CHAPTER II: LITERATURE REVIEW

2.1 Introduction

This chapter provides a review of the pertinent literature and studies regarding recovery capital and treatment motivation among formerly addicted individuals to polydrugs and non-polydrugs. Both the Recovery Capital and the Treatment Motivational Instrument, that have been the subject of past study in Malaysia and overseas, will be covered in this chapter.

2.2 Recovery Capital

A condition of health and functioning after the cessation of addictive substance use, frequently comprising abstinence from use, is commonly referred to as "recovery," a nontechnical expression used in both lay and professional contexts to refer to SUD (White 1998). As the importance of recovery has become more obvious over the past two decades, a number of academic, professional, and governmental organisations have produced official definitions for it. Several of these explanations are shown in Table 2.1.

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Table 2.1

Prominent addiction recovery definitions

Source	Year	Definition
American Society of Addiction Medicine (ASAM)	2005	When a patient's physical and mental health improve to the point that they may safely and happily stop taking addictive medications, we say that they are "in recovery."
Betty Ford Institute Consensus Panel	2006	A way of life marked by sobriety, personal health, and citizenship that is willingly maintained.
Center for Substance Abuse Treatment	2005	Sobriety and improved health, wellness, and quality of life are the results of the transformation that is recovery from substance abuse.
SAMHSA	2011	Recovery from mental diseases and drug use disorders is a process of transformation in which individuals improve their health and wellness, live autonomously, and try to realise their full potential.
Scottish Government	2008	Rehab is the process that helps addicts overcome their drug problems and return to healthy, productive lives.
UK Drug Policy Commission	2008	Addiction recovery entails regaining and maintaining voluntary self-control over substance use to improve health and well-being and to fulfil one's rights, responsibilities, and contributions to one's community.

The term "recovery capital," which borrows from the idea of "social capital" to describe the assets that influence the process of beating an addiction, has become widely used in the field's discussion. One of the primary premises is that people who have access to recovery funds are more likely to enter and remain in recovery. It considers both the wide range in the quantity of resources available to those in need of assistance in overcoming substance use disorders, and the even wider range in the quality of those resources (Best & Laudet, 2010; Best et al., 2020; Cloud &

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Granfield, 2008; White & Cloud, 2008). Individual, societal, and community recovery capital have all been highlighted by White and Cloud (2008).

A person's human recovery capital includes their morals and their intellectual, social, and professional abilities, while their physical recovery capital includes their bodily well-being and their recovery capital. Relatives, blood relatives, and other social connections like friends and acquaintances are all examples of social recovery capital The term "community recovery capital" describes the sum of a community's human and material resources that support people in their efforts to overcome substance abuse and build healthier lives. This also includes the disposition to behave in accordance with cultural norms and the cultural capital that stands in for those norms (Cloud & Granfield, 2008; White & Cloud, 2008).

It's the same as what Ross-Houle and Porcellato (2021) wrote in their journal article "Recovery capital in the setting of homelessness, high levels of alcohol intake, and unpleasant important life experiences." In the United Kingdom, substance abuse and addiction are considered to be among the most pressing issues affecting public health. The process of building up one's capital for recovery seems to involve four distinct tiers: the individual, the community, the relationships one has, and society. The 2017 United Kingdom Drug Strategy emphasises the value of rehabilitation programmes. The strategy relies on the idea of recovery capital to strengthen and expand people's access to support systems. They also imply that extra study is needed to fully grasp recovery communities' roles in bolstering recovery and creating recovery capital.

According to Best et al. (2022), getting sober requires a wide range of services and programmes that all work together to fulfil the complex needs of those recovering from substance abuse. O'Sullivan et al. (2019) in "Recovery Capital and

Quality of Life in Stable Recovery from Addiction" found that people with a variety of physical, sensory, and psychological limitations have much higher rates of SUDs. Meetings for SMART Recovery are led by trained volunteers who use a method that draws from cognitive behavioural therapy (CBT), rational emotive behaviour therapy (REBT), and motivational interviewing (MI). The quality of one's life may be enhanced by receiving encouragement and assistance from friends and trained professionals. Therapists specialising in rehabilitation often deal with clients who are currently engaged in the process of recovering from substance abuse problems (SUDs). If you or someone you know needs help quitting drinking, drug use, or another addictive activity, SMART Recovery can help. Two indices of recovery capital—self-stigma and abstinence self-efficacy—were found to have strong relationships with overall happiness.

