

## Research Article

# Live Well: A Recovery Model for Addiction Management

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Addiction is a primary, chronic disease of brain reward, motivation, memory, and related circuitry, characterized by craving, loss of control, physical dependence, and tolerance. Genetics, together with bio-psycho-social-spiritual factors, account for the likelihood a person will develop an addiction or related disorder. Relapse happens: a return to drinking, using, other addictive behavior, or an increase in harm from addiction. Yet, recovery is an idea whose time has come. Recovery is a different, better way of life with purpose and meaning. We believe people can learn to manage addiction. This article describes a Recovery Model to Live Well: more specifically, how to maintain change (abstinence or harm reduction), reduce risks for relapse, prevent relapse, develop a recovery lifestyle, confront relapse when necessary, and achieve well-being. Current research, recognized theories, evidence-based practice, and the lived experiences of hundreds of people in recovery ground and guide the Model.

## Addiction

Addiction is a broad, evolving construct that reflects a persistent, recurrent, maladaptive pattern of substance use, gambling, or other behavior that results in adverse consequences for self and others and can lead to clinically significant distress, marked impairment, or death. Substance use includes many legal products such as alcohol, nicotine, prescription medications, over-the-counter (OTC) drugs, as well as a host of herbal and natural products that have brain altering properties. Marijuana, cocaine, methamphetamine, heroin, and “designer” drugs make up popular illicit drugs. Many household products like solvents, sprays, or glue have psychoactive effects, especially when inhaled.

Definitions of addiction are descriptive, diagnostic, and research-based. Many people in recovery, together with addiction professionals, consider addiction as a bio-psycho-social disorder; Howard J. Shaffer, a recognized addiction scholar, describes an addiction syndrome. The American Psychiatric Association and the World Health Organization offer diagnostic definitions respectively in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD). Increasingly, definitions of addiction reflect basic research, for example the work of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute of Drug Abuse (NIDA), as well as the genetic research of Kenneth Blum and colleagues and the idea of a reward deficiency syndrome (RDS). The American Society of Addiction Medicine (ASAM) defines addiction as a brain-based chronic disease.

## According to ASAM

Addiction is characterized by a. inability to consistently abstain; b. impairment in behavioral control; c. craving or increased “hunger” for drugs or rewarding experiences; d. diminished recognition of significant problems with one’s behaviors and interpersonal relationships; and e. a dysfunctional emotional response.

The diagnoses substance abuse and substance dependence used by the DSM-IV-TR reflect addiction severity. In the DSM-5, clinicians

specify mild, moderate, or severe to describe current addiction severity. Treatment recommendations are based on addiction severity. Today, many addiction professionals [1]. ASAM-3 suggests six dimensions for a holistic, bio-psycho-social assessment and treatment planning. This Recovery Model considers addiction severity as *mild, moderate, or severe* and treatment intensity as *low, medium, or high*.

## Recovery

*Recovery is a different, better way of life with purpose and meaning.* Three major initiatives influence current concepts of addiction: the concept of recovery proposed by the New Freedom Commission on Mental Health, the definition of recovery promulgated by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Recovery Bill of Rights advanced by Faces and Voices of Recovery.

Influenced in part by the philosophy of Alcoholics Anonymous and social movements of the 60s and 70s, the New Freedom Commission on Mental Health established by President George W. Bush proposed a shift from the traditional medical psychiatric model of care toward the concept of recovery. The report, [2], boldly recommended recovery from mental illness as the expected goal of this transformed system of care. *Recovery* refers to the process in which people are able to live, work, learn and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual’s recovery [3].

A recovery approach to mental disorder or substance dependence emphasizes and supports a person’s potential for recovery. Recovery is generally seen as a personal journey rather than as a destination. Recovery involves hope, basic security, and empowerment as evidenced by a durable sense of self, self-determination, self-management, self-help, and self-care. Relationships--mutual support networks, reciprocal connections, and social inclusion--sustain recovery. Finally, a life with purpose and meaning for self and others manifests recovery.

In December 2011 SAMHSA [4] advanced a definition of “recovery” from mental disorders and substance use disorders as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. SAMHSA identified four recovery dimensions-- health, home, purpose, and community-- and advanced ten guiding principles for recovery.

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- *Recovery emerges from hope.*
- *Recovery is person-driven.*
- *Recovery occurs via many pathways.*
- *Recovery is holistic.*
- *Recovery is supported by peers and allies.*
- *Recovery is supported through relationship and social networks.*
- *Recovery is culturally-based and influenced.*
- *Recovery is supported by addressing trauma.*
- *Recovery involves individual, family, and community strengths and responsibility.*
- *Recovery is based on respect.*

Beginning in the early 90s, recovering men and women, their families and friends, mental health and addiction professions, together with concerned communities began organizing recovery initiatives. *Faces and Voices of Recovery*, incorporated in 2004, is dedicated to organizing and mobilizing the over 20 million Americans in recovery from addiction to alcohol and other drugs, their families, friends and allies, into recovery community organizations and networks. One of their major contributions is *The Recovery Bill of Rights*: a statement of the principle that all Americans have a right to recover from addiction to alcohol and other drugs. Find this powerful statement online.

