In search of recovery

Exploring frontiers of drug addiction recovery
through people, pathways and policy

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Op zoek naar herstel

Een verkenning van nieuwe gebieden van herstel bij drugsverslaving via mensen, herstelwegen en beleid

Proefschrift

ter verkrijging van de graad van doctor aan Tilburg University
op gezag van de rector magnificus, prof. dr. W.B.H.J. van de Donk, in het openbaar te verdedigen ten overstaan van een door het college voor promoties aangewezen commissie
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Thomas Francesco Martinelli

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Promotoren

prof. dr. H. van de Mheen, Tilburg University

prof. dr. G.E. Nagelhout, IVO Research Institute & Maastricht University

Promotiecommissie

dr. B.A.G. Dijkstra, Radboud Universiteit

dr. S. Stutterheim, Maastricht University

prof. dr. V.M. Hendriks, Parnassia Addiction Research Centre (PARC)

prof. dr. H.F.L. Garretsen, Tilburg University

prof. dr. C.L. Mulder, Erasmus MC: University Medical Center Rotterdam

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Content

Preface – about the cover

'Slaying the dragon', 'getting that monkey of your back' or 'kicking the habit'. There are a many proverbs and metaphors that are used to describe the process of overcoming addiction. One of the most popular ways to describe it is to say that someone is 'getting clean' or 'staying clean'. We may not have the intent to be overtly stigmatizing, to judge or to undermine what recovery is. However, such language can be loaded with moralistic connotations and inappropriate assumptions: if you are not 'clean', you must be 'dirty', for example. Still, such metaphors can also help to understand processes that are otherwise complex to explain.

On the front and back cover of this thesis, we see two characters that are being mangled by machines and brushes that look like something you would find at a carwash (admitted, it is a rather psychedelic version of a carwash). The reason I chose this image, is because the carwash is often used as a metaphor to describe addiction recovery through treatment. A person enters the treatment 'dirty' and addicted and comes out 'clean' and recovered.

Besides the stigmatizing connotations of 'clean and dirty', the idea of addiction *recovery* – the concept of interest in this thesis – is that recovering is not at all like going through a carwash. First, recovery is not a short-term outcome (like coming out clean after a wash), but rather a long-term process that continues over time. Second, the recovery process is individually unique and often includes changes in many areas of a person's life, depending on his or her situation and resources. Thus, the limited number of programs that can be chosen in a carwash (or in addiction treatment), for example, will not fit the needs of and be sufficient for everyone seeking to recover.

Instead, it may be better to think of recovery as rebuilding or fixing a burned down house. Treatment professionals may have helped to put out the fire but, depending on one's craft skills (or recovery capital), there are many other types of support that may be needed to (re)build a house that one can enjoy living in. Moreover, not everyone wants to live in the same house, or: recovery is an individually unique process with personal goals.

Now, I know what you are thinking: '*Why, Thomas, have you chosen to depict something on the cover that is not like recovery?*' Please, bear with me.

In some cases, it helps to contrast something with what it is not, rather than to define exactly what it is. This is called a negative or antonymic definition. Moreover, in the case of addiction recovery particularly, emphasizing what recovery is *not,* is also what often characterizes the recovery movement of persons with lived experience. This movement advocated that recovery was *not* what treatment professionals and policymakers said it was: merely the reduction or absence of symptoms. Instead, they found things such as connectedness, hope, identity, meaning, empowerment and being able to fulfill social and societal roles central to recovery. However, the recovery movement is not a homogenous phenomenon. Rather, it is made up of different philosophies and approaches from a diverse range of stakeholders. This makes it more difficult to precisely define recovery.

Thus, when I *searched for recovery*, knowing what it is *not* became an important part of explaining what recovery *is*. Hence the image of a character being mangled in a carwash-like installation. Struggling with what recovery is not, is part of finding out what recovery is.

Thomas F. Martinelli

Rotterdam, December 2022.

1. Introduction

1.1 Drug addiction

For many decades, people have been captivated by the phenomenon of drug addiction. Why do people engage in behavior that they know may seriously harm them? And, why is it so difficult to change this behavior sustainably? After decades of research, scientists from many different disciplines have gathered heaps of information about the pathology of drug addiction and about the effectiveness of treatments in reaching goals set by professionals (van der Stel, 2020). However, our fascination with the problem of addiction and how it can be treated by professionals, may have left the territory of broader solutions understudied. Consequently, our understanding of how *recovery* from drug addiction is *experienced* is limited. As a result, answers to basic but important questions that often arise in personal, family or community situations, such as 'How do people recover?' and 'What are important recovery goals?', are still lacking in scientific literature.

The stakes are high at both the personal and societal level. Globally, it is estimated that around 36 million people suffer from drug use disorders and may require treatment services (UNODC, 2021). In the United States (US), substance (including alcohol) use disorder is among the most prevalent mental health disorders (SAMSHA, 2019). There are no recent reliable estimates of the prevalence of drug addiction in Europe nor the Netherlands. Between 2007 and 2009, around 19% of Dutch people were estimated to meet criteria for a substance use disorder, of which 4% for an illicit drug use disorder (de Graaf et al., 2010). Moreover, despite incomplete data, 29 European countries reported that of the roughly half million individuals that entered drug treatment in 2015, the majority (about 63%) had been treated for drug problems before (Montanari et al., 2019). These numbers show that the magnitude of the phenomenon of drug addiction should not be underestimated and that treatment may not be sufficiently effective. However, there is also hopeful data. While studies examining prevalence of recovery are rare, they consistently show that most people who developed a drug addiction or who have drug-related problems resolve these problems eventually (Kelly et al., 2017; McCabe et al., 2016; White, 2012b). A substantial proportion do so without any formal treatment (Kelly et al., 2017). These lived experiences of people who recover form a treasure of information that can help answer the questions we still have about how people recover.

1.2 What is addiction?

Before introducing the concept of addiction recovery, a brief introduction to *addiction* is needed. Historically, the concept of addiction is debated and studied from a variety of perspectives. Stemming from the Latin *addicere*, 'addiction' is a term that has been used as early as in the Roman Empire to describe a state of being surrendered (or devoted) to habits or doing things compulsively (Rosenthal & Faris, 2019). Later in the 20th century, addiction also started appearing more in academia. However, initially it was not considered a scientific term but rather a layman's term, as it had stigmatizing connotations and was considered imprecise and difficult to define (Alexander & Schweighofer, 1988; Buchman et al., 2011; Shaffer, 1997). As Courtwright (2019, p. 3) summarizes:

> "Not everyone was happy with all the talk of addiction. Clinicians avoided it for fear of discouraging or stigmatizing patients. Libertarians dismissed it as an excuse for lack of discipline. Social scientists attacked it as medical imperialism. Philosophers detected equivocation, the misleading practice of using the same word to describe different things."

Using 'addiction' in the context of drug (and alcohol) use is considered to have emerged with the medical conceptualization of addiction in the beginning of the 19th century (Levine, 1978). Since then, multiple understandings of addiction have come about. Some saw addiction as a moral failure (Siegler & Osmond, 1968), others saw it as a brain disease (Leshner, 1997), and there were many theories in between. Common explanations of how substance addictions develop, hypothesize that it is a consequence of a process in which people lose control over consuming addictive substances to

achieve pleasant feelings (a high) (Everitt & Robbins, 2005; Robinson, 1993), and / or to escape from or cope with negative feelings (a low) (Baker et al., 2004). Still, the concept of addiction is being contested to this day (Heather et al., 2022). The Diagnostic and Statistical Manual (DSM), for example, changed its description of addiction in the most recent version (DSM-5) from "Substance-Related Disorders" to "Substance-Related and Addictive Disorders" to reflect developing understandings of addictions. In this thesis, we will use the term "addiction" as it provides a concise and commonly understood word to refer to a problematic condition characterized by long term, compulsive and harmful behavior. We recognize that within this concept there is a range of severity and nature of problems. This thesis focuses specifically on addiction recovery from problematic illicit drug use. However, much of the theory discussed is also applicable to legal substances (e.g. alcohol and prescriptions drugs) and behaviors (e.g. gambling).

1.3 What is recovery?

The process of recovery

In the last two decades, an international grassroots-inspired scientific movement around addiction recovery has emerged (Davidson & White, 2007). Based on lived experiences from people in recovery, this movement challenged traditional clinical views on recovery that define recovery as an outcome, having achieved symptom remission (abstinence) and improved functional status through treatment (van Weeghel et al., 2019). The recovery movement, instead, views recovery as a long-term *process* that takes place in a broad personal, as well as social and societal context, stretching far beyond problematic drug use (or other) behavior (Laudet & White, 2010).

While exact definitions of recovery are still debated within the recovery movement, it is increasingly agreed upon that recovery is a personal process that can take place in various ways, depending on circumstances, and may include improvements in multiple life domains, such as housing, relationships, employment, and wellbeing (Kaskutas et al., 2014; Neale et al., 2014). Because recovery goals (and their relative importance) can differ between individuals engaging in recovery, conceptualizing, defining and measuring recovery remains challenging and continues to evolve (Neale et al., 2015, 2016).

The concept of addiction recovery is also partially inspired by and linked to parallel developments in the mental health field (Davidson & White, 2007). Here, recovery was introduced by Deegan (1988, pp. 96–97), who, based on her personal experiences as a mental health patient, described it as

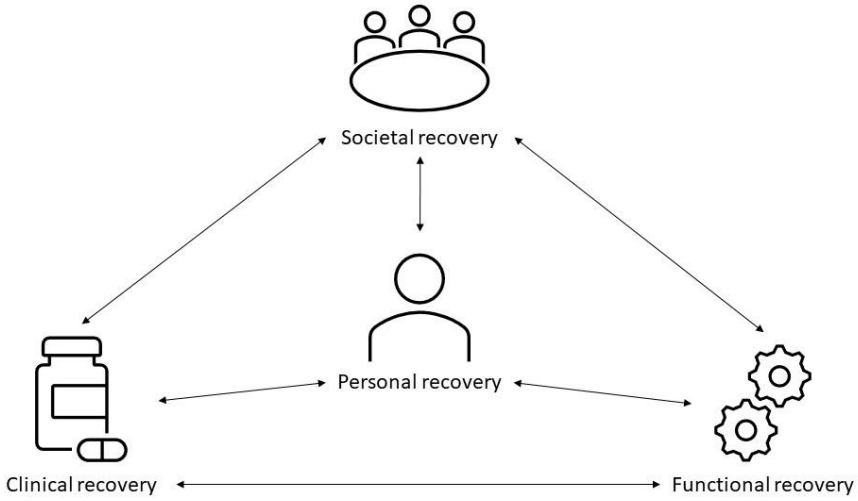
> "an attitude, a stance, and a way of approaching the day's challenges. It is not a perfectly linear journey. There are times of rapid gains and disappointing relapses. There are times of just living, just staying quiet, resting and regrouping. Each person's journey of recovery is unique."

This marked a deposition from clinical ideas about recovery, which is evident in the distinction that is made these days between *clinical* and *personal* recovery. In essence, this distinction is rooted in the difference between what a clinician thinks is important and what their clients are concerned with (van Weeghel et al., 2019). Typically, a clinician is more concerned with remission of symptoms and outcomes, while a person with mental health problems may be more concerned with loneliness, stigma, identity, and the process of getting better (Davidson & Roe, 2007).

In the Netherlands, Van der Stel (2013) united theories of mental health and addiction recovery by outlining four aspects of recovery: clinical, functional, societal and personal recovery (see Figure 1). Clinical recovery refers to the remission of symptoms, such as problematic drug use. Functional recovery refers to improving executive functions that underly the ability of self-regulation, such as self-control, self-motivation and the ability to make and stick to plans. Societal recovery concerns improvements in the area of housing, work, income and social relations, and access to such

resources. Lastly, personal recovery concerns the process of giving meaning to past experiences and (re)gaining a grip on one's life. The latter is closely linked to identity, motivation and coming to terms with one's past, present and future.

Figure 1: Four interrelated aspects of recovery, based on the work of van der Stel (2013)



Thus, addiction recovery is established as a multi-factorial complex concept. Perhaps unsurprisingly, it is also contested by various perspectives (Davidson et al., 2006; Neale et al., 2012; Slade et al., 2014). Critical scholars have questioned the underpinning assumptions that justify the extension of recovery beyond changing substance use. For example, recovery definitions that include a focus on citizenship, roles and responsibilities (UK Drug Policy Commission, 2008), have been criticized because they assume normative ideas of what it means to be a productive member of society and to live a satisfying life, and because they suggest that people who use drugs and who are not in recovery cannot fulfill such roles (Lancaster et al., 2015). Objections to the term 'recovery' have also been raised. 'To recover' implies that individuals will retrieve something that was lost. However, people with drug addiction might never have had such things (Laudet, 2007). Furthermore, the term is historically linked to *Alcoholics Anonymous* (AA) and their disease-concept of addiction. In AA, recovery cannot exist without abstinence and persons with addiction are thought of as chronically ill, meaning they can only ever be 'in recovery' and never be 'recovered' (Kurtz, 2002). Some suggest that the essence of recovery may be better captured by alternative terms such as "discovery", "personal development" or "self-actualization" (Neale et al., 2012, p. 17). These alternative terms highlight how addiction and recovery are not isolated phenomena and that many of the concerns of people who use drugs (e.g. the need to be healthy, happy or contribute to society) are also relevant to those who have never been addicted.

Recovery as an organizing principle and feature in drug policy

Besides referring to the process that people with drug addiction can experience, recovery has also been translated into policy ideas and visions about how treatment and support should be organized. Such recovery-oriented policy ideas are often described as shifting focus from a disorder-oriented approach, characterized by a focus on symptoms of addiction (and symptom reduction), towards a person-centered and broader wellbeing-oriented approach that emphasizes on lived experience

(White, 2007). An international movement of grassroots recovery advocates and scientists has impacted national drug policies and addiction services in various ways with such recovery principles. In the US, for example, a shared advocacy agenda was developed and recovery was adopted as a cornerstone of federal drug policy (Humphreys & Lembke, 2014; Humphreys & McLellan, 2010). These US recovery advocates then inspired actors in the United Kingdom (UK) and Australia (Best et al., 2010; Fomiatti et al., 2017; Gilman, 2011; Thomas et al., 2019). Recovery is now featured prominently in all three countries' drug policies. Subsequently, recovery also gained ground in the Netherlands and Belgium, inspired by these prior Anglosphere movements and parallel developments in the mental health sector (Vanderplasschen & Vander Laenen, 2017). In the Netherlands, a service user advocacy organization (Stichting het Zwarte Gat, translated as The Black Hole Foundation) initiated the Charter of Maastricht (2010), which endorsed recovery and was signed by the directors of the largest addiction treatment providers. Recovery is now featured in at least three national key practice-level policy documents (Expertise Center Forensic Psychiatry, 2020; GGZ Nederland, 2009, 2013) and in the recently (2017-2021) developed national Standards of Mental Health Care (Akwa GGZ, 2022). These developments have also inspired Belgian (Flanders) policymakers to endorse recovery (Bellaert et al., 2021; Van Deurzen, 2015). However, unlike the US, the UK and Australia, the Netherlands and Belgium have not consolidated recovery within their national drug policies.

Recovery in this thesis

In summary, recovery as used in this thesis is a complex concept rooted in lived experience. It is a concept that speaks to those who experience it and it is currently engrained in international discussions and policies about drug addiction. It is the key concept of interest in this thesis. Throughout the chapters we use the term broadly, recognizing that it can include a variety of life experiences from people who use(d) drugs and in some cases allow our study-participants to define it or elucidate on its meaning. The essence of the recovery concept in this thesis is that it refers to a process of improvement or growth regarding issues that arise together with drug use problems.

1.4 Recovery pathways and outcomes

Treatment and support for addiction

There are various pathways through which people recover. These can be assisted pathways, with the help of professional and informal support, or unassisted pathways, often coined as 'natural' or 'spontaneous' recovery (Granfield & Cloud, 1999; Waldorf & Biernacki, 1981). Although costs, accessibility and treatment philosophies may vary across countries and regions, available addiction services and support are generally similar in structure in most Western countries. They can be grouped in three categories: (1) community treatment, consisting of a variety of professional outpatient interventions including counseling and pharmacotherapies (e.g. opiate substitution treatment) without stay; (2) residential treatment, consisting of an array of professional rehabilitative facilities where a person stays within the confines of a particular therapeutic setting for a period of time (e.g. rehabilitation centers or Therapeutic Communities) and; (3) mutual aid (or 'self-help') groups, consisting of a range of peer-based organizations (e.g. *Alcoholics Anonymous* and SMART), often led and facilitated by persons with lived addiction experience. Within these addiction service and support categories, a range of (psychosocial, behavioral or pharmacological) interventions and therapies may be offered. Professional community and residential treatment are generally led by paid professionals and are characterized by the fact that they concentrate their efforts in restricted periods of time. Mutual aid and peer-based support, on the other hand, is often carried out by volunteers and not time-restricted. Twelve-step groups, for example, even encourage members to continue attendance for life (Kelly et al., 2009). Research into mutual aid groups, and

particularly groups other than AA, is rare (Humphreys, 2004). Furthermore, due to their non-professional nature, opinions about the value and effectiveness of mutual aid groups vary widely (Ferri et al., 2006; Peele, 1990; Vaillant, 2005).

Long-term process

Sparked by the recovery movement of the last two decades, recovery research has made important steps in uncovering the characteristics of pathways to recovery. Data on treatment careers, for example, show that people engage in a variety of (and usually multiple) forms of formal treatment and informal support (Kelly et al., 2017). Multiple 'attempts' to address substance use are often needed and it is argued that each attempt contributes to a gradual cumulative effect (Hser et al., 1997; Kelly et al., 2019). While not a rule, studies have found that recovery is a process that can take up to three to five years to reach a stable situation (Dennis et al., 2007; Hser, 2007; Langendam et al., 2000; Shah et al., 2006). Furthermore, there are indications that within the process of recovery, stages can be distinguished. The Betty Ford Institute Consensus Panel (2007), for example, distinguished three subsequent stages that indicate stability in recovery: early recovery (1–12 months), sustained recovery (1–5 years), and stable recovery (5 years or more). In contrast, addiction services are organized in short-term interventions and evaluations (Dennis & Scott, 2007) and multiple readmissions are common (Dennis et al., 2005; Scott et al., 2005). This acute care model of addiction is criticized for not matching with the long-term and continuous character of addiction and recovery (DuPont et al., 2015; Kelly & White, 2011; Vogel, 2018). Therefore, a gap between the long-term needs of persons seeking recovery and the current model of addiction services may exist.

Measuring recovery

To assess recovery outcomes during this long-term process, the concept of *recovery capital* was introduced (Cloud & Granfield, 2008). Inspired by the work of social scientists on social capital (Bourdieu & Wacquant, 1992; Coleman, 1990; Putnam, 1993), Cloud and Granfield (2001) first coined the term 'recovery capital' when discussing how individuals resolved their drug problems without any treatment. Distinguishing different forms of positive and negative recovery capital, such as social, physical, human and cultural capital, the authors conceptualized "a comprehensive framework for understanding the wide range of resources that can be drawn upon in an effort to overcome substance misuse" (Cloud & Granfield, 2008, p. 1975).

Yet, recovery capital is not equally available or accessible across the population of people with drug addiction. In other words, some persons have more resources to resolve drug addiction than others. Accordingly, White and Cloud (2008) argued that the balance between recovery capital and addiction severity and complexity can be an indicator to determine what type and intensity of interventions may be appropriate. For example, individuals with high recovery capital and low problem severity may benefit from brief low-threshold interventions, while those with low recovery capital and high problem severity may need a combination of intensive interventions (White & Cloud, 2008). Recovery capital can thus be instrumental in tailoring a range of interventions to individual needs, and tailoring interventions is considered crucial for the effectiveness of treatment (Goldstein, 1994; Leshner, 1999).

Traditional assessments, such as the Addiction Severity Index (McLellan et al., 1992) or the Maudsley Addiction Profile (Marsden et al., 1998), did not capture recovery capital very well, as they were primarily focused on addiction pathology and ignored any strengths or protective elements (Hennessy, 2017). Consequently, new measures were developed and tested, including the Assessment of Recovery Capital (Groshkova et al., 2013) in which not only personal but also social recovery capital is covered.

Another effort to measure recovery was made through a body of studies using the Life in Recovery survey (LiR) in the US (Laudet, 2013), Australia (Best, 2015), UK (Best et al., 2015), and Canada (Mcquaid et al., 2017). Initially commissioned by a US recovery advocacy organization (Faces and Voices of Recovery), the LiR captured long-term recovery experiences: an understudied phenomenon (White & Evans, 2013). The LiR-studies found that, compared to the situation during addiction, being in recovery was associated with significant improvements in various life domains. Steady employment increased by over 50%, people who furthered their education doubled, and involvement in crime decreased about tenfold (Laudet, 2013, p. 1). However, the LiR studies so far included persons with any substance addiction. Consequently, the majority of the study samples consisted of people with a history of alcohol addiction, leaving the population of persons with illicit drug addiction underresearched.

1.5 Recovery and relapse

As described above, recovery entails an idiosyncratic process in which different aspects of life may gradually improve. But what if they stop improving? Or worse, what if they deteriorate? This opposite situation of recovery is most commonly referred to as *relapse*, a term that is equally disputed. Despite the agnostic position on recovery, in which researchers have embraced the pluriformity of its manifestation, we often tend to think of *relapse* as dichotomous: in terms of 'success' or 'failure'.

In addiction research, relapse is often defined by researchers as 'any use' of substances, or the violation of complete abstinence (Witkiewitz & Marlatt, 2007). However, if you ask a person with drug addiction "Did you (have a) relapse this week?" this may be interpreted differently, depending on that person's idea of a relapse. It may mean any drug use, drug use above a certain threshold, or the violation of a personal rule or certain behavior that week. It may also mean that drug use was accompanied by negative consequences or by a feeling of loss of control. In any case, relapse refers to a situation or behavior that is different in meaning from recovery. Despite the fact that the majority of people eventually recover, a large part still struggles with setbacks and difficulties (Stuart et al., 2017). Therefore, besides studying which factors contribute to stable recovery, it is equally important to study which factors can negatively impact recovery by causing a relapse (or a similar experience).

1.6 Stigmatization of people with drug addiction

One of the major barriers to recovery is the stigmatization of people with drug addiction (Luoma, 2010; van Weeghel et al., 2019) and, unfortunately, drug addiction is a highly stigmatized condition. A WHO-study from 2001, for example, found that being addicted to drugs was more disapproved of by the general public than having a criminal record for burglary (Room et al., 2001, p. 276). Stigmatization is a term that refers to a process in which negative attitudes result into labelling, segregation, stereotyping, prejudice and discrimination, and discredit a person's social status (Goffman, 1963; Link & Phelan, 2001). To illustrate how stigmatization works, think of drinking champagne at a conference, or taking ecstasy at a rave. In this situation, substance use is generally socially accepted and can even be a sign of status. On the other hand, similar behavior by someone with a substance *addiction*, and particularly drug addiction, evokes high degrees of social disapproval or stigmatization.

Literature on stigmatization in the mental health field considers the negative effect of stigma on the stigmatized, such as hindering access to treatment (Link et al., 1997; Luoma, 2010; Ritson, 1999; Wakeman & Rich, 2018), and how such effects may be reduced (Room, 2005). Studies show that stigmatization, and even expected stigmatization, is associated with reduced quality of life, negative

impact on feelings of well-being and low self-esteem, which is also labelled as self-stigma (Crapanzano et al., 2018; Link et al., 1997; Matthews et al., 2017; Thornicroft, 2003; van Boekel, 2014). Additionally, public stigmatization may impact one's social and community status, as stigma-related discrimination reduces opportunities for employment, housing and social participation, social isolation and marginalization may follow (Link & Phelan, 2006; Rüsch et al., 2005).

There is also evidence that clients seeking recovery from drug addiction are confronted with stigmatization by health professionals from whom they seek help (Rao et al., 2009; Ronzani et al., 2009; van Boekel et al., 2015; Vistorte et al., 2018). This has been linked to poorer mental and physical health, non-completion of treatment, delayed recovery and increased involvement in risky behavior (Livingston et al., 2012; van Boekel, 2014). For people in recovery, the stigma from drug addiction often remains and can have lasting negative consequences.

One way to address stigmatization is through the *language* that is used to describe persons and concepts. For decades, advocates in the addiction field raised concerns about how certain terms to describe drug addiction and people with drug addiction elicit stigmatization (Keller, 1977). The term 'substance abuse(r)', for example, is considered stigmatizing because of negative connotations (e.g. child abuse), because it attributes blame to a person, and because it labels a person by his/her condition (SAMHSA, 2004). Over the years, several efforts have been made to change the language of addiction, such as replacing 'abuse' and 'dependence' with 'disorder' in the DSM-5 (American Psychiatric Association, 2013) or by promoting person-first language in policy documents (Botticelli & Koh, 2016). However, despite such long-going advocacy, empirical investigation of the effect of language on stigmatization is rare.