Some researchers also found that a refusal to engage in self-efficiency had a positive and substantial relationship with subjective well-being; this factor was incorporated into the final model. As a standalone predictor of quality of life, it did not hold up after controlling for other factors. The principles they established are in line with previous studies, which showed that an increase in capital predicted a 22% rise in quality of life.

Parlier-Ahmad et al., (2021) conducted a study of patients getting medication for opioid use disorder (MOUD) in the United States and discovered that women had greater recovery capital than men, but are also more likely to encounter prejudice. It was also noted that the recovery process is multifaceted, encompassing health, quality of life, and citizenship. Many of the men and women in this study who were getting outpatient MOUD with buprenorphine had high levels of recovery capital. The use of recovery capital as a person-centered treatment outcome besides

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abstinence may be a useful harm reduction method. Long-term holistic rehabilitation from substance use disorders (SUDs) has been neglected in favour of short-term stability and abstinence. The findings point to specific areas where therapeutic interventions might help build and develop resources necessary for a successful recovery.

2.2.1 Recovery Capital study in Malaysia

A drug is a specific phrase for a substance that, when consumed, has negative physical, mental, emotional, and behavioural impacts on a person's health. In order to prohibit the cultivation, manufacturing, distribution, importation, exportation, possession, and abuse of these substances, the Malaysian government has included them in the Dangerous Drugs Act of 1952. Dangerous Drugs are a class of substances covered by Section 2 of the 1952 Dangerous Drugs Act. The term 'Dangerous Drugs' refers to any substance or drug specified in the First Schedule of the Dangerous Drugs Act of 1952. According to Abdul Ghani and his colleagues (2014), narcotics in Arabic are referred to as al-Mukhadarat, which are potentially harmful and insane substances. This word is derived from the Arabic word for danger, mukhadara. According to the Dewan Bahasa dan Pustaka Dictionary (2007), the term 'abuse' also refers to the act or act of abusing something. According to the National Drug Policy, drug abuse is "the conduct of using drugs incorrectly, improperly, and not for medical causes, but for pleasure or to relieve delirium."

According Ambo et al.,(2022) "*Penyalahgunaan Dadah Jenis Syabu Dalam Kalangan Masyarakat Islam Di Sandakan, Sabah: Faktor Dan Langkah Mengatasinya* " is one of the cited research on drug abuse. This research aims to shed light on Syabu (Methamphetamine) use in the Muslim community of Sandakan, Sabah by exploring

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the factors that contribute to people taking the drug and potential solutions to the problem. Socioeconomic status and a lack of emphasis on Islamic religious education are two major aspects in the research's findings on drug abuse. Peer pressure can be a major contributor to drug abuse, but there are other factors at play as well. Addiction to drugs has far-reaching effects, including increased criminal activity, worsening health, and broken families.

2.2.2. Recovery Capital approach/ instrument

There is a dearth of studies that critically examine holistic views of recovery, but there has been a rise in interest in quantifying recovery capital and better understanding its many dimensions. Capital for Addiction Recovery Measurement Scale Developed by Groshkova et al (2012). The goal of all services is recovery, as stated by the Scottish Government in their paper titled "Road to Recovery." An initial item pool was established following discussions with practitioners and service user groups on the factors they deemed most critical to their own recovery. The term "recovery capital" refers to a way of measuring a person's development along the path to sobriety. In the Assessment of Recovery Capital, a higher score denoted a bigger quantity of recovery capital. The sum of the subscores served as the final score. Also, it's unclear how helpful clinicians find the ARC when creating treatment strategies.