## A Recovery Model

This article describes a Recovery Model to Live Well: more specifically, how to maintain change (abstinence or harm reduction), reduce risks for relapse, prevent relapse, develop a recovery lifestyle, confront relapse when necessary, and achieve well-being.

We use the quality- of- care concept of structure, process, and outcome developed by Avedis Donabedian to organize ten constructs and three theoretical frameworks. We review the theories briefly and define each construct.

## Structure, Process, Outcome

### Structure

Self and surroundings constitute structure. An ecological paradigm explains self and surroundings. Three major ecology theories support our idea of addiction management: 1. Bronfenbrenner's The Ecology of Human Development, 2. The Public Health Social Ecological Model (SEM), and 3. *Healthy People 2020*.

*Self* influences and is influenced by addiction, recovery, and relapse. Person includes the physical, mental, emotional, and spiritual elements of self. Self also means the entire person, the unity of elements that constitute individuality and identity of person. Self is the phenomenon of being, becoming, and beyond. Age, gender, race and ethnicity further define self. Bio-psycho-social theory, holistic health, and developmental theories ground our understanding of self. The concepts self-care, self-worth, self-in-relation, and self-efficacy further our appreciation of self. Addiction, relapse, and recovery impact the experience and expression of self across the lifespan.

*Surroundings* influence and are influenced by addiction, relapse, and recovery. Environment is the physical and social world that surrounds self: the diverse ever-changing world around the person: i.e., people, places and things. Physical environment includes the natural environment as well as the technological world of the 21st century. Social environment reflects family and friends, community, society, and culture. Surroundings may support or sabotage addiction management. Environment is one of the six addiction dimensions advanced by the American Society of Addiction Medicine.

### Process

Management and self-efficacy direct and drive addiction

management. Empowerment theory governs the addiction management process. Empowerment dynamics include management strategies and self-efficacy actions which direct and drive addiction management respectively.

*Management* is the ability to direct or handle something skillfully and effectively; to accomplish something; or to achieve your purpose. Because addiction is a chronic disease, management, not cure, is major recovery and relapse prevention dynamic. Strategic management theory, public health protocols for chronic disease management, the Stanford Chronic Disease Self-Management Program, Recovery Oriented Systems of Care (ROSC), twelve-step philosophy, and SMART Recovery® support addiction management. Individuals learn how to manage addiction much like people manage hypertension or Type 2 diabetes: one day at a time. Management strategies are tactics, actually action plans, to realize recovery and prevent relapse. Management strategies direct addiction management.

*I think I can, I think I can, I think I can!* Self-efficacy is an important part of the social-cognitive theory of personality developed by Albert Bandura. Self-efficacy is the belief one can act effectively here and now. People develop self-efficacy through mastery experiences, social modeling, social persuasion, and psychological responses to physiological states. People with a weak sense of self-efficacy experience and exhibit powerlessness. People with a strong sense of self-efficacy embody and express empowerment. Self-efficacy actions drive addiction management.

### Outcome

Addiction management outcome includes change, risks for relapse, relapse prevention, lifestyle, relapse, and wellbeing. Evidence-based practice suggests ways to evaluate outcome. As defined in the book *Evidenced-Based Addiction Treatment*, edited by Peter M. Miller [5], evidenced-based treatment is "a treatment that has been scientifically tested and subjected to clinical judgment and determined to be appropriate for the treatment of a given individual, population, or problem area." (p. 6) The Substance Abuse and Mental Health Services Administration (SAMHSA) provides A Guide to Evidence-Based Practices (EBP) on The Web. The site contains information about interventions for substance abuse prevention, substance abuse treatment, mental health treatment, and prevention of mental health disorders. SAMSHA offers evidenced-based behavior health practice tool kits in selected areas. While there are many kinds of evaluation, we are especially interested in outcome evaluation; see *Outcome-based Evaluation*, (2001) by Robert L. Schalock [6].

*Change* means stopping an addictive behavior or reducing harm from addiction. How to Maintain is the first addiction management goal. Support for change as a recovery milestone comes From the American Society of Addiction Medicine (ASAM), the Stages of Change Model, the Twelve Steps, the Serenity Prayer, and Reinforcement Theory. Management strategies together with self-efficacy actions guide maintenance of change. The University of Rhode Island ChangeAssessment Scale (URICA) is a simple, useful tool to evaluate change.