1.7 From outsider to insider perspective: the qualitative lens

So far, quantitative studies measured different aspects of recovery and helped us understand that addiction and recovery are long-term processes with a range of outcomes. However, scientific information about *how* recovery is experienced is much less available (Bjornestad et al., 2019). Because of their ability to explore and explain human behavior, qualitative methods have proven to be valuable for such inquiries (Whitley & Crawford, 2005). In the addiction field in general, a growing interest in qualitative studies have helped to:

> "understand and demystify drug taking, dispel unhelpful myths and stereotypes about drug users, build and develop theories of addiction and formulate and evaluate drug policy and practice" (Neale et al., 2005, p. 1591).

Prevailing negative stereotypes of people who use drugs (e.g. passive, anxious and morally inadequate), were challenged by ethnographic research showing how drug use and addiction could be understood as social experiences from autonomous individuals who actively make choices (Stephens, 1991). Similarly, qualitative research on people in drug treatment provided insights into both facilitating and contra-productive elements of treatment. For example, views of people who use drugs about addiction service providers (Neale et al., 1998), barriers faced to access support (Copeland, 1997), and experiences in addiction treatment (Klingemann, 2011; Lock, 2004; Thom et al., 1992).

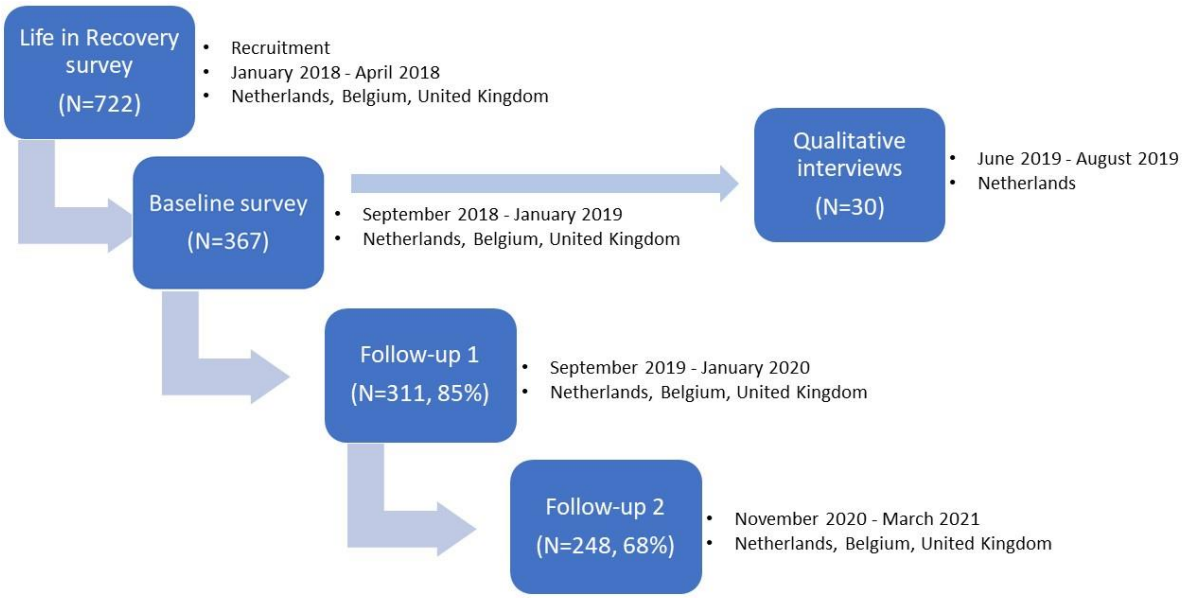
More recently, qualitative studies focusing specifically on recovery experiences have also started to emerge. Klingeman (2012), for example, found that developing better coping strategies for stress and cravings contributes to sustained recovery from alcohol addiction. Another study showed that persons who resolved an alcohol use problem without treatment or mutual aid support, apply a variety of narratives to that experience, a process that is shaped by social contexts (Mellor et al.,

2020). Furthermore, a body of qualitative studies explored long-term recovery experiences of ex-service users in Norway, describing it as a developmental process from dependency and reactivity to personal autonomy and self-agency where continuing contact and interest from services appeared beneficial (Bjornestad et al., 2019; Svendsen et al., 2020). Still, there remains a gap in the literature, particularly about experiences of long-term drug addiction recovery across a range of treatment settings, since the bulk of addiction recovery research concerns populations in or just after a particular treatment for alcohol problems.

1.8 The European Recovery Pathways study (REC-PATH)

This thesis is mostly built around data from the European Recovery Pathways study (REC-PATH) (for protocol paper see: Best et al., 2018). The research and valuable data on recovery discussed above almost exclusively includes US populations. In Europe, data are rare, if available at all. Given that drug use patterns and access to treatment for addiction can differ largely between Europe and the US, this leaves us largely in the dark about European recovery pathways. The aim of REC-PATH, was to study pathways to recovery from illicit drug addiction from different perspectives. We aimed to recruit a broad population of people in different stages of recovery, who had used a variety of treatment and support services (thus, not recruited from one type of setting). Recruitment took place in the UK, Belgium (Flanders), and the Netherlands, countries in which recovery as an organizing principle for addiction services and policy has recently gained ground. We used the Life in Recovery survey to recruit a convenience sample and then followed participants over the course of two years, with baseline, one- and two-year follow-up structured surveys (see Figure 2). A subgroup was also recruited for in-depth qualitative interviews. Policy analyses were performed to study in what way and to which extent recovery ideas were translated into policy.

Figure 2: Flowchart of data collection used in this thesis



The COVID-19 pandemic

The study described in this thesis partly took place during the COVID-19 outbreak. The subsequent pandemic has led to one of the most uncertain times in our history since World War 2. There are concerns that this has majorly impacted many aspects of society, including the things that help people sustain recovery. For a while, there was less access to (face-to-face) treatment, to (peer) support, to certain forms of employment, and to other meaningful activities. Coupled with heightened distress about potentially getting seriously ill, for example, this could have had a negative impact on people in recovery, prompting relapse or similar negative experiences. Therefore, the impact on people in recovery became an additional concept of interest of this thesis. Historical data indicate that it is likely that an event like the COVID-19 pandemic will happen again in the future (Marani et al., 2021). Insights into how the COVID-19 pandemic impact recovery can help us to better understand recovery and to organize better recovery supportive services in such events.

1.9 Outline of the thesis

In summary, we have established that research into recovery has made great advancements in defining and measuring recovery and demonstrating the long-term and extensive character of recovery. Furthermore, we know that recovery has been adopted as an organizing principle of addiction services and policy in some countries. However, we have also established that studies on recovery from *drug* addiction are scarce, particularly from the perspective of lived experience. Therefore, in this study we aim to answer the following main research question:

What does drug addiction recovery entail for those who experience it, for recovery support services, and for policy?

To answer the main research question we divided it into six sub-questions:

1. How do recovery outcomes compare between people in different stages of their recovery process?
2. How do various mutual aid groups support drug addiction recovery?
3. Are factors associated with return to problematic drug use different before and during the COVID-19 pandemic?
4. How is drug addiction recovery experienced from a first-hand perspective?
5. How is recovery adopted in Dutch policy and what are the notions of drug addiction and recovery which underlie that policy?
6. What role does language play in the stigmatization of people with drug addiction by care professionals?

Each sub-question is addressed in a separate chapter outlined in Table 1.

Table 1: Outline of thesis

Sub-question	Title	Method used	Data origins
1	**Chapter 2:** Comparing three stages of addiction recovery: long-term recovery and its relation to housing problems, crime, occupation situation, and substance use	We used the Life in Recovery survey (N=722) to cross-sectionally examine the relation between housing problems, crime, occupation situation and substance use with recovery stage.	The Netherlands, Belgium and the UK
2	**Chapter 3:** Are members of mutual aid groups better equipped for addiction recovery? European cross-sectional study into recovery capital, social networks, and commitment to sobriety	We used the quantitative baseline survey (N=367) from the REC-PATH study to cross-sectionally examine the relation between membership of a mutual aid group with recovery capital, participation in social networks, and commitment to sobriety.	The Netherlands, Belgium and the UK
3	**Chapter 4:** Factors associated with problematic substance use before and during the COVID-19 pandemic among a drug addiction recovery cohort: A prospective study in the Netherlands, Belgium and UK	We used the quantitative baseline survey from the REC-PATH study before the pandemic (N=367) and two follow-ups at 12 months apart (T1, N=311; T2, N=248). For both periods, we analyzed correlates of problematic substance use.	The Netherlands, Belgium and the UK
4	**Chapter 5:** Understanding drug addiction recovery through lessons of lived experience: A qualitative study in the Netherlands	We conducted 30 in-depth qualitative interviews with a subsample (15 women and 15 men) from the Life in Recovery survey from the Netherlands. Using the Life-line interview method, we elicited autobiographical data on their recovery pathways. We then undertook a data-driven thematic analyses.	The Netherlands
5	**Chapter 6:** Addiction and recovery in Dutch governmental and practice-level drug policy: What's the problem represented to be?	To investigate whether the Dutch recovery policies are coherent with its governmental drug policy, we applied Bacchi's 'What's the problem represented to be?'-approach to analyze problematizations of 'drug addiction'. We analyzed two influential practice-level policy documents and one governmental drug policy document.	The Netherlands
6	**Chapter 7:** Language and stigmatization of individuals with mental health problems or substance addiction in the Netherlands: An experimental vignette study	We conducted an (online) experiment examining how four different ways of referring to a person with (a) alcohol addiction, (b) drug addiction, (c) depression and (d) schizophrenia are related to stigmatizing attitudes by a convenience sample of care professionals in the Netherlands (N=361).	The Netherlands
	Chapter 8: Discussion	In this chapter the main findings of this thesis are described and discussed in relation to the addiction recovery literature. Furthermore, it contains the major strengths and limitations of the studies and recommendations for future research and for practice.	

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2. Comparing three stages of addiction recovery

Long-term recovery and its relation to housing problems, crime, occupation situation, and substance use

Martinelli, T. F., Nagelhout, G. E., Bellaert, L., Best, D., Vanderplasschen, W., & van de Mheen, D. (2020). Comparing three stages of addiction recovery: long-term recovery and its relation to housing problems, crime, occupation situation, and substance use. *Drugs: Education, Prevention and Policy*, *27*(5), 387–396. https://doi.org/10.1080/09687637.2020.1779182

ABSTRACT

Many studies on addiction recovery focus on recovery initiation and short-term outcomes for alcohol addictions. In this study, we examine associations between three recovery stages and recovery markers for persons in drug addiction recovery. Data were collected for a multi-country study (REC-PATH) among 722 individuals living in the UK, the Netherlands, and Belgium, who consider themselves in addiction recovery for a period of three months or more. We focus on typical life domains that characterize recovery: housing, crime, work or education, and substance use. The relation with time in recovery was examined for three recovery stages: early (<1 year), sustained (1–5 years), and stable (>5 years). Using the Life in Recovery survey, cross-sectional analyses reveal that participants in later recovery stages have lower odds of having housing problems, being involved in crime, and using illicit hard drugs and higher odds of having work or education, when compared to participants in the early recovery stage. This study provides further empirical support for defining drug addiction recovery as a gradual, long-term process that is associated with various life domains beyond abstinence. The findings suggest that drug policy, treatment and research need to be oriented towards long-term objectives and recovery goals that cover multiple life domains in order to support stable recovery.

Introduction

Defining recovery

Changing problematic substance use sustainably, often referred to as addiction *recovery,* is considered a difficult and complex process (Davidson & White, 2007). Traditionally, addiction recovery signified 'clinical recovery', which mainly refers to the absence of symptoms or abstinence. However, in recent years, a scientific and grassroots movement around addiction recovery has emerged (Davidson & White, 2007). This movement originated in the United States and quickly spread to Australia (D. Best et al., 2016), the United Kingdom (UK) (D. Best et al., 2010), Canada (McQuaid & Dell, 2018) and many other countries, and has influenced how addiction recovery is defined. One of the early definitions of addiction recovery describes it as a 'voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship' (Betty Ford Institute, 2007, p 222). This scope was later extended beyond sobriety to also include control over substance use (UK Drug Policy Commission, 2008). In the emerging paradigm, addiction recovery is associated with multiple life domains, such as (mental) health, legal issues, and social and economic functioning and wellbeing, and includes subjective indicators such as self-esteem, empowerment, and self-determination (D. Best et al., 2016; Dekkers, De Ruysscher, et al., 2020; Laudet & White, 2010). Furthermore, recovery is described as a personal process that can take place in various ways, depending on circumstances, context, and available support and resources (Kaskutas et al., 2014; John Francis Kelly & Hoeppner, 2015; Notley et al., 2015; W. L. White, 2007). While there are many other recovery definitions, it is clear that addiction recovery cannot be reduced to abstinence and that it concerns growth and change on various life domains.

The addiction recovery paradigm integrates elements from the addiction as well as the mental health field, two fields with many parallels in history, treatment challenges, and grassroot advocacy movements (Davidson & White, 2007). It highlights the need for a shift from a disorder-oriented approach towards a person-centred and wellbeing-oriented approach, through learning from lived experience (Slade, 2010; W. L. White et al., 2012). This shift is illustrated by the distinction between clinical and personal recovery (Slade, 2010), resulting in a conceptual paradox (D. Best et al., 2016). While clinical recovery refers to the absence of symptoms, personal recovery refers to personal growth and living a satisfying life, within the limitations imposed by illness (Anthony, 1993). Thus, on the one hand, subjective states and experiences are emphasized because recovery is defined as a personal process and "you are in recovery if you say you are" (Valentine, 2010). On the other hand, recovery is often defined through external and observable outcomes such as abstinence, well-being and social participation (Betty Ford Institute, 2007; UK Drug Policy Commission, 2008). In this paper, we deal with this distinction by examining the latter empirically, within a framework that integrates the subjective aspects of recovery: participants in this study determined themselves whether and for how long they were 'in recovery'.

Stages of recovery

As the long-term and gradual nature of addiction recovery is increasingly acknowledged, it is described as a process instead of an event (Dekkers et al., 2019; Hser, 2007; Laudet & White, 2010, 2008; A. Thomas McLellan et al., 2000; van der Stel, 2013; W. L. White et al., 2002, 2003). The Betty Ford Consensus Panel (2007) distinguished three subsequent stages in this process to indicate the stability of recovery or 'resilience to relapse': early recovery (1-12 months), sustained recovery (1-5 years), and stable recovery (5 years or more). While these stages are not empirically established timeframes, they are derived from available literature and common experiences of those in recovery. Similar timeframes are also suggested by other studies on long-term trajectories of persons entering addiction treatment. Dennis and colleagues (2007) showed that three years (or more) of abstinence is a strong predictor for stable recovery. Additionally, several studies, such as the Harvard Grant study on alcoholism (Vaillant, 2003, 2012) and a 33-year follow-up study on heroin addiction (Hser, 2007) indicated that five years of abstinence significantly improved the likelihood of stable recovery (Langendam et al., 2000; Schutte et al., 2001; Shah et al., 2006). However, it remains a question

whether different stages of recovery are associated with different levels of improvement regarding several established recovery markers beyond abstinence.

Recovery markers

Qualitative studies of individuals in alcohol and drug addiction recovery found that there are several markers of recovery besides discontinued or reduced substance use (Kaskutas et al., 2014; Neale et al., 2014). Employment, education and training, and housing were identified as the most notable priorities for individuals in addiction recovery (Laudet & White, 2010). Employment was even cited as the top priority and was also one of the key outcome domains in the Substance Abuse and Mental Health Services Administration National Outcome Measures in the US (SAMHSA, 2008). Besides a meaningful activity, employment can provide financial and social resources, which can strengthen a person's valued and dignified societal role. Housing was prioritized more by persons with more time in recovery, suggesting that this is an important indicator of recovery progress (Laudet & White, 2010). Having stable housing (a home) can help recovery processes in various ways. Organizing and dealing with everyday issues and being responsible for making choices about one's home offers opportunities to take more control over one's life (Borg et al., 2005) and offers a way of interacting with the surrounding neighbourhood and community (Topor et al., 2011). Consequently, stable housing can improve empowerment and citizenship. Furthermore, criminological studies that highlight the complex relationship between substance addiction and offending found parallels between processes of addiction recovery and desistance from crime (D. Best & Colman, 2019; D. Best & Savic, 2015; Colman & Vander Laenen, 2017). Tackling addiction can reduce and prevent crime (Gossop et al., 2005; Ministry of Justice, 2017; Wen et al., 2017), while on the other hand, involvement in criminal behaviour can be a barrier for addiction recovery. The question remains, however, how recovery processes relate to such life domains over time and how they develop across the recovery journey. In order to gain a better understanding of this, the current paper examines the relationship between different stages of recovery and occupational situation (employment and education), housing problems, involvement in crime and the criminal justice system, and substance use.

Relevance of the study

Conceptualizing addiction recovery as a long-term process should shape the way treatment, policy, and research is organized. However, this is currently not the case (D. Best & Colman, 2019; Laudet & White, 2010). Addiction treatment is mostly delivered via relatively short interventions (Dennis & Scott, 2007), often followed by relapse and multiple readmissions (Dennis, Scott, Funk, & Foss, 2005; Scott, Foss, & Dennis, 2005; White & Evans, 2013) . Consequently, the current model of care may not meet the long-term needs of a substantial group of persons seeking recovery (DuPont et al., 2015; Hser et al., 1997). In addiction research, post-treatment studies often have short follow-up periods (one or two years) focused on single treatment episodes (Hser et al., 1997; Laudet & White, 2010, 2008; A. Thomas McLellan et al., 2005; Morgan, 1994; Simpson, 2002; Simpson & Joe, 2004). As a result, there has been substantial interest in recovery initiation, but far less in the processes involved in sustaining recovery, and even less so for persons with illicit drug addictions (Laudet & White, 2008; McAweeney et al., 2005). To address this limitation, some authors have argued that five years should be used as a standard for assessing the effectiveness of treatment interventions (DuPont et al., 2015). Such a long-term approach could potentially challenge the typical short-term treatment and research paradigms.

Life in Recovery studies

A recent body of studies, designed to capture and understand addiction recovery pathways, was conducted in the United States (Laudet, 2013), Australia (D. Best, 2015), United Kingdom (D. Best et al., 2015), and Canada (Mcquaid et al., 2017). Using the Life in Recovery (LiR) methodology, these studies included participants in different stages of recovery and measured a wide range of experiences of individuals in recovery. The initial study (Laudet, 2013) commissioned by Faces and Voices of Recovery (FAVOR), a recovery advocacy organisation in the US, looked at the three

aforementioned recovery stages and measured items on key life domains which are typically affected by addiction, such as health functioning, work, and legal and social domains. The author concluded that "recovery from alcohol and drug problems is associated with dramatic improvements in all areas of life" (Laudet, 2013, p3). Similar findings were reported in the other LiR-studies (D. Best, 2015; D. Best et al., 2015; Mcquaid et al., 2017).

This paper extends this body of knowledge to continental Europe and specifically to individuals in drug addiction recovery (D. Best, Vanderplasschen, et al., 2018a). As part of the larger multi-country Recovery Pathways study (REC-PATH), we used the LiR to assess the association between the aforementioned recovery stages (early, sustained and stable) and established recovery markers in the UK, the Netherlands, and Belgium (Flanders). These countries were chosen as they are characterized by marked differences in the timing of the initiation of national recovery-oriented drug policies. The shift to a recovery-oriented drug policy started early in the UK in 2008 (D. Best et al., 2010), later in the Netherlands in 2013 (GGZ Nederland, 2013), and not until 2015 in Belgium (Flanders) (Van Deurzen, 2015; Vanderplasschen & Vander Laenen, 2017).

Previous Life in Recovery studies (D. Best, 2015; D. Best et al., 2015; Laudet, 2013; Mcquaid et al., 2017) found differences in recovery experiences between men and women. In Canada, for example, mental health problems were found to be a significantly more important factor for the initiation of recovery for women compared to men, and women reported greater untreated mental health or emotional concerns and more family violence (McQuaid & Dell, 2018). Therefore, gender differences were anticipated in this study as well. The primary research question is whether recovery markers on various life domains (housing problems, being involved in crime or the criminal justice system, having work or education, and substance use) differ between recovery stages and whether this applies similarly to both men and women.

Method

Life in Recovery survey

This study builds on previous research using the same survey: Life in Recovery (LiR) (D. Best, 2015; D. Best et al., 2015; Laudet, 2013; Mcquaid et al., 2017). As opposed to previous studies, the current study focused exclusively on individuals with a history of illicit drug addiction. Consequently, some items were modified. The LiR also functioned as a recruitment tool in the larger REC-PATH study (D. Best, Vanderplasschen, et al., 2018a), where we aimed to recruit 250 persons in each participating country, including equal proportions in each stage of recovery and an even balance between men and women. LiR participants were asked whether they wanted to continue participation in the REC-PATH study, which included an extensive baseline and follow-up survey and, possibly, an in-depth qualitative interview.

In total, 722 unique individuals completed the LiR between January and June 2018. This convenience sample was recruited using the same recruitment strategy in each country. We used social media, newsletters, conferences, alcohol and drug magazines, and printed flyers and posters to disseminate the call for participants and contacted prevention and treatment organizations to spread the call. "Anyone in recovery for at least three months or who has stopped or reduced problematic drug use for at least three months" was eligible to participate and invited to visit the project website and fill out the online survey. On the project website (https://www.rec-path.co.uk/), potential participants could access information about the study and give informed consent to access the survey. Several partner organizations and addiction recovery networks engaged to support the recruitment of study participants. Each country team ensured local ethics approval (METC Erasmus MC, the Netherlands; SHU Ethics Committee, UK; UGent Ethics Committee, Belgium).

We used online (n=582) and printed (n=140) surveys, to accommodate eligible participants that preferred a paper survey. The median completion time for the online surveys was 18.65 minutes. On the website, participants could choose the UK, Dutch or Belgian (Flemish) version of the survey. All

materials were available in English, Dutch, and Flemish. A collaborative and iterative approach (Douglas & Craig, 2006) was employed to translate the original English survey. Back-translation was performed by a native (English) speaker, followed by a small pilot study with a client panel (from addiction services), not associated with the project. No changes were needed after this pilot.

Variables

In this paper, we assess the relation between recovery stage and several recovery markers, while controlling for various covariates. The variables that were used in the analyses are described below.

'Recovery stage' was measured by asking "How long do you consider yourself in recovery? [years, months]". The sample was then divided into three groups: those in early (<1 year), sustained (1-5 years), and stable recovery (>5 years) (Betty Ford Institute, 2007).

Housing problems, crime or criminal justice system involvement, and occupational situation were all measured by multiple items that were combined to create composite variables. Each item had two response categories (yes/no). If participants answered 'yes' to one (or more) of the items related to the variable, it was scored as '1'; if they answered 'no' to all questions, it was scored as '0'. Having **'housing problems'** was measured with "Have you been having acute housing problems in the last 30 days?" and "Have you been at risk of eviction in the last 30 days?". '**Crime or criminal justice system involvement'** was measured by asking: "Have you been involved in offending in the last 30 days?" and "Have you been involved with the criminal justice system in the last 30 days?". **'Occupational situation'** was assessed with: "Have you been working full-time in the last 30 days?", "Have you been working part-time in the last 30 days?", "Have you been at college, university, or any other form of education including online course work in the last 30 days?", and "Have you volunteered in the last 30 days?". **'Substance use in the last 30 days'** was measured by asking how many days of the last 30 days participants had used alcohol, heroin, cocaine, crack cocaine, amphetamines, ecstasy/MDMA, cannabis, methadone, buprenorphine, and/or other illicit substances. These items were combined to create four dichotomous (yes/no) variables: 1) 'alcohol use in the last 30 days' 2) 'illicit hard drug use in the last 30 days' 3) 'cannabis use in the last 30 days 4) 'abstinent from illicit drugs, alcohol, and opiate substitutes in the last 30 days'.

Various sociodemographic variables were collected and used as covariates in the analyses. **'Age'** was used as a scale variable defined in years. Level of **'education'** consisted of three categories: none or primary education, secondary education, and higher education. As 'none or primary education' did not have sufficient cases, it was combined with secondary education into the category 'lower education'. **'Country'** was reported by asking participants "Where do you live?". England, Wales, Northern Ireland, and Scotland were combined into one category: the UK. **'Gender'** had three answering options: man, woman, and other. Three participants answered 'other' and were excluded from the analyses for lack of power. Gender was also included in the interaction model analyses to assess the interaction effect of gender with the recovery stages.

The LiR also included retrospective variables related to the dependent variables (**'Housing stability', 'Crime', and 'Occupational situation'),** preceding the period participants initiated recovery: "While you were experiencing problematic drug use, did you: (1) have stable housing? (2) get arrested? (3) have criminal charges laid against you? (4) complete a term of conditional release? (5) serve jail or prison time? (6) remain steadily employed? (7) further your education or training?" [yes/no]. Items 2 to 5 were combined into one as 'crime' and 6 and 7 were merged as 'occupational situation'.