This trend was halted using the **Assessment of Recovery Capital (ARC)** (Groshkova et al., 2013) and other metrics developed from it in applied studies of recovery whose focus was on goals other than scale development. The ARC assesses many aspects of a person's life, including their use of drugs and alcohol, their mental and physical well-being, the extent to which they are involved in their community, and their network of friends and family. However, the principal components analysis

showed that a one-component structure was the most appropriate for the data, rather than evidence of several domains. The Brief Assessment of Recovery Capital was developed by Vilsaint et al. (2017) and is based on the ARC's original 50 items but only evaluates a single, overarching factor (BARC-10). The results showed that this new measure had good internal consistency, concurrent validity, predictive validity, and measurement invariance across geography and gender, making it a useful tool for identifying individual differences in recovery capital.

The ARC is a part of a broader instrument called the REC-CAP that evaluates recovery capital by combining the ARC with other measures of recovery objectives, participation, and drive (Best et al., 2016). The tool's primary purpose is to highlight resources and barriers to recovery by measuring an individual's personal, social, and community recovery capital. The REC-CAP is designed for use in a variety of recovery settings to monitor progress by the participant and professional or nonprofessional staff, and can guide long-term recovery planning, in contrast to other measures such as the ARC, which are primarily used for research (Best et al. 2016, 2017).

Each of these metrics, except for the REC-CAP, is checked by comparing data from different people. They only consider a snapshot in time when assessing a person, thus they can't take into account individual differences or things like how far along in the healing process someone is. Therefore, the focus of such assessments will be on the traits that set people apart from one another, a concept known as interindividual variability in the academic jargon. The study of interindividual variability ignores these changes; future research should focus on measuring variations in capital within individuals to determine whether capital can increase, decrease, or change shape over time during a person's rehabilitation journey. Intra-individual variance is the second

form of variation (Nesselroade & Ram 2004). Measures that place more focus on differences between people are more likely to miss important factors in a child's growth and development (Molenaar 2004). Therefore, there needs to be an effort to create, test, and apply ecologically sound longitudinal measurements of recovery capital (e.g., measuring it in context as it is unfolding rather than only in the lab or at one sitting using retrospective recall).

These types of shifts within an individual can now be analyzed with the use of cutting-edge scientific innovations. Smyth et al. (2017) coined the term "slice of life approaches" to describe recent advances in measurement that concentrate on collecting extensive longitudinal data about a single individual over time as they go about their daily routines. The daily diary method and ecological moment assessment are two typical approaches. Respondents in studies using a daily diary technique are asked to compile their daily events into a single report (Bolger et al. 2003). Bolger, et al. (2003). These daily reports require no effort from the participant but offer a crystal-clear view of the day-to-day fluctuations and patterns occurring inside them.

The ability to evaluate oneself, to have faith in oneself, to remain sober, to have contact with trained specialists, and to have a support system are all examples of recovery capital. O'Sullivan et al. (2017) examined data from a sample of people who had sought out peer recovery services to determine recovery capital and Quality Of Life (QOL). The results of the study showed a correlation between lower levels of self-stigma and higher levels of satisfaction with one's life. Respondents completed the Alcohol Use Disorder Test and the Short Form 38 at three time points (baseline, six months, and twelve months) to assess changes in quality of life (QF). Relapse is defined as returning to drug use after having made an effort to abstain, as stated by the National

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Institute on Drug Abuse. Laudet et al. (2006) looked at how recovery capital affected the link between stress and happiness. The results demonstrated that social supports, spirituality, life purpose, religiousness, and 12-step involvement all had a significant role in stress management and increasing quality of life. Stress did not appear to be one of the ten statistically significant connections between continuous drug use observed by Moitra et al (2013).

