Article

Agreement for Recovery: First Spanish Consensus on the Concept of Alcohol Addiction Recovery

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Abstract

Introduction: Current literature does not dispose from a widely accepted definition of recovery in alcohol use disorder (AUD), and most proposals originate from anglophone countries. This study introduces a pioneering consensus in Spain on the definition of recovery in AUD.

Method: The Delphi method was used. The expert panel, comprising 54 multidisciplinary professionals from the Community of Madrid.

Results: A high level of consensus (≥80% agreement) was reached for 45% of the items and majority (≥60%) for 84%. Recovery is understood as a dynamic, personalized, and voluntary process, potentially enduring throughout one's lifespan. It entails a transformative lifestyle shift aimed at achieving a significant improvement in overall quality of life, encompassing physical and mental health, interpersonal relationships, and environmental factors. The journey of recovery is marked by heightened psychological well-being, is characterized by empowerment, personal growth, existential purpose, and positive identity reconstruction. Recovery is supported by substance use management, requires proactive individual agency and involves both personal and societal responsibilities.

Conclusions: This study represents a milestone as it is the first consensus in the Community of Madrid on the meaning of recovery in AUD. The proposed definition of recovery could be a potential reference for similar regions within Spain or even for other countries with cultural similarities. The elucidation of a clear framework of recovery provides a solid basis for future research efforts and clinical interventions in the Spanish AUD landscape.

Keywords

recovery; alcohol use disorder; consensus; Delphi method; wellbeing

Introduction

Alcohol use disorder (AUD) stands as one of the most prevalent addictive disorders, carrying significant global health and socioeconomic implications [1]. The prevalence of AUD falls within a prominent range, fluctuating from 13% to 30%, with an unequal gender distribution, at 10% among women and 20% among men in most Western countries [2,3].

Alcohol consumption, recognized as one of the main risk factors for global health, has emerged as a priority within the United Nations' 2030 Agenda for Sustainable Development [4]. By 2016, alcohol consumption was estimated to have contributed to approximately 3 million deaths worldwide, constituting 5.3% of total mortality [2]. In the United States, the age-adjusted death rate from alcohol-induced causes was 11.9 in 2019 [5]. Approximately 5.1%

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Table 1. Compilation of recovery definitions published up to 2022.

Source	Year	Definition
Center for Substance Abuse Treatment (CSAT) [10]	2005	Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life.
American Society of Addiction Medicine (ASAM) [11]	2005	A patient is in a "state of recovery" when he or she has reached a state of physical and psychological health such that his/her abstinence from dependency-producing drugs is complete and comfortable.
Betty Ford Institute Consensus Panel [12]	2007	A voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship.
UK Drug Policy Commission [13]	2008	The process of recovery from problematic substance use is characterized by voluntarily sustained control over substance use which maximizes health and wellbeing and participation in the rights, roles and responsibilities of society.
Substance Abuse and Mental Health Services Administration (SAMHSA) [14]	2011	Recovery from mental disorders and substance use disorders is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
ASAM [15]	2012	The goal of recovery is to improve quality of life by seeking balance and healing in all aspects of health and well-being. While addressing: the constant search for abstinence by the individual, the deterioration of behavioral control, the treatment of craving, the recognition of problems in behavior and interpersonal relationships, and the management of emotional responses.
Kaskutas *et al.* [7]	2014	Abstinence; essential recovery (e.g., handling negative feelings without using drugs or alcohol); enriched recovery (e.g., taking responsibility for the things I can change); and spirituality in recovery.
Neale *et al.* [16]	2016	Five factors in recovery: (1) Substance use, (2) material resources, (3) outlook on life, (4) self-care, and (5) relationships.
Best *et al.* [17]	2016	A social process, underpinned by transitions in social network composition that includes the addition of new recovery-oriented groups, where such groups are perceived as attractive, beneficial and relevant, and involves the concurrent emergence of a new recovery-based social identity.
The Recovery Science Research Collaborative [18]	2019	The recovery is an individualized, intentional, dynamic, and relational process involving sustained efforts to improve wellness.
Witkiewitz *et al.* [19]	2020	Alcohol recovery is a process that is dynamic and focuses on improvement of health and wellness.
National Institute on Alcohol Abuse and Alcoholism (NIAAA) [20]	2022	Recovery is a process through which an individual pursues both remission from AUD and cessation from heavy drinking. Recovery can also be considered an outcome such that an individual may be considered "recovered" if both remission from AUD and cessation from heavy drinking are achieved and maintained over time. For those experiencing alcohol-related functional impairment and other adverse consequences, recovery is often marked by the fulfillment of basic needs, enhancements in social support and spirituality, and improvements in physical and mental health, quality of life, and other dimensions of well-being. Continued improvement in these domains may, in turn, promote sustained recovery.

