Guide)
### Evaluating the reliability of a clinician rated measure of recovery capital

#### *Diagnosis and Treatment / Interventions: Mr Jones*

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#### *Use and dependence: Mr Jones*

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</tr>
<tr>
<td>Is a user-dealer (Subsidises the cost of their habit through selling drugs)</td>
<td></td>
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</tbody>
</table>

(See Rating Guide)
### Evaluating the reliability of a clinician rated measure of recovery capital

**Connections: Mr Jones**

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>?Unknown</th>
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</thead>
<tbody>
<tr>
<td>Seems to associate with illegal drug users (speed, heroin) (53)</td>
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<tr>
<td>Socialises almost exclusively with substance users (54)</td>
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<tr>
<td>Has a long standing connection with drug users in local area (3+ years) (55)</td>
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<tr>
<td>Appears to have criminal acquaintances (58)</td>
<td></td>
<td></td>
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<tr>
<td>Appears to have criminal friends (57)</td>
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(See Rating Guide)
Evaluating the reliability of a clinician rated measure of recovery capital

6. Ms J. Lee- AGE: 35

Please read the following set of case notes. You can click on the link below to open the case notes in a separate window while answering the questions. Please feel free to print these notes or open them separately in your browser for ease of reference while completing the study.

Case Notes for Ms Lee: click here

Ms J. Lee

GENDER: Female, DOB: 22/05/1976, AGE: 35

Presenting problem: Ms Lee presented with distress and concerns regarding her current family situation.

Living arrangements: Currently staying with friends in “Capital City A1” while looking for alternative accommodation in the same area, although she reports that she has been unsuccessful for the past few months.

Education: She attended both primary and secondary schools in “Country Town B1”. She moved with her family at around age 13 years to “Capital City A1” where she was enrolled in an inner city high school. She left high school after completing year 10. Ms Lee stated that she was generally a good student and was also good at sports.

Occupation/employment: She reported that following high school, she worked in various fast food outlets, but often had periods of unemployment. Her most consistent employment was in her early twenties where she worked as a waitress in a cafe after moving out of home at age 18 years. Following frequent workplace issues she is currently receiving Centrelink unemployment benefits, after being mostly unemployed for the past 5 years. She reports that she has no savings or other financial resources.

Family history/childhood: Initially, Ms Lee and her family of origin resided in “Country Town B2”. Ms Lee was the second youngest of 5 children. She reported that her mother was 35 years old when she was born and, given the large family, she recalled more parenting by her eldest sister than her mother. She describes her childhood as a time of emotional and physical neglect on the part of her parents, although her eldest sister was very protective of her.

Family/relationships/social networks: Ms Lee is currently single, following an intense and physically violent relationship between the ages of 23 and 32 years. She reported that she had met her ex-partner when she was working at the cafe as a waitress and was immediately attracted to him, which was reciprocated, and they developed an “intense and passionate” relationship. She became pregnant soon after and she reports that it was after her child was born that her new ex partner became violent, abusive, and cruel towards her. At age 26 years she became pregnant again. She reports that the violence and abuse continued, she became more isolated from her family of origin, and was afraid to leave the relationship. While physical assault was infrequent, on one occasion, she was hospitalised after he hit her and she was knocked unconscious.

It was following this incident 3 years ago that her family was able to help Ms Lee and her children to leave the relationship and find alternative accommodation. She reports a good relationship with her eldest sister, but little contact with other family members.

Approx 2 years ago her children were removed by the state authorities. Ms Lee describes the period leading up to this as ‘a crazy nightmare of anger, pain, drinks, and drugs’. Since that time she has managed to form a few stable friendships with others like herself who are recovering from AOD problems.