However, it's likely that events occurring inside a single day still have substantial weight for recovery and recouping financial resources. For example, social interactions at lunchtime may have an afternoon-long impact on one's disposition and appetite (Cleveland and Harris 2010). At the end of the day, a person's mood or cravings may be more affected by negative social encounters than by the good support of a buddy who is also in recovery, or by their involvement in social recovery capital. Technology (typically cell phones, in current research) is used in ecological momentary assessment (EMA) approaches to regularly poll people for their impressions at various times during the day (Stone and Shiffman 1994). Researchers can examine how various techniques and tools for recovery fared on different days. Applying mixed-effects and multilevel models (Pritikin et al., 2017; Oravecz and Brick, 2019) to such data allows researchers to unearth phenomena that matter at different times and places for a single individual, as well as those that distinguish individuals from one another. If one's positive mood is low, that person may feel the effects of negative social settings more keenly than if their positive mood were higher.

Furthermore, EMA techniques allow researchers to explore individual variations in such processes. An interaction may have a dramatic impact on one person's mood and desire while having no effect on another, demonstrating the disparate sensitivity to

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the emotional and psychological impacts of social settings. Moreover, fascinating is the idea that this responsiveness can alter within a person over time, with different patterns of change for each individual. These patterns may originate from the body's natural recuperative processes, or they may be the result of external stimuli including social interactions, the surrounding environment, and the availability of resources.

2.3. Treatment Motivation

Patients' commitment and chances of continuing therapy are strongly predicted by their degree of intrinsic desire. Furthermore, the addict's preparedness for treatment and the outcome of therapy depends greatly on the addict's level of treatment motivation (Cahill et al., 2003). Having an openness to and preparation for change is important to the concept of "treatment motivation," yet this inclination might shift over time and in response to different stimuli (Bulut & Bozkurt, 2019). According to Dillon et al. (2016) and Wild et al. (2016), clients who lack intrinsic motivation upon admission are more likely to drop out of treatment early; clients who require high levels of intrinsic motivation make good users with high levels of cognitive commitment. When patients are very motivated to get better, they are less likely to relapse and more likely to stick with therapy and see positive results.

One of the most important factors in whether or not drug abusers will sustain their habit is their psychological history. A person's desire to give up drugs and focus on a healthy lifestyle comes from within and is driven by the satisfaction of psychological demands (Chan et al., 2019). Wegman et al. (2017) found that even after successful treatment for drug addiction, most former addicts resumed their drug use, proving that a lack of motivation remains a significant barrier to recovery. Additionally,

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studies show that drug-seeking behaviour (Almeman et al., 2017), an inability to handle stress (Hong et al., 2017), and the invitation of previous connections all contribute to Methadone treatment dropout (Salleh, 2012).

Gender, co-occurring drug use, early trauma and hardship, drug use history, and a lack of self-control and lack of motivation are all crucial individual factors (Wemm & Sinha, 2019). As reported by (Chan et al., 2019). There is a correlation between the number of reported mental health, social, and substance use problems and the number of people actively seeking or in treatment. Possible explanations for these variations include (a) a lack of self-awareness on the part of untreated respondents and (b) stronger immediate reasons for seeking therapy on the part of those who are receiving it. Researchers have discovered that interventions using motivational interviewing grounded in self-determination theory have a significant impact on health and self-improvement, crime reduction, stress, and drug use (Ayres et al., 2014; Scherbaum & Specka, 2008).

There were a number of factors that contributed to an increase in confidence and a decrease in mental discord. When applying the notion of self-determination to the study of drug users' mental states and decisions to use or not use drugs, Chan et al. (2019) took a relativistic approach. To address this need for operational definition, they have researched and implemented the Treatment Motivation Questionnaire (TMQ), which is based on the self-determination theory of Deci and Ryan (1987). Internal motivation, external motivation, help-seeking behaviour, and therapist-patient rapport are the four dimensions of motivation that this tool may assess (Cahill et al., 2003; Millere et al., 2014). However, the validity of the TMQ among native Malay speakers has not been studied till recently.