Note: Adapted from Kelly & Hoeppner (2015) [21]. AUD, alcohol use disorder.

of the global burden of disease and injury is attributed to alcohol consumption, as measured in terms of disability-adjusted life years (DALYs) [3]. The imperative to address issues related to alcohol consumption is undeniably clear. Consequently, initiatives aimed at promoting and supporting recovery from AUD emerge as a fundamental public health concern.

The objectives of such initiatives have been shaped by the interpretation of recovery within its socio-cultural and historical context. Notably, the paradigm shift stemming from the WHO's [6] expanded conception of health, defining it as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity", is significant. This change in perspective, acknowledging that health encompasses more than just the absence of illness, has prompted a substantial reconsideration of the concept of "recovery" across various disciplines, driving the understanding of recovery beyond mere symptom remission [7–9].

Since the early years of the 21st century, as delineated in Table 1 (Ref. [7,10–21]), paradigmatic shifts regarding the concept of recovery have been widely embraced by stakeholders [18]. Various stakeholders (patients, professionals, institutions, etc.) have endeavored to formulate technical definitions of recovery (for further insights, refer to reviews by [19,22]), which have resulted in constructive approaches to outlining the concept and specifying its constituents. However, the multitude of definitions suggests a lack of a unified theoretical framework [21]. For instance, the Center for Substance Abuse Treatment (CSAT, [10]) posited that recovery is "a process of change through which an individual achieves abstinence and improved health, wellness and quality of life". The UK Commission on Drug Policy [13] broadened this definition by incorporating the individual's engagement in society, addressing "participation in the rights, roles and responsibilities of society". Similarly, the Betty Ford Institute Consensus Panel [12] characterized recovery as "a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship". Hence, although all definitions in the early 2000s encompass abstinence, it is not regarded as synonymous with recovery [7,23–25].

More recent definitions [14,17–19] have primarily emphasized notions of well-being and quality of life, delinking substance management from the definition itself (Table 1). While acknowledging that abstinence may be particularly recommended in cases of severe addictive disorders [18,19], these definitions highlight broader aspects of recovery beyond mere substance management. Despite subtle differences among the various proposals, common elements are identified suggesting that recovery involves changes in lifestyle, well-being, and available assets, understood in the context of recovery capital [7,21,26–30]. The only definition that appears to deviate from this trend is the one recently proposed by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) [20], which reintegrates substance management into the definition of recovery and includes remission of symptoms characterized by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5) [31]. Likewise, while all definitions in this century understood recovery as a process, the NIAAA [20] introduces, in part, an understanding of recovery as an outcome.

Thus, despite these commendable efforts, the lack of consensus among experts on the meaning of recovery in this field persists [18,19,21]. The precise definition and practical application of these definitions are crucial for scientific inquiry. The absence of consensus hampers the assessment of measurement validity, as well as the definition of outcomes and agreement on meanings and values within the specific domain [18].

Establishing a consistent definition of recovery across studies is pivotal for several reasons. First, a consensus definition will afford a more comprehensive understanding of the clinical trajectory of AUD and how symptoms progress over time [19,20]. Identifying the most pertinent domains and components will facilitate the assessment and monitoring of the recovery process. Second, a unified definition will encourage in-depth exploration of various individual recovery styles and their accompanying experiences, thereby paving the way for thorough investigation into the pathways, styles, and stages of AUD resolution [29]. Third, a consensus definition will streamline the assessment and dissemination of treatments for AUD, enhancing understanding of which treatments are linked to short- and long-term AUD recovery [32]. This, in turn, could inform clinical practice by guiding therapeutic interventions and aiding the development of novel treatments to bolster recovery efforts. Fourth, a shared definition for recovery will provide an understandable framework for individuals with AUD, their families and friends, healthcare professionals, and policymakers, clarifying expectations about goals for change during the recovery process [19,21]. Furthermore, it will contribute to mitigating the stigma associated with AUD by highlighting its feasibility and prevalence, offering optimism and a positive portrayal of the AUD recovery journey [7]. This shared definition will also facilitate the implementation of new public policies to address this disorder and allocate necessary resources [33].