Daily activities: leisure, recreation etc: Reports some recreational activities such as reading, and has recently tried to increase her physical activity by walking several times a week.
Evaluating the reliability of a clinician rated measure of recovery capital

Personality and Functioning: Ms Lee was engaged fully in the interview process. She was personable, well presented, and able to recall details about her history without difficulty. Her thinking was clear, organised, and there was no evidence of a current mental health disorder or psychotic symptomatology. Ms Lee demonstrates good insight into her issues and appears to be functioning well enough with basic living. Although she describes great frustration when faced with challenging tasks such as dealing with child protection agency and a tendency toward impulsivity when she finds things difficult to manage.

Substance Use/Abuse History: Ms Lee began using methamphetamine several years ago towards the end of the relationship with her partner. She stated that she enjoyed the "hit" and fell comforted, confident, and strong when she used it. She reported that her use of the drug increased following the separation from her partner and she quickly developed a dependence on it. Since her children were removed by state authorities and subsequent treatment, Ms. Lee ceased her methamphetamine use. She indicated however that she currently consumes alcohol as she 'needs something' to get her through rough days, and will drink an average of 2 standard glasses per day, and drinks to excess approx. twice per week.

Drug/other Convictions/Comments: Following her increased use of methamphetamines, Ms Lee reported having a drug induced psychosis (paranoia, hallucinations). Around this time she was engaging in shoplifting and minor crime to support her drug use and was subsequently placed on community service and a good behaviour bond. It was due to these activities that her children were removed from her care.

Previous history of mental health issues/treatment: Ms Lee noted that following her psychotic episode 2 years ago, she was admitted to hospital, and referred to a drug unit where she was detoxed and spent some time recovering. She indicated that since that time she has been "clean".

Previous history of medical issues/treatment: Ms Lee also stated that she contracted Hepatitis C from needle sharing (asymptomatic).

Please use the following Check-List to rate Mr Smith for Recovery Capital.

* Note that items followed by a number (eg. (1)) have a corresponding explanation available in the Rating Guide

CRCM for Ms J. Lee

*Level of housing: Ms Lee

- Is homeless
- Lives hostel / crashing with friends etc.
- Temporary / shared accommodation
- Lives in long term rental
- Lives in house owned by them
- *Unknown

*Stability of housing: Ms Lee

<table>
<thead>
<tr>
<th>Recent history of unstable accommodation (1)</th>
<th>Yes</th>
<th>No</th>
<th>*Unknown</th>
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</thead>
<tbody>
<tr>
<td>Is currently living/staying away from primary place of residence (eg Mark ‘Yes’ if Fly-in-fly-out, tourist etc) (2)</td>
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(See Rating Guide)
**Evaluating the reliability of a clinician rated measure of recovery capital**

*Local connections: Ms Lee*

- Lived in "local area" less than 6 months
- Lived in "local area" 6+ months
- Lived in "local area" 3+ years
- Lived in "local area" 20+ years (or whole life)
- ? (Unknown)

* "Local Area" refers to the area that the person considers their "home" or primary place of residence. This being the entire metropolitan area in large cities, or the local region / township if in regional and rural areas.

*Language: Ms Lee*

<table>
<thead>
<tr>
<th>Is literate (3)</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
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<tbody>
<tr>
<td>English is first language (4)</td>
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</table>

(See Rating Guide)

*Educational issues: Ms Lee*

| Exhibited behavioral problems at school (5) | Yes | No | Unknown |
| Educated in "local area" 1+ years | | | |

(See Rating Guide)

*Highest level of high school education: Ms Lee*

- Did not complete primary education
- Completed primary education
- Completed Year 10
- Completed Year 12
- ? (Unknown)

*Post-Secondary education: Ms Lee*

- Participated in formal education after school (not completed) (6)
- Completed formal education after school (7)
- None

(See Rating Guide)

*Stability of employment: Ms Lee*

- Not currently employed
- Current job held less than 6 months
- Current job held more than 6 months
- Current job held more than 12 months
- ? (Unknown)
### Evaluating the reliability of a clinician rated measure of recovery capital