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2.4. Polydrug and non-polydrug user

Polydrug and non-polydrug are widely used in the world, including in Malaysia. An increasing correlation between methamphetamine and illicit opioid epidemics is being revealed by shifting patterns of use as polydrug becomes more readily available (Al-Tayyib et al, 2017; Cicero, Ellis, & Kasper, 2019; Ellis et al, 2018; Glick et al, 2018). When combined with illegal opioids, polydrug use may raise the risk of accidental overdose (Al-Tayyib et al, 2017; Glick et al, 2018), infective endocarditis (Wright et al, 2018), and the prevalence of high-risk sex behaviors and hazardous injecting practises (Nerlander et al, 2018; The Lancet Editorial, 2018; Zule & Desmond, 1999). Also, it may lead to an uptick in cases of psychopathology like depression, anxiety, schizophrenia, and violent behaviour (Anglin et al., 2000; Brecht & Herbeck, 2013; Darke et al., 2017; Degenhardt et al, 2017; Grant et al, 2012; R. Jones et al., 2018; Lappin et al., 2018; Sexton et al., 2006, 2009; Zweben et al, 2004).

The DSM-5 also includes a section on the symptoms of all substance use detoxification. As an example, methamphetamine dependence and abuse have been combined into a single diagnosis called amphetamine-type substance in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. This disorder falls under the umbrella term "stimulant use disorders" (DSM-5). According to the DSM-5, methamphetamine is most closely linked to stimulant use disorder. Using amphetamine-type drugs, cocaine, or other stimulants in a way that causes clinically significant impairment or distress (as demonstrated by at least two symptoms) over the course of a 12-month period is what is meant by "addiction" in this setting.

However, opioid use disorder is characterized by a continuous desire for opioids despite negative personal, family, or occupational results, as described in the

Diagnostic and Statistical Manual of Mental Disorders (DSM-5) published by the American Psychiatric Association. Heroin, morphine, codeine, fentanyl, and synthetic opioids like oxycodone are all examples of opioids. Opioid use disorder is defined by the triad of opioid craving, tolerance, and withdrawal upon abrupt discontinuation of opioid use. Opioid-use disorder is defined by the presence of two or more of eleven symptoms that occur repeatedly over a 12-month period. These problems are exacerbated by chronic opioid use, the physical and psychological dependence that develops when stopping opioid use, and the neglect of critical activities in favour of opioid use.

Similar results have been found in studies of the relationships between cocaine and methamphetamine users in various nations. Evidence from studies examining topics like the ineffectiveness of opioid substitution treatment (OST) and a stated lack of enjoyment following stabilization on OST demonstrates that injection drug users frequently combine polydrug, non-polydrug and opioids to enhance their high. The authors' research reveals that multiple factors contribute to polydrug and non-polydrug use , such as the availability of polydrug and the user's perception of the combination's invigorating effects. Opioid addicts may turn to stimulants and opioids as a kind of self-medication when they experience withdrawal symptoms, but this may be an indication of a more fundamental issue, as suggested by Palmer et al. (2020).

The effects of both polydrug and non-polydrug use were studied by Daniulaityte et al. (2020). This research highlights the complex nature of the motivational and behavioral processes associated with polydrug and non-polydrug use , such as self-treatment and substitution behaviors, attempts to persist when homeless, and increased risk taking. Eighty-plus % of study respondents reported abusing OTC pain medications regularly prior to taking heroin/NPF. In bivariate analyses, polydrug

and non-polydrug use was found to be significantly associated with both prescribed and non-prescribed use of pharmaceutical stimulants; however, in the multivariable model, only non-prescribed use of pharmaceutical stimulants remained statistically significant (aOR=2.97, 95% CI = 1.78 - 4.96; p 0.0001). The association between prior histories of diverted pharmaceutical stimulant use and polydrug and non-polydrug use in the previous six months may be explained by substitution behavior, in which one substance is exchanged with another with similar effects but more easily available (Lamonica & Boeri, 2012).