Lastly, we included several descriptive variables to collect basic information about the study sample. **'Problem drug (ever)'** was measured by asking whether one of the substances listed was "Ever a problem?" [yes/no] to them. **'Age first drug use'** was measured by asking "How old were you when you first used any illicit drug?" **'Treatment history'** was measured by asking "Have you ever sought or received help from one of the following services/organizations? [yes/no]: (1) 12-step fellowships, (2) Peer-Based recovery support (non-12 step), (3) Residential rehabilitation, Therapeutic Communities

and/or Detox, (4) Specialist Outpatient Treatment, and (5) any other service (e.g. a church / place of worship)"

Analyses

Survey data were processed and analysed using SPSS 24. Chi-square tests were performed to report differences in sample characteristics by country (Table 1) and dependent variables by recovery stage (Table 2). Logistic regression analyses were performed to estimate associations between recovery stage (independent variable) and housing problems, crime or criminal justice system involvement, occupational situation, and substance use in the last 30 days (dependent variables), adjusted for covariates (Table 3). Sustained and stable recovery were compared to early recovery. These analyses were also performed on separate country samples (not in tables). Lastly, interaction effects between gender and recovery stages were analysed for the key dependent variables (Tables 3 and 4).

Results

Table 1 describes the characteristics of the total sample and per country. Although the study used the same recruitment strategy in each country, those responding and completing the survey differed in several aspects. Gender distribution was similar in the UK (61% men) and the Netherlands (59% men), while relatively more men (74%) were recruited in Belgium. In the UK, more participants with higher education (70%) were recruited, while in Belgium less educated participants were recruited (75%). The most reported illicit substances that were 'ever a problem' to the participants were cannabis in the UK (70%) and cocaine in the Netherlands (67%) and Belgium (69%).

The largest proportion of participants in the UK were in 'stable recovery' (56%), while in Belgium and the Netherlands most participants were in 'sustained recovery' (respectively 44% and 46%). A relatively large proportion of persons in 'early recovery' (32%) was recruited in Belgium compared to the UK (10%) and the Netherlands (17%). Mean age of first use of an illicit substance was between 15 and 16 years. Reported 12-step fellowship participation was similar in the Netherlands (73%) and UK (75%), but much lower in Belgium (27%). Other peer-based support services were mainly reported in the UK (52%). Respondents in the UK reported less use of residential treatment (58%) compared to the Netherlands (78%) and Belgium (76%). Reported utilisation of specialist outpatient treatment was similar across all countries (around 70%). All differences between countries were significant ($p < 0.05$), except for outpatient treatment, having stable housing, being employed, and 'ever had a problem with': cannabis, ecstasy/MDMA, and other illicit drugs.

Table 1: Differences in sample characteristics between countries

	Total n=722	UK n=311	Netherlands n=230	Belgium n=181	p-value Chi2
Gender					p = 0.004
Male	63.3	60.8	58.7	73.5	
Education					p < 0.001
Lower	50.6	30.2	59.1	74.6	
Higher	49.4	69.8	40.9	25.4	
Problem substance (ever)					
Alcohol	70.1	75.2	72.2	59.1	p = 0.001
Heroin	37.4	56.9	17.4	29.3	p < 0.001
Cocaine	62.6	55.6	67.4	68.5	p = 0.003
Crack Cocaine	33.1	46.0	23.9	22.7	p < 0.001
Amphetamines	56.6	60.8	47.8	61.3	p = 0.004
Ecstasy/MDMA	43.4	44.4	45.2	39.2	p = 0.425
Cannabis	66.5	70.1	66.1	60.8	p = 0.106
Methadone	23.5	39.2	11.3	12.2	p < 0.001
Buprenorphine	11.5	22.5	2.6	3.9	p < 0.001
Tobacco	78.5	84.2	71.3	78.5	p = 0.001
Prescription Drugs	41.8	55.3	29.6	34.3	p < 0.001
Other	19.7	15.1	20.9	23.2	p = 0.059
Recovery Stages					p < 0.001
Early (<1 year)	17.6	10.3	16.5	31.5	
Sustained (1-5 years)	40.2	33.8	45.7	44.2	
Stable (>5 years)	42.2	55.9	37.8	24.3	
Age *mean* (SD)	*41.2 (10.7)*	*45.5* (9.3)	*40.1* (11.2)	*35.5* (9.1)	p < 0.001[a]
18-29	14.5	3.6	20.4	25.4	
30-49	62.0	62.6	57.8	65.7	
50+	23.5	33.8	21.7	8.8	
Age first using illicit drugs *mean (SD)*	*15.6* (4.4)	*15.2* (3.4)	*16.2* (5.6)	*15.7* (4.1)	p = 0.036[a]
Have you ever sought/received help from..					
12-step fellowships (yes)	62.0	74.9	72.6	26.5	p < 0.001
Peer-based support services (yes)	38.1	52.4	29.6	24.3	p < 0.001
Residential treatment (yes)	68.7	57.9	77.8	75.7	p < 0.001
Outpatient treatment (yes)	70.4	68.2	73.0	70.7	p = 0.467
Other services (yes)	18.1	25.4	17.4	6.6	p < 0.001
Before you initiated recovery..					
Did you have stable housing (no)	49.6	53.1	45.7	48.6	p = 0.192
Were you involved in crime (yes)	62.0	74.0	50.0	56.9	p < 0.001
Were you employed or studying (yes)	42.4	39.2	41.7	48.6	p = 0.123

[a] One-way ANOVA analysis

Note: All numbers are percentages unless otherwise specified.

Table 2 shows the extent to which housing problems, crime, work and education, and substance use in the last 30 days were prevalent in different stages of recovery. Housing problems, crime, and occupational situation were significantly associated ($p < 0.001$) with the recovery stages. Housing problems were found to be less common for individuals in stable recovery (2%), than for those in sustained (6%) and early (14%). Being involved in crime was also less common in each progressive recovery stage: 27% in early, 12% in sustained, and 6% in stable recovery. An active occupational situation was more common in the later recovery stages, with 54% having work or education in early, 82% in sustained, and 88% in stable recovery. Illicit hard drug use was reported less in each progressive stage of recovery: 17% in early, 8% in sustained and 5% in stable recovery. For cannabis use, this was 17% in early recovery, which levelled off to 9% in sustained and stable recovery. No significant differences between the recovery stages was found for alcohol use and abstinence from alcohol, drugs and opiate substitutes.

Table 2: Differences in housing problems, crime, occupation situation, and substance use by recovery stage

Recovery Stage:	**Early (n=127)**	**Sustained (n=290)**	**Stable (n=305)**	**p-value Chi2**
Housing problems	14.2	5.5	2.0	p < 0.001
Have you been having acute housing problems in the last 30 days? (yes)	11.0	5.2	2.0	P < 0.001
Have you been at risk of eviction in the last 30 days? (yes)	8.7	1.7	1.0	p < 0.001
Crime	26.8	12.1	5.6	p < 0.001
Have you been involved in offending in the last 30 days? (yes)	11.8	5.9	4.3	p = 0.012
Have you been involved with the criminal justice system in the last 30 days? (yes)	15.7	7.2	1.6	p < 0.001
Occupation situation	53.5	82.4	88.2	p < 0.001
Have you been continuously working full-time in the last 30 days? (yes)	19.7	32.8	52.5	p < 0.001
Have you been continuously working part-time in the last 30 days? (yes)	8.7	24.1	23.3	p = 0.001
Have you been at (..) education (..) within the last 30 days? (yes)	15.7	31.4	25.6	p = 0.004
Have you volunteered in the last 30 days? (yes)	28.3	45.9	36.1	p = 0.002
Substance use in the last 30 days				
Alcohol use (yes)	25.2	18.6	24.9	p = 0.131
Illicit hard drug use (yes)	16.5	7.9	4.9	p < 0.001
Cannabis use (yes)	17.3	9.0	8.9	p = 0.019
Abstinent from alcohol, illicit drugs and opiate substitutes (yes)	63.0	73.4	70.2	p = 0.099

Note: All numbers are percentages unless otherwise specified.

In Table 3, multivariate logistic regression analyses, including the covariates, are reported on the associations between the three recovery stages and housing problems, crime, occupational situation, and substance use. The associations found in Table 2 were confirmed for housing problems (OR=0.34; 95% CI: 0.16-0.74 in sustained stage and OR=0.12; 95% CI: 0.04-0.36 in stable stage), crime (OR=0.44; 95% CI: 0.25-0.79 in sustained stage and OR=0.24; 95% CI: 0.11-0.51 in stable stage), and occupational situation (OR=3.58; 95% CI: 2.18-5.85 in sustained stage and OR=4.94; 95% CI: 2.75-8.90 in stable stage). For substance use, only the association with illicit hard drug use (OR=0.51; 95% CI: 0.27-0.99 in sustained stage and OR=0.40; 95% CI: 0.17-0.90 in stable stage) remained significant. For housing problems, crime and occupational situation, the corresponding covariate that measured the related variable *before* initiating recovery was included in the analysis. Furthermore, separate country models of these analyses were performed, which yielded similar results, although not always significant.

Table 3: Multivariate logistic regression of recovery length with having housing problems, being involved in crime or criminal justice, and having work or education, and substance use in the last 30 days

	Housing problems OR (95% CI)	**Crime** OR (95% CI)	**Occupation situation** OR (95% CI)	**Alcohol Use** OR (95% CI)	**Illicit Hard Drug Use** OR (95% CI)	**Cannabis Use** OR (95% CI)	**Abstinent from drugs, alcohol, and opiate subs** OR (95% CI)
Recovery Stage							
Early	1	1	1	1	1	1	1
Sustained	0.34 (0.16-0.74)**	0.44 (0.25-0.79)**	3.58 (2.18-5.85)***	0.80 (0.48-1.36)	0.51 (0.27-0.99)*	0.60 (0.32-1.13)	1.41 (0.88-2.25)
Stable	0.12 (0.04-0.36)***	0.24 (0.11-0.51)***	4.94 (2.75-8.90)***	1.54 (0.87-2.74)	0.40 (0.17-0.90)*	0.84 (0.40-1.74)	1.00 (0.59-1.67)
Gender							
Male	1	1	1	1	1	1	1
Female	0.97 (0.47-2.02)	0.87 (0.49-1.56)	0.81 (0.53-1.24)	1.45 (0.99-2.11)	0.82 (0.45-1.49)	0.88 (0.51-1.49)	0.78 (0.55-1.10)
Age	0.97 (0.93-1.01)	0.99 (0.96-1.02)	1.00 (0.98-1.03)	0.97 (0.95-0.99)**	0.97 (0.94-1.00)	0.98 (0.95-1.01)	1.02 (1.00-1.04)
Education							
Lower	1	1	1	1	1	1	1
Higher	0.68 (0.31-1.45)	1.78 (1.00-3.18)	1.71 (1.09-2.68)*	1.52 (1.01-2.27)*	1.24 (0.67-2.29)	1.04 (0.63-2.04)	0.78 (0.54-1.13)
Before recovery: Housing							
No stable housing	1	NA	NA	NA	NA	NA	NA
Stable housing	2.05 (1.00-4.19)*	NA	NA	NA	NA	NA	NA
Before recovery: Crime							
No crime	NA	1	NA	NA	NA	NA	NA
Crime	NA	2.53 (1.41-4.51)**	NA	NA	NA	NA	NA
Before recovery: Occupation							
No occupation	NA	NA	1	NA	NA	NA	NA
Occupation	NA	NA	1.59 (1.05-2.42)*	NA	NA	NA	NA
Country							
UK	1	1	1	1	1	1	1
Netherlands	0.20 (0.07-0.54)**	1.52 (0.72-3.20)	1.58 (0.93-2.68)	0.99 (0.62-1.58)	0.84 (0.40-1.74)	1.03 (0.53-2.04)	1.15 (0.75-1.75)
Belgium	0.31 (0.12-0.78)*	6.21 (3.07-12.53)***	0.59 (0.35-1.00)	2.42 (1.47-3.99)**	1.27 (0.60-2.67)	2.30 (1.18-4.48)**	0.43 (0.27-0.68)***
Interaction effect[a]							
RecStage*Gender	p = 0.019	p = 0.583	p = 0.484	p = 0.353	p = 0.978	p = 0.087	p = 0.218

* p < 0.05
** p < 0.01
*** p < 0.001
NA = Not Applicable
[a] Separate analysis

Table 4: Multivariate logistic regression of housing problems with recovery stage stratified by gender

	Housing problems OR (95% CI)	
	Women	Men
Recovery Stage		
Early	1	1
Sustained	1.69 (0.31-9.29)	0.15 (0.05-0.44)***
Stable	0.13 (0.01-1.72)	0.13 (0.04-0.48)**
Age	0.99 (0.92-1.06)	0.95 (0.90-1.00)*
Education		
Lower	1	1
Higher	0.18 (0.04-0.77)*	1.38 (0.52-3.65)
Before recovery: Housing		
No stable housing	1	1
Stable housing	1.36 (0.38-4.94)	2.69 (1.09-6.65
Country		
UK	1	1
Netherlands	0.14 (0.02-0.79)*	0.24 (0.07-0.86)*
Belgium	0.34 (0.06-1.88)	0.31 (0.10-0.97)*

* $p < 0.05$
** $p < 0.01$
*** $p < 0.001$

The interaction between gender and recovery stage was analysed for each dependent variable in Table 4 and was only found significant for housing problems ($p = 0.019$). Men had lower odds of having housing problems in sustained (OR=0.15; 95% CI: 0.05-0.44) and stable recovery (OR=0.13; 95% CI: 0.04-0.48) compared to those in early recovery. For women, no relation between housing problems and recovery stage was found (see Supplement Table for gender comparisons on each outcome measure).

Discussion

The findings from this convenience sample of 722 persons in drug addiction recovery in the UK, the Netherlands and Belgium, are in line with earlier findings about the gradual, progressive character of recovery and its relation to different life domains (D. Best, 2015; D. Best et al., 2015; Laudet, 2013; Mcquaid et al., 2017). Overall, the findings reveal that people with more time in recovery are less likely to have housing problems, be involved in crime or the criminal justice system or to use illicit drugs, while it is more likely that they have work or attend education compared to participants in earlier stages of recovery. These findings were consistent across the three countries, despite marked differences in the recruited recovery populations.

Although we did not examine changes over time within individuals prospectively, this study suggests that several life domains improve over time while in recovery, which may indicate that quitting or reducing problematic substance use facilitates improvements on these domains. Vice versa, it can also mean that certain living conditions help individuals sustain addiction recovery. The latter interpretation is in line with theories of desistance from crime that claim that a range of life events and interpersonal transitions trigger the growth of recovery capital (D. Best & Colman, 2019; D. Best

& Laudet, 2010; Sampson & Laub, 2003). Having stable housing, a job or engaging in education and not engaging in crime and illicit drug use can create alternative life roles that help to sustain recovery. However, more research is needed to understand the direction of these relations and how change over time is sustained or altered by shifts in these life domains.

The findings show that the odds of having better living conditions are higher among those in sustained recovery than among those in early recovery, and higher for those in stable recovery than those in sustained recovery. Differences between recovery stages remain visible in later stages, indicating that support needs might change over time. This underlines the widening recognition that addiction recovery is a process that continues to unfold long after initiation (Dennis, Scott, & Laudet, 2014; Flynn, Joe, Broome, Simpson, & Brown, 2003; Laudet & White, 2010, 2008). Moreover, it raises the question whether long-term recovery check-ups can be beneficial (Scott, Dennis, et al., 2005). A recent study conducted in four Forensic Psychiatric Hospitals in the Netherlands (Schaftenaar et al., 2018) found that patients who were provided the opportunity of voluntary contact (up to two years) after treatment recidivated later and at a lower rate than patients from two control groups. Given the parallels between recovery and desistance processes (D. Best & Colman, 2019; D. Best & Savic, 2015; Colman & Vander Laenen, 2017), a similar effect can be expected in addiction treatment. This justifies further exploration of long-term monitoring and continuing care for individuals in addiction recovery to identify shifting support needs and reduce relapse rates (Vanderplasschen et al., 2019).

Longer time in recovery was associated with lower odds of using illicit drugs. While this finding may not be surprising in itself, it is important to consider this finding within the context of the broader addiction recovery paradigm in which substance use is only one of many recovery markers (D. Best, 2015; D. Best et al., 2015; Laudet, 2013; Mcquaid et al., 2017). Qualitative research on people in addiction recovery showed how life priorities develop and change over time (Laudet & White, 2010), because other life domains, such as work, relationships or health, become more important than using substances. Alternatively, reducing substance use may help to improve these life domains. Given the complex character of addiction and recovery, the relationship between substance use and improving life domains is likely to be dynamic and multidirectional (Dom, 2017). Interestingly, a relation with time in recovery was not found for current alcohol and cannabis use. These substances are generally more socially accepted and regulated (alcohol) or decriminalized (cannabis) and form less of a barrier to sustaining recovery than other illicit substances. However, these results might be different when focusing on persons in alcohol addiction recovery. The findings further suggest that recovery may not require total abstinence from all substances for everyone. It underlines the notion that recovery is about more than (quitting) substance use and that people who continue to use substances can experience recovery with improvements across multiple life domains. This is in line with a recent study (Witkiewitz et al., 2018) on individuals in recovery from alcohol use disorders that found that individuals who engage in drinking following treatment may function as well as those who are abstinent. This suggests that broader inclusion criteria (apart from abstinence) should be considered in future research and treatment, as we did in this study, and further emphasizes the importance of personally driven and contextually determined definitions of addiction recovery. Abstinence is not sufficient as a single benchmark to determine success.

The relationship between time in recovery and having housing problems was not found for women. We know, however, that housing problems are more prevalent among men (Armoedebestrijding, 2017; de Vet et al., 2019; Homeless Link, 2015; Straaten et al., 2016), so there is a greater scope for improvement for men. Furthermore, in the social housing sector at least, women with children are given housing priority (Malos & Hague, 1997). This suggests that housing support may need to be different for women and men and indicates that recovery pathways can be different for men and women. Notably, no other gender differences were found, as opposed to earlier studies that used the LiR (D. Best et al., 2015; McQuaid & Dell, 2018). It is plausible, however, that gender differences do exist regarding indicators that we did not analyse in this study and that there may be gender commonalities in stages of recovery for some key markers.

Strengths & Limitations

The main strength of this paper is the exploration of three stages of recovery which have been suggested in previous research, but did not yet have an empirical basis. A limitation of the study is the use of a convenience sample with several country differences, albeit based on the same recruitment methods. Part of these differences may be explained by the fact that addiction and addiction recovery populations differ from country to country. In the Netherlands and the UK, where recovery-oriented drug policies have been implemented for a while, more established recovery networks exist, while in Belgium a large part was recruited through treatment networks, given the more recent recovery shift. This explains the younger age, greater number of people in early recovery, and unequal gender distribution in Belgium: it resembles the population in treatment (Antoine, 2017). This may have led to differences in recruitment. We were able to control for these differences by adding country of residence, age, and gender as covariates to the analyses and we found consistent results when analysing separate country models; although not always significant, which may be related to lack of statistical power. We are not able to assess the generalizability of our findings to the entire Dutch, UK and Belgian recovery population, since empirical knowledge on this population is not available. Nonetheless, our findings are consistent with studies that examined long-term recovery in relation to various life domains (D. Best et al., 2015; Laudet, 2013; Laudet & White, 2010, 2008; Mcquaid et al., 2017).

The subjective definition of addiction recovery can be seen as both a weakness and a strength of this study. A weakness, because it makes it difficult to operationalize addiction recovery and not everyone with a history of substance addiction will identify with the term 'recovery' (Doukas & Cullen, 2009). However, we used multiple phrasings and explanations of 'recovery' in recruitment messages. Moreover, we think this subjective definition is a strength rather than a limitation. *Time in recovery* is often defined as 'time since most recent use of any illicit substance' (Laudet & White, 2010, 2008). However, focusing on abstinence fails to do justice to the concept of recovery as developed in the field of addiction (Davidson & White, 2007; Laudet & White, 2010; van der Stel, 2013; W. L. White, 2007). We argue that, if addiction recovery is regarded as a personal process, it is better to not predefine it in one-dimensional inclusion criteria. This is illustrated by the positive results in a range of life domains in spite of continuing substance use among some study participants.

While our findings show that housing problems, crime and occupational situation are associated with more time in recovery, we were not able to assess changes on the individual level with our cross-sectional survey. We do not know when changes in these life domains happened and if they contributed causally to recovery stability. However, we did control for the prevalence of these issues *before* initiating recovery by including these variables as covariates and found significant differences *between* recovery stages.

Additionally, the timeframe of 30 days for outcome measures does not provide information on the stability of outcomes over longer periods of time. Furthermore, the substance use measure does not provide information on the quantity and circumstances under which substances were used, while these factors are risks for the development and continuation of addiction (Dom & van den Brink, 2016). Another limitation is that we did not define 'housing problems' in the survey, which may have been interpreted differently by respondents.

Finally, this study emphasizes the importance of individual functioning and 'normalized' living conditions (Hopper, 2007; Price-Robertson et al., 2017). Thus, it provides a decontextualized picture of addiction recovery and does not address social and structural factors that may play an important role in recovery processes (Price-Robertson et al., 2017; Vandekinderen et al., 2014). To complement the current study, qualitative research is needed to understand individual addiction recovery processes in a broader context.

Conclusion

Persons with longer time in drug addiction recovery are less likely to have housing problems, be involved in crime, use illicit hard drugs and more likely to have work or education. The current study underlines and extends the growing body of knowledge on addiction recovery (D. Best, 2015; D. Best, Savic, et al., 2018; Betty Ford Institute, 2007; Kaskutas et al., 2014; John Francis Kelly & Hoeppner, 2015; Laudet, 2013; Laudet & White, 2010, 2008; Mcquaid et al., 2017; W. L. White, 2007), by looking at typical life domains associated with long-term recovery and by focusing explicitly on (illicit) drug addiction recovery. Although we did not assess change over time in another way than through retrospective self-report, the results from this study provide a first empirical basis for defining addiction recovery as a gradual and long-term process that includes distinct stages and is related to multiple life domains. In line with the broad definition of addiction recovery, our findings imply that drug policy, treatment, and research need to be reoriented towards longer-term objectives. Moreover, they highlight the importance of looking at shifting support needs over time. For future research, it is important to acknowledge that no single outcome category can define addiction recovery (success), such as abstinence. Finally, we emphasize the value and importance of studying individuals in (various stages of) recovery, in addition to the often-studied population of individuals in active addiction or treatment.

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3. Are members of mutual aid groups better equipped for addiction recovery?

European cross-sectional study into recovery capital, social networks, and commitment to sobriety

Martinelli, T. F., van de Mheen, D., Best, D., Vanderplasschen, W., & Nagelhout, G. E. (2020). Are members of mutual aid groups better equipped for addiction recovery? European cross-sectional study into recovery capital, social networks, and commitment to sobriety. *Drugs: Education, Prevention and Policy*, 1–10. https://doi.org/10.1080/09687637.2020.1844638

ABSTRACT

An increasing body of evidence shows that informal mutual aid groups benefit those in addiction recovery. However, attention for mutual aid groups in practice and policy varies internationally and is only recently emerging in continental Europe. Existing evidence is mostly limited to studies of Alcoholics Anonymous groups in the United States. The aim of this cross-sectional study is to examine the relationship between membership of a variety of mutual aid groups and recovery capital, participation in social networks, and commitment to sobriety for individuals in drug addiction recovery (N ¼ 367), living in the UK, the Netherlands, and Belgium. A convenience sample of participants completed an extensive assessment about their recovery experiences. Sixty-nine percent of participants reported lifetime (ever) membership of different mutual aid groups. Analyses reveal that membership of mutual aid groups is strongly associated with more participation and (self-reported) changes in social networks, greater levels of recovery capital, and a stronger commitment to sobriety. The findings suggest that participation in mutual aid groups may support addiction recovery through multiple mechanisms of change in favor of recovery. These findings highlight how mutual aid support may complement formal addiction treatment.

Introduction

Even though drug addiction is often conceptualized as a chronic relapsing disorder (McLellan, Lewis, O'Brien, & Kleber, 2000), many people experience recovery. Reviews estimate that more than half of individuals with a lifetime alcohol or drug dependence will achieve stable recovery (Sheedy & Whitter 2009; White 2012). Many studies included in these reviews focus on abstinence as a (single) success indicator for recovery. However, in recent years, a more holistic concept of addiction recovery has emerged that integrates elements from the mental health field (Davidson & White, 2007; Kaskutas et al., 2014). Established recovery markers include personal, social and clinical outcomes (Best, Savic, et al., 2018; Dennis, Scott, & Laudet, 2014; Laudet & White, 2010; van der Stel, 2014). As such, addiction recovery is characterized as a long-term developmental pathway with transitions and stages, including early (<1 year), sustained (1-5 years), and stable (>5 years) recovery (Betty Ford Institute, 2007; Martinelli, Nagelhout, et al., 2020). Consequently, it is argued that the study of entire pathways of recovery, including multiple interventions, treatment and support services, is at least equally important as studying specific interventions (Hser et al., 1997; John F. Kelly et al., 2017).