#### *Stability of employment cont.: Ms Lee*

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<th></th>
<th>Yes</th>
<th>No</th>
<th>?Unknown</th>
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<tbody>
<tr>
<td>Frequently unemployed in past work-history (8)</td>
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<tr>
<td>Interested / committed to current job (9)</td>
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<tr>
<td>Has reputation of being reliable worker / no major recent history (within 5yrs) workplace problems (10)</td>
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<tr>
<td>Employed in local area</td>
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<tr>
<td>Has smooth work relationships (11)</td>
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(See Rating Guide)

#### *Income: Ms Lee*

- Earns less than $18,000 (or living on Social Benefits)
- $18,000 - $29,999
- $30,000 - $55,000
- Earns more than $55,000
- ? (Unknown)

#### *Financial: Ms Lee*

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<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>?Unknown</th>
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<tbody>
<tr>
<td>Has serious financial problems (debits) (12)</td>
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<tr>
<td>Rely on welfare / social benefits (13)</td>
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<tr>
<td>Has savings</td>
<td></td>
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<tr>
<td>Currently manages finances effectively (14)</td>
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<tr>
<td>Owns house</td>
<td></td>
<td></td>
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<tr>
<td>Owns business / own company</td>
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(See Rating Guide)

#### *Childhood History: Ms Lee*

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<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>?Unknown</th>
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<tbody>
<tr>
<td>Born in 'local area'</td>
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<tr>
<td>Stable Childhood (15)</td>
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<tr>
<td>Experienced physical / sexual abuse as a child (16)</td>
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<tr>
<td>Had rewarding parental relationship (17)</td>
<td></td>
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<tr>
<td>Had rewarding other relationship (eg sibling, aunty etc., if not stated assume No) (18)</td>
<td></td>
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</table>

(See Rating Guide)

#### *Family support / network (Family of Origin – person’s parents, siblings, aunts, uncles etc): Ms Lee*

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<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>?Unknown</th>
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<tbody>
<tr>
<td>Regular contact with member of family of origin (relationship is rewarding) (19)</td>
<td></td>
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<tr>
<td>Views family of origin positively (20)</td>
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<tr>
<td>Member of family of origin lives in 'local area' (relationship is rewarding)</td>
<td></td>
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<tr>
<td>Family of origin reinforce problematic lifestyle (21)</td>
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## Evaluating the reliability of a clinician rated measure of recovery capital

### *Family of Procreation* - i.e. partner and/or children: Ms Lee

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
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<tbody>
<tr>
<td>Currently dissatisfied with relational circumstance (e.g., relationship strife) (22)</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
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<tr>
<td>Aporomous separation in last 6 months</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
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<tr>
<td>Spouse has criminal involvement (23)</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
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<tr>
<td>Has children (including partner’s children)</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
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<tr>
<td>Has dependent offspring (e.g., &lt;18 years) (24)</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Has children who live in ‘local area’</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Lives in a family unit with children (including partner’s children) (25)</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Indication of poor functioning in family of procreation (e.g., family services involved, DVI)</td>
<td>☐</td>
<td>☐</td>
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</tr>
</tbody>
</table>

### *Social support / network: Ms Lee*

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
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<tbody>
<tr>
<td>Is socially isolated (26)</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
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<tr>
<td>Has stable support network (3+ stable people) (27)</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Has adult networks in ‘local area’ (28)</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Death / chronic illness of significant other (if mentioned) (29)</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Has capacity to form functional adult attachments (sibling, partner, colleagues)</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
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<tr>
<td>Maintains long term attachments (1+y) past or present (long standing partner, friend, acquaintance)</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Has current partner in ‘local area’</td>
<td>☐</td>
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### *Personality and Functioning: Ms Lee*

