

**A participative approach to curriculum development for adults in addiction recovery across the European Union.**

**www.recoveu.org**

**Deliverable 6.1:**

**Evaluation Approach Review**

**WP6: Development of a Draft Evaluation Toolkit for trainers**

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# CONTEXT

The RECOVEU project brings together partners from the United Kingdom, Cyprus, Romania, Italy and Ireland with the aim of developing ‘Access to Learning’ resources for people in recovery from addiction.

Although the role of learning in the recovery process has been highlighted there is limited evidence across Europe to inform adult learning practice with people in addiction recovery and there is no data which specifically identifies the barriers they experience or how to support them as adult learners. The RECOVEU Consortium has undertaken this innovative project to begin to develop a coherent EU-wide approach to adult learning in the addiction recovery community. Cross-European collaboration will offer new insights into the issues involved in this under-developed area and demonstrate the potential for transferable, innovative solutions. Project outcomes support the aims of the EU Lifelong Learning Programme by improving the attractiveness and accessibility of learning opportunities available to a group of adult learners who are particularly at risk of social exclusion and marginalisation.

A key factor in the project is the development of an *Evaluation Toolkit,* designed to support educators to assess the effectiveness of the ‘Access to Learning’ course materials and their impact, i.e. whether there are meaningful outcomes for participants: for example, an increase in self-efficacy for education and/or the contribution of learning activities to sustained participation in learning. The Evaluation Tools included in the Toolkit have been designed in a way to aid on-going evaluation of learning activities and are presented in the form of questionnaires to be completed by service users. Pre-existing tools have been utilised and new tools developed.

To support development of the Evaluation Tools, this *Evaluation Approach Review*:

1. Identifies and develops the theoretical base for evaluation (e.g. self-efficacy, self-esteem, and recovery capital).
2. Reviews current evaluation approaches used by partners that are relevant to both adult learning and addiction recovery interventions. This also includes assessing their effectiveness in this context.

Following this, two versions of the Evaluation Toolkit were developed:

1. A *draft* Toolkit – *Facilitation Pack Section 3 (Pilot): Evaluation Toolkit* – which formed the basis for evaluation of the pilot of RECOVEU course materials.
2. The *final* Toolkit – *Facilitation Pack Section 3 (Final): Evaluation Toolkit* – which includes amended Evaluation Tools and guidelines/instructions for use following pilot feedback and analysis of the Evaluation Tools data (see *Del. 7.1: Pilot Delivery Review*, *Del. 7.2 Qualitative Feedback Review*, and *Del. 7.3 Evaluation Toolkit Feedback Review*).

The Evaluation Toolkit supports two other sections of the Facilitation Pack: *Facilitation Pack Section 1 (Final): Delivery Guidelines* and *Facilitation Pack Section 2 (Final): Course Pack* (both also produced in draft versions). The draft and final versions of the Facilitation Pack are given on the project website: [www.recoveu.org](http://www.recoveu.org), together with the course materials.

Together the *Delivery Guidelines*, *Course Pack* and *Evaluation Toolkit* comprise course content that forms the basis for an E-learning Platform, which is also located on the project website.

# THEORETICAL BASE FOR EVALUATION

## Adult Learning/Education and the Recovery Process

Bamber (2010) argues that education is an underexploited route to and method of recovery, and claims that “Education raises expectations, creates opportunities and catalyses the profound process of self-transformation that is recovery from addiction, putting greater distance between the self and the recovered-self” (p.39). Rowley (2012) suggests that providing people in recovery with options to enter education or training of their choice may be one way of promoting a sustained recovery. In her in-depth analysis of men in addiction recovery she found that the men’s access to learning through formal education, independent learning, or informal learning had been pivotal as they built resources within themselves to sustain recovery. What mattered most was that they could enter an environment where they could discover topics at their own pace and work with groups of people who shared their interests. Distance learning courses and informal learning, through internet research, reading books and newspapers, was just as important as formal learning. The topic of the learning is not of importance in the initial stages of adult learning; it is the act of learning that provides people in drug recovery with the reflection skills to start exploring their own behaviour and the behaviour of others.

This resonates with the work of Biernacki (1986) who proposed that an individual with positive high school experiences that showed the benefits of education would be better able to reintegrate into education or the workforce after recovery more easily than someone who had a negative experience of education. Rowley’s work supports evidence (e.g. Granfield and Cloud, 1999, 2001) that suggests that people who are habitually addicted to drugs can and do recover without formal intervention from healthcare or drug services but more pertinently can feel that their recovery is sustained by learning as an adult.

## Best Practice Approaches to Evaluating Learning

Considerable research has been undertaken into developing evaluation tools and processes for evaluating learning. The following presents an overview of some best practice approaches to this that are relevant in the context of the RECOVEU project.

### Recognising and Recording Progress and Achievement (RARPA)

RARPA was developed by a group of practitioners who were considering the issue of how to recognise and validate learning that takes place where there is no accredited qualification as an outcome. It was developed by the Learning and Skills Development Agency (now the Learning and Skills Network) and NIACE as a new measure of success. RAPRPA is designed to support teaching and learning practices. It claims to help teachers to deliver personalised learning, with a view to ensuring that learning is taking place and that the learner is making progress, and is intended to encourage learners to engage actively by measuring their own progress and achievements.

#### Key features of RARPA:

* Learner centred approach.
* The purpose is to improve the quality of the learner's experience.
* The application of RARPA should be fit-for-purpose: it can be adapted to suit learners, the length of the programme and the nature of the subject or discipline.
* The approach, both in the five-stage process and in the quality assurance of learning, is meant to be straightforward and free of unnecessary bureaucracy.
* The approach should complement and sit within existing processes for quality assurance and learner recording.
* The five-stage process is mapped to the revised Common Inspection Framework[[1]](#footnote-1) and should encourage effective self-assessment and the gathering of evidence of effective learning.

#### The RARPA Toolkit website**[[2]](#footnote-2)** outlines five key elements:

1. **Aims** appropriate to an individual learner or groups of learners.
2. **Initial assessment** to establish the learner’s starting point.
3. **Challenging learning objectives/outcomes**: identification of appropriate objectives for the learner.
4. **Formative assessment**: recognition and recording of progress and achievement during the programme, using appropriate assessment tools for specific learners and contexts.
5. **Summative assessment**: end of programme learner self-assessment; tutor review of overall progress and achievement. This should indicate ‘value-added’ and ‘distance travelled’ by learners/participants during a course, programme or community activity. It will be related to the appropriately challenging learning objectives identified at the beginning of, and during, the programme/activity, as appropriate. It may include recognition of learning outcomes not specified during the programme.

#### Good practice includes:

* Pulling together all the measurement processes that have been used throughout the programme to provide a summative view of ‘value-added’ and ‘distance travelled’.
* Using appropriate assessment tools for individuals and contexts, including: records of learner self-assessment, group and peer assessment, tutor records of assessment activities, individual/group progress and achievement learners’ files, journals, diaries, portfolios, artwork, videos, audiotapes, performances, exhibitions and displays, individual or group learner testimony, artefacts, photographs, and other forms of evidence.
* Checking whether the course met learners’ initial expectations.
* Comparing learners’ perceptions of knowledge/skill levels at the beginning of the course with those at the end.
* Identifying additional aspects people might have gained, e.g. confidence, social skills, increased employability.
* Identifying future plans and progression.