These recovery pathways are partially shaped by various addiction treatment and support systems, including support by experienced peers, referred to as *mutual aid* (White, 2004). Mutual aid groups, also known as self-help groups, are based on *mutual aid* principles, defined as a "process of giving and receiving non-professional, non-clinical assistance to achieve long-term recovery from alcohol and/or other drug-related problems" (White, 2009, p2). Persons in early recovery can benefit particularly from personal guidance by someone with a similar *lived* experience (W. L. White, 1996). These 'guides' have developed sensitivities and skills important to support a shift from a culture of addiction towards one supportive of recovery. The idea that lived experiences can be helpful to provide insights into the mechanisms and commitment to drive change is not limited to the addiction field. The mental health field has a long history of this being practiced (Mead & MacNeil, 2006; O'Connell et al., 2020) and recently this idea has also emerged in the context of desistance from crime (D. Best et al., 2019; Lenkens et al., 2019; Seppings, 2015).

Recognition of the benefits of attending mutual aid groups is well established and evidence is expanding (Best, Manning, Allsop, & Lubman, 2020; Costello et al., 2019; Humphreys, 2004; Kaskutas, 2009; Kelly, Humphreys, & Ferri, 2020). Moreover, it is becoming clearer *how* mutual aid groups can be beneficial for recovery. In a review, Moos (2008) identified the 'active ingredients' that underlie mutual aid groups, namely: social bonding, norms and role models, and building self-efficacy and coping skills. Similarly, in recent landmark publications on the benefits of *Alcoholics Anonymous* (AA), effectiveness of AA on establishing abstinence and mechanisms of behavior change in AA are revealed: increasing social networks, boosting self-efficacy and coping skills, and supporting motivation over time (John F. Kelly, 2017; John F. Kelly et al., 2020). These findings suggest that it is not just the treatment philosophy of mutual aid groups (e.g. Twelve Steps) that facilitates recovery, but also highlight the importance of mutual aid principles (e.g. experienced peers helping others) and being a member of social groups. Experiencing membership of a social group can provide people with important social connections and positive identities. This is in line with many studies that focus on the importance of social support in recovery pathways (D. Best et al., 2012; Dobkin et al., 2002; Kaskutas et al., 2002; Litt et al., 2009; Longabaugh et al., 2010; Pagano et al., 2004).

In Europe, there is a variety of addiction-related mutual aid organizations which vary markedly in their histories, structures, philosophies, procedures and membership (Humphreys, 2004). A limitation of most existing studies is that they are particularly focused on alcohol-related Twelve Step groups (AA) in the United States. Other Twelve Step groups (e.g. *Narcotics Anonymous:* NA) and alternative mutual aid groups (e.g. SMART recovery or other [local] types of recovery groups) have received far less public, professional and scientific attention and scrutiny (Dekkers, Vos, et al., 2020; W. L. White et al., 2020; Zemore et al., 2017). For example, no clinical trial has yet compared

addiction treatment with and without NA involvement, despite most NA-studies involving treatment populations (White et al., 2020). As a result, it is unclear whether the findings described above apply to mutual aid groups and mutual aid principles in general, or just to AA, and whether these findings hold across different international contexts. Furthermore, while Twelve Step groups are more common they are not appealing to everyone (Zemore et al., 2017). Thus, examining alternative groups is equally important.

In the current study, we focused on recovery capital, participation in social networks and commitment to sobriety as outcomes. Recovery capital, defined as a set of internal and external resources that help persons recover, was included because the accumulation of recovery capital is thought to influence resiliency and coping skills and can help to mitigate the biobehavioral stress associated with addiction (Cloud & Granfield, 2008; Granfield & Cloud, 1999; Laudet & White, 2008; Vilsaint et al., 2017). Consequently, recovery capital can boost recovery coping skills and self-efficacy, which was found to be linked to mutual aid group participation (John F. Kelly, 2017; Moos, 2008). Moreover, assessment of recovery capital can be an important marker for recovery, as the concept focuses on measuring strength-based indicators, as opposed to the traditional deficit-based forms of assessment of pathology and harm (D. Best, Vanderplasschen, et al., 2020; Groshkova et al., 2013; A.Thomas McLellan et al., 1992; Vilsaint et al., 2017). Furthermore, participation and changes in social networks were studied, as this was also found to be one of the underlying mechanisms of benefits from mutual aid groups (John F. Kelly, 2017; Moos, 2008). Lastly, *commitment* to sobriety was analyzed, as this is found to be a good predictor of future behavior (John F. Kelly & Greene, 2014). Being "committed to change" denotes that recovery is a top priority and implies a strong desire (John F. Kelly & Greene, 2014). Furthermore, in this context, 'sobriety' is broader than abstinence and more consistent with the concept of recovery as described above (Helm, 2019).

To examine these outcomes, we analyzed the extent to which support from group-based mutual aid shapes recovery pathways of persons in drug addiction recovery. We specifically examined associations with *mechanisms of behavior change for recovery* that are linked to mutual aid in studies focusing on alcohol addiction: recovery capital, social networks and commitment to recovery (Best et al., 2016; Kelly, 2017; Moos, 2008). We hypothesized that, for persons in drug addiction recovery, membership (present or in the past) of mutual aid groups is associated with more participation in social networks, more commitment to recovery, and more recovery capital. Because there is relatively little information about members of mutual aid groups in Europe, we performed several additional analyses on treatment and support utilization, current group membership and differences between members of Twelve Step groups versus other groups. Accordingly, we aim to answer the following research questions (RQs):

1. [RQ1] Which types and combinations of treatment and support are used by people in drug addiction recovery?
2. [RQ2] Is lifetime (ever) membership of mutual aid groups associated with greater recovery capital, more participation in social networks, and more commitment to sobriety in persons with a history of illicit drug addiction?
3. [RQ3] Is current membership of mutual aid groups more positively associated with recovery capital, social networks, and commitment to sobriety compared to lifetime, but non-current, membership?
4. [RQ4] Are the associations, between mutual aid group membership and recovery capital, social networks, and commitment to sobriety, different among lifetime members of Twelve Step groups compared to lifetime members of non-Twelve Step groups?

Method

Sample and design

The data collection method used in this study is the baseline assessment of the REC-PATH (Recovery Pathways) study. A detailed description of the project can be found in the protocol paper (D. Best, Vanderplasschen, et al., 2018a). Briefly, REC-PATH is a prospective multi-country cohort study designed to map pathways to drug addiction recovery in the United Kingdom (UK), Netherlands, and Belgium (Flanders).

Initial recruitment took place between January and June 2018 using the brief Life in Recovery (LiR) survey in the UK (N=311), Netherlands (N=230), and Belgium (Flanders, N=181) (Martinelli, Nagelhout, et al., 2020). We used social media, newsletters, conferences, alcohol and drug magazines, printed flyers and posters, and contacted prevention and treatment organizations to disseminate the call for participants. 'Anyone in recovery for at least three months or who has stopped or reduced problematic drug use for at least three months' was eligible to participate and invited to visit the project website. On the project website (https://www.rec-path.co.uk/), potential participants could access information about the study and give informed consent to access the survey. Some respondents (e.g. without access to internet) received printed information, consent, and survey forms. Among this convenience sample, persons that left contact details and who agreed to further participation, were contacted and completed an extensive assessment between March and October of 2018 in the UK (N=118), Netherlands (N=136), and Belgium (N=113). The inclusion criteria were that participants identified themselves as being in recovery for at least three months and were 18 years or older. The data were collected online (n=210), by telephone (n=90) or face-to-face (n=67), depending on the participant's preference. Participants received a compensation of ten EUR or GBP for completing the extensive assessment. The study protocol and measures were standardized across the three countries. The assessment was analyzed cross-sectionally for this paper. Ethics approval was provided by the METC Erasmus MC (Netherlands); SHU Ethics Committee (UK); Ghent University Ethics Committee (Belgium).

Variables

Sample characteristics

The following descriptive items were included to provide more details on the study sample: "What is your employment status?" [in paid employment/in sheltered employment/training or education is main occupation/unemployed/retired/other], "Do you experience any chronic mental health problems?" [yes/no], "At what age did you first realize you had a problem with substance use?" [age]. We also asked if participants had "ever attended" a mutual group [yes/no], which is different from the independent variable described above, as attendance does not imply involvement while membership does. To measure days of use and abstinence from illicit drugs and alcohol, participants were asked to fill in: "Days used in the last 30 days" [Alcohol, Heroin, Cocaine, etc.]. The response categories of 'heroin', 'cocaine', 'crack', 'amphetamines', 'ecstasy/MDMA', 'cannabis', and 'other illicit substance' were combined as 'illicit drugs'. If a participant used zero days of the last 30, they were scored as abstinent.

Independent variable

Lifetime mutual aid group membership was measured by combining response categories from the item "Have you ever considered yourself a member of". *Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Other 12-step group, Non 12-step self-help group, SMART recovery group* were the response categories. If 'yes' was answered to any of these response categories, it was scored as 'yes' in the dichotomous variable 'Member of mutual aid group'. To describe different combinations of treatment and support, participants were asked "Have you ever attended?" followed by "Specialist Community (out-patient) treatment, or counseling (including medication reduction or maintenance treatment and low threshold services)" and "Residential rehabilitation or rehab (including residential detoxification and therapeutic communities)". If no treatment or mutual aid group membership was

reported, this was scored as 'natural recovery' (Blomqvist, 1996). Furthermore, *current* membership was assessed by asking "Are you currently attending? [AA/NA/Other 12-step groups/Non 12-step groups/SMART]?"

Dependent variables

Social networks were measured through the Exeter Identity Transition Scales (EXITS) (C. Haslam et al., 2008), which are divided in three subscales: (1) current membership of different (social) groups (α=0.918), (2) maintaining different groups after initiating recovery (α=0.875) and (3) joining new groups since recovery initiation (α=0.945). Each subscale had four items which could be scored from one to seven: 'strongly disagree' to 'strongly agree'. For example: "I belong to lots of different groups" and "After starting my recovery journey, I have joined one or more new groups".

Recovery Capital was measured through the Brief Assessment of Recovery Capital (BARC-10) (Vilsaint et al., 2017) and consisted of ten items (α=0.838) with a six point Likert-scale: strongly disagree (1) to strongly agree (6). For example, "I get lots of support from friends" and "I regard my life as challenging and fulfilling without the need for using drugs or alcohol".

Commitment to recovery was measured through the Commitment to Sobriety Scale (John F. Kelly & Greene, 2014) and consisted of five items (α=0.762) with a six point Likert-scale: strongly disagree (1) to strongly agree (6). For example: "I am totally committed to staying free from problematic use" and "I will do whatever it takes to recover from my addiction".

Covariates

Gender, age, country of residence and education level were also measured through self-report. Education level had four categories: (1) "Never went to school / never completed primary school", (2) "Primary level of education", (3) "Secondary level of education" and (4) "Higher education". The first two response categories were combined as "none/primary level of education" because of the low numbers in the first category.

Recovery stage was measured by asking respondents "How long do you consider yourself to be in recovery?" There were three response categories: "less than one year" [early], "one to five years" [sustained] and "more than five years" [stable].

Analyses

Survey data were processed and analyzed using SPSS 25. We assessed internal consistency (Cronbach's alpha) of each outcome (sub)scale through reliability analyses. Chi square tests, Independent sample T-tests and Spearman's rho tests were performed to test differences in sample characteristics (sociodemographic and descriptive variables) between lifetime members of mutual aid groups and non-members of mutual aid groups. Frequency analyses were performed to show which combinations of treatment and support were used by participants (RQ1). Two-tailed independent T-tests were performed to determine differences on each dependent variable (social networks, recovery capital and commitment to sobriety) between lifetime members and non-members (RQ2) and between current members and (lifetime but) non-current members of mutual aid groups (RQ3). Multivariate regressions were performed to estimate associations between mutual aid group membership (independent variable) and social networks, recovery capital and commitment to sobriety (dependent variables), adjusted for the covariates mentioned above (RQ2). To explore differences on the dependent variables, we performed separate two-tailed independent T-tests between lifetime members of Twelve Step groups, non-Twelve Step groups, and lifetime members of both groups (RQ4).

Results

Of the total sample, 69% reported lifetime membership of mutual aid groups. Table 1 reports the sample characteristics of the total sample split by mutual aid membership. The proportion of men (65%) and women (35%) did not differ significantly between both subsamples. Non-members of mutual aid groups were on average younger than lifetime members, with a mean age of 38 and 43 years, respectively. Of the lifetime members, a larger proportion was from the UK (40%) and the Netherlands (43%), compared to 17% from Belgium. Education levels of participants also differed between subsamples. Lifetime members reported higher levels of education compared to non-members. No significant differences between both groups were found for reported mental health problems and mean 'age when participants first realized they had a problem with substance use' (Table 1). Paid employment (64% vs 45%) and current abstinence from drugs (94% vs 75%) and alcohol (81% vs 52%) were all reported more often by lifetime mutual aid members. The average number of days on which alcohol (1.6 vs 5.6) and illicit drugs (0.8 vs 3) were used in the past 30 days was lower for lifetime members of mutual aid groups compared to non-members.

Table 1. Sample Description split by lifetime membership of mutual aid groups

	Lifetime members of mutual aid Groups N=253 (68.9%)	Non-members of mutual aid groups N=114 (31.1%)	Differences [A, B, C]
Gender, %women	34.8	35.3	$P = 0.921^{A}$
Age *Mean in years (SD)*	*42.9 (10.7)*	*38.46 (10.4)*	$P < 0.001^{B}$
Country, %			$P < 0.001^{A}$
UK	39.7	15.7	
Netherlands	43.4	23.5	
Belgium	17.1	43.3	
Education level, %			$P < 0.001^{C}$
None/primary	4.8	17.4	
Secondary	39.7	48.8	
Higher	55.6	34.8	
Recovery Stage, %			$P = 0.002^{C}$
< 1 year	11.9	24.3	
1-5 years	39.3	40.9	
> 5 years	48.8	34.8	
Chronic mental health problems, % yes	34.7	42.6	$P = 0.144^{A}$
In paid employment, %	63.5	45.2	$P = 0.001^{A}$
Abstinent from illicit drugs, %	94	74.8	$P < 0.001^{A}$
Days used illicit drugs in past 30 days, *Mean (SD)*	*0.83 (4.32)*	*2.96 (7.52)*	$P < 0.001^{B}$
Abstinent from alcohol, %	80.6	52.2	$P < 0.001^{A}$
Days used alcohol in past 30 days, *Mean (SD)*	*1.64 (4.86)*	*5.48 (8.53)*	$P < 0.001^{B}$
At what age did you first realize you had a problem with substance use? *Mean*	*25.2*	*23.8*	$P = 0.129^{B}$
Have you ever *attended* a mutual aid group? (yes)	100	31.6	$P < 0.001^{A}$
Have mutual aid groups played a role in enabling your recovery? (yes)	95.3	10.5	$P < 0.001^{A}$
Are you currently attending a mutual aid group? (yes)	71.9	4.4	$P < 0.001^{A}$

[A] Chi2 test
[B] Independent sample T-test
[C] Spearman's rho

Types and combinations of treatment and support (RQ1)

Table 2 shows the combinations of treatment and support, or recovery pathways, that were used by participants. Most participants reported having utilized multiple forms of treatment and support. About 41% of participants reported lifetime membership of mutual aid groups in combination with attendance of residential and outpatient treatment. The combination of mutual aid group membership and residential treatment was reported by 14%. Mutual aid group membership combined with outpatient treatment was reported by 9% of participants. About 5% of participants had solely been a member of mutual aid groups. The same proportion of participants had solely attended outpatient treatment (5%) or solely attended residential treatment (5%) and 5% reported not having used any treatment or support (natural recovery). The proportion of participants that had used outpatient and residential treatment was 16%.

Table 2. Recovery pathways: combinations of treatment and support ever used (N=367)

	N (%)
Natural recovery[A]	17 (4.6)
Only Member of Mutual Aid group	20 (5.4)
Only Patient of outpatient treatment	18 (4.9)
Only Attended residential treatment	21 (5.7)
Mutual Aid + Outpatient	33 (9.0)
Mutual Aid + Residential	50 (13.6)
Outpatient + Residential	58 (15.8)
Member/Patient/Attended all three types of treatment and support	150 (40.9)

[A] Never used any treatment or support

Mutual aid group membership and recovery capital, social networks, and commitment to sobriety (RQ2)

Table 3 shows mean scores of the social group membership (EXITS), recovery capital (BARC) and Commitment to Sobriety (sub)scales and differences between lifetime members of mutual aid groups versus non-members. On each (sub)scale, lifetime members scored significantly ($p<0.001$) higher than non-members. The only exception is the 'EXITS Maintaining Social Groups' subscale which showed no significant difference ($p=0.177$) between both groups.

In Table 4, multiple regression analyses are reported showing the relation between mutual aid group membership and the outcome (sub)scales. For these analyses, age, gender, recovery stage, country and education level were included in the model as covariates. All (sub)scales, except for 'maintaining social groups' ($\beta=0.057$, 95% CI=-0.058, 0.172, $P=0.330$) were significantly ($P \leq 0.01$) associated with the independent variable: lifetime membership of mutual aid groups.

Table 3. Differences in Social group membership, Recovery Capital and Commitment to sobriety by mutual Aid group membership

(Sub)Scale	Lifetime Member of Mutual Aid (N=253)	Non-Member of Mutual Aid (N=115)	Differences between lifetime vs non-members T-test (2-tailed)[1]	Current Members (N=182)	Lifetime but non-current members (N=71)	Differences between current vs non-current members among lifetime members T-test (2-tailed) [1]
EXITS: Member of different groups (α=0.918), Mean (SD)	4.44 (1.72)	3.73 (1.82)	3.61 p <0.001	4.54 (1.62)	4.18 (1.93)	1.51 p = 0.132
EXITS: Maintaining social groups (α=0.875), Mean (SD)	2.58 (1.62)	2.33 (1.46)	1.41 p =0.159	2.57 (1.59)	2.63 (1.72)	-0.31 p =0.761
EXITS: Joining new groups (α=0.945), Mean (SD)	5.60 (1.60)	4.38 (1.89)	6.42 p <0.001	5.80 (1.32)	5.08 (1.32)	3.30 p =0.001
Recovery Capital (BARC-10) (α=0.838), Mean (SD)	5.23 (0.63)	4.77 (0.77)	6.11 p <0.001	5.26 (0.58)	5.15 (0.74)	1.29 p =0.197
Commitment to Sobriety (α=0.762), Mean (SD)	5.58 (0.59)	5.11 (0.87)	6.10 p <0.001	5.68 (0.48)	5.33 (0.74)	4.492 p <0.001

α = Cronbach's Alpha
[1] = T-value

Table 4: Multiple linear regression analyses of the relationship between social group membership, recovery capital and commitment to sobriety and lifetime membership of a mutual aid group

Independent Variables:		**Social group membership, β (95% CI)** Member of different groups	Maintaining social groups	Joining new groups	**Recovery Capital, β (95% CI)**	**Commitment to sobriety, β (95% CI)**
Lifetime membership of mutual aid groups		0.188*** (0.074, 0.301)	0.055 (-0.061, 0.171)	0.292*** (0.183, 0.402)	0.211*** (0.105, 0.319)	0.288*** (0.177, 0.394)
Age		0.008 (-0.110, 0.125)	0.056 (-0.064, 0.177)	-0.085 (-0.198, 0.029)	0.044 (-0.068, 0.155)	0.156** (0.043, 0.267)
Gender,	Men	Ref	Ref	Ref	Ref	Ref
	Women	0.070 (-0.034, 0.174)	-0.122* (-0.228, -0.016)	0.056 (-0.044, 0.156)	-0.021 (-0.119, 0.077)	0.041 (-0.058, 0.140)
Recovery Stage,	Early	Ref	Ref	Ref	Ref	Ref
	Sustained	0.104 (-0.048, 0.256)	0.008 (-0.148, 0.163)	0.089 (-0.057, 0.236	0.230** (0.086, 0.373	0.104 (-0.043, 0.248)
	Stable	0.145 (0.023, 0.313)	-0.084 (-0.257, 0.088)	0.148 (-0.014, 0.311)	0.266*** (0.107, 0.425)	0.039 (-0.122, 0.200)
Country,	UK	Ref	Ref	Ref	Ref	Ref
	Netherlands	0.142* (0.017, 0.267)	-0.017 (-0.145, 0.110)	0.122* (0.002, 0.243)	-0.143* (-0.262, -0.026)	-0.058 (-0.177, 0.062)
	Belgium	0.163* (0.019, 0.306)	-0.038 (-0.185, 0.109)	0.080 (-0.059, 0.218)	-0.175** (-0.310, -0.039)	-0.043 (-0.180, 0.094)
Education,	Low	Ref	Ref	Ref	Ref	Ref
	Secondary	0.143 (-0.049, 0.336)	-0.070 (-0.267, 0.127)	0.132 (-0.053, 0.318)	0.103 (-0.078, 0.285)	0.018 (-0.166, 0.202)
	Higher	0.154 (-0.051, 0.359)	0.010 (-0.200, 0.220)	0.226* (0.029-0.425)	0.055 (-0.139, 0.249)	-0.124 (-0.319, 0.073)

* P < 0.05
** P < 0.01
*** P < 0.001
Ref = Reference category
β = Standardized Beta coefficient
CI = Confidence interval

Differences between current and lifetime members (RQ3)

Table 3 also shows the scores of current members of mutual aid groups and reports on the differences between current versus non-current (but lifetime) members. Current members consistently score higher on each (sub)scale, except on the 'EXITS Maintaining Social Groups' subscale. The difference between current and non-current members is significant (p<0.001) for the 'EXITS Joining New Groups' subscale and the Commitment to Sobriety Scale.

Differences between Twelve Step and non-Twelve Step group members (RQ4)

Table 5 shows the (sub)scale scores of participants that reported lifetime membership of either Twelve Step or non-Twelve Step groups and lifetime members of both groups. For Twelve Step group members and members of both Twelve Step and non-Twelve Step groups, the mean score is significantly higher for all subscales compared to non-members, except for 'EXITS Maintaining Social Groups', consistent with the main analyses. For non-Twelve Step group members, only the 'EXITS joining new groups' subscale and BARC-10 was significantly higher compared to non-members. Furthermore, Twelve Step members had significantly higher mean scores on the 'Commitment to Sobriety' scale compared to non-Twelve Step members. Members of both groups scored significantly higher on the 'Commitment to Sobriety' scale compared to non-Twelve Step members. No other significant differences were found.

Table 5: Explorative analysis of Social group membership, recovery capital and commitment to sobriety among members of Twelve Step groups and members of Non-Twelve Step groups

(Sub)Scale	Lifetime members of only Twelve Step group(s) (n=148)	Lifetime members of only non-Twelve Step group(s) (n=47)	Lifetime members of both group(s) (n=58)
EXITS: Member of different groups (α=0.918), Mean (SD)	4.38 (1.63)	4.29 (1.94)	4.71 (1.74)
EXITS: Maintaining social groups (α=0.875), Mean (SD)	2.64 (1.71)	2.37 (1.28)	2.63 (1.64)
EXITS: Joining new groups (α=0.945), Mean (SD)	5.64 (1.49)	5.22 (1.89)	5.82 (1.61)
Recovery Capital (BARC-10) (α=0.838), Mean (SD)	5.28 (0.59)	5.04 (0.75)	5.26 (0.61)
Commitment to Sobriety (α=0.762), Mean (SD)	5.65 (0.54)	5.27 (0.77)	5.68 (0.43)

α = Cronbach's Alpha

Discussion

Previous studies on alcohol-related mutual aid groups demonstrated that the underlying mechanisms of change in mutual aid groups are found in changing social networks (from user networks to recovery networks), increasing recovery capital and maintaining commitment to recovery (Best et al., 2016; Kelly, 2017; Laudet & White, 2008; Moos, 2008). The current study examined whether these key domains are also associated with membership of mutual aid groups for people in (illicit) drug addiction recovery in a European context. Our findings show that lifetime members of mutual aid groups report greater levels of recovery capital, more participation and changes in social networks, and a stronger commitment to sobriety compared to non-members. This suggests that lifetime mutual aid group members may be better equipped to sustain addiction recovery. While recovery pathways for participants also involved other forms of treatment and recovery support, the robustness of the findings is strengthened by the finding that current members of mutual aid groups consistently report more recovery resources than lifetime (but non-current) members. Furthermore, our findings extend mutual aid research to a European context and suggest that positive recovery outcomes are not limited to Twelve Step groups and can be found in other mutual aid groups as well.

As hypothesized, membership of mutual aid groups was found to be associated with more participation and changes in social networks after initiating recovery. At first glance this finding seems unsurprising, because those who join a mutual aid group coincidentally join a new social network. However, this finding highlights that participants see mutual aid groups and the people in the groups as social contacts, which is a fundamentally different role than a treatment professional usually fulfills. We did not find a significant association for 'maintaining social groups' after initiating recovery. Both non-members and lifetime members scored low on this subscale, suggesting that many participants may have cut ties with social groups after initiating recovery. The changes in socials networks usually concern a change from negative social networks to positive networks (i.e. from a heavy user network to a network of peers in recovery) and are found crucial in facilitating

abstinence, self-efficacy, and other benefits for recovery (D. Best et al., 2016; John F. Kelly, 2017). Our findings suggest that, for non-members, negative networks have been dropped to an equal degree compared to lifetime members. However, new networks took their place to a lesser extent compared to lifetime members. This important characteristic of mutual aid groups is also emphasized in a recent scoping review, in which the authors conclude that mutual aid membership is beneficial because it extends support beyond structured treatment and allows access to recovery supportive environments (Parkman et al., 2015). This transition to recovery supportive social networks is also key to the recently outlined Social Identity Theory of Recovery (SIMOR: Best et al., 2016) and was found in prior studies on AA (Kelly, Stout, Magill, & Tonigan, 2010; Kelly, Magill, & Stout, 2009). In essence, mutual aid groups can complement formal treatment by acting as a conduit to community resources through extending recovery supportive social networks (Fiorentine & Hillhouse, 2000).