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<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
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<tbody>
<tr>
<td>Been assessed as having low level of mental functioning (low IQ, possible brain damage) (29)</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Has insight into their problems (31)</td>
<td>☐</td>
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<tr>
<td>Is able to set goals commensurate with own capacity (32)</td>
<td>☐</td>
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<tr>
<td>Able to manage every-day problems (33)</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Engages in organised local activities (34)</td>
<td>☐</td>
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</tr>
<tr>
<td>Has constructive leisure pursuits (35)</td>
<td>☐</td>
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<tr>
<td>Has a good self presentation (socially oriented and communicative) (36)</td>
<td>☐</td>
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<tr>
<td>Copes well with stress / frustration (has coping strategies other than aggression, substance use)</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Has empathy for others (37)</td>
<td>☐</td>
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<tr>
<td>Significant history of aggression (28)</td>
<td>☐</td>
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<tr>
<td>Frequently engages in recklessness, risk taking and impulsive behaviour (irrespective of intoxication)</td>
<td>☐</td>
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(See Rating Guide)
### Evaluating the reliability of a clinician rated measure of recovery capital

#### Diagnosis and Treatment / Interventions: Ms Lee

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<th>Yes</th>
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(See Rating Guide)

#### Traumatic events and risk assessments: Ms Lee

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(See Rating Guide)

#### Use and dependence: Ms Lee

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(See Rating Guide)

#### Impact: Ms Lee

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(See Rating Guide)

#### Legal / criminal contexts: Ms Lee

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(See Rating Guide)
### Evaluating the reliability of a clinician rated measure of recovery capital

**Connections: Ms Lee**

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<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
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</thead>
<tbody>
<tr>
<td>Seems to associate with illegal drug users (speed, heroin) (53)</td>
<td></td>
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<tr>
<td>Socialises almost exclusively with substance users (54)</td>
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<td>Has a long standing connection with drug users in local area (3+ years) (55)</td>
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<td>Appears to have criminal acquaintances (58)</td>
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*(See Rating Guide)*
Evaluating the reliability of a clinician rated measure of recovery capital

7. Feedback: Optional

Thank you for your time in completing our Clinician Recovery Capital Measure study. Your contribution is greatly appreciated and valued. We would also appreciate any feedback that you might have about the usability of the checklist as a clinical tool. Below are some questions, with an opportunity to provide general feedback.

Details regarding entry into the draw to win a book voucher can be found at the bottom of this page

1. Please rate how realistic the case notes were:
   - [ ] Not realistic
   - [ ] A little realistic
   - [ ] Somewhat realistic
   - [ ] Quite realistic
   - [ ] Very realistic

How would you rate the “usability” or the scale? Please consider aspects such as the ease of use, clarity of questions and so on.

- [ ] Quite difficult to use
- [ ] Slightly difficult to use
- [ ] Neutral
- [ ] Fairly simple to use
- [ ] Quite simple to use

Were there any individual items that stood out to you as problematic? If so, please describe below.

If this scale was shown to have good reliability and validity, how likely would you be to use it in your own professional work?

- [ ] Very unlikely to use this scale
- [ ] Unlikely to use this scale
- [ ] Hard to say
- [ ] Quite likely to use this scale
- [ ] Very likely to use this scale

Please provide any general comments you may wish to contribute:

PARTICIPANT PRIZE DRAW

As mentioned, by consenting to participate in the survey, you have the opportunity to be placed into a draw to win a $50.00 voucher from a local or online bookstore. If you would like to enter your details to participate in the prize draw, please click on the following link: I wish to enter the participant prize draw

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Evaluating the reliability of a clinician rated measure of recovery capital

8. Recovery Capital: Additional Information

Thank you again for your time. Please find below some additional information regarding the concept and measurement of Recovery Capital.

Recovery Capital

The concept of Recovery Capital (RC) was developed by Cloud & Granfield, following their investigations into the stories of those who have recovered from Alcohol and Other Drug (AOD) issues without formal treatment. These authors drew on social science in an attempt to capture key social and personal resources available to individuals in the process of initiating and maintaining abstinence from AOD problems. RC is defined as ‘the sum total of one’s resources that can be brought to bear on the initiation and maintenance of substance misuse cessation’ (Granfield and Cloud, 2008).