### Measuring the distance travelled

Meldrum, Read and Harrison (n.d.) in their *A Guide to Measuring Social Impact*, suggest that what is important in assessing the impact of any learning or development programme is measuring the ‘distance travelled’ – finding out the actual change in an individual or organisation. For example, in a job-readiness programme, we are not just interested in how confident a person feels before the programme, but how much more confident they feel after completing it, i.e. the ‘distance travelled’. For example, if we imagine confidence levels on a scale from ‘completely scared’ to ‘incredibly confident’, we want to know how far a person has travelled up the scale over the course of the programme.

This means:

* Devising a scale on which to measure the change.
* Asking the chosen questions more than once so that the distance travelled along the scale can be measured.

Guidelines do not necessarily need to be given as to what each point on the scale means. However, giving people a framework helps them decide to where to mark. If the data is to be aggregated, the more defined the indicators, the more accurate the comparisons. Clients/participants can be asked the questions chosen as often as necessary – before they join the programme, at the beginning, midway, at the end and even 6 or 12 months later. Such data can be used more than summatively to describe a programme; it can also be used formatively to track progress throughout a programme, enabling remedial action or support needed to be identified and carried out.

### Measuring the wider outcomes of learning

Jones and Dixon (2014), in recognition of the growing significance of wider outcomes in the measurement of impact and commissioning of services, developed a wider outcomes planning and capture tool to give learning providers a focused and consistent way of planning and capturing the wider outcomes of learning, including wider social and personal outcomes.

Based on case studies of the Offender Learning Programme for 2013-2014 (funded by BIS), the aim of the project was to identify and evidence the wider outcomes of the personal and social development (PSD) learning provision for offenders in custody provided by the Offender Learning and Skills Service (OLASS). PSD provision in this context refers to unaccredited learning that results in improvements in personal and social skills – ‘soft’ skills, such as self-esteem, confidence and communication. PSD can provide a stepping stone from informal learning to formal and accredited learning, as well as employment. In prisons this learning is primarily aimed at offenders who face multiple barriers to education and employment, such as low confidence and self-esteem, learning difficulties and disabilities, mental health issues and substance misuse.

Providers are encouraged to identify changes (positive and negative, intended and unintended) in relation to six categories:

* Social relationships
* Individual agency
* Health,
* Employability/employment
* Volunteering
* Learning

#### Key points from the project

* Feedback from participants suggested that the wider outcomes tool is useful. Grouping outcomes into categories was felt to be particularly helpful – this enabled staff to identify and articulate the potential outcomes of their provision, and to define the outcomes they planned to measure.
* Face-to-face training was provided for each participating prison. This included an introduction to the wider outcomes tool and guidance on using it, and different research methods and tools for gathering evidence. All the prisons found this very helpful as it gave them time to reflect on their practice.
* It was particularly useful to have the training on their premises and for participants to have the opportunity to attend the training with another prison, as they were able to exchange ideas.
* The main challenge faced by staff based at all of the prisons involved was access to a computer and the wider outcomes tool. Computer access was not always possible, particularly one with access to the internet or email. The tool was also electronic and software restrictions limited access to or use of it. This was overcome by creating an alternative version of the tool but it did cause some ‘frustration’ and led to some delay in work being completed.

### Measuring soft outcomes

An East-Wales Objective 3 Programme Research Report (2006) explored the methodology for measuring ‘soft’ outcomes, defined as “Intangible and hard to measure directly, represent intermediary stages on the way to achieving a hard outcomes” (p.3) and “things that encourage beneficiaries to achieve something in their lives, allow reintegration to the mainstream, and encourage them to get involved in education or work” (p.11). The authors of the report suggest that ‘distance travelled is the “progress made by beneficiaries in achieving ‘soft’ outcomes that lead towards sustained employment or associated hard outcomes, as a result of participating in a project and against an initial baseline set on joining it” (p.3). Soft outcomes are in contrast to ‘hard outcomes’ that are “clearly definable and quantifiable results that show the progress a beneficiary has made towards achieving desirable outcomes by participating in a project” (p.3).

The authors of the report draw on the work of Lloyd and O’Sullivan (2000) who suggest that common elements of tools to measure soft outcomes and distance travelled are based on indicators which relate to the outcomes projects want to track and include a scoring system, usually in the form of a scale. A baseline assessment is made for each individual, which is then used as a reference for their progress in subsequent evaluations. Some tools also provide systems for analysis and reporting results, and some are based on self-assessment, while others are based on assessment by project staff.

The East-Wales Objective 3 Programme aimed to identify a universal set of soft indicators and the most commonly used tools and techniques for measuring them. It was difficult to identify universal indicators, although three ‘soft’ indicators were most commonly identified: motivation, communication skills and timekeeping. Four of the most commonly used tools and techniques for measuring ‘soft’ outcomes are given below, together with the advantages and disadvantages of each (note that these are quoted verbatim from the report: pp. 23-28):

#### 1. Recorded observations of individual/group activities, i.e. observations of participants’ behaviour

* Advantages: Allows recording of anecdotal evidence; allows systematic reviews; allows individual approach to beneficiaries regarding their abilities and disabilities.
* Disadvantages: Requires high level of skills from observer and special training preparation; potentially involves high subjectivity and bias; lacks systematic recording, which results in the production of a lot of data but limited conclusions.

#### 2. Evaluation forms and questionnaires

* Advantages: Relatively easy to design, with many examples from other projects; flexible, allows adjustment of tools to reflect project’s objectives; less time-intensive; possible to design semi-structured questionnaires with space for comments and observations from staff.
* Disadvantages: Based on the subjective opinion of beneficiaries; high level of potential bias; does not catch changes in attitudes and behaviour of beneficiates.

#### 3. Diagnostic and psychometric tests/assessment scales

* Advantages: Some tools have been widely tested and authorised; tests are useful in establishing baseline and measuring distance travelled; computer based tests maybe prompted by project staff; some of them (e.g. Richter Scale) can be used in projects aiming to developing communities.
* Disadvantages:
* Using psychological tests and scales demands well-qualified staff who have been trained not only in using certain scales but in dealing with more detailed individual and psychological issues.
* Danger of leaving beneficiaries with psychologically bad conditions by going too far in analysing peoples’ abilities, attitudes and emotions.
* Questions are often difficult to understand and badly formulated, so beneficiaries with low learning abilities may face a problem to answer on them.
* The majority of tools have a commercial character and as such they are relatively expensive and require attendance at special training for the project staff, after which they become trainers/instructors.
* Some of them (e.g. Rickter Scale) may be use only when beneficiaries stay in the project for a long time.

#### 4. Individual action plans/ongoing and periodical reviews

* Advantages: Based on the baseline assessment then regularly reviewed; based on one-to-one client and supervisor review, which targets those soft skills which the individual needs to work on; can include personal objectives and priorities.
* Disadvantages: Time-consuming, requires systematic assessments and relatively extensive paper work; not applicable to short-term projects and projects based on drop-in services.

## Self-Efficacy

### Self-efficacy, recovery and adult learning/education

Self-efficacy is defined as “people’s judgments of their capabilities to organize and execute courses of action required to attain designated types of performances” (Bandura, 1986, p.391). It is a judgement of confidence to perform a task, or engage in an activity which depends mostly on the task at hand and is independent of any socially or culturally assigned values. Self-efficacy beliefs determine how people feel, think, motivate themselves and behave (Bandura, 1997).