Our findings also show that lifetime members of mutual aid groups were more committed to sustaining recovery, compared to non-members. In his review, Kelly (2017) shows that AA participation helps to support recovery motivation over time. However, to consider yourself a member of a mutual aid group also requires commitment to attend meetings revolving around working on recovery. Thus, at least some motivation is already required. The relation between commitment to recovery and mutual aid group membership is therefore likely to be bi-directional.

Furthermore, we found that members of mutual aid groups reported more recovery capital and, thus, are better equipped to sustain recovery. Recovery capital captures growth of positive strengths and meaningful gains that help people advance in their recovery journeys and the BARC is considered a good indicator of that advancement (Best & Laudet, 2010; Laudet & White, 2008; Vilsaint et al., 2017). This finding may mean that persons with greater recovery capital are more likely to join mutual aid groups, because they possess a more resourceful network or are better able to find suitable support for their addiction problems, for example. It may also indicate that mutual aid group participation helps members to achieve long-term recovery by increasing recovery resources, such as coping skills and self-efficacy (White, 2009).

Currently, evidence for the effectiveness of mutual aid groups is primarily based on Twelve Step groups (i.e. AA and NA) that share a strict regime and recovery philosophy (Humphreys, 2004; Kaskutas, 2009; Kelly, 2017; Kelly et al., 2020; Parkman et al., 2015; White et al., 2020). Research on alternative mutual aid groups is still very sparse (Zemore et al., 2017). In our study we also encountered members of other non-Twelve Step groups, such as SMART or other (local) types of recovery groups, sometimes associated with formal treatment programs. Additionally, we performed separate analyses on subsamples with members from non-Twelve Step groups. While this analysis was exploratory in nature and had a limited number of participants in non-Twelve Step groups, our findings indicate consistent results across all lifetime members compared to non-members. For members of non-Twelve Step groups, slightly lower outcomes were found compared to Twelve Step group members and members of both Twelve Step and non-Twelve Step groups. These findings support the notion that, besides particular group philosophies, mutual aid group principles and the more generic model of peer support may also be effective (John F. Kelly, 2017; Moos, 2008). This suggests that, to some extent, AA research may be generalized to other mutual aid groups. Nevertheless, we also found differences between Twelve Step and alternative group members, such as the slightly lower outcomes for non-Twelve Step members, and more studies are needed to explore these differences.

In this paper, we examined lifetime membership of mutual aid groups as part of entire addiction recovery pathways, sometimes referred to as treatment careers (Hser et al., 1997). Traditionally, the study of addiction interventions is performed more directly, separated and with a short-term scope, in order to reduce external effects. This can be seen as a limitation of our study, since we cannot

assess to what extent the findings are attributable to membership of mutual aid groups, or to other treatment and support that was used in combination with mutual aid groups. However, to compensate for this, we also examined the difference between lifetime only and current group membership and found stronger associations in the latter subsample, suggesting that mutual aid group membership is to some extent associated with the outcomes. Moreover, we argue that the reality of addiction recovery is often much more complex and chaotic compared to the theoretical and rational paradigms from which it is often studied, in which one-dimensional inputs produce predictable outcomes. Our findings underline this notion as most participants used multiple treatment and support mechanisms. Increasingly, studies show that recovery is more like a build-up of gradually emerging trajectories instead of happening at some 'turning point' (Dekkers, De Ruysscher, & Vanderplasschen, 2019, 2020; Hser, 2007; Laudet & White, 2010, 2008; McLellan, Lewis, O'Brien, & Kleber, 2000; van der Stel, 2014; White, Boyle, & Loveland, 2002, 2003). Furthermore, recovery can be a long-term process with successive stages that can take up several years (Dennis et al., 2005, 2007; Martinelli, Nagelhout, et al., 2020). Therefore, long-term evaluation of recovery pathways, is at least equally important as studying the outcomes of single interventions (Hser et al., 1997), as this longitudinal framework allows us to better capture and reveal the long-term and cumulative effects of recovery experiences.

Implications

In Europe, many strategies have emerged in the last decade to address drug addiction, including the expansion of professionally delivered treatment (European Commission, 2012). In this context, the addiction recovery movement has suggested to integrate peer-based support services in the formal treatment system and community-based care, including mutual aid groups (GGZ Nederland, 2009, 2013; UK Drug Policy Commission, 2008; Van Deurzen, 2015). So far, limited attention and studies into efficacy of peer-based support services was realized (Ashford et al., 2019; Bassuk et al., 2016; Hayashi et al., 2010; Kerr et al., 2017; Reif et al., 2014). However, the expanding evidence on the benefits of mutual aid group participation should justify further exploration of its inclusion into system-wide practice of addiction services and to encourage services to refer to mutual aid groups, both Twelve Step and other groups. Furthermore, our findings are in line with studies of effectiveness of mutual aid groups on addiction recovery in the United States (John F. Kelly, 2017; John F. Kelly et al., 2020; Moos, 2008; W. L. White et al., 2020). Therefore, we argue that in Europe, a variety of mutual aid groups need to be facilitated and recommended to persons seeking to initiate or sustain addiction recovery.

Limitations

The cross-sectional design and voluntary nature of mutual aid groups make it difficult to study the true causal effects of mutual aid group participation. On the one hand, this may mean that people with more recovery capital, social networks and motivation are more likely to 'fit in' mutual aid groups, have better access to it, or are better equipped to find them. On the other hand, our findings may indicate that mutual aid groups help develop and sustain these resources. The latter explanation is in line with theories and emerging evidence around mutual aid (Costello et al., 2019; Humphreys, 2004; Kaskutas, 2009; Kelly et al., 2020; White, 2009).

In this study, participants self-defined the inclusion criteria of being in addiction recovery, which can be seen as both a weakness and strength of this study. A weakness, since it is difficult to operationalize the concept and there is some debate around the term 'recovery' (Doukas & Cullen, 2009). However, multiple phrasings and explanations of 'recovery' were presented in our recruitment messages. Moreover, the subjective definition is a strength rather than a limitation because defining recovery as 'abstinence of any illicit substance' (Laudet & White, 2010, 2008) fails to do justice to the holistic concept of recovery as developed in the field of addiction (Davidson & White, 2007; Laudet & White, 2010; van der Stel, 2013; W. L. White, 2007). If addiction recovery is

regarded as a personal process, it might be better to not predefine it in one-dimensional inclusion criteria.

A final limitation of this study is the use of a convenience sample. We are not able to assess the generalizability of these findings to UK, Dutch or Belgian (or any other country) recovery populations, including mutual aid group participants, primarily since no data are available on this population. We found a difference in mutual aid group membership between countries, albeit using similar recruitment methods: a significantly smaller proportion was Belgian. Part of this difference may be explained by differing addiction recovery populations or recovery networks in each country.

Conclusion

Previous research focusing on alcohol addiction recovery and Twelve Step groups demonstrated that the benefits of mutual aid groups work through social networks, recovery capital and commitment to recovery. In the current study, we recruited persons in drug addiction recovery in three European countries (the UK, Netherlands, and Belgium). About two third of the sample reported lifetime membership of a variety of mutual aid groups, including Twelve Step groups. We found that lifetime members of mutual aid groups had greater recovery capital, more and changed social networks, and higher commitment to sobriety, compared to non-members. Prior studies show that mutual aid groups help to develop and sustain these outcomes (John F. Kelly, 2017; Moos, 2008). Our study contributes to the literature on addiction recovery by expanding these findings to a population of persons in (illicit) drug addiction recovery, members of non-Twelve Step groups, and to a European context across multiple national sites. Given the cross-sectional study design and the convenience sample, further studies are needed to confirm our findings, which are theoretically consistent with prior research

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4. Factors associated with problematic substance use before and during the COVID-19 pandemic among a drug addiction recovery cohort

A prospective study in the Netherlands, Belgium, and UK

Martinelli, T. F., Nagelhout, G. E., Best, D., Vanderplasschen, W., & van de Mheen, D (submitted). Factors associated with problematic substance use before and during the COVID-19 pandemic among a drug addiction recovery cohort: A prospective study in the Netherlands, Belgium and UK.

ABSTRACT

The COVID-19 pandemic and measures have placed various burdens on societies and individuals. Emerging evidence suggests that people in drug addiction recovery were negatively affected. This study investigates whether risk and protective factors associated with return to problematic substance use differed between the periods before and during the pandemic for those in recovery. A convenience sample of persons in drug addiction recovery for at least three months, completed an assessment at baseline before the pandemic (T0, N=367) and at two consecutive follow-ups 12 months apart (T1, N=311; T2, N=246). The final follow-up took place during the pandemic (2020-2021). We analysed rates and predictors of problematic substance use in both periods, and whether relations between predictors and problematic use differed between the periods. Rates of problematic use did not differ significantly before and during the pandemic for those who were followed-up. However, the relationship between problematic use and commitment to sobriety differed between both periods (OR=3.24, *P*=0.010), as higher commitment was only associated with lower odds of problematic use during (OR=0.27, *P*<0.001), but not before the pandemic (OR=0.93, *P*=0.762). In both periods, persons who were engaged in psychosocial support had lower odds of problematic use. The COVID-19 pandemic may not have been followed by significant return to problematic substance use for people in recovery. However, with restricted access to environmental resources, they may have been more dependent on commitment from themselves. Targeting personal recovery resources with interventions could therefore reduce the chances of return to problematic substance use during a pandemic.

Introduction

Ever since the first cases of COVID-19, the pandemic has been placing a burden on societies and individuals. In response to the quickly spreading virus, governments launched measures such as quarantine, lockdowns, and social distancing. Although these measures have slowed the spreading of the coronavirus, there are concerns about how they have affected public health, including access to addiction recovery services, as well as individuals' anxieties, fears and social contacts (Marsden et al., 2020).

The pandemic is likely to have impacted the markets and use of illicit drugs through effects of the virus itself, restrictions on movement and gathering, as well as social, economic and health consequences (Dietze & Peacock, 2020; Price et al., 2022). Access to (face-to-face) treatment, (peer) support, work, and other meaningful activities was limited (Blanco et al., 2020; Nadkarni et al., 2020). So far, one of the most notable changes in drug treatment has been the expansion of online digital services in clinical and community practices to compensate for the lack of face-to-face support (Bergman & Kelly, 2021; Blanco et al., 2020). Some studies suggest that people in treatment settings were affected in both positive and negative ways (Liese & Monley, 2021; Smith et al., 2021). However, limited data are available on populations in addiction recovery outside treatment or support settings.

A cross-sectional study in the United States, found that the COVID-19 pandemic 'did not affect recovery at all' (as reported by participants) for the majority (89%) of participants in recovery from alcohol use disorder, and that mild relapses (i.e. violation of abstinence, but resolved at the time of data collection) were infrequent (Gilbert et al., 2021). Another study found that during a lockdown period in Israel, about half of all adult participants in recovery from a substance use disorder reported cravings, prompted by boredom, loneliness, lack of support, and financial stress (Bonny-Noach & Gold, 2021). A review further suggests that discontinuation of opioid substitution therapy delivery because of the pandemic, may cause involuntary withdrawal, which can lead to relapse to illicit opiate use (Mallet et al., 2021). Lastly, pandemic-related recovery barriers were identified, including cancelled support meetings, changes in job format (i.e., being fired or furloughed) and lack of social support, which was coped with through self-care, leisure activities (or hobbies), taking caution against exposure, and strengthening personal relationships (Shircliff et al., 2022). Yet, the impact of the pandemic on people in addiction recovery is only beginning to emerge and early publications about expected impacts from the pandemic suggested a higher risk of relapse, impacting recovery stability (Da et al., 2020; Dunlop et al., 2020; Marani et al., 2021; Melamed et al., 2020; Volkow, 2020).

Following addiction recovery research from the last two decades, it is increasingly agreed upon that recovery is a personal *process* that takes place in various ways, depending on circumstances, and may include improvements in multiple life domains, including housing, relationships, employment, and wellbeing (Kaskutas et al., 2014; Neale et al., 2014). Reviews estimate that more than half of all individuals with a lifetime alcohol or drug dependence will achieve stable recovery (Kelly, 2017; Sheedy & Whitter, 2009; W. L. White, 2012). Still, drug addiction is often described as a chronic relapsing disorder (McLellan et al., 2000a). Relapse is therefore considered a serious risk for persons in recovery, particularly in the early stages of recovery (Laudet & White, 2010; Martinelli, Nagelhout, et al., 2020). A considerable amount of research has focused on short-term relapse among individuals who have been in treatment for addiction. However, much less is known about relapse among individuals in long-term recovery outside treatment settings, and relapse is often poorly defined in research (Moe et al., 2022; Sliedrecht et al., 2022). While many studies only consider (any)

violation of abstinence a relapse, it remains unclear to what extent such an event impacts broader recovery processes (Moos & Moos, 2006). This knowledge gap applies particularly to research on people who use(d) illicit drugs, while much more is known about alcohol relapse (Connors et al., 1996; Miller et al., 2001; Vaillant, 1988; Vuchinich & Tucker, 1996; Witkiewitz & Marlatt, 2007).

Factors known to increase the risks of relapse include stressful and negative life events (e.g. death of a spouse) (Marlatt & Gordon, 1985), negative mood states such as (psychological di)stress, social isolation, perceived stigma (Connors et al., 1996; Friedmann et al., 1998; Link et al., 2001; Marlatt & Gordon, 1985; Miller, 1996; Sinha, 2007), low self-efficacy (DiClemente et al., 1985), and low motivational states (Miller, 1985). In contrast, social support, social group membership, treatment engagement, and recovery capital (Cloud & Granfield, 2008) are considered protective against relapse (Havassy et al., 1991; Vaillant, 1988). In the US and the UK, a rise in psychological distress was observed in the general population in 2020, compared to 2018-19 (McGinty et al., 2020; Pierce et al., 2020). In the Netherlands, persons with mental health problems reported higher levels of negative impact of COVID-19 on their mental health and poorer ability to cope compared to people without mental health problems (Pan et al., 2021). Consequently, the COVID-19 pandemic and related measures may also be followed by negative experiences of people in drug addiction recovery in these countries.

The current study is part of a larger, multi-year longitudinal study of individuals in drug addiction recovery which was already initiated before the pandemic and continued during the pandemic. This provides a unique insight into the impact of the pandemic on stability of people in recovery as it allows us to examine outcomes before and during the pandemic. Furthermore, two recent reviews established that many studies define relapse poorly, leading to contentiousness and vagueness around the concept (Moe et al., 2022; Sliedrecht et al., 2022). Therefore, in this paper, we focus on past 12-month problematic alcohol or drug use among a drug addiction recovery cohort. Participants defined whether the use was problematic themselves. Revealing which factors are related to return to problematic use, particularly in an event like the COVID-19 pandemic, will provide insights into how services should sustain, and potentially improve, support for people in recovery during insecure times when access to treatment and support is restricted. Therefore, this paper examined rates and (changing) risk- and protective factors for problematic substance use among individuals in drug addiction recovery in the period before (2018-2019) and during the COVID-19 pandemic (2019-2020).

Method

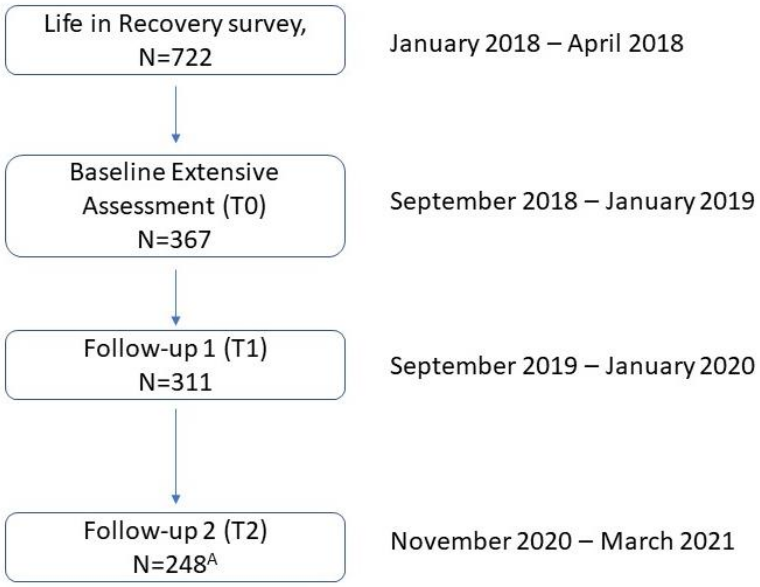
Study sample

Starting in 2018, we recruited a convenience sample of 722 adults from the Netherlands (N=230), United Kingdom (N=311), and Flanders (Belgium) (N=181) (D. Best, Vanderplasschen, et al., 2018b). Participants were included if they considered themselves to be in recovery from illicit drug addiction for at least three months at recruitment. We used the Life in Recovery survey (LiR) as a screening and recruitment instrument (Martinelli, Nagelhout, et al., 2020). The sample included persons in different stages of recovery: early (<1 year), sustained (1-5 years), or stable (>5 years). We recruited via available networks of recovery agencies and treatment services, social media, and snowball sampling.

Following the LiR, we performed a comprehensive baseline assessment with two follow-ups, measuring a range of recovery markers to map recovery pathways over time (Best et al., 2021). Each participant who left contact details in the LiR, was invited to start with a baseline measure at the end of 2018 (N=367), with follow-ups in 2019 (85% of baseline cohort) and 2020-2021 (68% of baseline

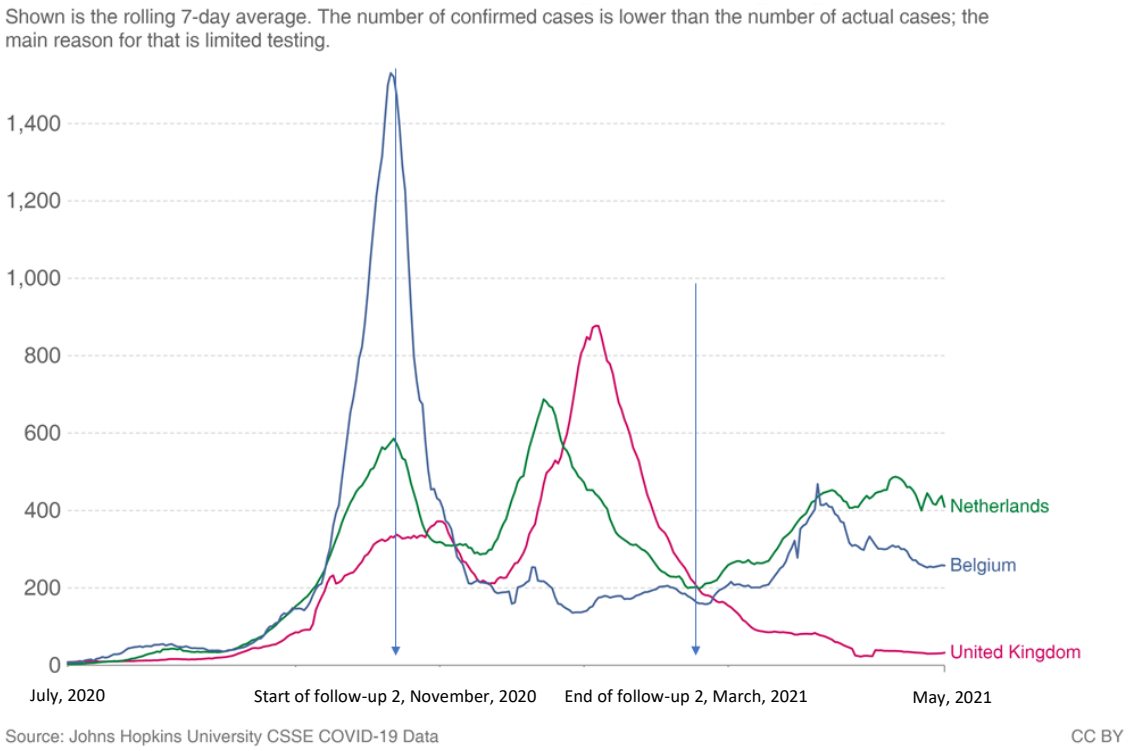
cohort), outlined in Figure 1. The last wave of data collection took place during the COVID-19 outbreak between November 2020 and March 2021, as shown in Figure 2. Data collection involved online surveys or structured (telephone or face-to-face) interviews, depending on the participants' preference. Participants received 15 Euro or British pounds for each completed survey. Each country team ensured local ethics approval (METC Erasmus MC, the Netherlands; SHU Ethics Committee, UK; Ethical Committee of Ghent University, Belgium). All participants provided informed consent.

Figure 1: Flow chart of data collection



[A] Two participants from the final follow-up (T2) were excluded from analyses because of missing data

Figure 2: Daily confirmed cases of COVID-19 between July 10, 2020, and May 10, 2021, in the UK, Netherlands and Belgium and timing of measurements



Procedures and measures

We obtained sociodemographic data (age, gender, and education level) and recovery stage from the LiR in 2018 (Figure 1) (Martinelli, Nagelhout, et al., 2020). Furthermore, participants completed a questionnaire three times (Figure 1). Each questionnaire included validated measures of substance use, involvement with formal and informal support services, recovery capital, quality of life, physical and psychological health, and social networks which are described below.

Outcomes

Past 12-month problematic substance use was assessed by asking: *"Have you used this substance PROBLEMATICALLY in the past 12 months?"* [yes/no] separately for alcohol, cannabis, heroin, cocaine, crack, amphetamines, ecstasy/MDMA, and other drugs (open category). Although our sample consists of persons in recovery from illicit drug addiction, we have included problematic use of alcohol in the outcome measure because it is an addictive psychoactive substance and because there are indications that so-called *substitute use* can potentiate relapse to former or new addictive behaviour (Sinclair et al., 2021). We measured problematic alcohol or drug use at follow-up one (T1) and follow-up two (T2).

Risk- or protective factors for relapse

The following variables were measured at baseline (T0) and first follow-up (T1) and served as predictors at T0 for relapse at T1, and as predictors at T1 for relapse at T2 in the regression analyses. In the GEE-analyses they were used as time-varying variables (combining the measurements at baseline and follow-up).

Engagement with psychosocial support was measured by asking participants *"Are you currently engaged with this kind of service/support?"* [yes/no]: Mental health services, housing support, and employment service. 'Yes' to one of the items was scored as 'yes' for the variable.

Past 12-month negative life events consisted of eleven dichotomous items, derived from the Australian social networks and recovery (SONAR) study (Best et al., 2016), that asked whether participants had experienced impactful negative life events in the past 12 months: *"death of a spouse"*; *"death of a close family member"; "death of a close friend"; "accident"; "witness a fatal overdose"; "own overdose"; "loss of a job"; "divorce"*; *"child taken into care"; "relationship separation"* and; *"eviction"* [yes/no]. 'Yes' to one of the items was scored as 'yes' for the variable.

Social group membership (range 1-7, Cronbach's Alpha = 0.918) was assessed using the four-item (averaged) Exeter Identity Transition Scale (EXITS) about current group membership (Haslam et al., 2008). A higher score means that the participant agrees more with the statements about being a member of different social groups.

Recovery capital (range 1-6, Cronbach's Alpha = 0.838) was assessed with the Brief Assessment of Recovery Capital scale (BARC-10) (Vilsaint et al., 2017) and consisted of ten items (averaged) with a six-point Likert scale: strongly disagree to strongly agree. A higher score indicates more recovery capital.

We assessed *commitment to sobriety* (range 1-6, Cronbach's Alpha = 0.762) using the Commitment to Sobriety Scale (Kelly & Greene, 2014)**,** which consisted of five items (averaged) with a six point Likert-scale: strongly disagree (1) to strongly agree (6). A higher score indicates a higher level of commitment.

Social support (range 1-7, Cronbach's Alpha = 0.878) was measured using four items (averaged) with a seven-point Likert scale. The items came from studies investigating the relationship between social identity and addiction recovery (Best et al., 2016; Haslam et al., 2005), asking about emotional support, help, resources, and advice received from other people. A higher score indicates more perceived social support.

Psychological health (range 1-5, Cronbach's Alpha = 0.915) was measured using a ten-item (averaged) scale from Maudsley's Addiction Profile (MAP) (Marsden et al., 1998). A higher score indicates better psychological health.

Perceived stigma (range 1-5, Cronbach's Alpha = 0.841) was assessed through the eight-item (averaged) Perceived Stigma of Addiction Scale (PSAS) (Luoma et al., 2010). A higher score indicates more perceived self-stigma.

Covariates
Age was used as a scale variable defined in years.

Education level was assessed by asking participants *"What is your highest educational qualification?"* [Never went to or completed primary school/Primary level of education/Secondary level of education/Higher education]. Due to insufficient cases, the first three categories were combined as one category: 'lower education'.