These resources are grouped as follows:

Social Capital

Resources accrued through the possession of a durable network of friends and acquaintances, providing information, emotional support, etc. The expectations, obligations and opportunities involved in such relationships may have a strong positive influence on an individual’s recovery.

Physical Capital

Economic assets, including investments and earning capacity that together provide greater options during recovery. Financial stability brings with it such benefits as health insurance and the greater capacity for significant short and long term adjustments to lifestyle that facilitate recovery.

Human Capital

Includes a wide range of attributes associated with effective functioning in society. Characteristics such as physical and mental health, genetic heredity, skills, knowledge and education, all influence the prospects for developing prosocial values and success through legitimate means outside of drug culture.

Cultural Capital

Values and beliefs, perceptions and dispositions associated with membership of a particular cultural group. The capacity to act within these cultural norms allows for meeting basic needs and capitalising on opportunities. Those who accept conventional norms are conferred an advantage in recovery over those who remain ensnared in the drug culture with its associated values.

The perceived benefits of using the concept of RC in the assessment and treatment of clients with AOD issues are in the allocation of therapeutic resources and the selection of interventions tailored to the needs of the individual. In looking beyond the apparent severity of a client’s condition it may become clear that individuals who present in similar ways may in fact face very different obstacles to recovery. So much so in fact, that Individual 1 with an apparently less severe condition may be judged to require more intensive interventions than client 2 with an apparently more severe condition. For instance, client 2 with a more severe condition and greater RC may not require hospitalisation for recovery while Individual 1 does.

In a similar way, the choice of therapy may be guided through a quantified insight into the strengths and weaknesses of the client and point toward specific areas for focus of attention. The hope is that the use of the concept of RC might lead to better outcomes for clients and all those involved in their care.
Evaluating the reliability of a clinician rated measure of recovery capital

Following is a list of references dealing with Recovery Capital:


For further information on this study or Recovery Capital, please email Ben May: 31812948@student.murdoch.edu.au
Appendix B

Online Rating Guide

Rating Guide CRCM Study

Exit this survey

CRCM RATING GUIDE

Use the information below to help answer the CRCM questions

* “Local Area” refers to the area that the person considers their “home” or primary place of residence. This being the entire metropolitan area in large cities, or the local region / township if in regional and rural areas.

Stability of housing

(1) Score Y if client is temporarily staying with a friend / family member or has recently moved out of their usual accommodation. This includes being remanded in prison.

(2) Score Y if the client currently living / staying away from the city, town or region that the person considers their “home” or primary place of residence, i.e. score Y if clients are seasonal workers, tourists or visiting friends.

Language

(3) Score Y if client attended school and his / her literacy is not otherwise questioned.

(4) Score N if client was born in, and predominantly raised in a non-English speaking country and/or interpreter was required

Educational issues

(5) Score Y if client exhibited behavioural problems at school (e.g. disruptive, aggressive, truancy, saw a psychologist etc.).
Post-Secondary education

(6) Score Y if client engaged in any further education for a month or more, even if they did not complete the qualification.

(7) Score Y if client completed any type of qualification after school (apprenticeships, or other trade qualification).

Stability of employment cont.

(8) Score Y if client has a history of losing jobs and spending frequent amounts of time unemployed.

(9) Score Y if client is committed to their employment / motivated to maintain work, seems to derive pleasure / job satisfaction from working. If client unemployed score N.

(10) Score Y if client has a reputation as a reliable worker / upstanding citizen. Also score Y if client has a history of being a reliable worker with no recent history within last 5 years of employment difficulties as a result of deviance and/or substance misuse.

(11) Score Y if client gets along with supervisors and colleagues.

Financial

(12) Score Y if client has significant debts.

(13) Score Y if client receives welfare benefits.

(14) Score Y if client has accommodation and money for food and essentials.

Childhood History

(15) Score Y if client enjoyed a stable childhood. Score N if domestic violence, substance use, sexual abuse, death of parent, serial foster care, acrimonious divorce occurred.
(16) Score N unless physical / sexual abuse as a child is mentioned.