It has been suggested that self-efficacy is a strong predictor of a wide sphere of behavioural functioning: psychosocial and health functioning, work-related and academic performance, and perseverance in the face of difficult problems (Bandura and Locke, 2003). These authors also suggest that high self-efficacy beliefs are necessary to mobilise and sustain coping behaviours. In terms of addiction, self-efficacy is about a person’s belief in their ability to change their addictive habits. Numerous studies have also shown a strong relationship between self-efficacy and drinking/drug use behaviours (Kadden and Litt, 2011). People who have the necessary skills and strong coping efficacy are more likely to resist high-risk drinking or drug use activities. Self-efficacy is also associated with participation in continuing care and the amount of subsequent alcohol and drug use (McKay et al., 2004), and has been found to predict the duration of abstinence (Tate et al., 2008).

In relation to intervention studies, it has been suggested that that specific treatment-related activities promote changes in self-efficacy; Borrelli and Mermelstein (1994) found that meeting behavioural goals through intervention was accompanied by increased self-efficacy and higher rates of abstinence at follow-up. Greater participation in skills-building activities has also been found to be associated with greater self-efficacy, with in turn, high self-efficacy being closely related to positive treatment outcomes (Ilgen, McKellar and Moos, 2007).

In relation to learning and education, self-efficacy beliefs have been shown to be related to educational performance, and are positively correlated with academic achievement (e.g. Jinks and Morgan, 1999; Pajares and Schunk, 2001; Zimmerman, Bandura, and Martinez-Pons, 1992). Webb-Williams (2006) argues that self-efficacy theory is potentially a useful explanatory construct that can be applied to many educational issues and suggests that it is logical to predict that individuals with a high sense of personal self-efficacy would demonstrate superior performance on a task, in contrast to individuals with low self-efficacy. Self-efficacy has emerged as a highly effective predictor of motivation and learning: the higher the self-efficacy for a given activity, the more likely a person is to succeed at that activity; the higher the self-efficacy for learning, the more likely they are to be motivated to learn.

People with high self-efficacy approach difficult tasks as challenges not threats, set challenging goals for themselves and maintain commitment to achieving them, sustain effort in the face of failure and quickly recover after setbacks, develop an intrinsic interest in activities, and attribute failure to factors which are adaptable (for example, insufficient effort or skills). These attributes contribute to academic performance and learning and it is argued that if teachers can develop a strong sense of efficacy in their students, they would equip them for life; Bandura (1997) suggests that “The major goal of formal education should be to equip students with the intellectual tools, efficacy beliefs and intrinsic interests to educate themselves in a variety of pursuits throughout their lifetime” (p.214).

Pintrich and De Groot (1990) argue that increased self-efficacy beliefs may lead to increased use of metacognitive strategies and thus, to increased performance levels. This is because self-efficacy beliefs influence the self-regulatory sub-functions of self-evaluation/monitoring, goal setting, strategy use, and time planning and management. Thus, new skills learned lead to high performance if they are used effectively. Low performance can arise, not through a lack of knowledge, but from inefficient use of skills. Pintrich and De Groot concluded that “students must have both the ‘will’ and the ‘skill’ to be successful in classrooms” (p.38).

### Evaluating self-efficacy

Self-efficacy theory was developed by Bandura (1986) who outlines his recommendations for constructing self-efficacy scales in his *Guide for Constructing Self-Efficacy Scales* (Bandura, 2001, 2006). He cautioned that self-efficacy should, in the main, be assessed using context-specific measures consistent with the achievement index with which they are being compared, rather than with more general measures. He argues that the construction of sound self-efficacy scales must rely on an informative conceptual analysis of the factors which govern particular domains of functioning. That is, subscales must be tailored to activity domains and items must assess the multifaceted ways in which self-efficacy beliefs operate within these domains. Bandura posits that accurate prediction of outcomes from self-efficacy beliefs can only be obtained by assessing self-efficacy at the optimal level of specificity that corresponds to the domain of functioning being analysed; in other words, self-efficacy judgements should be consistent with, and tailored to, the performance/behaviour domains with which they are compared.

## Self-Esteem

### Self-esteem, recovery and adult learning/education

Self-esteem refers to how one feels about the self: it is “a positive or negative attitude toward a particular object, namely, the self”, and “expresses the feelings that one is ‘good enough’. The individual simply feels that he is a person of worth.” (Rosenberg, 1965, pp. 30-31). A person with high self-esteem is satisfied with the person they are and meets their own standards as a human being (Coopersmith, 1967; Rosenberg, 1985). It has become hugely fashionable to suggest that positive self-esteem immunises people against susceptibility to a multitude of social problems (Dubois and Tevendale, 1999; Emler, 2001; Kohn, 1994) and this view has become widely popular all over the world. In particular, there has been a drive to eradicate practices or circumstances that might damage self-esteem “from the precincts of educational establishments” (Emler, 2001, p.3).

Low self-esteem has been suggested to be a risk factor for substance use (Ward, 1995) and individuals in the grip of addiction often report feelings of worthlessness that are often characterised by a lack of stability in life, insignificance to others, and a sense of immorality. People who have negative feelings about themselves are more likely to use drugs and alcohol in an effort to feel better. Improved self-esteem is therefore seen as a priority on the path to recovery and the goal of intervention is to decrease vulnerability to negative social influences by exposing individuals to skills training such as relapse prevention techniques and the enhancement of self-esteem (Akhter, 2013). Research also suggests that interventions that combine recovery awareness training with skills training, like in the RECOVEU course, are useful for raising self-esteem (Botvin, 2000).

Early studies suggested a relationship between self-esteem and learning such that improved self-esteem leads to better attitudes towards learning/education and improved performance. However, this has been questioned and it has since been claimed that there is no direct relationship between self-esteem and learning (Baumeister et al., 2003; Kobal and Musek, 2001; Robinson, Taylor and Piolat, 1990). It has also been suggested that participation in learning can act as a causal factor over self-esteem with Baumeister et al. (2003) concluding that the weak self-esteem–academic performance relationships actually reflect an effect of performance on self-esteem. This suggests that the act of engaging in learning would help to facilitate improved self-esteem; this in turn may support recovery from addiction given the proposed theoretical relationship between self-esteem and substance use.

### Evaluating self-esteem

Self-esteem is typically measured using self-report questionnaires. The most widely used measure of self-esteem is the 10-item Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965), which measures global ‘state’ self-esteem by asking respondents to reflect on their current feelings, using on a 4-point agree/disagree scale. Many self-esteem measures have been criticised and are poorly validated, and this poses challenges for researchers and practitioners trying to investigate self-esteem (see Blascovich and Tomaka, 1993, for a review). The RSES, in contrast, is considered a highly reliable and valid quantitative tool for assessing self-esteem and has been used extensively in cross-cultural studies across the world (Schmitt and Allik, 2005).

## Recovery Capital

### Recovery capital and adult learning/education

Recovery capital describes the breadth of external and internal resources people in recovery will need to sustain a drug free life (Rowley, 2012). They are the same resources as those required to build social, human and cultural capital for any individual and include the personal and psychological resources a person has, and the social networks involving trust, norms and values that support a drug free lifestyle.