2.5. Theoretical of Study

2.5.1 Recovery Capital Theory

Since healing is a dynamic process, its characteristics may vary over time and across situations for various individuals. A person's plan for recovery may depend on wholly different behaviors than those of another person. Recuperation is a complicated process that varies for each individual and environment. According to a group led by H. Cleveland of The Pennsylvania State University, the process of initiating and sustaining long-term recovery is dynamic and might vary from person to person (2021). They claimed that because everyone's recovery from substance addiction disorders is unique, it is crucial to assess long-term progress in a method that allows for an in-depth investigation of people' changing requirements.

On the one hand, these interrelationships have the potential to produce fruitful trajectories, with more money leading to better recovery and so more money being accumulated. The other side of this is that someone who faces repeated setbacks may quickly deplete their recovery capital (by, for example,

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overburdening social supporters), leaving them with fewer resources to deal with the next challenge. "Rock bottom" may be reached during active addiction because of a feedback loop between an individual's declining sense of well-being and their worsening social interactions. Because people have different amounts of capital going into the recovery process, they don't all have the same amount of success after going through treatment for substance use disorder.

2.5.2 Social Capital Theory

The concept of recovery capital is analogous to that of social capital. It focuses on the people and tools believed to aid in long-term sobriety (Granfield & Cloud, 1999; Laudet & White, 2008). People with disabilities and other marginalised groups can benefit greatly from the social capital ecology model of inclusion because it takes into account the steps and relationships often need to gain access to resources (Magasi et al., 2015). The evolution of our species has made us a social species. The human race has an inbuilt tendency toward group effort. There is a mutual desire among us to help, share, and give, and to get the same from others. The things they want and need often involve the help of others or the exchange of goods and services. The benefits gained through such interactions are sometimes called "social capital." Humans' ability to care for one another, to think and act in compassionate and collaborative ways, and to work together are the foundations of social capital. Social capital is a concept that addresses fundamental questions about human behaviour and motivation, such as the factors that motivate people to help others even when it benefits them little.

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Is it possible that this can be explained by the logic of free will? Could instinct be the result of years of biological development? Is it due to human nature, cultural norms, or religious dogma? Is it reasonable to expect people to work toward social harmony, peace, and justice without compensation for their time or effort? (Uphoff, 1999) It focuses on the differences between competing and cooperating, selfishness and altruism, logic and ethics, and the motivations behind doing things for their own sake vs doing them for their own sake. Although the idea of social capital is intrinsic to our everyday lives and familiar to us on an intuitive level, the theory behind it is highly intricate, with several dimensions working at different levels and a wide variety of circumstances influencing its positive or negative impacts. Many people who are new to the concept of social capital find it intimidating since specialists may make it seem almost mystical.

2.5.3 Transtheoretical Model

Transtheoretical Model of Change (TTM; Prochaska & DiClemente, 1984) has become a leading model in the study of addiction during the past twenty years. To better comprehend and intervene in human intentional behavior change, the transtheoretical model (TTM) provides a unified framework. The model's structural elements are the different levels of change, the different stages of change, and the various processes of change. The model has been used with a wide range of health risk and health preventative activities, although it has been originally and primarily studied in relation to the initiation and cessation of addictive behaviours. This is due to the fact that insights gained from researching addictive behaviours may be used to a wide variety of medical

mysteries. Significant new insights into this process and the best ways to intervention have been brought to light in the past 15 years, with far-reaching implications for both treatment and the study of the condition.

Health care providers' understanding of and approach to patients exhibiting risky behaviours has undergone a substantial conceptual shift as a result of the TTM. The recognition that customer motivation is a spectrum that may be influenced, rather than a simple yes/no, is an essential part of this shift. The TTM posits that patient motivation can be improved in part by encouraging patients to think outside the box when faced with complex change (e.g., shifting motivation and ambivalence). A lack of this may explain why many treatment programmes have had such dismal results and significant dropout rates (DiClemente et al., 1992). The TTM's five stages of transformation correspond to increasing levels of drive manifested in increasingly distinct patterns of thought and activity (precontemplation, contemplation, preparation, action, and maintenance).