Country was measured by asking participants "*Where do you live?".* England, Wales, Northern Ireland, and Scotland were combined into one category: 'the UK'.

Recovery stage was measured by asking *"How long do you consider yourself in recovery?"* [years, months]. This was categorized into three groups: early (<1 year), sustained (1–5 years), and stable recovery (>5 years). These stages of recovery are based on the model from the Betty Ford Institute Consensus Panel (Betty Ford Institute, 2007).

Analysis

Data were processed and analysed using SPSS 27. To assess whether participants who were lost to follow-up differed from those who continued in the study we compared characteristics between people with and without follow-up data using chi square tests, independent sample t-tests, and Spearman's rho tests. A p-value less than 0.05 was considered significant. To assess to what extent the risk- or protective factors were associated with subsequent relapse, we performed prospective multivariate regression analyses, separate for each follow-up period. Furthermore, to assess whether the associations differed between waves, we performed generalized estimating equation (GEE) analyses and examined the interactions between predictors and follow-up wave while controlling for covariates. Missing values were omitted from the analyses.

Results

The study sample (N=367) had a mean age of 41.5 years (SD=10.8) and consisted of 65% men, spread over the UK (N=118, 32%), Netherlands (N=136, 37%) and Belgium (N=113, 31%). Among participants, 16% were in early recovery (<1 year), 40% in sustained recovery (1-5 years), and 44% in stable recovery at baseline. Drop-out analyses revealed that compared to participants with data on the first follow-up (T1), participants without follow-up data were more often from the UK and Belgium, and reported membership of social groups less often. Participants without data on the second follow-up (T2), were also more often from the UK and Belgium, were educated to a lower level, and reported having less social support compared to participants with follow-up data (T2). No other statistically significant differences were found between participants that remained in the study versus those who dropped out.

Table 1: Characteristics of the study population at baseline

Baseline variables	Total sample at baseline (N=367)*	Total sample at T1 (N=311)*	Total sample at T2 (N=246)*
Age, *mean* (SD) [a]	41.5 (10.8)	41.7 (10.9)	42.5 (10.9)
Gender			
Men	239 (65%)	201 (65%)	157 (64%)
Women	128 (35%)	110 (35%)	89 (36%)
Country			
United Kingdom	118 (32%)	93 (30%)	72 (29%)
The Netherlands	136 (37%)	126 (41%)	111 (45%)
Belgium (Flanders)	113 (31%)	92 (30%)	63 (26%)
Education			
Lower	187 (51%)	156 (50%)	116 (47%)
Higher	180 (49%)	155 (50%)	130 (53%)
Recovery stage at recruitment			
Early (<1 year)	59 (16%)	41 (13%)	28 (11%)
Sustained (1-5 years)	146 (40%)	132 (42%)	108 (44%)
Stable (>5 years)	162 (44%)	138 (44%)	110 (45%)
(Current) **Engagement with psychosocial support** (yes)	134 (37%)	114 (37%)	90 (37%)
Social group membership[b], *mean* (SD), range 1-7, α=0.918	4.2 (1.8)	4.3 (1.7)	4.3 (1.7)
Recovery capital[c], *mean* (SD), range 1-6, α=0.838	5.1 (0.7)	5.1 (0.7)	5.1 (0.7)
Commitment to sobriety[d], *mean* (SD), range, range 1-6, α=0.762	5.4 (0.7)	5.4 (0.7)	5.5 (0.7)
Social support[e], *mean* (SD), range 1-7, α=0.878	5.5 (1.3)	5.5 (1.3)	5.5 (1.3)
Psychological health[f], *mean* (SD), range 1-5, α=0.915	2.3 (0.9)	2.2 (0.8)	2.2 (0.8)
Self-stigma[g], *mean* (SD), range 1-5, α=0.841	2.8 (0.4)	2.8 (0.4)	2.8 (0.4)

[a] N=366 at T0, N=310 at T1 and N=245 at T2 because of missing data about 'age' from one participant
[b] A higher score indicates more participation in social groups
[c] A higher score indicates more recovery capital
[d] A higher score indicates more commitment to sobriety
[e] A higher score indicates that a participant experiences more social support
[f] A higher score indicates a better psychological health
[g] A higher score indicates more self-stigmatization
[*] Percentages may not add up to 100 as a result of rounding
α = Cronbach's Alpha

As can be seen in Figure 3, in the period between baseline and the first follow-up (before the COVID-19 pandemic), 19% of participants had used substances problematically. In the period between the first follow-up and second follow-up (during the COVID-19 pandemic), 15% of participants had used problematically. This difference was not statistically significant (Chi^2=1.93, *P*=0.165). Of the persons who reported problematic use at T2 (N=36), 64% (N=23) also reported problematic use at T1.

Figure 3: Rates of problematic substance use of the total sample across both follow-up periods

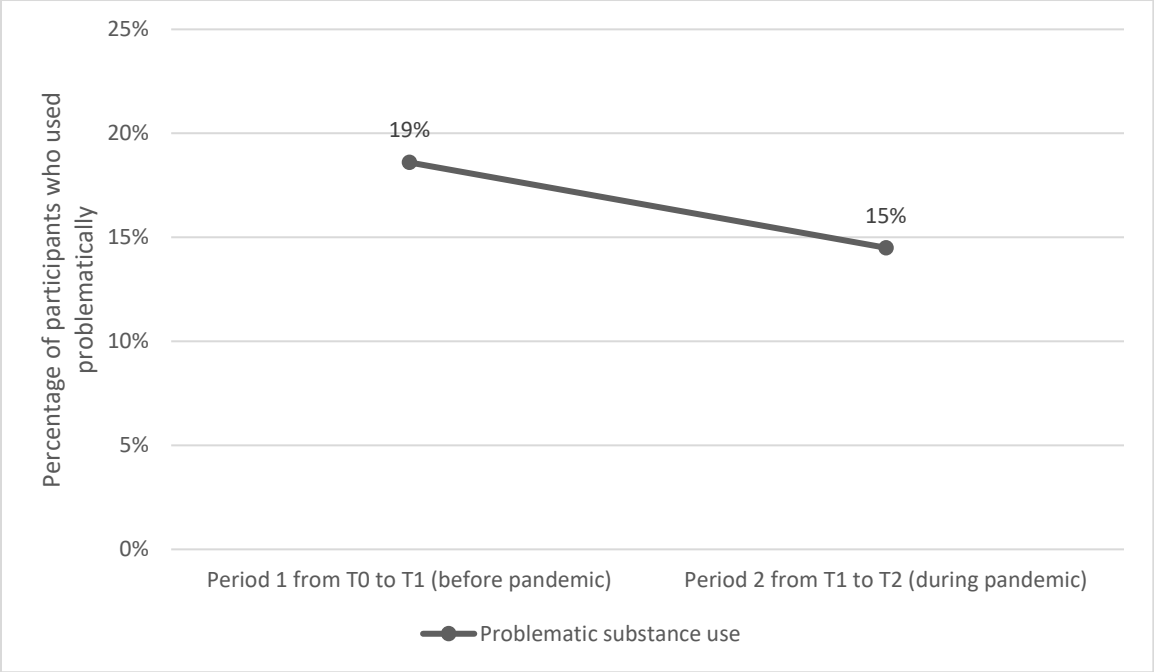


Table 2: Multivariate regression and GEE analyses of predictors of *past 12-month problematic use of alcohol or drugs*, adjusted for age, gender, education level, country, and recovery stage

Independent variables	Drugs or alcohol Relapse at T1[a] (Nagelkerke R Square = 0.267)			Drugs or alcohol Relapse at T2[b] (Nagelkerke R Square = 0.497)			GEE-analyses[c] of interaction: predictor x wave		
	Odds ratio	95% CI	*P* value	Odds ratio	95% CI	*P* value	Odds ratio	95% CI	*P* value
Age	0.98	0.94, 1.01	0.205	0.98	0.93, 1.03	0.383	-	-	-
Gender							-	-	-
women (ref)									
men	0.90	0.44, 1.84	0.762	0.42	0.15, 1.20	0.105			
Education level									
Lower (ref)									
Higher	1.10	0.51, 2.35	0.813	0.80	0.28, 2.32	0.683			
Country							-	-	-
Belgium (ref)									
UK	0.55	0.19, 1.56	0.257	0.44	0.08, 2.31	0.332			
Netherlands	0.48	0.23, 1.04	0.064	0.27	0.08, 0.89	0.032			
Recovery stage							-	-	-
Early (ref)									
Sustained	0.52	0.23, 1.22	0.135	0.17	0.05, 0.64	0.009			
Stable	0.34	0.12, 0.94	0.038	0.16	0.03, 0.81	0.026			
Engagement with psychosocial support	0.42	0.21, 0.83	0.013	0.26	0.09, 0.76	0.014	1.51	0.51, 4.48	0.459
Past 12-months negative life events T1	2.46	1.12, 5.40	0.025	1.30	0.44, 3.78	0.635	0.48	0.14, 1.72	0.259
Social group membership	0.95	0.76, 1.17	0.605	0.96	0.70, 1.30	0.784	0.99	0.69, 1.44	0.974
Recovery Capital	0.62	0.30, 1.26	0.183	1.38	0.58, 3.30	0.467	0.45	0.15, 1.35	0.156
Commitment to sobriety	0.93	0.58, 1.49	0.762	0.27	0.15, 0.50	<0.001	3.24	1.33, 7.89	0.010
Social support	0.90	0.67, 1.21	0.496	0.79	0.55, 1.12	0.190	1.16	0.77, 1.73	0.485
Psychological health	0.90	0.56, 1.44	0.649	1.75	0.79, 3.88	0.170	0.52	0.264, 1.01	0.055
Self-stigma	0.95	0.55, 1.63	0.842	1.05	0.47, 2.33	0.901	0.99	0.43, 2.29	0.976

[a] N=310
[b] N=244
[c] N=310

Table 2 shows that in the first period (before the COVID-19 pandemic), not engaging in psychosocial support at baseline and experiencing past 12-month negative life events was associated with higher odds of problematic substance use at T1 (before the pandemic). At T2 (during the pandemic), not

engaging in psychosocial support and having less commitment to sobriety at baseline was associated with higher odds of relapse. Table 2 further shows that the relationship between commitment to sobriety and relapse differed between T1 and T2 (GEE: OR =3.24, 95% CI=1.33, 7.89, *P* = 0.010). At T1, commitment to sobriety was not associated with problematic substance, while at T2 a lower commitment to sobriety was associated with higher odds of problematic use.

Discussion

This study builds on data from multi-year longitudinal study which was initiated before, and continued during, the COVID-19 pandemic. This provides a unique insight into how the pandemic may have affected individuals in recovery from drug addiction. Among a cohort of people in drug addiction recovery, rates of problematic substance use were approximately equal in the period before (19%) and during (15%) the COVID-19 pandemic. Although these rates appear low compared to previous literature on return to problematic use and relapse (A T McLellan et al., 2000b; W R Miller et al., 2001; Moos & Moos, 2006), the comparability to such studies is limited. Return to problematic use or relapse is often pre-defined by the researchers (i.e. as any violation of abstinence) in such studies, and they often contain post-treatment study samples (Moos & Moos, 2006; Witkiewitz & Marlatt, 2007). The approximately equal problematic use rates are in line with a study that found that the pandemic did not affect recovery nor led to high rates of relapse for persons in recovery from alcohol use disorder (Gilbert et al., 2021). Still, the factors associated with problematic use in our study, differed before and during the pandemic. In the period before the COVID-19 pandemic, participants who did not engage in psychosocial support (with housing, employment, or mental health) at baseline and participants who experienced negative life events had higher chances of problematic use. In the period during the pandemic, participants who did not engage in psychosocial support and those with less commitment to sobriety had higher chances of problematic use.

Factors associated with problematic use and relapse can be categorized as either *internal* factors of the person (i.e. distress and self-efficacy) or *external* factors of the environment (i.e. social support and treatment engagement) (Marlatt & Gordon, 1985). Unlike before the pandemic, lower commitment to sobriety was associated with more chance of problematic use during the pandemic. Given that access to external resources, such as face-to-face contact with professional, social and peer support, was limited during the pandemic (Bergman & Kelly, 2021; Blanco et al., 2020), internal resources, such as commitment, may have been needed more to prevent a return to problematic substance use. Thus, those with stronger commitment were potentially more resilient. Earlier studies found that commitment to sobriety is associated with more participation in mutual aid groups (Martinelli, van de Mheen, et al., 2020), a change in social identity (from 'user' to 'in recovery') (Dingle et al., 2019), and less substance use (John F. Kelly & Greene, 2014) among people in addiction recovery. This suggests that mutual aid groups and other interventions aimed at social identity and commitment may increase internally driven resilience that is needed during a pandemic.

Both before and during the pandemic, engaging in psychosocial support was associated with lower risks of problematic substance use, suggesting continued support needs during recovery. Psychosocial factors, such as mental health, housing and employment are found to be important factors associated with recovery stability and progress (Martinelli, Nagelhout, et al., 2020; McQuaid & Dell, 2018). In line with our findings, engagement with such psychosocial support is also found to be protective in studies of relapse (Vaillant, 1988). While the ideal situation might be not to need support, our findings may indicate that persons in recovery continue to have long-term external

support needs. In line with recovery literature, this suggests that support needs may continue to persist over time while in recovery (Ingram et al., 2022) and thus that continuous assessment of these needs and support may prevent return to problematic use (McKay, 2021).

Limitations

While we were able to recruit and retain a large recovery convenience sample over an extended period, it is unknown to what extent our findings are generalizable to the population of persons in (drug) addiction recovery. Second, for the outcome measure that was collected during the pandemic, the 'past 12 months' also included a short period before the COVID-19 outbreak for some participants who responded early during the data collection. Thus, we do not know for all participants whether the problematic substance use occurred before or during the pandemic. This last follow-up is also two months further from the predictors compared to the first follow-up which may have affected the relation. Furthermore, while antecedent events and states may be predicting factors for problematic use, they may also be coincidental, or the consequence of third factors that triggered both the antecedent and the problematic use. Third, the retention rates in the last follow-up are significantly lower (68%) compared to the first follow-up (85%). We do not know which proportion of the population lost to follow-up used problematically in the last period, thus, we do not know the problematic substance use rates of all participants during the COVID-19 pandemic. Problematic use rates may have been higher among the dropout-sample, as we expect that persons who returned to problematic substance use may not want to participate anymore in research about recovery. Another reason problematic use rates were not higher in the last follow-up may be that participants gained more recovery experience over time, becoming more stable compared to the early stage. Fourth, the responses to the COVID-19 outbreak and infection rates differed among the participating countries (see Figure 2). Thus, their impact on problematic substance use may have differed between countries. To compensate for this, we included country as a covariate in our main analyses. Finally, we let participants judge whether their use was problematic. On the one hand, this can be seen as a weakness, as we do not know exactly what the use entailed (any violation of abstinence or return to heavy use over a certain period, for example). On the other hand, it is also a strength, as we allowed participants to put their experience in the context of their own lives and continual flow of behaviour. In doing so, we may have avoided the binary 'failure versus success' dichotomy, which Miller (William R. Miller, 1996) criticizes as an oversimplification of the addiction relapse process. Our operationalization may be useful in future studies to give insights into which factors shape resilience and stability in certain domains of recovery.

Conclusions

In this study we explored how the COVID-19 pandemic may have impacted risk and protective factors for relapse. Despite anticipated negative effects (Da et al., 2020; Dunlop et al., 2020; Marani et al., 2021; Melamed et al., 2020; Volkow, 2020), but in line with another study focused on alcohol recovery (Gilbert et al., 2021), we found no evidence that more people returned to problematic substance use during the pandemic than in the period before the pandemic. This suggests that most people can sustain recovery, even in the context of significant adversity and reductions in access to (face to face) support. Still, we found that the relation between relapse and commitment to sobriety differed between the two periods. During the pandemic, more commitment to sobriety was associated with lower chances of problematic substance use. This suggests that in events when access to external and social resources are limited, personal factors, including commitment, become more important for recovery stability. Therefore, personal factors and coping resources may serve as suitable intervention targets as they can be trained and developed with therapy (John F. Kelly &

Greene, 2014). Lastly, engaging in support services was protective for relapse, regardless of the pandemic. This means that finding ways to keep environmental resources available during events, similar to the COVID-19 pandemic, is also crucial to mitigate the vulnerability of persons with less internal recovery resources.

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5. Understanding drug addiction recovery through lessons of lived experience

A qualitative study in the Netherlands

Martinelli, T. F., Roeg, D., Bellaert, L., van de Mheen, D., & Nagelhout, G. E (submitted). Understanding drug addiction recovery through lessons of lived experience: A qualitative study in the Netherlands.

ABSTRACT

Drug addiction recovery is still understood poorly. Perspectives from lived experience are insufficiently researched, but are crucial to understand how people recover from addiction. We aim to further this understanding through autobiographical data from persons in drug addiction recovery. We conducted a qualitative interview with 30 participants from various parts in the Netherlands. Participants self-identified as being in recovery from drug addiction. We undertook a data-driven thematic analysis. Participants experienced recovery as a learning process: learning (1) to recognize and understand addiction; (2) that recovery goes beyond drug use; (3) to give meaning to experience and to reconsider identity; (4) that recovery is a gradual process and; (5) how universal life processes shape recovery. From a lived experience perspective, drug addiction recovery is entwined with many aspects of life. The experiences of recovery suggest that recovery encompasses a personal and social development beyond clinical and behavioral aspects.

Introduction

Globally, around 36 million people suffer from drug use disorders and may require treatment (UNODC, 2021). Data shows that the majority of people entering drug treatment had been treated before (Montanari et al., 2019). Consequently, drug addiction is often described as a chronic relapsing disorder (A T McLellan et al., 2000a; NIDA, 2020). However, evidence shows that the majority of individuals with drug addiction recover at some point in their lives (John F. Kelly et al., 2017; W. L. White, 2012). Traditionally, addiction recovery was often seen as synonymous with abstinence from any substance use. However, an emerging body of recovery research has shed new light on what recovery entails. Inspired by the mental health field, recovery is now thought of as an unique and socially negotiated process characterized by (sometimes gradual) improvements on a variety of life domains (Bathish et al., 2017; Davidson & White, 2007). The general consensus now, is that recovery is a process and not an outcome, and that it concerns more than the traditional one-dimensional outcome of abstinence, including improvements on personal, functional and societal life domains (van der Stel, 2013).

Still, understandings of recovery processes are limited, and vary depending on perspectives (e.g., professional, scientific, or lived experience). Therefore, further exploring addiction recovery experiences is crucial. A better understanding of how processes of change occur in people's lives may facilitate (evaluation of) treatment, guide developments of new treatments, and support people with addiction and their family, policy makers and treatment providers.

In the last two decades, research made advancements and researchers developed instruments to measure different aspects of recovery (D. Best et al., 2012; D. Best, Vanderplasschen, et al., 2020; Groshkova et al., 2013; Laudet & White, 2008) and were able to identify mechanisms through which treatment and support contribute to recovery (John F. Kelly et al., 2009, 2012). Furthermore, longitudinal studies show that addiction and recovery are long-term processes (Hser et al., 2007; Martinelli, Nagelhout, et al., 2020; Vaillant, 2003). However, qualitative knowledge about people who resolve drug problems is much less available.

For the drug field in general, qualitative studies have "helped us to understand and demystify drug taking, dispel unhelpful myths and stereotypes about drug users, build and develop theories of addiction and formulate and evaluate drug policy and practice" (Neale et al., 2005, p. 1591). However, such knowledge about recovery, including *how* it is experienced, is rare (Bjornestad et al., 2019). Furthermore, much of what we know tends to be based on professional treatment perspectives. In other words, we know a lot about what professionals can effectively do about outcomes that *they* defined and much less about what can be done by those who recover based on *lived experience* (van der Stel, 2020).

To add to the current knowledge, this study aimed to achieve a deeper understanding of how persons in recovery from drug addiction experience drug addiction recovery in the Netherlands. Since 2010, the Netherlands has embraced the emerging concept of recovery in its practice-level policy for the largest providers of addiction services (Charter of Maastricht, 2010; Martinelli et al., 2022). However, implementation of this new vision is mostly limited to the education and deployment of so-called experts by experience and the impact on recovery experiences of clients is still unknown (Bellaert et al., 2021). The following research question guided our study: *How do people experience their recovery process from drug addiction?*

Materials and methods

Design, sample & recruitment

We recruited 30 persons from the Netherlands in recovery from illicit drug addiction and conducted a single in-depth interview with each of them. Participants participated in two prior assessments

from the REC-PATH cohort study (described in: Best et al., 2018), aimed at mapping recovery pathways from the perspective of persons recovery. Between January and June 2018, a convenience sample of 722 persons (of which 230 from the Netherlands) in recovery from drug addiction for three months or longer first completed the quantitative Life in Recovery survey (LiR) (Martinelli, Nagelhout, et al., 2020). We recruited them through social media, newsletters, conferences, alcohol and drug magazines, and printed flyers and posters. Demographics were collected through the LiR (Martinelli, Nagelhout, et al., 2020). For this study, we recruited a subsample aiming for an equal distribution in gender (15 men and 15 women) and self-attributed recovery stage (three months to one year; one to five years; more than five years), and strived for maximal variation in terms of age and treatment history in order to cover a diverse sample (see Table 1 for sample characteristics). We stratified participants by key demographics and then randomly selected. Ethics approval was provided by the METC Erasmus MC in the Netherlands.

Interviews took place in the summer of 2019 (one year after recruitment) and lasted about 90 minutes (range: 80 to 110 minutes). The first author, anthropologist and experienced qualitative researcher, conducted the interviews, meeting participants in their homes, at the office or in a quiet bar or restaurant. Participants had spoken with him before when participating in the cohort study. We approached 33 participants by telephone. Three participants did not respond and none refused. We used the *lifeline interview* method, which allows for a retrospective lens to elicit autobiographical data covering personal recovery trajectories (Berends, 2011). The interview was pilot tested on a person in recovery from alcohol addiction, which did not lead to significant changes in the protocol. Interviews included (1) making a timeline of the participant's life from the moment that their substance use 'got out of control' until the present day; (2) choosing periods that were important for recovery to focus on in-depth; (3) a focus on barriers and facilitators for recovery in those periods; and (4) the meaning and definition of recovery. We included sample interview questions in Table 2 and a full interview protocol as a Supplement. We translated quotes from the interviews from Dutch to English and for readability purposes we used pseudonyms throughout the results (see Table 1).

Table 1. Sample characteristics

Pseudonym	Age[A]	Gender	Recovery stage	Highest education[B]	Service/support history
Isabelle	53	Woman	>5 years	Higher education	Twelve step groups, residential treatment, outpatient treatment
Peter	45	Man	>5 years	Higher education	Twelve step groups, residential treatment, outpatient treatment
Daisy	30	Woman	1-5 years	Secondary education	Twelve step groups, residential treatment, outpatient treatment
Yvette	26	Woman	<1 year	Higher education	No specialized addiction treatment
Simon	38	Man	<1 year	Secondary education	Twelve step groups, residential treatment, outpatient treatment
Kyle	42	Man	1-5 years	Primary education	Twelve step groups, residential treatment, outpatient treatment
Alexander	59	Man	>5 years	Higher education	No specialized addiction treatment
Manuel	47	Man	1-5 years	Secondary education	Twelve step groups, non-twelve step groups, residential treatment, outpatient treatment
Jolien	30	Woman	1-5 years	Higher education	Twelve step groups, non-twelve step groups, residential treatment, outpatient treatment
Edwin	48	Man	>5 years	Secondary education	Residential treatment, outpatient treatment
Yara	36	Woman	<1 year	Higher education	Twelve step groups, residential treatment, outpatient treatment
Angelina	36	Woman	<1 year	Higher education	Twelve step groups, residential treatment
Sara	54	Woman	>5 years	Higher education	Twelve step groups, residential treatment, outpatient treatment

Willem	28	Man	<1 year	Secondary education	Twelve step groups, non-twelve step groups, residential treatment, outpatient treatment
Ben	47	Man	1-5 years	Higher education	Twelve step groups, residential treatment, outpatient treatment
Stefan	58	Man	1-5 years	Higher education	Twelve step groups, non-twelve step groups, outpatient treatment
Wilma	43	Woman	1-5 years	Higher education	Residential treatment, outpatient treatment
Giovanni	35	Man	1-5 years	Higher education	Outpatient treatment
Steven	27	Man	>5 years	Primary education	Residential treatment, outpatient treatment
Sofia	19	Woman	<1 year	Secondary education	Outpatient treatment
Stef	29	Man	<1 year	Secondary education	Twelve step groups, non-twelve step groups, residential treatment, outpatient treatment
Paul	41	Man	>5 years	Secondary education	Twelve step groups, residential treatment
Mark	31	Man	<1 year	Higher education	Residential treatment
Mary	30	Woman	1-5 years	Higher education	Twelve step groups, residential treatment
Kees	38	Man	1-5 years	Secondary education	Twelve step groups, non-twelve step groups, residential treatment, outpatient treatment
Jane	48	Woman	>5 years	Higher education	Twelve step groups, non-twelve step groups, residential treatment
Jay	40	Man	<1 year	Secondary education	Twelve step groups, residential treatment, outpatient treatment
Anna	34	Woman	>5 years	Primary education	Twelve step groups, residential treatment, outpatient treatment
Andrea	48	Woman	>5 years	Secondary education	Residential treatment, outpatient treatment

[A] Age when recruited for the REC-PATH cohort study in 2018.