Recovery capital is an emergent concept which specifically refers to the resources and strengths that individuals in addiction recovery need to acquire (Best, 2012). It is closely related to social capital as it explores the resources people need to make sustained behavioural change but only in terms of addiction recovery, rather than in the wider social context. Granfield and Cloud (2001) talked to people who had completed college education and maintained employment prior to becoming habitually addicted; the social capital gained through these experiences seemed to make them more able to develop new habits in recovery, with recovery also being linked to increased social capital gained through education. This supports Heyneman (1998) who suggested that social capital was a valuable by-product of education, giving access to new groups of people, relationships and opportunities. Fitzsimmons (1999) suggests that education is intensifying as an instrument of capital, especially in relation to the use of education as an agenda for employability strategies which aid transition into the workplace.

Recovery capital is embedded in bio-psycho-social approaches to addiction such as that of Zinberg (1984), who recognised that the nature of a drug, the person taking it, and their environment, would have a specific impact on a person’s reaction and ability to cease and maintain recovery. Recovery capital refers to the internal and external resources necessary for an individual to achieve and maintain recovery from substance misuse as well as make behavioural changes; the resources (social, physical, human and cultural) are necessary to begin and maintain recovery from substance use, abuse, and dependence (Best and Laudet, 2010; Cloud and Granfield, 2008).

Recovery capital has emerged as an organising concept which describes the elements in a person’s life that provide them with the capacity to achieve and sustain recovery from addiction (White, 2007). It coincides with a shift in principles that underpinned intervention and pathological theories towards a sustained recovery paradigm. The relationship between recovery capital and recovery-related outcomes is such that longer remission results in greater accrual of recovery capital; in turn, this increases the chance of longer remission because it reduces biological, psychological and social stressors, which are major pathways to relapse (Kelly and Hoeppner, 2014).

Work on recovery capital in the UK has been championed by Best (2010, 2012; Best and Laudet, 2010; Groshkova, Best and White, 2013) who has developed an explanation for the factors prevalent in sustained recovery pertinent to people in the UK: integration with non-drug using networks, access to training and education, access to employment and reintegration into communities with the absence of drug-using behaviours. Best and Laudet (2010) argue that there are three parts to recovery capital:

1. Personal recovery capital – personal skills and resources (e.g. competencies, coping skills, self-esteem, self-efficacy and positive identity).
2. Social recovery capital – the social network, an individual’s engagement with this, and their commitment to normative values.
3. Community recovery capital – based on a contextual component to resources for the recovery journey (e.g. available recovery champions, clear roads to recovery supports from treatment, underlying community resources such as housing and job opportunities that will help to enable and sustain recovery pathways).

Later work by Best et al. (2010) has broken this down further into 10 personal and pro-social components of recovery capital that can be measured across the long-term recovery journey (see Section 2.5.2 below and Footnote 6).

There has been very little theoretical or empirical work done regarding the link between education and recovery. Keane’s (2011) report was the first of its kind to examine the role that education plays in addiction recovery and the development of recovery capital. He reported that education was an important factor in recovery and developing recovery capital and suggested that we should support recovering drug users to access education in order to improve their chances of achieving social reintegration. Furthermore, he points out that engaging with adult education can improve social capital by opening up opportunities to develop new networks of friends that are outside the confines of the addiction recovery network. Social learning, or learning as part of a group, is an important way to help students gain experience in collaboration and to develop important skills in critical thinking. In turn, these support recovery. Such environments have been found to contribute to better learning outcome and foster benefits such as the development of critical thinking skills, the co-creation of knowledge and transformative learning (Pallot and Pratt, 2005). Rowley (2012) suggests that the men in her study used education as a way to build social capital and test ways of behaving without drugs; they became embedded in settings such as college tutorial groups and internet discussion rooms and used these as communities of practice to learn.

### Evaluating recovery

There is little evidence regarding recovery evaluation tools and there are no specific studies on recovery education evaluation tools. Recovery from addiction is multi-faceted and occurs against complex bio-psychosocial needs. A multitude of studies on treatment dominate the literature but the overall complexity of addiction issues which are biopsychosocial in form are extremely difficult to measure and no specific tools exist to capture this. The tools that do exist were developed in the context of addiction treatment rather than in the context of bio-psychosocial needs, and the quality, consistency and context of how the tools are applied relates to the treatment field; the medical model. This approach uses instruments that are either treatment-based or evaluate personal recovery (e.g. SMART Recovery[[3]](#footnote-3), TOP[[4]](#footnote-4)).

The limitations regarding the literature and evaluation tools are clear – no substantive literature on recovery exists, be it papers, analysis or reports on recovery tools; there are no quality ratings, and there is no consistent persistent use of recovery evaluation tools at either a national or international level (see Deady’s, 2009, review of screening, assessment and outcome measures). Findings on existing tools are weak, with few references or demonstrated impact on services. There is a lack of appropriate research methods and measurements of outcomes for use of evaluation tools within the addiction field, and there have been no studies or cost benefit analysis re social return on investment.

There is a developing evidence base in the literature around social capital (family, peers, mutual aid groups, and new social networks), and around physical capital (work, finance, transport and housing), but these do not look specifically at education in relation to recovery. The only study undertaken on education specifically was by Keane (2011) who used a grounded theory approach to evaluate the effects of adult education on addiction recovery. However, no specific recovery tools were identified in his literature review or used in his research.

There is an emerging methodological clarity and understanding of recovery capital; to date assessment and evaluation of this is in its infancy. Typically, assessment of recovery capital uses the Recovery Capital Scale (Granfield and Cloud, 1999; White and Cloud, 2008) or a later iteration of this: the ARC (Assessment of Recovery Capital scale; Groshkova, Best and White, 2013). These measures have evolved from work into recovery capital undertaken in the US by Robert Granfield, William Cloud and William White, and continued in the UK by David Best[[5]](#footnote-5). They are self-assessment instruments that help a client to measure his or her degree of recovery capital. The scales can be completed and discussed in an interview format or can be self-completed by the client and then discussed with the practitioner. They can also be used within an intervention process to evaluate the impact and effectiveness of a programme. The Recovery Capital Scale asks for an agree/disagree response to 35 separate questions on aspects of recovery capital (e.g. *I live in a home and neighbourhood that is safe and secure*). The ARC asks for a yes/no response to 50 questions across ten dimensions of recovery capital[[6]](#footnote-6). Neither of these scales includes education as a factor in recovery capital, however.

# EVALUATION APPROACHES USED BY PARTNERS

## Partner Summary of Evaluation Approaches

In order to determine which types of evaluation tools partners deem to be the most useful and/or effective in practice, and why, partners completed a *Partner Summary of Evaluation Approaches Form* (see Appendix 1). This asks for a number of fields to be completed (see below) in order to identify and assess current evaluation strategies relevant to both adult learning and addiction recovery interventions; this information was used to inform the development of the RECOVEU Evaluation Tools. The form also requests that partners provide information on evaluation tools that are *not* useful or effective; this information was also important for making decisions about which evaluation tools are the most appropriate.

Information requested from partners:

* Name of evaluation tool.
* Type and content – what the tool evaluates and how. Relevant variables included: adult learning/addiction recovery, adult learning area, type of addiction, type of assessment (e.g. multiple choice), online/pen and paper.
* The context in which it is used – where and who with.
* Value placed on the evaluation tool and why.
* Any other relevant comments.