It is noteworthy that all consensus proposals thus far have originated from Anglo-Saxon countries. However, cultural differences and alcohol consumption patterns in Latin countries suggest the necessity of a customized approach. Hence, the objective of this study has been to conduct the inaugural Spanish consensus on the concept of recovery from alcohol dependence among professionals in the Community of Madrid, employing the Delphi method. This approach aims not only to address an existing gap in the scientific literature but also to adapt definitions to cultural realities and local contexts, thereby furnishing a more comprehensive and applicable framework.

Materials and Methods

Design

The Delphi methodology was implemented to fulfill the established objective. The Delphi method constitutes a qualitative technique for gathering information, allowing

the collection of expert opinions through repeated consultations. It is appropriate when seeking to collect consensus and representative opinions from a collective [34].

Expert Panel Selection and Composition

The selection of experts was carried out through a meticulous process, supported by meetings with specialized technicians from Institute of Addictions of the Madrid City Council (General Subdirectorate of Addictions of Madrid Salud) and the Regional Office of Coordination in Mental Health and Addictions of the Ministry of Health of the Community of Madrid. The determination of the number of experts (between 30 and 50) followed recommendations from various authors [35,36].

The application of the Expert Biogram [37] ensured an individualized selection of panelists based on their professional experience, scientific production (for physicians, psychologists, and psychiatrists), professional profile, and work involvement.

Sixty professionals working in treatment centers for individuals with alcohol addiction were invited. The experts were chosen from the multidisciplinary teams of the Addiction Treatment Centers (*Centros de Atención a las Adicciones*-CAD), the drug addiction care network, and the mental health centers integrated into the Mental Health and Addictions Coordination Office of the Community of Madrid. Professionals from the Primary Care and Internal Medicine Services of the Community of Madrid also participated. They were informed that their participation would not be remunerated, and approval was requested to include their names in the final document. Ninety percent agreed to participate (n = 54), and 48 experts completed both phases of the study (80%).

Finally, the expert panel consists of professionals from primary care and general medicine (n = 10), psychiatry (n = 14), psychology (n = 13), nursing (n = 9), occupational therapy (n = 1), and social work (n = 1).

Materials

Recommended Readings for Panelists

Searches were conducted in databases such as PUBMED, MEDLINE, EMBASE, PSYCINFO, PSYKE, and Psicodoc, from the year 2000, using the terms "substance use disorder" AND "recovery". Broad terms were chosen to ensure the retrieval of all relevant articles. The committee evaluated the selected articles and conducted a literature review, generating two documents provided to the panelists. These documents, along with a book chapter and four additional articles chosen during the review, constituted the recommended readings. They included:

I. Introduction to alcohol dependence recovery: Document elaborated by the scientific committee compiling different elements of the recovery concept (https://www.inrecovery.es/documentos-proyectos).

II. What is recovery and its conceptualization in consensuses?: Document from the scientific committee summarizing the results of recovery consensuses published up to 2019 (https://www.inrecovery.es/documentos-proyectos).

III. What is meant by alcohol dependence recovery?: Book chapter [22].

IV. Articles of interest related to the research field: (1) Ashford *et al.* [18]: "Defining and operationalizing the phenomena of recovery"; (2) Kelly *et al.* [38]: "Beyond Abstinence Changes in Indices of Quality of Life"; (3) Kelly and Hoeppner [21]: "A biaxial formulation of the recovery construct"; (4) Witkiewitz *et al.* [19]: "What is Recovery?".

Preparation of the Delphi Questionnaire

Following the literature review, elements of recovery highlighted in quantitative and qualitative studies on recovery samples in substance use disorders, as well as in expert reviews and consensuses proposing definitions and measures on recovery, were identified. Additionally, three recognized scales in the recovery process were used as references: the World Health Organization Quality of Life Scale (WHOQOL-Bref [39]; Spanish version by Benitez-Borrego *et al.* [40]); Patient Reported Outcome Measure (PROM) Alcohol Dependence [16] and the Assessment of Recovery Capital (ARC, [41]; Spanish version by Sión *et al.* [42]).