(17) Unless otherwise stated (e.g. client has maintained contact with a parent, client speaks of a positive relationship with a parent) assume that clients who experienced an unstable childhood did not have a rewarding relationship with their parent and score N.

(18) Unless otherwise stated assume that clients who experienced an unstable childhood did not have a rewarding relationship with another family member and score N.

**Family support / network (Family of Origin – person's parents, siblings, aunts, uncles etc)**

(19) Score N if current communication with family of origin is not mentioned.

(20) Try to gauge an impression of client's perception of their family. If maintain regular contact and it is not otherwise stated assume they view family relationships as positive score Y.

(21) Score Y if family of origin engages in deviant behaviour and/or problematic substance use.

**Family of Procreation- i.e. partner and/or children**

(22) Score Y if client is dissatisfied with current relational circumstances e.g. doesn't like being single, relationship strife, etc.

(23) Score Y if client partner/spouse engages in illegal activity including illegal drug use. Score N if client does not have partner.

(24) Score Y if client has child / children below the age of 18 years of age.

(25) Score Y if client lives with dependent children (this includes living with a partner who has children, a single parent living with children).
Social support / network

(26) Score N if client has a regular social contact with family member(s) / partner / friends or there is a general sense of client belonging to community.

(27) Score Y if client has regular contact with stable others (i.e. 3 or more stable individuals). For example a general sense that the client is part of the community and has people that he/she can turn to.

(28) Score Y for clients who live, work and have established themselves in local area. E.g. someone who is known, has a history in local area.

(29) Score Y if death or illness of significant other is mentioned. Score N if these are not mentioned.

Personality and Functioning

(30) Score N if the client's IQ, mental functioning is not mentioned specifically.

(31) Score Y if client demonstrates insight into their problems e.g. able to identify link between substance use and criminality / personal problems.

(32) Score Y if report indicated that the client is realistic in their ability to set goals for themselves e.g. has realistic expectations of themselves.

(33) Score Y if client is able to identify and manage everyday problems e.g. evidence in adult life of capacity to address everyday problems.

(34) Only score Y if client has established constructive hobbies, interests that they participate in local area.

(35) Score Y if client engages in a constructive leisure pursuit.

(36) Score Y if client is socially oriented and communicative.

(37) Score Y if client has regard for others and their welfare, capable of
understanding feeling of others. Score Y if client is able to express remorse about the impact that their offending has on to others / general ability to be empathic.

(38) Score Y if report indicate difficulty controlling temper, a significant proportion of offences are aggression related.

**Diagnosis and Treatment / Interventions**

(39) Score N unless client has acute medical condition e.g. broken leg, road traffic accident injury.

(40) Score N if unless client has a history of a chronic medical condition e.g. Hepatitis C, heart disease etc.

(41) Score Y if client has ever had formal contact with psychologist / psychiatrist.

(42) Score Y if client has appropriately attended an alcohol and drug agency. If client has not attended alcohol and drug services, but does not warrant their intervention still score Y. Detox / contact with alcohol and drug workers whilst in prison do not count.

**Traumatic events and risk assessments**

(43) Score N unless self harm behaviour is noted.

(44) Score N unless suicidal behaviour is noted.

(45) Score N if rape or sexual abuse as an adult is not specifically mentioned.

(46) Score N if domestic violence is not mentioned.

(47) Score N if domestic violence not stated in report.

**Use and dependence**

(48) Score Y if client is physically, emotionally, psychologically dependent, acknowledges a daily habit, “binge” use does not count.
(49) Score Y if client has more than two years of problematic substance use e.g. criminality, relationship troubles, dependence.

**Impact**

(50) Score Y if most of time is taken up with using substances or obtaining substances. This does not include weekend / binge drinkers.

**Legal / criminal contexts**

(51) Speeding and minor traffic offences do not count.

(52) Speeding and minor traffic offences do not count.

**Connections**

(53) Score Y if client associates with peers / acquaintances that misuse substances (i.e. has contacts with the drug using community).