Information on the different types of evaluation tools is summarised in Tables 3.1 to 3.3 below. The tables are separated into three separate categories of evaluation tools:

Table 3.1: Overview of adult learning evaluation tools

Table 3.2: Overview of addiction recovery evaluation tools

Table 3.3: Overview of relevant miscellaneous tools

The tables also gives partner country, reference or link to the tool, indication of whether or not an example has been provided, and comments about whether or not the tool was appropriate for informing the RECOVEU Evaluation Toolkit.

**Table 3.1 Overview of adult learning evaluation tools**

| **Evaluation tool** | **Country / example (Yes/No)** | **Type of content – what the tool evaluates and how**  | **The context in which it is used – where and who with?** | **Value placed on the evaluation tool and why** | **Other comments / link to tool** | **Appropriateness for informing RECOVEU evaluation tools** |
| --- | --- | --- | --- | --- | --- | --- |
| Evaluation of prevention sessions in EAP (Employee Assistance Programmes)  | Romania (Yes) | Set of questions to find out opinions and suggestions about the training delivered. Mix of tick box and open-ended. | Participants on drug recovery programmes. |  |  | Some questions used to inform the RECOVEU course feedback forms. |
| Training evaluation measure | Romania (Yes) | Set of open-ended questions for feedback on the usefulness of specific training.  | Participants on drug recovery programmes. |  |  | Some questions used to inform the RECOVEU course feedback forms. |
| Proposal of Evaluation Form (staff to complete) | Italy (Yes) | Adult learning, Vocational Guidance (Drug addiction)  | This tool is used by staff to evaluate the effectiveness of the training and/or vocational guidance interventions. | This tool is very useful to monitor the interventions and make corrections. | Adapted by SANSAT from the Balance of Competences Skills Assessment (used nationally in Italy and France – for interventions addressed to drug addicts). | Asks basic questions designed for trainer to record participants’ responsiveness to adult learning course. Not relevant for RECOVEU.  |
| Evaluation by participants (for each module) | Italy (Yes) | Adult learning, Vocational Guidance (Drug addiction) | Participants are asked to fill this tool express their satisfaction level with a learning module. | Useful to monitor the interventions, understand the needs of participants and make corrections. | Asks basic questions on effectiveness of learning module. Used to inform the RECOVEU course feedback forms.  |
| Self-evaluation template (participant to complete) | Italy (Yes) | Adult learning, Vocational Guidance (Drug addiction) | This tool has to be filled by participants: they are asked to evaluate their motivation and their level of active participation. | Very useful both for participants (to reflect on their own attitude) and trainers. | Mixed questions about school and job experiences and feedback on module attended. Does not assess motivation. Last few questions used to inform RECOVEU course feedback forms. |
| CDETB – Progress Framework Tracking Pack | Ireland (Yes) | Tracks adult learning and progress across 5 different skills groups (read words/texts, read signs/symbols, rules of reading/grammar, find information on documents, reading strategies for different purposes) | 1:1 with service providers completing the form. | Rarely used – it is very comprehensive and too time consuming. Service users would need to be with the project for a long time for this to be used.  | Educational based tool that drills down to very specific questions on tasks learnt (e.g. read own name and address).  | Too specific and time-consuming for RECOVEU.  |
| Soilse In-house Evaluation | Ireland (Yes) | In-house evaluation tool. Highlights and critiques how servicer users experience a programme, the assets they gain and how things can be changed in the future. | Group settings/discussion – asks for group responses to four open-ended questions about relationships, skills, the service, and improving quality.  |  | Based on ‘A Model of Best Practice’ from the UK National Institute of Social Work.  | This model of group discussions was used for the Follow-Up Session course feedback from participants.  |