A Delphi questionnaire was developed comprising 123 items grouped into 7 thematic blocks. Each item assessed experts' perceptions of different dimensions of alcohol use disorder recovery, using a scale from 1 to 10 (1-Completely Disagree; 10-Completely Agree). The "Typeform" tool was utilized for the design and distribution of the survey to panelists.

All questions were reviewed by the scientific committee to avoid overlap and enhance their comprehensibility.

Procedure

The research was conducted based on a thematic index developed by the scientific committee. Teleworking sessions were held between the scientific and technical committee, considering this guide. From these meetings, the focus was defined, and the crucial questions for the project were determined.

The consultation was divided into two rounds. In the first round, links to the questionnaire blocks were sent via email. Upon completing a block, the experts automatically received the link for the next one, offering them the option to continue immediately or postpone it, thus facilitating completion. After analyzing the results of the first round, the second wave of questions was sent, including only those with discrepancies in the first round (intermediate responses: 4, 5, and 6). The format was modified to allow experts to argue their choices, enriching the study and enabling conclusions to be based on solid grounds.

During the process, follow-up, reminder, and data validation tasks were carried out according to the protocol established by the committee. Support was provided through a specific email to address any queries from the panelists throughout the process.

Data Analysis

A descriptive data analysis was conducted. The results of the initial questionnaire were interpreted using the following criteria, based on the percentage of agreement on a specific response relative to the total:

I. Unanimity: When 100% of the panelists agreed on the same response.

II. Consensus: When less than 100% but at least 80% of the panelists agreed on the same response.

III. Majority: When less than 80% but at least 60% of the panelists agreed on the same response.

IV. Discrepancy: When less than 60% of the panelists agreed on the same response.

During the extraction of results from the initial round, two panelists were only partially included due to incomplete questionnaire submissions; their responses were considered up to Part D.

The responses from the second round were evaluated using the same criteria as the first. The comments provided by the panelists were also taken into consideration.

Results

Overall, after both rounds, the level of agreement was 84.02%, and the level of discrepancy did not exceed 16% of the questions. In the first round, the experts achieved a majority agreement on 75.61% of the items. Therefore, the second round consisted of 30 items, of which only seven maintained discrepancies.

Table 2 presents the consensus or discrepancy results across thematic areas wherein the 123 items were categorized for expert response. The thematic areas exhibiting the highest consensus ($\geq$80% agreement), both in agreement and disagreement, ranked as follows in descending order: the section related to general characteristics of recovery (Section A, 70%), followed by psychological aspects of recovery (Section D, 62.79%), lifestyle and civic engagement (Section F, 46.15%). Sections addressing physical health and, social relationships and spirituality obtained the same percentage of consensus (Sections C and G, 33.33% respectively). Slightly lower consensus was achieved in the section addressing environmental and material conditions (Section E, 26.32%), and finally, the questions about symptom reduction and substance management (Section B, 14.28%). The agreement percentages per item can be found in the **Supplementary Table 1**.

The response percentages in each section of the survey, following the completion of the two rounds of questions, are presented below. The agreement percentages per item can be found in the **Supplementary Table 1**.

Characteristics of Recovery (Section A)

Consensus was reached on 70% of the items concerning the characteristics of recovery, with an additional 20% reaching majority agreement. Based on these responses, recovery, as perceived by the panelists, is viewed as a dynamic (97.9%), individualized (97.9%), and voluntary (87.5%) process, which can last a lifetime (83.3%). This process involves improvements in the individual's quality of life (95.8%), to the extent that recovery cannot be discussed if there is no improvement in quality of life (60.4%).

Symptom Reduction and Substance Management (Section B)

This section had the highest level of discrepancy, with 71% of items showing no agreement in the first round, which decreased to 35% in the second round.

Table 2. Percentage of concurrence or discrepancy among the experts of the Madrid Consensus in the different sections of the questionnaire after the two rounds.