2.5.4 Development stages of Recovery

Numerous stage models, including Brown's recovery model (1985), which distinguishes between active alcoholism, transitioning, early recovery, and ongoing recovery, are consistent with the recovery-stage paradigm. The rehabilitation process comprises a variety of stages, and Gorski's (1989) model include both the early and late stages. There have been identified several periods of recuperation, both in terms of time and content.

Early Recovery

The National Institute on Drug Abuse (NIDA; 2012) defines early recovery as the time period commencing when abstinence-focused activities are began and concluding after around 3 months (White, 2009), however some researchers and practitioners extend this time frame (Laudet & White, 2008). According to recovery-stage models, people in early recovery are most vulnerable to relapse, have the least level of stability, and should prioritise sobriety and building a support structure (Brown, 1985; Gorski, 1989). Most research into drug and alcohol recovery has focused on the early stages of recovery.

Middle Recovery

As the individual becomes more secure in their abstinence, they are able to change their focus from abstinence-specific goals to more universally relevant ones, such as securing gainful employment. Many individuals may never exit this stage, which is defined as lasting anywhere from three months after the onset of abstinence-focused behaviours to several years into recovery (NIDA, 2012). (Laudet & White, 2008). While the danger of relapse is lower than in the early phases of recovery, it nevertheless exists for many individuals, particularly those who cease utilising treatment supports (Brooks et al., 2009; Gorski, 1989). One reaches a point of relative equilibrium and stability as they move through the recuperation process.

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Late Recovery

The later stages of recovery are the most stable, with less emphasis on abstinence and relapse prevention and more focus on personal development (Flores, 2001; Laudet & White, 2008). It is true that the risk of relapse is lowest at this point, yet a sizeable minority (25%) still report relapsing after a lengthy period of therapy (Dennis et al., 2007; Hser et al., 2001). At this stage, those who can live fascinating, exciting lives devoid of addiction have the greatest chance of success (Brooks & McHenry, 2009; Flores, 2001; Laudet & White, 2008). It is common knowledge that most of the early success can be attributed to prioritizing sober networks and learning to abstain (Simpson & Joe, 2004). Researchers have paid less attention to later stages of rehabilitation, making it more difficult to establish acceptable goals, especially given the vast diversity of individual and contextual characteristics that may be relevant (Laudet & White, 2010; Simpson & Joe, 2004). For example, the amount of therapeutic help, aftercare, and emphasis on the self, relationships, and job that are developmentally suitable for later periods of recovery is not yet apparent.

2.5.5 Addiction Theory and Long-Term Recovery

The importance of addiction theory is not limited to its role in informing drug treatment strategies but extends to the ways in which it may influence both short- and long-term outcomes for those who recover from addiction (Goode, 2007). If addiction is the consequence of a dynamic interaction between biological predisposition, contextual context, and the addict's own sense of worth and belief in their own ability to change, then any effective intervention must consider all three of these factors. Treatment

therapies that are only focused on the addict's substance use can at most provide some degree of stability. To make matters worse, individuals may try abstinence-based recovery, for which they are neither read nor able to make the necessary changes in their environment or sense of self-worth.

2.6 Summary

Previous research has shown that an interdisciplinary approach is essential for both long-term healing and acute stability. In view of the recent growth of the recovering capital construct in addiction rehabilitation in Malaysia, it is crucial that those who use polydrugs and non-polydrugs do so with a thorough grasp of its domains. And the notion of recovery capital is still in its infancy in Malaysia, hence there is less definitive evidence on it compared to other models of recovery in the field of addiction treatment. A drug treatment programme that is to be executed on a broad scale must first account for the nature of the substance being abused and the difficulties experienced by those who engage in polysubstance abuse.

2.7 Conclusion

In this chapter, we have looked at all the theoretical literature that has been utilised to investigate what factors lead recovering polydrugs and non-polydrugs addicts in Malaysia to become motivated to seek treatment. An overarching theory was built as a result of these analyses. The next chapter looks at how the proposed conceptual model can be used to create hypotheses and measures.

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