**Table 3.2 Overview of addiction recovery evaluation tools**

| **Evaluation tool** | **Country / example (Yes/No)** | **Type of content – what the tool evaluates and how**  | **The context in which it is used – where and who with?** | **Value placed on the evaluation tool and why** | **Other comments / link to tool** | **Appropriateness for informing RECOVEU evaluation tools** |
| --- | --- | --- | --- | --- | --- | --- |
| Recovery Capital Scale (William White) | UK (Yes)  | 35 questions (scored 1-5, strongly disagree to strongly agree) that identify which areas a person would like to work on in terms of increasing recovery capital. The questions are useful and used commonly as a self-measure. | Used in some residential settings in the UK as an addiction specific QoL (quality of life) measure – there are no records around who may use this.  | There is a range of literature to support this scale but it is unlikely that anyone is trained in working with it in the UK sector. | See:<http://www.williamwhitepapers.com/recovery_toolkit/> | This is appropriate for RECOVEU but the updated version of the scale by David Best (see next row in table) might be more appropriate as it has subscales for personal and social recovery.  |
| Assessment of Recovery Capital Scale (ARC) (David Best) | UK (Yes) | Ten subscales, each having 5 questions – respondents answer ‘yes’ is a specific statement applies to them.  |  | Relatively new scale – psychometric properties assessed in:Groshkova, T., Best, D. and White, W. (2013). The assessment of recovery capital: Properties and psychometrics of a measure of addiction recovery strengths. *Drug and Alcohol Review, 32*, 187-194.  |  | Used for RECOVEU. Permission for use received from David Best.  |
| ITEP (international Treatment Effectiveness Project) – Node Link Mapping Tools  | UK (Yes) | Mapping-based intervention for helping keyworkers and clients identify effective treatment goals. Allows for self-assessment working with a practitioner to evaluate progress in recovery and treatment journey. | No clear records of which services use these but community drug treatment settings would aim to have some element of mapping in the process. | Maps considered effective, if time is available.Issue with time available to complete the process – 10-20 minutes is a 'good' appointment slot but these are unusual – practitioners are so ‘client-loaded’ they do not have time to complete these forms fully in the community.  | See:<http://www.nta.nhs.uk/uploads/itep_routes_to_recovery_part4_240309.pdf>This is NHS/BTEI care planning manual for mapping achievable goals.  | Tool for mapping treatment/progress. Not relevant for RECOVEU. |
| TOP: Treatment Outcomes Profile  | UK,Ireland (Yes – July 2013 vs)(Same form used in UK and Ireland) | A mandatory tool for services to measure outcomes and report to the National Drug Treatment Monitoring Service (NDTMS) which has moved to Public Health England. Evaluates levels of substance use, injecting risk behaviour, crime, health and social functioning.  | All services funded by NHS and Public Health England. To be completed by a keyworker using 1:1 interview with client. UK – completed by a generic case manager who has no contact with the client. Ireland – 1:1 assessment as part of recovery process. Completed:1. At assessment
2. Halfway into the programme
3. At programme end
4. 6 months after programme is complete
 | UK – seems to be only used for data gathering. Ireland – It is a useful international validated tool and a way to capture progress in terms of drug use and crime. It is used in a lot of services in Dublin and was developed in UK. It is a little subjective as it scores how people are feeling on the day and not an overall picture of how they are managing recovery. Soilse use this as one of their evaluation tools for all service users. | Public Health England collects a range of data and also absorbs the data regarding drug treatment. | Mandatory data gathering tool. Ireland use this to assess progress. Not relevant for RECOVEU. |
| Drug Avoidance Self-Efficacy Scale (DASES) | UK (Yes) | Designed to assess a client’s recovery self-efficacy – an individual’s confidence in their ability to successfully cope with risk situations without using drugs. 16-item self-report questionnaire. Clients imagine themselves in a particular situation and rate self-efficacy to resist drug use. | Was developed for a specific range of projects. So far has been restricted to 16-30 age group (but seems appropriate for older group).  |  | Available at EMCDDA Evaluation tool bank:<http://www.emcdda.europa.eu/html.cfm/index78046EN.html?EIB_AREAS=w271&EIB_PHASES=w268&order=INSTRUMENT&ordertype=asc> (scale can be used without charge).Formatted version at: <http://www.nd.gov.hk/pdf/bdf-2010R2-q03-eng.pdf>  | Has been shown to demonstrate predictive validity (on 16-30 ages). Lengthy to read/complete because it gives hypothetical situations. 7-point scale is not practical for small group analysis. Not relevant for RECOVEU as not looking at recovery self-efficacy.  |
| Rosenberg Self-Esteem Scale (SES) | UK (Yes)  | 10-item self-report measure of global and university-dimensional self-esteem. Statements relate to overall feelings of self-worth or self-acceptance. 4-point scale (strongly agree – strongly disagree). 5 minutes completion. Has also been administered as an interview. | Has demonstrated good reliability/validity across a large number of different sample groups. Has been validated for use with male, female, adolescent, adult and elderly populations.Validated for use with substance abusers and other clinical groups, and is regularly used in treatment outcome studies. Might be some issues with cultural bias due to comprehension and/or translation, although the scale has been widely used in cross-cultural studies. |  | Available at EMCDDA evaluation tool bank:<http://www.emcdda.europa.eu/html.cfm/index78046EN.html?EIB_AREAS=w271&EIB_PHASES=w268&order=INSTRUMENT&ordertype=asc>Also:<http://fetzer.org/sites/default/files/images/stories/pdf/selfmeasures/Self_Measures_for_Self-Esteem_ROSENBERG_SELF-ESTEEM.pdf> | The SES is in the public domain. No permission needed to use the measure. Used for RECOVEU to measure general self-esteem pre- and post-intervention.  |
| Personal questionnaire (SOCRATES M-SO-F and SOCRATES M-SO-F)  | UK (Yes) | 32-item questionnaire for drug user’s ‘significant others’ to complete. There are a number of different types of SOCRATES scales that are used to consider relationships, impact of drug use, and reactions to different scenarios.  | Used widely in residential treatment around the UK. Male and female versions. | Practitioners report these as useful in starting conversations. | Available at EMCDDA evaluation tool bank:<http://www.emcdda.europa.eu/html.cfm/index78046EN.html?EIB_AREAS=w271&EIB_PHASES=w268&order=INSTRUMENT&ordertype=asc> | Not relevant for RECOVEU as it is not used by the service user or provider.  |
| WHO (World Health Organisation) Quality of Life-BREF version (WHOQOL-BREF) | UK (Yes)  | An international cross-culturally comparable QoL assessment instrument. 26 items across 4 domains (physical health, social relationships, environment). Self-report measure. (BREF version is the shorter version of the original instrument).  | Reported use in residential and community treatment.  | Reported as a helpful method to aid discussion around QoL with people in treatment. | Details available at: <http://www.who.int/substance_abuse/research_tools/whoqolbref/en/>To obtain permission to use, email: WHOQOL@who.intUser agreement available at:http://www.who.int/mental\_health/publications/whoqol/en/Can get free download through above site (1997) but not formatted properly (also scoring syntax).  | Need permission to use – user agreement lasts for one year. Questionnaires will be sent when this completed. Not used for RECOVEU as it does not fit into the overall structure of modules/tools.Have copy of field trial version/manual (2006):<http://www.who.int/mental_health/media/en/76.pdf>2004 version: <http://www.who.int/substance_abuse/research_tools/en/english_whoqol.pdf> |
| Maudsley Addiction Profile (MAP)  | UK (Yes)  | Evaluates overall addiction profile and measures response to interventions – a face-to-face structured interview undertaken at different stages through treatment – designed as an outcome research tool. The MAP measures problems in 4 domains: substance use, health risk behaviour, physical and psychological health, and personal/social functioning. | Often used in residential and more extensive community treatment settings (if staff have time available). Can be repeatedly administered at points during and after an index treatment episode. Changes in these measures can then be attributed to treatment or other processes over the intervening period. | The Maudsley is seen as a foremost authority on assessing addiction and treatment outcomes – Gossop and Strang are key players in the field. Reference as: Marsden, J., Gossop, M., Stewart, D., Best, D., Farrell, M., Lehmann, P., Edwards, C. and Strang, J. (1998). The Maudsley Addiction Profile (MAP): A brief instrument for assessing treatment outcome. *Addiction,* *93*(12), 1857-1867. | Available at EMCDDA evaluation tool bank:<http://www.emcdda.europa.eu/html.cfm/index78046EN.html?EIB_AREAS=w271&EIB_PHASES=w268&order=INSTRUMENT&ordertype=asc> | The map is a public domain research instrument – can be used free of charge for not-for-profit organisation. Not relevant for RECOVEU as too long in this format.  |
| EuropASI – European Addiction Severity Index(Based on the Addiction Severity Index) | Cyprus (Yes – have accessed through EMCDDA instrument list) | This is a lengthy assessment tool that covers: social history, educational, family, judicial system, substance abuse, physical and sexual abuse history and employment history of the last 30 days, 90 days and 1 year.Face-to-face structured interview. Multidimensional clinical and research instrument. Service-provider completes (takes 30-45 minutes). | Every client entering the inpatient phase of treatment.‘The EUROPASI can be used for different purposes in assessing substance abuse clients: a) to assess the problem severity of the interviewee, and b) for periodic repeated administrations to monitor and quantify change in problems commonly associated to substance abuse.’ | This tool originated in the United States and is one of the most widely used and well researched testing tools around the world for substance abuse.  | For information and instrument see: <http://www.emcdda.europa.eu/html.cfm/index3647EN.html>‘Designed to provide basic diagnostic information on a client prior, during and after treatment for substance use-related problems, and for the assessment of change in client status and treatment outcome.’ | ‘The ASI is in the public domain’ – so can put link to this on RECOVEU site.Too lengthy for RECOVEU purposes and not self-report.  |
| SCID – Structured Clinical Interview for DSM Disorders | Cyprus (No) | Most comprehensive assessment tool to assess mental health including all of the psychiatric diagnosis. Semi-structured interview guide for making diagnoses. Administered by clinician or mental health professional.  | Used in the Counselling Centre before entering the inpatient phase and also repeated as need be. | Widely used and accurate assessment of mental health. Many versions assessing mental health in different areas (including a Research Version, which contains more disorders).  | For background information and links to where can buy instruments see: <http://www.scid4.org/>and<http://www.appi.org/products/structured-clinical-interview-for-dsm-5-scid-5> | Available by permission only – need to pay fee to use instrument in research studies, clinical trials, training courses, etc. Can be modified by the researcher to remove unwanted elements. Not relevant for RECOVEU but could put link on website.  |
| Drinker Inventory of Consequences (DrInc-2L)  | Romania (Yes) | History of use and inventory of consequences (over life time and previous 3 months)Pen/paper, face-to-face.2 versions – yes/no responses; 4-scale Likert (never to daily). Also short form.  | As part of the admission procedure and final discharge evaluation in the counselling programme – social worker/addiction counsellor completes. Could be used as a self-report questionnaire.  | Very important.  | Standard toolAvailable online. Test manual can be found at <http://pubs.niaaa.nih.gov/publications/ProjectMatch/match04.pdf>All versions included together with scoring sheet (scores on different dimensions).  | 50 questions on consequences of drinking. Not relevant – RECOVEU is not focused on alcohol addiction.  |
| The AUDIT Test for Alcohol Addiction (Alcoholism) | Romania (Yes) | Determines level of alcohol use and type of drinking. Interview version of the form is given in the manual (see right for link). NOTE – this manual calls the test: *The Alcohol Use Disorders Identification Test.* | As part of the admission procedure in the counselling program for clients who are not clear about their drinking pattern.Social worker/addiction counsellor completes. There is a self-report version in the manual.  | Important.  | Standard tool. Development manual for this can be found at <http://www.talkingalcohol.com/files/pdfs/WHO_audit.pdf>Does not say whether this can be freely used.  | 10 questions on levels of drinking. Not relevant – RECOVEU is not focused on alcohol addiction.  |
| Pre and Post Test | Romania (Yes) | Specific knowledge on alcohol and drug addiction and recovery.Pen/paper – list of open-ended questions.  | Used in educational and responsibility training courses. Social worker/addiction counsellor completes.  | Very important  |  | Not relevant for RECOVEU because requires interview with service user.  |
| Drugs and Alcohol Star (The Outcomes Star for drug and alcohol recovery) | Ireland (Yes) | Addiction recovery – ‘An evidence-based tool for supporting and measuring change’. Focuses on 10 areas seen as critical in supporting people in recovery (e.g. use of time, emotional health, money, etc.). Scored from 1-10 in a ‘star design’. Also includes an action plan template.  | Both group and 1:1’s with services users. Self-report tool. Can be done pre/post and at other regular intervals as required.  | Good tool – it is easy to follow and service user completes it. Soilse would use this in group settings at the beginning for a baseline assessment and again at the end, as a form of review and progress tracking. | Need to buy license to use (based on the number of workers/managers using the tool – £330 minimum). Star Recovery website:<http://www.outcomesstar.org.uk/drugs-star/>  | Very good but cannot use for RECOVEU as there is no funding to pay for licenses.  |
| COAIM – Change Outcome and Impact Measuring | Ireland (Have manual only) | Addiction Recovery – scoring scales/functional analysis. Grounded in a model of change behaviour/harm reduction model. Uses motivational interviewing across 10 individual, wide-ranging areas (personal, social and practical).  | 1:1 or group setting. | Helps to motivate service users, helps to promote change. Do not use this in Soilse. Soilse do use motivational interviewing amongst many other tools but not in this format.  | Soilse has provided the manual but the tool is not included.  | Not relevant for RECOVEU as too complicated.  |