Section	Unanimity	Consensus (agreement & disagreement)	Majority (agreement & disagreement)	Discrepancy	Total questions
(A) General aspects	-	70.00%	20.00%	10.00%	10
(B) Symptom reduction/Substance management	-	14.28%	50.00%	35.71%	14
(C) Physical health	-	33.33%	44.44%	22.22%	9
(D) Psychological health	13.95%	48.84%	30.23%	6.97%	43
(E) Environment & material resources	-	26.32%	57.89%	15.79%	19
(F) Lifestyles & citizenship	7.69%	38.46%	46.15%	7.69%	13
(G) Interpersonal relationships & spirituality	-	33.33%	53.34%	13.33%	15
Total	3.09%	37.79%	43.14%	15.95%	123

Note: Unanimity: 100% of the panelists coincide in the same answer. Consensus: Between 99%–80% of the panelists coincide in the same answer. Majority: Between 79%–60% of the panelists coincide in the same answer. Discrepancy: Less than 60% of the panelists coincide in the same answer.

Regarding substance management, some items reached consensus or majority agreement criteria. It was considered that substance management should be included in the definition of recovery, addressing issues such as the intensity or frequency of consumption (66.7%), or the priming once consumption began (67.4%). The majority of consulted experts considered abstinence from the primary substance as an indispensable element for recovery (62.5%), along with abstaining from alcohol and other psychoactive substances (except coffee and tobacco) as part of the recovery process (77.1%). Additionally, there was consensus that the definition of recovery should reference diagnostic criteria for dependence (80.4%), and the majority of experts agreed that symptom reduction should be a measure of recovery (78.3%).

During the second round, three experts expressed that the severity of dependence would determine whether abstinence should be considered a standard of recovery, deeming it necessary in cases of severe dependence.

Physical Health (Section C)

The consensus response rate was 33.3%, with an additional 44.44% exhibiting majority agreement. Overall, professionals agreed that recovery should include improvement in the individual's general physical health (85.4%). This implies satisfaction with the ability to perform activities of daily living (87.5%), sleep (66.7%), work capacity (85.4%), and having sufficient energy (72.9%). In essence, recovery aims to enhance overall functionality, addressing not only organic aspects potentially affected by the toxic effects of alcohol (66.7%). Additionally, the majority disagreed (75.0%) with the statement that "recovery means not needing medical treatment to function in daily life".

Psychological Health (Section D)

This section garnered the lowest level of discrepancy, with a unanimity rate of 13.95% and a consensus rate of 48.84%. Unanimity was observed regarding the active role of the individual in recovery. Furthermore, experts unanimously identified two central aspects of recovery: well-being and self-care. Well-being is presented as the objective of recovery, explicitly understood as the process through which improvements in well-being are achieved (100%), and should be defined by the individual in recovery (87.5%) (**Supplementary Table 1**).

Consensus was reached in identifying the following elements of recovery (**Supplementary Table 1**): life satisfaction, self-acceptance, autonomy, meaning in life, emotional regulation, and coping strategies. Additionally, the majority also considered empowerment, personal growth, purpose in life, and reconstruction of identity in a more positive way to be relevant aspects of recovery that should be integrated into the definition of recovery.

Environment and Material Conditions (Section E)

Consensus was reached on the importance of the healthiness of the physical environment around the individual (80.9%) and the safety of the environment in which the person lives (80.9%), as well as the need to engage in leisure activities (85.1%) and having places where alcohol is not present (91.5%). The majority emphasized the need to consider economic aspects in definitions and standards of recovery (74.5%) and their influence on this process (76.6%).

Experts concurred on the importance of access to healthcare services (70.2%) and the availability of information for daily life (74.5%). Finally, the majority agreed on the emancipatory aspect of recovery (61.7%).

Lifestyle and Citizenship (Section F)

In this area, the combination of responses by unanimity, consensus, and majority exceeded 90%. Unanimously, the experts considered that "recovery implies the acquisition of a healthy lifestyle". This process should include the pro-social aspects of the individual (84.8%) and the active assumption of responsibilities (89.4%), in terms of both rights (61.7%) and civic duties (68.1%). The role of physical activity (63.8%) and dietary care (69.6%) was highlighted.