*Risks* for relapse are legion. Risks that originate in the person (self) include craving, cross-addiction, complacency, non-compliance, and co-morbidity. Co-morbidity embraces co-occurring medical conditions, trauma, dual disorders, and personality disorders. Addictive personality is *not* a diagnostic code; however, certain personality traits and types increase risk for relapse. Risks that come from the environment (surroundings) include cues, circumstances (life events), and crises. Effective management strategies and self-efficacy actions suggest a written Risk Reduction Plan. Useful tools to address risks for relapse include the Addiction Severity Index (ASI) as well as Scaling 1-5 for each Risk.

*Relapse Prevention* is the way recovering men and women, sometimes with the help of addiction professionals, identify threats to relapse, act early in the relapse process, and prevent relapse. Marlatt introduced a cognitive-behavioral approach for relapse prevention [7]. According to Marlatt, 1. *immediate determinants* of relapse include high-risk situations, a person’s coping skills, outcome expectancies, and the abstinence violation effect; and 2. *covert antecedents* such as lifestyle imbalances, urges, and cravings. Gorski identified *The Phases and Warning Signs of Relapse* [8-10]; he also described Post-Acute Withdrawal Symptoms (PAWS) that often contribute to relapse. Effective management strategies and self-efficacy actions suggest a written Relapse Prevention Plan. The AWARE Questionnaire (Advance **W**arning of **R**elapse) measures signs of relapse as described by Gorski.

*Lifestyle* is a pattern of change over time, a different way of being, thinking, feeling, and believing, together with new ways of connecting with people, places, and things [11-15]. Support for lifestyle as an addiction management milestone comes from Adler’s concept of lifestyle, role theory, Therapeutic Lifestyle Changes (TLC), and Achievement Motivation Theory. Management strategies and self-efficacy actions help us develop a recovery lifestyle. Tools to assess lifestyle include Lifestyle Assessment Inventory and The Wellness Inventory.

**Relapse** happens. It is characterized by a return to drinking, using, gambling, or other addictive behaviors after a period of abstinence or an increase in harm associated with use. Relapse is a process that begins long before the actual drink, use, wager, or actual addictive behavior [16-18]. Remission and exacerbation, complications and progression, are all common to chronic diseases, including addiction. Bio-psycho-social theories of addiction help explain relapse. Management strategies and self-efficacy actions emphasize crisis management and corrective actions. Ways to assess relapse include the breathalyzer and toxicology screens, self-report, together with collateral information from family and friends, employers, and even the legal system [19-25].

*Well-being* is the capacity to affirm and advance a lifestyle with purpose and meaning. Well-being reflects a desired state of health, happiness, prosperity, and welfare [26-28]. It embraces wholeness and quality of life. Support for the importance of well-being as an addiction management milestone comes from Wellness Theory, Leading Health Indicators, Positive Psychology, and The Promises of Alcoholics Anonymous, and Self-actualization Theory [29-33]. Management strategies, together with self- efficacy actions, guide progress toward well-being. Tools to assess well-being address Wellness, Quality of Life, Life Satisfaction, and Authentic Happiness.

**A Recovery Model to Manage Addiction**

How do we actually use the Recovery Model to manage addiction? How do we maintain change (abstinence or harm reduction), reduce risks for relapse, develop a recovery lifestyle, confront relapse, and achieve well-being (a life with purpose and meaning)? How do we realize recovery and prevent relapse? How do we live well?

We have developed a five-step Addiction Management Plan:

1. Determine addiction severity and treatment intensity.
2. Set SMART recovery or relapse prevention goals.
3. Inventory self and surroundings as assets or liabilities.
4. Develop goal-oriented management strategies and self-efficacy actions.
5. Evaluate outcome.

The Plan reflects addiction severity, treatment intensity, goal setting, as well as the Recovery Model constructs and theories. Individuals and health professional can print or upload the plan It is easy to remember the five steps. Use the Recovery Model to manage addiction, realize recovery, and live well!

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**Table 1:** Addiction management plan

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Addiction Severity:** mild, moderate, severe

**Management Intensity:** low, moderate, high

**GOAL:**

Inventory self and surroundings as assets or liabilities.  <b>Assets or Liabilities Self:</b>  Physical            ___    ___ Mental                ___    ___ Emotional            ___    ___ Spiritual             ___    ___ Age                     ___    ___ Gender                ___    ___ Race/Ethnicity      ___    ___  <b>Surroundings:</b>  People                ___    ___ Places                 ___    ___ Things                 ___    ___	Develop goal-oriented management strategies and self-efficacy actions that consider addiction severity/management intensity and reflect self and surroundings assets or liabilities.  1.   2.   3.   4.	Did I achieve the goal? If <b>yes</b> , celebrate and continue. If <b>no</b> , how can I improve my Addiction Management Plan? Review and revise as needed:  <b>1. Goal setting:</b>  ___ S = specific ___ M = meaningful ___ A = achievable ___ R = rewarding ___ T = trackable  <b>2. Addiction severity/management intensity:</b>   <b>3. Assets/liabilities:</b>   <b>4. Management strategies/self-efficacy actions:</b>
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