**Table 3.3 Overview of relevant miscellaneous tools**

| **Evaluation tool** | **Country / example (Yes/No)** | **Type of content – what the tool evaluates and how**  | **The context in which it is used – where and who with?** | **Value placed on the evaluation tool and why** | **Other comments / link to tool** | **Appropriateness for informing RECOVEU evaluation tools** |
| --- | --- | --- | --- | --- | --- | --- |
| TDI – Treatment Demand Indicator | Cyprus (No) | Covers demographics, profile of drug use, route of administration, number of using years and if help was offered before at any other centre. Also asks questions regarding HIV and HEP testing and results. Pen-and-paper tool. | Used for every client requesting help at the Agia Skepi Counselling Centre and every client that enters inpatient treatment. Required by the EMCDDA for data collection – data gathering process for mandatory treatment monitoring and reporting. | ‘The primary purpose of the information collected by the TDI indicator is to gain insights intothe characteristics, risk behaviours and drug use patterns of people with drug problems in the community, and to help to estimate trends in the extent (prevalence and incidence) and patterns of problem drug use; ideally, in combination with other drug indicators.’ (TDI Manual, p. 17) | Manual can be found at: <http://www.emcdda.europa.eu/attachements.cfm/att_188852_EN_EMCDDA-TDI-Protocol-3.0.pdf> | Data is collected nationally and delivered to the EMCDDA, who then report on numbers and characteristics of clients presenting to treatment facilities at the European level. Not relevant for RECOVEU. |
| Pompidou Form (part of National Drug Treatment Reporting System) | Ireland (Yes) | EMCDDA – Pompidou. Collects mandatory data on demographics, assessment, treatment, substance use and treatment, risk behaviours.  | Individual – completed by service provider. | Gets a baseline of information at assessment and also has an exit part to document.  |  | Data gathering tool for mandatory EMCDDA reporting. Not relevant for RECOVEU. |
| Biopsychosocial Assessment | Cyprus (No) | This is an in-house assessment tool created to cover basic information on demographics and also requests information on education, social, family, incarcerations, substance abuse, work history. | Used as initial assessment for every client at the the Agia Skepi Counselling Centre and then again during the admissions process in the inpatient phase of treatment. |  |  | In-house background data gathering tool. Not relevant for RECOVEU. |
| Initial Evaluation Form | Romania (No) | Evaluates problems, history of use and resources on bio-psycho-social-spiritual areas for any kind of addiction, | Used as part of the admission procedure in the counselling programme.Social worker/addiction counsellor completes. Pen/paper, face-to-face. | Very important |  | In-house background data gathering tool. Not relevant for RECOVEU.  |
| Final Evaluation Form | Romania (No) | Assesses progress in the SDP counselling programme, achievement of objectives from the intervention plan, and period of abstinence. | Used as part of the final/ discharge evaluation in the SDP counselling programme.Social worker/addiction counsellor completes. Pen/paper, face-to-face. | Very important  |  | In-house progress data gathering tool. Not relevant for RECOVEU. |
| Follow-Up Evaluation Form | Romania (No) | Achievement of objectives from the ‘After care plan of action’. Completed minimum 3 months after discharge.  | Used as part of the after-care intervention in the SDP counselling programme.Social worker/addiction counsellor completes. Pen/paper, face-to-face. | Very important  | Is under development – SDP starting to use first drafts of the form at time of writing.  | In-house follow-up data gathering tool. Not relevant for RECOVEU. |
| Holistic Needs Assessment  | Ireland (No) | Assesses housing needs of service users. | Individual self-report.  | Not available in electronic version – only paper copy.  | Not currently used – looking to roll out to services in the future. | Data gathering tool. Not relevant for RECOVEU. |

# TOOLS FOR THE EVALUATION TOOLKIT

Chapter 2 has discussed the theoretical basis for development of the RECOVEU Evaluation Toolkit and Chapter 3 presents the evaluation tools currently used by RECOVEU partners. The EMCCDA (European Monitoring Centre for Drugs and Addiction) website[[7]](#footnote-7) also gives a comprehensive list of evaluation instruments used in addiction recovery. Many of the tools cited here and in the evaluation tool bank supplied by EMCDDA are proven to be effective but, as is demonstrated by the lists of tools given in Chapter 3, services may choose to develop their own, or use local tools connected with funding and service level agreements. Within the UK, for example, there is no one national approved approach to evaluation with the exception of the TOP (Treatment Outcomes Profile) form supplying mandatory data. However, it seems that case-workers do not even get to complete these; instead they are completed by a generic case manager who has no contact with the client. Furthermore, when developing evaluation tools for use with interventions aimed at drug recovery, one of the key issues is that services will only complete what they absolutely have to for data reporting, especially when linked to payment by results. Taking these points into account, it is essential that the tools used for RECOVEU are quick and practical to complete, that they can be easily completed by the client themselves, and that the resulting data is easy to analyse.