Relationships and Spirituality (Section G)

Interpersonal relationships were identified as another central element of recovery. Notably, experts underscored the significance of enhancing social relationships (93.6%) and finding satisfaction therein (85.1%), actively seeking out recovery support groups (91.5%), and honing social skills (83.0%). The majority also highlighted the importance of involvement (74.5%) and care (74.5%) in relationships, along with the effort to improve the well-being of those around them (63.8%).

Regarding the importance of spirituality, there was discrepancy, as it was only considered as a support for recovery (65.2%). Most panelists rejected the idea that recovery constituted a spiritual state (60.9 %).

Discussion

This study represents a milestone for being the first consensus on the meaning of recovery in alcohol use disorder carried out in the Community of Madrid and, to the best of our knowledge, in Spain. Active participation was remarkable, with a 90% acceptance rate among the invited experts and 80% completed both phases of the study, despite not receiving remuneration for their participation. The experts were selected from multidisciplinary teams covering various areas of intervention in the care and prevention of addictions, ensuring a comprehensive representation of the care provided to individuals diagnosed with AUD. This variety of approaches encompasses the multiple ways in which individuals can address their progress in the recovery process.

Out of all the questions posed, 45% reached consensus (in 56 questions, more than 80% agreed). By including responses that obtained majority agreement (44 questions with agreement above 60%) along with the consensual responses, the level of agreement reaches 84%. This robustly supports the conclusions of the document, given the substantial agreement among the participating experts, despite the heterogeneity of the group [43].

The main findings indicate consensus that recovery from alcohol addiction is a dynamic, individualized, and voluntary process, characterized by sustained lifestyle change. This process is defined with a long-time perspective, potentially lasting a lifetime. The fundamental goal of this change is to achieve a significant improvement in the individual's quality of life, covering areas such as physical health, psychological health, interpersonal relationships and their environment. The results suggest that recovery manifests in a substantial improvement in the subjective perception of well-being. This well-being is characterized by key elements such as empowerment, personal growth, the acquisition of a sense of purpose, and reconstruction of identity in a more positive way. This proposal aligns with those formulated by other groups, especially with consensuses published since 2010—see Table 1, [14,15,18,19,44]. Ultimately, this consensus approach reaffirms the dynamic and multifaceted nature of recovery, distinguishing it as an ever-evolving process that is tailored to the uniqueness of each individual.

The inclusion of abstinence and the absence of addiction symptoms as essential components of recovery has been a contentious issue. This consensus reveals a predominantly favorable perspective towards seeking abstinence from alcohol and the remission of dependence symptoms, aligning with other definitions of recovery predating 2010 and the proposal by NIAAA in 2022 (see Table 1). The majority of panelists considered global abstinence, encompassing both alcohol and other psychoactive substances (except for tobacco and coffee), as an element of recovery, albeit not determinative. This aligns with the view that recovery from AUD is best defined in terms of one's overall relationship with all psychoactive substances, rather than solely in reference to alcohol [45]. Similarly, while most experts agree that discontinuation of alcohol consumption is an indispensable component for recovery, discrepancies arise regarding whether abstinence should be an absolute standard of recovery. The lack of agreement persists on whether it is possible to be in recovery without completely ceasing alcohol consumption. There may be resistance to moving beyond abstinence as a necessary condition for AUD recovery, as abstinence has long been considered the "gold

standard" outcome for AUD clinical trials and is deeply ingrained in treatment program philosophy and recommendations [46]. The demonstrated effectiveness of controlled drinking programs for patients with alcohol abuse supports this perspective (see [47]); however, the criteria for alcohol abuse (DSM-IV) resemble those of mild dependence in the DSM-5 classification. Therefore, absolute alcohol abstinence is not considered an assimilable criterion for recovery, nor is it considered the sole path to recovery. Thus, the proposal from Madrid aligns with indispensable principles of recovery, such as individualization and patient choice. As some professionals expressed, it is necessary to address the diversity of patients with this diagnosis, differentiated also by the severity of their dependence, with absolute abstinence being the most recommended path in cases of severe dependence [9,11,48].