[B] Higher education refers to Higher Vocational Education ('Hoger Beroepsonderwijs' or 'HBO' in Dutch, similar to college degree education) or University; Secondary education refers to high school and; Primary education refers to primary school

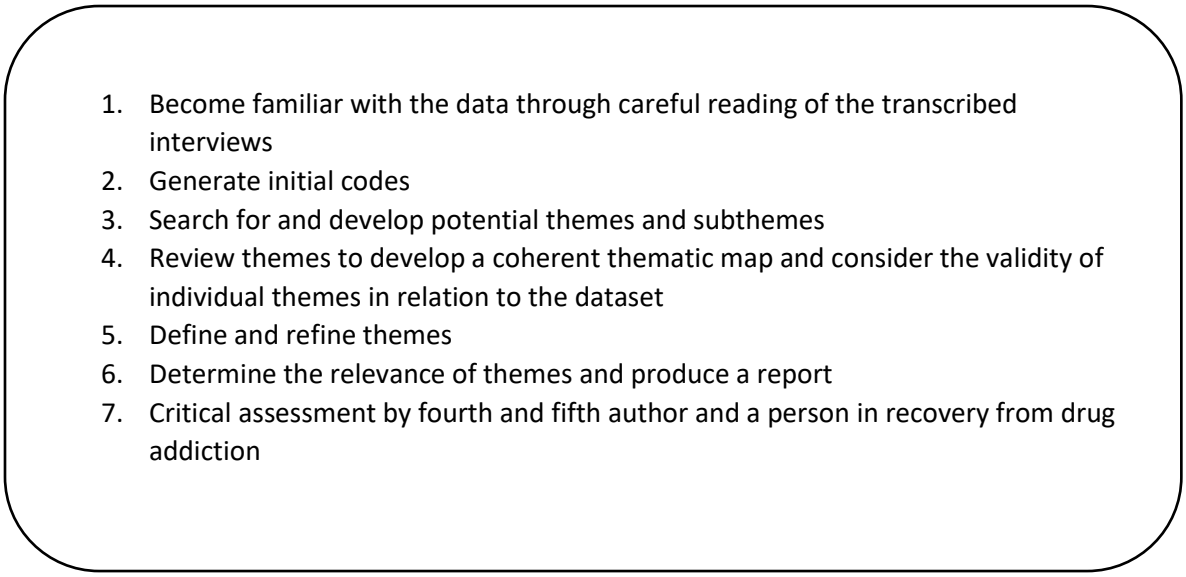
Table 2. Examples of interview questions

Topic	Question / prompt
Opening questions: making a timeline	If you look back at the period between the starting point at which your drug use became problematic and where you stand today, what were meaningful positive or negative periods, moments or events? Which of those periods would you like to talk about first?
Looking at a specific period	Can you tell me more about that period? What things did you want to change during that period? Which things of that period did you want to keep? (tangible or mindset)
Deepening questions	What helped you get ahead in that period? What was not at all helpful for you during that period? How was your social life during that period? Were you part of certain groups or communities? In what way was drug use a part of your daily life during that period (or not)?
End of interview	If you look at where you are now, what is important to you? If you look back at the timeline we discussed, how would you define your recovery?

Data analyses

The interviews were audio recorded and transcribed verbatim. We entered 973 pages of transcripts and field notes into NVivo for systematic coding and reviewed them line-by-line. We used a seven-step data condensation method, based on an inductive approach using data-driven thematic analysis (Braun & Clarke, 2006) outlined in Figure 1. The first author performed steps 1 to 6 and discussed this with the second author. To strengthen the reliability of data interpretation, the second and third author each co-coded a subset of transcripts (N=5) and discussed this to reach consensus. During regular meetings between the first and second author, interpretations and themes accompanied by quotes from the transcripts were discussed, as well as whether saturation of data was reached. We reached saturation after analyzing 27 interviews, after which the remaining interviews provided little new information to address the research question. To ensure the structural validity of the findings and the inclusion of the most relevant themes (Hill et al., 1997), two more authors and one expert with first-hand recovery experience critically reviewed the findings and provided detailed feedback (step 7, Figure 1).

Figure 1: Steps of data condensation. (Based on Braun & Clarke, 2006)



Results

The main finding is that participants implicitly described addiction recovery as a continuous and wide-ranging learning process, covering how to sustain recovery but also learning about addiction and understanding how one got into that state. This learning process formed the overarching framework through which we discuss five main themes or 'lessons': participants learned (1) about their addiction and how to understand it; (2) that recovery is not only about drug use; (3) that recovery is to reconsider the self and seeing things in a new light; (4) that recovery is a gradual process; and (5) that recovery is shaped by universal life lessons.

1. Learning about your Addiction and how to understand it

When we asked participants about the period when their 'addiction got out of hand', many explained that this experience did not necessarily relate to drug use: *"I knew I needed help, but not for my drug use"*. There was a sense that something was not right and a feeling of dissatisfaction. Isabelle, in the example below, learned that her problem may be related to drugs only after she visited a psychiatrist for burn-out symptoms. At the time, she had stopped working for a while and was using drugs all day in bed and started having anxiety symptoms:

> There was a very sharp psychiatrist sitting there. And of course, you are tested, and all sorts of things come out. He was like: "I'm not going to do anything with you, I'm going to send you to addiction treatment". I was like… Addiction? Addiction? I was like, get outta here! To myself some of it seemed okay, I have it all under control.
> Interviewer: It really came as a total surprise?
> Yes, it did. And Frank, my partner, was also like: "how?" (Isabelle, woman, 53 years)

In retrospect, she found it odd she did not realize that her problems (e.g., anxiety) were related to her drug use and that she took so long to come to this conclusion. She, and other participants in similar situations, thought this delayed realization was due to negative stereotypes of 'drug addicts' (e.g., 'junkies' with shopping carts, being homeless). They assumed that if you manage to sustain a home, a family, or job, there is *"no way"* that you can be addicted.

For others, it was clearer that their drug use was problematic and most of them contemplated stopping or reducing their use. However, despite this awareness, they did not know *how* to change or even *what* needed to change:

> I wasn't sure what I wanted to change. I didn't want to use anymore because use always led to bullshit. So, I did what I had to do to avoid using. I didn't have a very clear idea of what I wanted differently, really, because I didn't know very well. (Peter, man, 45 years)

Peter said that there were many times when he wanted to change his life (e.g., each time he was released from prison). However, each time he tried, he only focused on his drug use, and failed. Most participants recognized this. Awareness of addiction and wanting to change was important, however, it seemed insufficient to sustain recovery. The realization that addiction is a broader problem besides drug use was crucial.

2. *Addiction Recovery is not about Drug Use*

Participants often described recovery like a *"mindset"*, *"attitude"*, or *"lifestyle"*. Participants rarely mentioned (changing) drug use patterns when discussing recovery experiences. Below we describe what participants considered key to their recovery.

Understanding underlying Causes

Most participants emphasized the need to address underlying causes of their addiction, to learn *why* they used drugs. Daisy (woman, 30 years) illustrates this through her failed recovery attempt when she primarily addressed her drug use: *"You can be clean and you can be in recovery. But being clean doesn't work for me. I tried that".* First, she avoided triggers that induced craving: *"Because I was starting to feel better physically, I thought, well, I'm fine. I just had to stop for a while".* However, after four months in a rehab center, she was sent away for dating another patient. She relapsed and felt worse than before. In retrospect, she felt that she was not taking her recovery serious: *"I was busy with all sorts of things except recovery".*

Isabelle also focused on her drug use to recover. Although she did not relapse, she realized her situation was not improving either:

> No, it was pretty tough after that [rehab]. I got into serious dislike with my employer. That ended up with me being fired. At one point I was like 'okay, I'm clean', when that first exercise was over. But I'm starting to feel worse and worse. (Isabelle, woman, 53 years)

She continued to search for help and was eventually diagnosed with autism. She learned that she was self-medicating to dampen the excessive stimuli she experienced due to autism. Learning this helped her to develop other strategies to dampen stimuli and reduced her craving for drugs.

Goals and Meaning

Participants also described that having purpose and goals contributed to their recovery. Having goals functioned as motivation to seek out and participate in activities, which in turn improved social relations, income, and structure. We encountered practical goals, including day routines or jobs, and emotional goals, including *"becoming happier"* and acquiring *"a sense of peace"* or *"serenity"*. Such goals were highly interrelated, as practical goals could contribute to emotional feelings of self-worth and identity.

Yvette, in the first year of her recovery, needed practical goals *"because, why would you get up if you don't have a goal, anyway?"* (Yvette, woman, 26 years). Maintaining goals also provided purpose in these initial stages. For Simon, this gave his life direction:

> What do you really want? That was mainly to build up my job and study: to work in the addiction services in 5 years' time before my 40th birthday. (Simon, man, 38 years)

A goal that most male participants mentioned was financial stability. A difficult goal, as drug addiction is expensive and often came with debts. Gaps in CVs or lack of education hindered acquiring desired jobs, which led to stress and feelings of worthlessness. Participants linked financial stability to (in)dependence. As addiction is often characterized by dependence, becoming *"free of dependence"* was part of recovery. Noteworthy is that getting jobs and paying back debts means more to participants than mere financial stability. It equaled *"doing good"* or *"living well"* which resulted in feeling good about oneself. Participants linked these feelings of self-worth and self-esteem with *"being part of society"* and *"doing your part"*:

> That now, I am on the train and I'm going to work with all the other working people. So that now I *am* becoming a productive member of society. Yes, look at me! (Kyle, man, 42 years)

Instead of *finding* goals or a purpose, recovery could also mean to radically change the nature of one's ambitions. Peter described that he had completely turned his life around after being homeless and in prison for about twenty years, but that the 'old Peter' was still there:

> Despite all the shit I've been through, I've always had ambitions. I've always had the desire to be successful in my way. (..) I just really wanted to get out. From that scene, from that world, from that prison. So that is… Ambition is something that has remained. But I often looked in the wrong places, you know? (Peter, man, 45 years)

He always had goals and an ambitious attitude. In recovery, he learned to harness this drive to achieve goals in a more socially acceptable manner.

Recovery is an Attitude

"Becoming happier" was another goal described by participants. Changing or quitting drug use was not necessarily the way to reach that goal. They tried other things as well, including *"a new job", "breaking up",* or *"moving"*. Some decided they *"might as well try"* reducing their drug use. However, this did not always deliver the expected results:

> What didn't work out was to be much happier. (..) A bit happier, but not… The idea was that if I do this, it would be the end of… These are of course the dynamics of addiction. Oh, you take a drug, and you feel better all at once. It works the other way around too. Oh, I quit a drug in one go and then you will start feeling better again. But it doesn't work that way at all. You are just the same asshole as when you were using. (Alexander, man, 59 years)

Alexander sees his expectation of 'instant happiness' as his addiction-attitude. Eventually, he gradually became happier. However, he learned and accepted that there was no instant solution. This change in attitude represented the process of recovery to him. Participants also described such changes in attitude as feeling more *"real"* or *"authentic"*. Daisy, for example, noted that she does not *"feel fake anymore"* (woman, 30 years).

Serenity, Rest and Routine

Participants' lives during drug addiction were often chaotic, fast, and restless. Some experienced traumas, situations of crime or homelessness, and lived in prisons or psychiatric institutions. However, unrest also originated from the pace at which they experienced society, including the pressure to work, earn money, and be successful. Consequently, participants often strived for serenity, rest, and routine in recovery. Manuel, for example, had been homeless for 11 years and said:

> Yeah, I really wanted rest man. Because I was always running, everywhere. There was so much unrest. (man, 47 years)

Some participants described needing rest as a paradoxical feeling: doing 'nothing' to improve your situation.

3. *To recover is to reconsider the Self: seeing Things in a new Light*

Participants often described their recovery as a reconsideration of their identity, meaning that they saw themselves and their behavior in a new light. This was often achieved by *"listening to myself", "considering my needs",* and *"staying close to myself".* Jolien illustrates:

> I used to just put 10 appointments in my calendar, you know? I went everywhere, I was doing everything. And (..) then I came right back home, and I was completely over-stimulated and stuff. I don't do any of that anymore. (woman, 30 years)

She implemented boundaries as part of her recovery to not overstimulate herself. Getting to know herself and learning how she responds to different situations was an important part of this. For others, a diagnosis from a professional helped with this:

> I always thought, I'm weird, I'm not right, I'm crazy. That's why you get aggressive, you go against everything. Then I was like, it's normal. This behavior is normal. (..) It's in my brain, not in my character. (Edwin, man, 48 years)

For Edwin, drug use was a way to alleviate his busy mind, which he learned was rooted in an attention deficit hyperactivity disorder. He further learned that childhood traumas were affecting his behavior later in life. Knowing that this behavior came from something that happened *to* him, and not from some character flaw, helped him to reconsider his addiction past and his identity and change the way he looked at himself.

For some reconsidering the self was about accepting vulnerability to addiction. For Manuel (man, 47 years), drugs had led his life and would take over his life again if he ever started using again. It was important to close that door permanently in his mind and to change his identity from a drug user to a non-user. This was a recurring theme for other participants as well. Some had relapsed after trying substances again after some time of abstinence or replaced one substance with another. While some saw accepting this vulnerability as a *"liberation"*, or an improvement, others saw it like a *"grieving"* process:

> In the beginning, I thought, well I'm going to do this for a while because, yeah, how can you never celebrate your birthday again without...? Look, I get that the drugs need to be gone, but New Year's Eve and everything without anything? How? (Yara, woman, 36 years)

Yara added that she felt like this mostly at the beginning of her recovery. Yara reconsidering herself was also relational, as she was now viewed by, and had to explain herself to others as a *non-user* of alcohol and drugs. Her experience illustrates that drug and alcohol use have meaning to the user and that it is a social, contextually sensitive, practice.

4. *A gradual process*

The recovery experiences of participants show that recovery is a process rather than an event, in diverse ways.

Planting a Seed

Becoming aware of addiction was not always the start of recovery. For many, it took years before they put this awareness into action and attempted to change their situation. However, some described this early awareness as a *planted seed* for recovery. Life-impacting events, such as the birth of a child, becoming homeless, an unhealthy relationship, meeting persons with similar lived experience, treatment, or a judicial punishment or measure had planted such seeds.

Daisy explained how she relapsed a few months after treatment, when she was unable to bear the precarious situation of her child's hospitalization. However, her *"failed attempt"* at recovery was not a waste. Having had a *"taste"* of recovery in treatment, helped her initiate recovery again:

> I had just tasted enough of recovery, or at least the feeling I had when I was sober. And there were good days in between when I thought 'I don't want this', you know? I continued to use but I knew 'I don't want this'. (Daisy, woman, 30 years)

Stages of Recovery

Participants also distinguished distinct stages in their recovery. The first stage was often described as a period to "*stabilize*":

> Especially in the beginning, you have the idea that you are standing there with a big spotlight on you, that completely dazzles you. And it takes quite a long time before you get used to that. (..) And at a certain point you get the overview again, but that is a whole process that you go through. (Jolien, woman, 30 years)

Reflected on this first stage, participants often explained how difficult it was to maintain other aspects of life. Recovering costed a lot of energy and focus, and time was needed. Sara, described needing time as letting a wound *"breathe"*:

> You also must make sure that your wound can breathe. That comes first. Because if you just put a plaster on it, it won't do the trick either. (..) Giving someone the space to take care of it and let them know: 'look, this hurts'. (Sara, woman, 54 years)

Highlighting the intensity of this first period, some participants who were twelve-step group members cited the '*90 meetings in 90 days'*-principle: the program's advice to join at least one meeting a day in the first 90 days. Residential treatment facilities, where participants were disengaged from daily worries and tasks to solely focus on treatment, also had this early intensity. Ben added that it helped not to work in the first stage of recovery:

> If you don't have to work, don't do it, and really focus on your recovery, that's already a full-time job. A roof over your head, food, the rest will all come later. (Ben, man, 47 years)

This way he was able to put his recovery at the top of his priorities.

Participants also distinguished later stages of recovery when discussing transition periods:

> As my recovery progressed, I also began to address other facets of recovery. (..) Going back to look for work. Becoming financially stable. (Willem, man, 28 years)

After the first stage, participants aimed their attention, energy, and time towards other aspects of life, such as work, study, or a romantic relation. In contrast, such things were described as *"distractions"* in the early recovery stage, which could even lead to relapse. In these transitions, participants also encountered difficulties. Kees (man, 38 years), for example, acquired a job at a walk-in center for people with mental health problems and addiction. However, this was *"too confronting"* for him. Edwin (man, 48 years) also described how he had *"paused"* his recovery a few times for a job. He said that *"when you are working on your recovery, you are vulnerable*" and this is not a situation that generally goes well with a job, where you must perform.

Early Recovery Paradox

Some participants described the early stage of recovery as *"sitting on a pink cloud"*, referring to a powerful positive energy and feeling good. This was the result of taking control over elements in life that seemed uncontrollable before. However, there were also difficulties:

> Then I would also reconcile with four to five people in one week. Almost every day going to someone to do penance. Then they said to me: “Yes, that can be toned down a bit. Why don’t you divide it over five years, isn't that okay too?” (…) I was a bit too fanatic. (Simon, man, 35 years)

Simon became too zealous in his recovery and overdid things, exhausting himself and others. The other paradox of early recovery was that, despite the pink cloud, participants also emphasized the need to avoid *“triggers”*. Furthermore, the newly found energy gradually became “*normal*”:

> I felt a lot of love in myself and around me. I heard the birds whistle. That became a bit less, but I still felt very good. I had a lot of strength and was looking forward to the future. But when I look at the last year, it has become a bit more normal. When I am occasionally with people around me, who hear my story for the first time or I talk about it, I notice that it no longer affects me in the same way as before. (Simon, man, 35 years)

Simon had explained how, after the pink cloud, he had to find another source of enthusiasm and energy. He felt like he was not progressing as fast as after that.

Continuing or Moving on

Some participants continued recovering even years after starting. Paul (man, 41 years) described it as *“peeling away layers of the onion”*. While he had already dealt with many things, he still found issues to work on. Other participants felt they had to *“move on”*. Kees worked in prevention. He described how, lately, he wanted to distance himself more from his past:

> I don't feel like talking about the Kees I was then. I have benefited a lot from that for a while, also you know, providing information for others, but it bothers me a lot now. (Kees, man, 38 years)

Others also noted that, after following a certain treatment regime or mutual aid program, they felt the need to *“break free*” from that after some time. Participants developed their *“own method”* for recovery or became *“rebellious”* or *“stubborn”*. Sara, with more than five years of recovery experience, noted how she sometimes saw other people struggle when they *“stick too much”* with what they were taught:

> Then I think to myself ‘just let it go, man’. If you're in your recovery and things are going well, let go of those steps at some point. But people are so afraid of relapsing. (woman, 54 years)

5. *Universal life lessons*

Participants dealt with a variety of life events, not just addiction. This makes recovery experiences complex and causes and effects are often non-linear. In this context, participants also described processes in their recovery that may be called *universal*, because many people may experience them, regardless of addiction experiences. In other words, ‘normal’ developmental processes in life. Additionally, participants applied specific recovery experiences broadly in their lives. While still crucial to recovery, many recovery ‘lessons’ transcend the context of addiction recovery.

Coming of Age

Participants described a process similar to the normative idea of entering adulthood or coming of age.

> I can now genuinely enjoy sitting on the couch on a Saturday night and putting on a movie. I am now mainly concerned with what I like, just… It's very different. Social life is... I still have it, but it’s just in a different way. (Angelina, woman, 36 years)

When we asked Angelina why she described her social life as different, she reflected on her life course and age: *"I'm 36 now"*. It became more important for her to listen to herself, instead of relating to peers, representing a shifting self-perception. Such shifts not only took place regarding identity. Giovanni, in recovery from cannabis addiction, told us that he had recently smoked cannabis again. However, this was not like his addicted use:

> I have learned so much as a person, not just in recovery. (..) Your perception changes, hasn't yours too? Don't you think differently about things than when you were 18? I notice that in myself too. I used to dive into everything and now I'm like 'shit, if I do this, then this could happen'. You just change. (Giovanni, man, 35 years)

Giovanni thinks this happens to everyone who gets older. He *"just happened"* to experience some things on this path that most people will not, but the general process of change is similar.

"This should be taught at schools"

Participants also applied the lessons learned in recovery beyond the context of recovery. They described how other people, without addiction experiences, could benefit from their recovery experiences. Angelina (woman, 36 years) said that she sometimes shares her recovery experiences with her parents. Being self-reflective, open, and honest about inner experiences has helped her, and her parents also *"get something out of it"*. Furthermore, participants in mutual aid groups regarded the experience where peers *"really listen"* to each other *"free of judgement"* and *"share"* as something that anyone could benefit from:

> Why are there not such groups for people who feel alone or who are depressed, or you name it? (..) Because it is also about struggles or pitfalls or things you run into. Normal people, non-addicts, have this too. (Simon, man, 38 years)

Ben (man, 47 years) underlined this. He said that the principles of mutual aid groups, such as self-reflection, fulfill such a universal need that they *"should be taught at elementary schools"*. This social connection and willingness to help others is something the world needs more of, according to Ben. He added that besides the healing potential of such experiences, they may also work preventive, boosting resilience for many potentially difficult life events.

Discussion

The goal of this study was to achieve a deeper understanding of drug addiction recovery experiences. We found five central themes that highlight how people learn in recovery: (1) about addiction and how to understand it; (2) that recovery is *not* (only) about drug use; (3) that recovery is to reconsider the self and seeing things in a new light; (4) that recovery is a gradual process; and (5) that recovery is shaped by universal life lessons.

Experiences and awareness of drug addiction were multifaceted. For some, recovery involved learning that their drug use was problematic. In contrast, others were so focused on their drug use as the problem, that they were unaware of the underlying causes of their problems. The process of recognizing and understanding the connection between addiction and broader life aspects was a crucial element of recovery. This connection between addiction and various aspects of the individual and social environment is well known in the addiction field (Jessor, 1987; Mellor et al., 2020; Moos et al., 1990). However, it may not be common lay knowledge, as we found that many participants were unaware of this before recovering and addiction services are criticized for their narrow focus on substance use (Davidson & White, 2007; Tucker et al., 2020). Psychoeducation, in which treatment providers try to offer clear and accurate information to help gain insight and understanding about a disease or condition in order to improve treatment outcomes (Lukens and McFarlane, 2004) may be used to transfer this knowledge.

Aligning psychoeducation in addiction services with lessons from collective lived experiences transcending treatment settings, such as provided by this study, may further improve treatment outcomes. Currently, much information about addiction and recovery is dominated by perspectives from treatment providers (van der Stel, 2020) and is often inconsistent and incoherent between different providers of treatment and support (Renae Fomiatti et al., 2017). Given that many people with addiction problems, including participants in our study, end up using multiple sources of treatment and support (Martinelli, van de Mheen, et al., 2020), they are likely to encounter various and sometimes conflicting narratives about addiction and recovery. This may be unhelpful in the process of understanding one's situation.

Throughout the interviews, participants conveyed that they experienced recovery like a mindset, attitude, or even a lifestyle and that shifting perspectives of how persons look at themselves and at things that have happened in the past, helped them to (re)gain control and was a crucial part of their recovery. This is similar to the concept of *personal recovery* found in the mental health field (Anthony, 1993). Personal recovery is understood to drive recovery on clinical, functional, and societal outcomes and includes giving meaning to past events, (re)gaining control over one's own life, and forming a new identity to (re)establish personal and social values (van der Stel, 2013).

We also found how recovery involved social connectedness, as participants reconsidered their place in society and started to live *"good"* and "*authentic"* lives. Furthermore, having hopes and goals motivated participants, and they were highly reflective of their sense of self or identity, of the meaning of their past experiences and recovery, and described processes that enhanced feelings of empowerment. Leamy and colleagues (2011) outlined a framework that includes five similar key personal recovery processes for persons with mental health problems: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment (CHIME). This framework has also been applied in the context of addiction recovery (De Ruysscher et al., 2017). Our study adds insights into *how* persons in recovery from drug addiction experience such processes.

Although participants experienced recovery as a process with distinct stages, we found no sequentiality. Some participants started with changing their drug use, while others prioritized psychological wellbeing, work, or family. Participants went through processes of trial and error, focused on various aspects, and their efforts did not always lead to improvements. This is in line with other studies based on lived experience that show how recovery processes are complex and discontinuous (Kougiali et al., 2017; Witkiewitz & Marlatt, 2007). This chaotic and complex reality is argued to apply to any significant behavior change (Resnicow & Page, 2008). Still, our study suggests some directionality in the recovery process. We found how life events can plant *seeds* and that people continue to improve themselves or 'move on' from their addiction experience. Others also found this cumulative effect of recovery that can develop over years and throughout multiple treatment episodes (Dennis et al., 2007; Hser et al., 1997). Addiction treatment and support should therefore orient towards long-term goals and support, instead of the currently dominant acute model of care (DuPont et al., 2015; Martinelli, Nagelhout, et al., 2020; Scott et al., 2021).