Following best practice as outlined in Chapter 2, new evaluation tools must allow for the evaluation of ‘distance travelled’; they must therefore support delivery on more than one occasion. In developing evaluation tools, the outcomes to be tracked need to be linked to course outcomes, as is suggested by Bandura (2001, 2006) and Lloyd and O’Sullivan (2000). The content of the RECOVEU Evaluation Tools, therefore, must be linked to outcomes/skills that people might have gained – increased self-efficacy/confidence, self-esteem, social skills (especially in relation to learning and education), and employability, as well aspects of recovery capital. As outlined by the East-Wales Objective 3 Programme Research Report (2006), important is measuring improvements in personal and social skills, i.e. ‘soft’ skills such as self-esteem, self-efficacy/confidence and social interaction.

Training must be given for trainers/practitioners on using any evaluation toolkit, and guidelines for scoring and analysing the data must be provided. The toolkit must also have the facility to check whether an intervention/course has met learners’ expectations so that requisite revisions to the course can be identified. Also relevant is access to digital versions of the tools for ease of electronic completion if required. Specifically important is that the evaluation tools are free to access and are easy to learn how to use. The East-Wales Objective 3 Programme Research Report (2006) cautions about the usefulness of tools that have a commercial character, and are expensive to acquire or require special training for staff; this limits access to them, or they may be utilised without the correct information on how they should be used.

Taking these issues into account, Table 4.1 shows the Evaluation Tools and additional materials that were included in the RECOVEU Evaluation Toolkit.

**Table 4.1 Evaluation Tools and materials to be included in the RECOVEU Evaluation Toolkit**

|  |  |
| --- | --- |
| **Tools / materials** | **Rationale for inclusion**  |
| ***Learning Self-Efficacy Questionnaire******And******Employability Self-Efficacy Questionnaire*** | To assess self-efficacies for learning and employability. The inclusion of self-efficacy scales responds to the theoretical argument that high self-efficacy beliefs help to sustain coping behaviours and increased abstinence, and that participation in education helps to build social and recovery capital. Consistent with arguments outlined by Bandura (2001, 2006) and Lloyd and Sullivan (2000), these scales have been developed specifically for RECOVEU and items are linked to course content.  |
| ***Rosenberg Self-Esteem Scale*** (RSES; Rosenberg, 1965) | A pre-existing tool used to assess self-esteem; one of the ‘soft’ skills seen as important in recovery. The inclusion of self-esteem also responds to the theoretical argument that engaging in learning will facilitate improved self-esteem, which will then aid the path to recovery and limit the chance of relapse. The RSES was chosen because it is a reliable and valid measure, even when used in cross-cultural studies.  |
| ***Assessment of Recovery Capital Scale***(ARC; Groshkova, Best and White, 2013) | A pre-existing evaluation tool used to assess recovery capital; the ARC was chosen because of its facility to assess recovery capital in multiple contexts. Recovery capital theory has been included in order to explore whether the RECOVEU course is supportive of sustained recovery across different contexts.  |
| ***Module Feedback Form*** | To determine learners’ impressions of modules on the course to allow for the assessment of impact and the identification of revisions needed to the course materials.  |
| * Guidelines/procedures for use of the Evaluation Tools
* Instructions for scoring and analysing the Evaluation Tools
 | For the use of trainers/practitioners; these are included in the Evaluation Toolkit. Additional guidelines/instructions are included in the Train the Trainers Module (Del. 9.7).  |
| Provide Evaluation Tools in electronic format (Word)  | To aid completion by clients/participants.To aid analysis by trainers/practitioners.  |

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# APPENDIX 1 – Partner Summary of Evaluation Approaches Form

**Work Package 6: Development of a Draft Evaluation Toolkit for Trainers**

 **Partner Summary of Evaluation Approaches *(to support D6.1: Evaluation Approach Review)***

|  |  |
| --- | --- |
| Prepared by: |  |

* The following table asks for information on the evaluation tools that you use to assess whether interventions for adults in addiction recovery are having a positive effect. For the purposes of this project, this covers tools that assess the effectiveness of adult learning interventions or addiction recovery interventions.
* Please complete the table in relation to the tools that you find the most effective/useful. Conversely, please also provide information on any tools that you find to be not at all useful; this information would also be valuable.
* If your organisation does not use evaluation tools to assess the effectiveness of interventions for adults in addiction recovery, please explain why in the last column.
* Please also provide examples of the evaluation tools that you find to be the most effective in practice. We realise that partners from Cyprus, Italy and Romania might not have these evaluation tools in English. However, if you have an evaluation tool that you find specifically useful and you think that we could use it (or a version of it) in RECOVEU, please translate it into English if at all possible (the days given for this WP have been worked out to cover this eventuality).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name and reference of evaluation tool** | **Example sent**(✓ if yes) | **Type of content – what the tool evaluates and how** Indicate anything of relevance, e.g. adult learning /addiction recovery, adult learning area, type of addiction, type of assessment (e.g. multiple choice), online/pen and paper. | **The context in which you use it – where and who with?** | **What value does your organisation place on this evaluation tool and why?**(Please also indicate tools that are bad examples) | **Any other comments** (If your organisation does not use evaluation tools to assess the effectiveness of interventions for adults in addiction recovery, please explain why here) |
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**RECOVEU Consortium Details**

This document has been produced by the RECOVEU Consortium. The lead partner for this phase of the project and the main author of this report was Staffordshire University.

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1. Framework for inspections carried out, respectively, under section 5 of the Education Act 2005 (as amended), section 109 of the Education and Skills Act 2008, the Education and Inspections Act 2006, and the Childcare Act 2006. [↑](#footnote-ref-1)
2. The RARPA Toolkit and example of tools to record impact can be found at: <http://www.learningcurve.org.uk/courses/ladder4learning/resources/rarpatoolkit>

and <http://www.learningcurve.org.uk/courses/ladder4learning/resources/rarpatoolsforassessing> [accessed 1st April 2015]. [↑](#footnote-ref-2)
3. http://www.smartrecovery.org/ [↑](#footnote-ref-3)
4. http://www.nta.nhs.uk/healthcare-TOP.aspx [↑](#footnote-ref-4)
5. Granfield and Cloud (1999); Cloud and Granfield (2004, 2008); White (2010); White and Cloud (2008); Best et al. (2012). [↑](#footnote-ref-5)
6. (1) Substance Use and Sobriety, (2) Global health (Psychological), (3) Global Health (Physical), (4) Citizenship / Community Involvement, (5) Social Support, (6) Meaningful Activities, (7) Housing and Safety, (8) Risk taking, (9) Coping and Life Functioning, (10) Recovery Experience. [↑](#footnote-ref-6)
7. <http://www.emcdda.europa.eu/html.cfm/index78046EN.html?EIB_AREAS=w271&EIB_PHASES=w268&order=INSTRUMENT&ordertype=asc> [↑](#footnote-ref-7)