Symptom reduction, although in the second round the experts agreed that "the definition of recovery should refer to the diagnostic criteria for alcohol dependence" and that "recovery should be measured in terms of symptom reduction", the discrepancy persisted in equating recovery with the remission of dependence symptoms. Thus, similar to the definition by National Institute on Alcohol Abuse and Alcoholism (NIAAA) [20], while it is proposed that the definition of recovery should refer to diagnostic criteria, recovery and symptom remission are not considered equivalent. This proposal is consistent with those of other groups that have also expressed disagreement with equating abstinence or symptom reduction with recovery [7,14–19], showing a preference for achieving an improvement in quality of life rather than absolute abstinence from alcohol and other substances (Table 1).

This consensus addresses the improvement of overall physical health as an integral component of recovery, leading to increased functionality in individuals undergoing recovery. According to the experts, overcoming addiction is not limited solely to mitigating organ-specific aspects affected by the toxic effects of alcohol, nor is it solely about obtaining the physical benefits associated with cessation of consumption. This approach is in line with new recovery perspectives, which emphasized improvements in functioning rather than mere relief of deficits [46,49].

The experts unanimously identified two fundamental aspects in psychological recovery: well-being and self-care. In relation to well-being, it is emphasized that individuals in recovery should define it themselves, giving it a subjective and personal character, in contrast to its operationalization by external professionals. As for the relevance of self-care, this perspective aligns with definitions post-2010 (see Table 1), and especially with the proposal by Kaskutas *et al.* [50] and the works of Neale *et al.* [44,51], where it was suggested as a factor in recovery.

Our experts reached a consensus on psychological recovery elements, including life satisfaction, self-acceptance, autonomy, meaning in life, regulation emotional, and coping strategies. Moreover, the majority also included empowerment, personal growth, purpose in life, reconstruction of identity in a more positive manner, and overcoming stigma as recovery elements. The psychological health dimensions highlighted by the panelists have been defined as dimensions of psychological well-being in the Ryff model [52,53], facilitating their operationalization. Additionally, they align with definitions proposed for personal recovery in the general mental health field, referring to the development of a meaningful life with hope, dignity, and autonomy [54]. Consistent with this, many of these elements and processes also fit into the theoretical framework on recovery in the general mental health field proposed by Leamy [8], who emphasizes five fundamental recovery processes: connection with others, hope and optimism for the future, positive sense of identity, purpose in life, and empowerment. Similarly, they have been supported by quantitative and qualitative studies on recovery [7,55].

It is noteworthy that this consensus includes emotional management and coping strategies, aspects that have been scarcely addressed in previous definitions. The American Society of Addiction Medicine [15] mentions the importance of regulation emotional in its definition of recovery, as well as a recent review [56] shows that impaired emotional and socio-cognitive functions in AUD could compromise efforts to initiate and maintain recovery. This review highlights the importance emotional self-regulation, success in interpersonal/social interactions, emotional insight, and awareness of social dysfunctions in the efficacy of clinical treatment in alcohol use disorder. Likewise, the crucial role of coping strategies as pillars for staying drug-free has been highlighted [24,57].

Regarding the environment and material conditions, there was consensus on the importance of the healthiness and safety of the individual's environment in the recovery process, as well as the crucial role of having leisure options and alternatives free of alcohol consumption. Social determinants of health, both individual and community, have been described in the literature as having an impact on AUD recovery [55,58]. These aspects are framed within the physical capital suggested by the recovery capital framework (see [59]), which posits that socioeconomic status and material conditions are factors influencing recovery. Thus, this approach highlights the need for leg-

islative, policy, financial, and organizational interventions aimed at public health. Additionally, recovery, conceived as a lifestyle change, is linked to improvements in physical activity and diet, aligning with Neale's proposal [44] to "have a good daily routine" as an element of recovery.

The concept of recovery also encompassed social responsibility in terms of rights and citizenship duties. This aspect can be related to the notion of "citizenship" introduced in the Betty Ford Institute Consensus Panel definition [12] and the suggestion of the UK Drug Policy Commission [13], which posits that recovery involves "participation in the rights, roles, and responsibilities of society".

In the relational domain, various aspects were highlighted, including increased interpersonal relationships, satisfaction with them, and improvements in social skills. The majority of experts also emphasized the importance of the involvement and care that the individual in recovery should dedicate to their personal relationships. This underscores the relevance of interpersonal relationships, especially highlighted in the Social identity model of recovery (SIMOR; [19]). Similarly, this relational dimension is framed in the Social Recovery Capital, included in the extension of Kelly and Hoeppner's biaxial formulation of recovery [60].