(54) Score Y if client spends almost all of their time with substance users e.g. clients who are entrenched in their drug use, this includes user dealers, street drinkers.

(55) Score N if client does not regularly use illegal drugs or has made changes to get away from drug using friends.

(56) Score Y if the report mentions deviant acquaintances.

(57) Score Y if the report mentions deviant friends.
Appendix C

Substance Use & Misuse Instructions for Authors

Instructions for Authors

***Note to Authors: please make sure your contact address information is clearly visible on the outside of all packages you are sending to Editors.***

Aims and Scope:

For over 40 years, Substance Use & Misuse (formerly The International Journal of the Addictions) has provided a unique international multidisciplinary environment for the exchange of facts, theories, viewpoints, and unresolved issues concerning substance use, misuse (licit and illicit drugs, alcohol, nicotine, and caffeine), "abuse," dependency, eating disorders, and gambling.

Manuscript submissions must include:

- All papers should be submitted online - http://mc.manuscriptcentral.com/lsum. Hardcopies are not permitted. Text files should be submitted as Microsoft Word files. All tables and figures should be submitted as separate individual digital files.
- Substance Use and Misuse conducts a double-blinded review process. Authors should be sure NOT to include any identifying information in the body of their work (including tables and figures). All identifying information will be asked for during the submission process and will be kept confidential. Any manuscripts containing identifying information will be returned to the Authors.
- All parts of the manuscript should be typewritten, double-spaced, with margins of at least one inch on all sides.
- Number manuscript pages consecutively throughout the paper.
- Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces.
- A list of 5-10 key words must also accompany the manuscript, as well as a glossary, containing a list of brief scientific definitions of key terms and concepts.
- Each article should be summarized in an abstract of not more than 100 words, containing the following information: year of data collection, brief description of the sample as well as the total N, brief description of the area (country, urban, etc.), instruments used for data collection and the data.
analysis techniques, whether the study's implications and limitations are noted and whether future research is suggested, and source of funding for the study.

- Avoid abbreviations, diagrams, and reference to the text in the abstract.
- A copy of Informa Healthcare's copyright agreement stating that the manuscript has not been published elsewhere. Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. All accepted manuscripts, artwork, and photographs become the property of the publisher. A copyright agreement can be downloaded here.

All ACCEPTED manuscripts are required to provide:

- Foreign language abstracts in French and Spanish
- A photograph and short biography of each contributing author

Footnotes

Use sparingly if at all. Number all text footnotes consecutively throughout the manuscript and compile them on a separate page at the end of the manuscript.

References

Cite in the text by author and date (Smith, 1983).

Prepare reference list in accordance with the APA Publication Manual, 4th ed.

Examples:


**Illustrations**

Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be submitted as separate digital files following these guidelines:

- 300 dpi or higher
- Sized to fit on journal page
- EPS, TIFF, or PSD format only
- Submitted as separate files, not embedded in text files

Color illustrations will be considered for publication; however, the author will be required to bear the full cost involved in their printing and publication. The charge for the first page with color is $1000.00. The next three pages with color are $500.00 each. A custom quote will be provided for color art totaling more than 4 journal pages. Good-quality color prints should be provided in their final size. The publisher has the right to refuse publication of color prints deemed unacceptable.

**Tables and Figures**

Tables and figures (illustrations) should not be embedded in the text, but should be included as separate files. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet. All original figures should be clearly marked in pencil on the reverse side with the number, author's name, and top edge indicated.

**Proofs**

Page proofs are sent to the designated corresponding author. They must be carefully checked and returned within 48 hours of receipt. Please note that in the proof stage, only typographical errors, printer's errors and errors of scientific fact can be corrected. No substantial author's changes will be made.

**Reprints**

Each corresponding author of the article will receive a complete copy of the issue in which the article appears. Reprints of an individual article are available for order at the time authors review page proofs.
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(http://www.icmje.org/index.html#conflict)