Finally, it is important to note the panelists' discrepancy regarding the role of spirituality in recovering from this addiction. This aspect could be explained by cultural factors since, in our country, despite the presence of mutual aid groups based on the 12-step program, neither referral to these programs nor knowledge of the 12-step program is widespread among our professionals [22].

One limitation of this study is the difficulty in generalizing the consensus findings to other contexts with sociocultural characteristics different from those of our country. For instance, in geographical areas where alcohol or substance use is less normalized than in Spain, or where nicotine use is not as widespread. The applicability of this consensus may be hindered in countries where professionals predominantly focus on treating the acute phase of addiction recovery.

Implications for Professionals, Administrations, and Society

The most notable feature of this consensus is the inclusion of a multiprofessional group from various areas, such as addiction networks, mental health, general hospital, and primary care. It is not exclusively a consensus among physicians or psychologists but among professionals involved in substance-related treatments. The altruistic participation of around fifty professionals in Madrid, capable of reaching an agreement on AUD recovery, represents a milestone. Consequently, we believe that this consensus could serve as a potential reference for other autonomous regions in Spain or even for other countries with cultural similarities in alcohol consumption.

Regarding the implications of this consensus for professionals in the field of addiction, it is noteworthy that the concept of recovery itself implies a shift in the care paradigm. This shift translates into a move from acute phase-focused approaches to continuity of care models. Furthermore, establishing that the goal of recovery is to improve quality of life implies a transition from a pathogenic (recovering from) to a salutogenic (recovering for) approach. The former focuses on avoiding or escaping certain situations, while the latter emphasizes the lifestyles sought to achieve and maintain. Acceptance of this perspective suggests the need for training activities so that professional teams can adopt and maintain this paradigm shift.

In this context, Primary Care teams could play a crucial role in the continuity of care for individuals with alcohol addiction, especially upon completion of acute treatment [32]. This new responsibility would naturally entail the adaptation of their service portfolio by the health administration.

It is essential for professionals to be familiar with mutual aid groups or those oriented towards supporting recovery, thus facilitating the coordination and guidance of patients and families towards these resources. Given that mutual aid associations often play a crucial role in supporting continuity of care for patients, it would be reasonable for local and regional administrations to support the implementation and maintenance of these associations.

Finally, there is a need to promote the creation of recreational spaces free from alcohol, as patients often encounter difficulties in participating in leisure activities that do not involve the consumption of this substance. Socially, there should be an encouragement of understanding alternative leisure activities and the right to not be "passive drinkers" in leisure venues.

Conclusions

The recovery from alcohol use disorder is conceptualized as a dynamic, individualized, and voluntary process, with the potential to extend throughout one's lifetime. This process involves a lifestyle change aimed at achieving a significant improvement in quality of life, encompassing as-

pects such as physical health, psychological well-being, interpersonal relationships, and environment. As a result of this process, there is an enhancement in the perception of psychological well-being, characterized by empowerment, personal growth, a sense of purpose in life, and positive identity reconstruction. Recovery from alcohol use disorder is grounded in substance management, requires active commitment from the individual, and entails both personal and social responsibilities.

Availability of Data and Materials

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Author Contributions

GR, LE, MP, RO, AS and RJ designed the research study. LE, GR, AS, VA and DM performed the research. LE and GR performed the literature review. LE generated the initial item bank. MP, AS, RO, RJ, DM, LE, VA and GR provided help and advice in the writing and selection of the items. ML developed the software. MP, RO, RJ and GR selected the professionals. LE and ML analyzed the data. VA translated the manuscript. All authors contributed to the drafting or important editorial changes in the manuscript. All authors read and approved the final manuscript. All authors have participated sufficiently in the work and agreed to be accountable for all aspects of the work.

Ethics Approval and Consent to Participate

All procedures were approved by the 12 de Octubre Ethics Committee (nº CEIm 19/086). Informed consent was obtained from the participants and the study was conducted in accordance with the Declaration of Helsinki.

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Conflict of Interest

The authors declare no conflict of interest.

Supplementary Material

Supplementary material associated with this article can be found, in the online version, at https://doi.org/10.62641/aep.v52i4.1633.

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