The universal processes we found, such as coming of age, are also described in the addiction literature. A popular explanation of why people stop or reduce their drug use is the idea of *maturing out*, for example. Winick (1962) noted how persons who became addicted to heroin in their late teens eventually stopped using as they got older and took on *adult roles*, which had been avoided before. Others criticized this notion for being too simplistic, vague and imprecise, and that Winick's theory assumed that drug use and addiction are immature behaviors (Waldorf & Biernacki, 1981). As a sole explanation of why people initiate recovery, maturing out is indeed too simplistic. However, we found that recovery experiences can be similar to the normative idea of maturing as participants described a shift in self-perceptions where relate less to peers and more to themselves. Understanding recovery as part of such broader maturing processes may help treatment providers to

recognize and stimulate recovery in areas beyond substance use. It can help treatment providers to see their patient as a whole person instead of as a disorder. The latter is one of the most prominent critiques on professional treatment by patients' advocacy groups in the mental health and addiction fields (D. Best et al., 2010; Braslow, 2013; Davidson & White, 2007; van Weeghel et al., 2019).

Furthermore, recognizing the commonness of recovery experiences, without understating the impact of drug addiction, may contribute to reduce stigmatization of people with drug addiction. Stigmatization and subsequent discrimination are considered major barriers to recovery (Davidson et al., 2006; van Weeghel et al., 2019). Focusing on deficits, while neglecting resilience, capacity and humanity, reinforces the devaluation of people with drug addiction (del Vecchio, 2006). Instead, it may help to emphasize that people with drug addictions are persons first, entitled to the same rights, responsibilities, and opportunities like anyone else.

Strengths and Limitations

A strength of this study is that we purposively selected participants in varying recovery stages and of varying ages, and an equal number of men and women. Since we did not recruit from a specific treatment setting, the current sample covers a broad arrange of recovery experiences that supersedes that of studies that recruited from one setting. Data-driven thematic analysis involves higher level conceptual interpretation, inherent to the coding process, which may be seen as a limitation because other researchers may allocate different code structures and deduct different interpretations of the same data. By checking and discussing the coding process regularly with the coauthors, we strengthened the validity of these interpretations. Lastly, our findings primarily involve individual experiences of recovery. Participants discussed structural and social factors that can influence recovery pathways, such as stigma or welfare opportunities, to a lesser extent. This may have been less important for the participants, but could also have been a result of using the lifeline interview that elicits autobiographical information, or the result of internalized societal notions that highlight individual experiences and responsibility (Lancaster et al., 2015).

Conclusions

Our study contributes to the expanding recovery literature by providing insights into how people with drug addiction experience recovery over time. Because our sample is highly heterogenous and recruited from a variety of settings, our findings provide narratives of recovery experiences that supersede those of studies performed in a particular treatment setting. We found that understanding the nature of addiction and recovery and addressing different life aspects cohesively are crucial recovery experiences. We also found that recovery involves common or universal life processes. Without understating the impacts of drug addiction, we need to recognize the commonness of these processes.

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6. Addiction and recovery in Dutch governmental and practice-level drug policy

What's the problem represented to be?

Martinelli, T. F., Vander Laenen, F., Nagelhout, G. E., & van de Mheen, D. H. (2022). Addiction and Recovery in Dutch Governmental and Practice-Level Drug Policy: What's the Problem Represented to be? *Journal of Drug Issues*, 002204262210875. https://doi.org/10.1177/00220426221087590

ABSTRACT

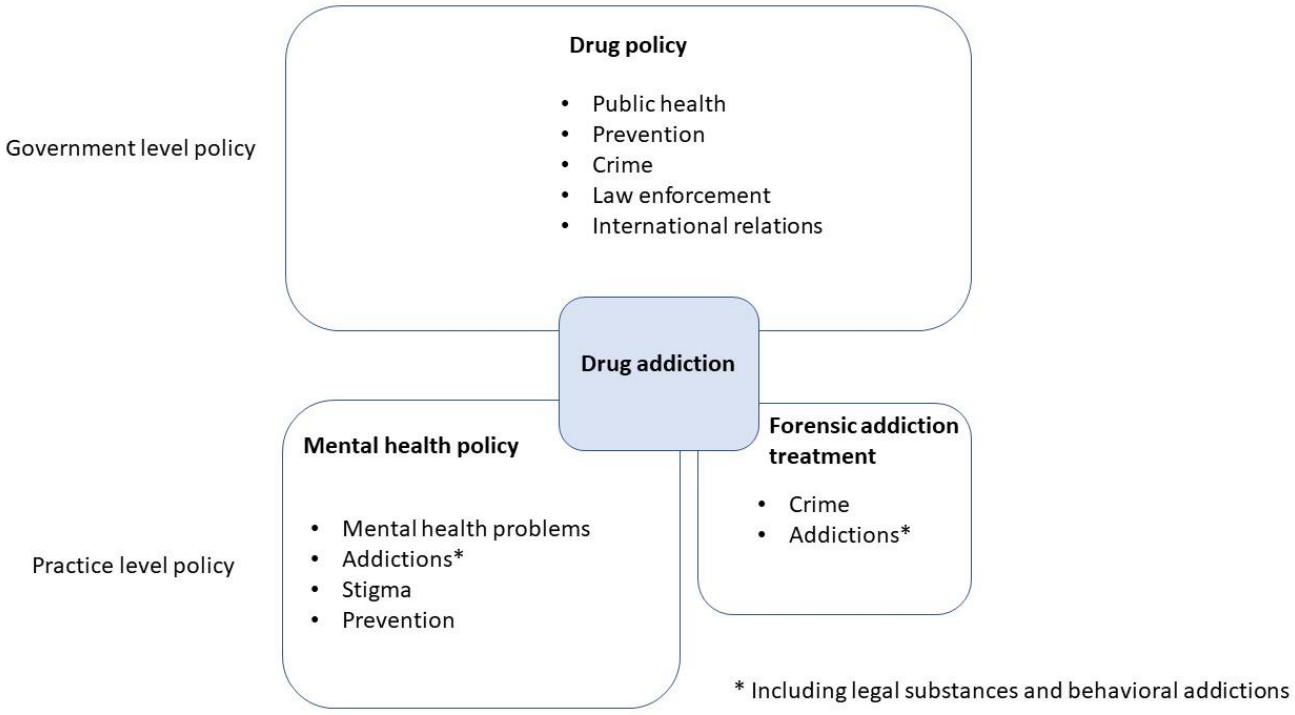
Around 2009, 'recovery' was introduced in the Netherlands as a new approach to drug addiction and addiction services. Recovery is now featured in practice-level policy but is absent in governmental drug policy. To investigate whether the Dutch recovery vision is coherent with governmental drug policy, we apply Bacchi's *What's the problem represented to be?*-approach to analyse problematizations of 'drug addiction'. We analysed two influential practice-level policy documents and one governmental drug policy document. We found that governmental policy addresses the harms and public nuisance of drug addiction, while practice-level policy addresses the well-being of persons with addiction. Despite these different starting points, the Dutch recovery vision seems coherent with both problematizations. Its adoption in the Netherlands was less subject to political debate compared to other countries. This may be a result of recovery being driven by bottom-up efforts without government intervention, leading to constructive ambiguity between government- and practice-level policies.

Introduction

Drug policy in the Netherlands is historically controversial. The essence of this reputation can be traced back to the late 1960s, when Dutch drug policy deviated from international standards and framed drugs more as a public health and social issue, instead of a criminal (justice) issue (Grund & Breeksema, 2018). Consequently, most of Dutch drug policy became the responsibility of the Ministry of Health. Dutch strategies for addiction services, harm reduction and prevention of marginalization and stigmatization of drug users reflect this health focus. In the late 1970s and early 80s, for example, a shift in the Netherlands occurred, when traditional drug treatment services were criticized by user organizations, left wing political parties and progressive treatment professionals for their abstinence-only focus and poor results (Tops, 2006). The Netherlands became the first place in the world to have government-approved needle exchange and supervised injecting facilities and has had drug-testing available as early as 1992, as part of an early warning program combining surveillance and harm reduction (Ritter & Cameron, 2005; Spruit, 2001; Tops, 2006). Another famous example is the so-called *tolerance policy* ('gedoogbeleid' in Dutch) allowing the possession and sale of a limited amount of cannabis products in '*coffee shops'*, which was initiated to protect cannabis users from engaging with more harmful substances, by separating the cannabis (soft drug) market from the hard drug market (Blok, 2011; van Laar & van Ooyen-Houben, 2009).[1] In the late 80s, however, Dutch drug policy changed direction and got increasingly repressive, as law enforcement programs were initiated to reduce drug-related public nuisance, aimed at people who use drugs (Mol & Trautmann, 1991).[2]

The current Dutch drug policy is primarily based on a white paper from 1995 (*Nota "Het Nederlandse Drugbeleid: Continuïteit En Verandering" - Drugbeleid*, 1995) and has since only been complemented with specific subjects, mostly around law enforcement (van Laar & van Ooyen-Houben, 2009). In the following years, much of the (mental) health sector was privatized (*Zorgverzekeringswet*, 2006) and Dutch drug addiction services could evolve almost independently from governmental drug policy. As such, they are now independent organizations that are financed through health insurance.[3] The fifteen largest addiction service providers are affiliated with the branch organization 'The Dutch Mental Health Sector' ('De Nederlandse GGZ'). Consequently, we can distinguish two types of policy that address drug addiction in the Netherlands: one drafted by the Dutch national government, in the form of *drug policy* (including both public health and law enforcement perspectives), and the other drafted by the Dutch mental health and specialized addiction sector, representing the *practice-level policy of addiction services* (see Figure 1). Dutch governmental drug policy consists of a whitepaper and a myriad of 'letters to parliament', while practice-level addiction policy consists of a few key vision and mission documents and guidelines from the national branch organization. Although both types of policies address drug addiction, they start from fundamentally different premises about the problem of drug addiction. So far, no studies have compared these two types of policies.

Figure 1: Different policies that address drug addiction in the Netherlands



Around 2009, the concept of *recovery* was introduced in the Netherlands as a new approach to deal with addiction. This new concept, which originated in the United States (US) is also gaining interest in other parts of the world, challenges existing addiction service approaches, and is often described as a *paradigm shift* (Davidson & White, 2007). Briefly, it is described as a shift from a clinical disorder-oriented approach, characterized by a focus on symptoms of addiction (and symptom reduction), towards a person-centred and broader wellbeing-oriented approach, through learning from lived experience (W. L. White, 2007). Typically, a clinician is more concerned with remission of symptoms and outcomes of addiction treatment, while a person who experiences addiction may be more concerned with things as loneliness, stigma, or identity, and the *process* of getting better (Davidson & Roe, 2007). While a definition of recovery is still debated, it is increasingly agreed upon that recovery is a *process* that can take place in various ways, depending on circumstances, and may include improvements in multiple life domains, such as housing, relationships, employment, and wellbeing (Kaskutas et al., 2014; Neale et al., 2014). In the Netherlands, most addiction services have embraced recovery as a concept to approach addiction. Directors of the largest treatment providers agreed to endorse recovery through the Charter of Maastricht, initiated by a service user advocacy organization who emphasized the need for a broader focus of recovery in addiction services at that time (Charter of Maastricht, 2010). Recovery is now featured in three practice-level policy documents (Expertise Center Forensic Psychiatry, 2020; GGZ Nederland, 2009, 2013) and in the recently developed national Standards of Care (2017-2020).[4] The Dutch governmental drug policy (*Nota*, 1995) uses the term recovery in relation to addiction but here it refers to merely becoming abstinent which is not the same concept of recovery as described above. No Dutch governmental drug recovery policy currently exists.

The historical reputation of the Netherlands has often made the country subject of international debate on drug policy. However, with the legalisation of cannabis in countries such as Canada, Uruguay and the US, the Netherlands no longer deviates as much internationally with its *tolerance*

policy or other public health focused drug approaches, including harm reduction strategies. However, Dutch addiction services have adopted a seemingly new approach to drug addiction which merits attention, particularly because of the way they have adopted it. It appears that, opposed to other countries which have endorsed the addiction recovery concept in governmental drug policy, recovery is adopted bottom-up in the Netherlands without involvement of the government (Bellaert et al., 2021). Furthermore, while different international studies have described problematizations of drug policy and translations of recovery movements into drug policy ideas (Fomiatti, 2017; Gilman, 2011; Humphreys & Lembke, 2014; Lancaster et al., 2015; Thomas et al., 2019), we are not aware of any studies that look at practice-level policies in relation to governmental-level drug policies. Given that the recovery movement is gaining interest in other European countries as well (Bellaert et al., 2021), the Dutch case can be particularly relevant for an international audience.

To understand to what extent recent developments in the Netherlands in the practice of drug addiction services are coherent with the unchanged and older Dutch governmental drug policy, this paper aims to reveal and compare the rationale through which two types of policy address the problem of drug addiction: government-level drug policy and practice-level addiction policy. To do so, we analysed the problematization of drug addiction by applying the *"What's the Problem Represented to be?"* (WPR) approach (Bacchi, 2009; Bacchi & Goodwin, 2016) to analyse both policies.

Literature

From a theoretical perspective, scientists debated the concept of drug addiction. Historically, addiction has been framed as 'moral failure' (Siegler & Osmond, 1968), a disease (Jellinek, 1960) and a biopsychosocial phenomenon (Engel, 1977), for example. More recently, influential institutes, such as the US National Institute on Drug Abuse, consider drug addiction to be a chronic and relapsing brain disorder (National Institute on Drug Abuse, 2021). At the same time, other researchers refute the idea that drug addiction is a brain disorder by emphasizing the psychological and social aspects of addiction (Heather et al., 2018). As such, different definitions of drug addiction and assumptions of the underlying mechanisms of drug addiction currently co-exist in the academic world. Furthermore, some argue that because of these variations over time and contexts, addiction should not be seen as an actual existing condition, but rather as a social construct that is subject to power struggles, cultural and political developments and events (Levine, 1978; O'Mahony, 2019; Seddon, 2009). More widely accepted is the notion that drug addiction has a major impact on health and consequently on the ability to live a fulfilling and productive life. From a policy perspective, this impact of drug addiction on health is an important driver for policy development.

In the last two decades, several shifts towards addiction recovery-oriented governmental drug policies have taken place, particularly in the US, the United Kingdom (UK) and Australia. Scholarly work critically examined these recovery movements (D. Best et al., 2010; Braslow, 2013; Duke, 2013; Renae Fomiatti, 2020; Renae Fomiatti et al., 2017; Lancaster et al., 2015; Neale et al., 2014; Seear & Fraser, 2014; Thomas et al., 2019). While the term 'recovery' is strongly linked to the abstinence-based Alcoholics Anonymous and other twelve step fellowships, addiction recovery as used in this paper is mainly influenced by the parallel mental health recovery movement (Davidson & White, 2007; W. L. White, 1998). Discussing this parallel mental health recovery movement in the US, Braslow (2013) argues that although recovery is framed as a revolutionary answer to the deinstitutionalization and the psychopharmaceutical revolution in mental health, many recovery ideas were already broadly supported by the medical and mental health sector. Additionally, Braslow (2013) describes recovery in the US as deeply embedded within sociocultural values of neoliberalism, because of the focus on the individual and his or her own responsibility. In the UK, studies also linked the reframing of drug policy towards recovery to parallel developments within wider political, economic, and social contexts. Duke (2013) argues, for example, that the strategies behind the Big

Society agenda (Cameron, 2010), with underlying emphases on neoliberal values (e.g. empowerment, freedom, citizenship, and responsibility), "fit easily within the recovery agenda, which places emphasis on the role of individuals, families, communities, and volunteers in supporting the recovery process" (Duke, 2013, p. 48). A comparative study of UK and Australian drug policy documents that feature recovery underlined this observation (Lancaster et al., 2015). In both countries, drug policy frames *all* drug use and dependency as a problem of the individual needing 'curative attention', ignoring alternative experiences of drug use and health paradigms (Lancaster et al., 2015).

Besides revealing how recovery is framed, policy analyses in the US, UK, and Australia also describe the translation of recovery movements into policy ideas. Humphreys and Lembke (2014) describe how both in the US and in the UK dissatisfaction with the addiction service system combined with the prominent role of (academic) recovery advocates was key in the development of recovery policies. In the US, government funded programs, such as the Recovering Community Services Program, and the Substance Abuse and Mental Health Services Administration (SAMHSA) allowed addiction services to organize themselves, paving the way for a shared advocacy agenda and the adaptation of recovery as a cornerstone of federal drug policy (Humphreys & Lembke, 2014; Humphreys & McLellan, 2010). These US recovery advocates also increasingly inspired actors in the UK and offered new ideas on how to organize addiction services (Best et al., 2010; Gilman, 2011). By 2008, recovery was featured prominently in UK governmental drug policy (UK Drug Policy Commission, 2008). In Australia, new recovery policy ideas were in turn influenced by UK advocates in a similar fashion (Fomiatti, 2017; Thomas et al., 2019).

In sum, these international recovery movements shared dissatisfaction with systems of addiction services and saw a prominent role for academic advocates of new recovery policy ideas. Furthermore, researchers have criticised the adoption of recovery in several national drug policies for imposing certain political values and citizenship goals upon drug users. So far, emerging recovery movements in continental Europe, including in the Netherlands, have received limited scholarly attention, and there are no studies yet examining its influence on drug or addiction policies (Vanderplasschen & Vander Laenen, 2017).

Approach

Inspired by Foucault's (1988) work on 'problematization' and 'thinking problematically', the study of problematizations in drug policy has seen a recent uptake, particularly in the US and Australia. In a recent special issue in the International Journal of Drug Policy (Houborg et al., 2020), drug scholars applied Bacchi's (2009; Bacchi & Goodwin, 2016) post-structural analytic strategy 'What's the problem represented to be' (WPR) approach to study problematizations in drug policy. In short, Bacchi (2009) argues that instead of policy simply addressing problems as they emerge, *problems* are constructed in a certain way by integrating particular facts, values, theories and interests. In other words, a problem is *produced* as a particular type of problem that needs regulation or intervention in a particular way. Studying such problematizations gives insights into underlying assumptions of policy and can also reveal 'silenced' assumptions that are often not made explicit. Using this method, Lancaster et al. (2015: p.617) argued, for example, that key reports on the place of recovery in Australian and UK drug policy framed people who use drugs "*as worthy of citizenship in the context of treatment and recovery*". However, this also implicated a *silenced assumption*, namely that those who continue to use drugs are unworthy of such rights. We are not aware of studies applying Bacchi's (2009) WPR approach to recovery in continental Europe. In the Netherlands, despite its historically controversial drug policy, a strong tradition of monitoring and evaluation of drug policy (van Laar & van Ooyen-Houben, 2009), and the introduction of addiction recovery in practice-level policy documents since 2013, no policy studies around addiction recovery have yet been performed.

As a tool, the WPR approach formulates six methodological questions, which we outlined in Table 1. The application of this approach to drug policy and related subjects has led to a diversity of analyses highlighting different ways of thinking about governmentality and laying bare potential stigmatizing or marginalizing effects of said policies (Houborg et al., 2020; Seear & Fraser, 2014).

Table 1. Questions from the What's the Problem Represented to be (WPR) approach

1. What's the problem represented to be?
2. What presuppositions or assumptions underlie the representation of this problem?
3. How has this representation of the problem come about?
4. What is left unproblematic in the problem representation? Where are the silences? Can the problem be conceptualized differently?
5. What effects (discursive, subjective, lived) are produced by this representation of the problem?
6. How/where has this representation of the 'problem' been produced, disseminated, and defended? How could it be questioned, disrupted, and replaced?

Source: Paraphrased from Bacchi and Goodwin (2016, p. 20).

Method

We collected the data in this paper as part of a larger European study (REC-PATH) in the Netherlands, Belgium and the UK that focuses on examining personal and structural factors that influence drug addiction recovery pathways (Best et al., 2018). Fundamentally, studying recovery pathways of individuals (see for examples: David Best et al., 2021; Martinelli, Nagelhout, et al., 2020; Martinelli, van de Mheen, et al., 2020), requires studying the policy context in which addiction and recovery occur and evolve (Bellaert et al., 2021). For REC-PATH, the authors have extensively engaged with and published international recovery literature before writing this paper. Each national research team in the project was tasked with studying the recovery policy in their respective country, without specific requirements of that investigation. This WPR-study was approached as a distinct project and the findings are not particularly linked to results of the larger project.

We analysed two practice-level addiction policy documents and one government-level drug policy document (Table 2). The practice-level policy document by 'The Dutch Mental Health Care Sector' (GGZ Nederland, 2013) represents the most influential document as it covers the largest addiction service providers in the Netherlands. The other practice-level document by the Expertise Centre Forensic Psychiatry represents a more specialised document that covers drug addiction treatment in forensic settings. We selected these documents because they are the most recent comprehensive and influential policy documents available that address drug addiction in the Netherlands. The documents were all published in Dutch and analysed by the first author whose native language is Dutch.

Table 2: Documents used for analysis

Policy documents	Published by	Year
Dutch Drug Policy: Continuity and Change	Ministry of Health	1995
A Vision on Addiction and Addiction Services	The Dutch Mental Health Care Sector	2013
National Care Program for Forensic Addiction Services	Expertise Centre Forensic Psychiatry	2014-2020*

* First published in 2014 and updated several times with minor changes, last update in 2020

The WPR approach (Bacchi, 2009; Bacchi & Goodwin, 2016) was used for analyses of the policy documents. Guided by the questions outlined in Table 1, the first author investigated how addiction is problematized in Dutch drug policy and in practice-level policy. After examining assumptions and issues that are framed as 'problems', we reflected on what was framed as a solution to the problem of addiction. In each step of the analysis, the first author discussed results via online videocalls with the second and last author, who are both senior drug scholars with ample expertise in policy research internationally and in the Netherlands. We encountered no major disagreements in these discussions, however, the senior co-authors occasionally provided or asked for additional information or literature around certain topics of the investigation that helped to validate interpretation. Finally, a draft of the manuscript was presented to the third author who, without prior involvement, joined the final discussion on the interpretation of the findings. This discussion helped to resolve some unclarities in the manuscript. This expert-reflection strengthened the validity and credibility of the problem interpretation.

First, we scrutinized and analysed the policy documents. The analysis focused on identifying for each type of policy: problem representations of drug addiction (Q1, Table 1); assumptions underpinning these problem representations (Q2, Table 1); what was left unproblematized in these representations (Q4, Table 1); and alternative ways of framing of representations (Q6, Table 1). Scrutinizing the documents in this way allowed us to think about the potential effects that are produced by these problem representations (Q5, Table 1) and how the concept of recovery fits in this context.

Results

Problematization of 'Drug Addiction' in Governmental Drug Policy

The *problem* of drug addiction represented in Dutch governmental drug policy, is about drug use and risks for public health. However, not all drug use is seen as an unacceptable risk to public health. This depends on "*the circumstances under which and the extent to which drug use takes place*" (Nota 1995: p.4). Particularly drug use that results in social and individual harms is considered problematic in the governmental drug policy. People who use drugs problematically, referred to as addicts, are individuals that cause harm to themselves or to their environment. Furthermore, drug addiction is described as a *lifestyle* and a form of "expression of social or cultural resistance for youth", which is purposively discouraged by withholding repressive law enforcement (so there is nothing to resist against) (Nota 1995: p.8).

Notably, only *hard drug* use is problematized. The Dutch 'Opium Act' (*Act of 23rd of June 1976*, 1976) makes a distinction between drugs with acceptable risks, referred to as *soft drugs* (including cannabis products), and drugs with unacceptable risks named *hard drugs* (including heroin and cocaine for example). Cannabis use is explicitly unproblematized in Dutch drug policy: "*the risks of cannabis use are not qualified as "unacceptable", in contrast to the risks associated with the use of hard drugs, such as heroin*" (Nota 1995: p.36). Thus, the problematized subjects of drug addiction in Dutch governmental drug policy are persons that use hard drugs in a way that results in harms to themselves or to others.

The distinction made here, between acceptable and unacceptable drug use, is a so-called *dividing practice*. According to Bacchi and Goodwin (2016), practices of differentiation and subordination are fundamental governing mechanisms. Here, based on the substance(s) they use, the Dutch drug policy produces the idea that there are different categories of people with drug addictions who require different types of governing. The underlying assumption is that the extent of individual and social harms is associated with the type of substance(s) a person uses. This distinction justifies the tolerance policy towards cannabis users and a tougher repressive approach towards hard drug users. In practice, this means that the police may, but generally will not, address someone that uses

cannabis in a public place (unless this use causes obvious nuisance to others), while users of other illicit drugs will have an increased chance of being addressed by police. Discriminatory enforcement of drug policy may be exceptional; however, Uitermark (2004: p.518) argues that this flexible approach to drug enforcement offers more opportunities to set 'sophisticated and sensible priorities' compared to a fixed prohibitionist approach. It allows one to weigh the undesired effects of criminalization of users and other policy measures against one another (de Kort & Cramer, 1999).

The rationale of setting policy priorities based on harm and risk assessment of substances has also been proposed in the research of Nutt et al. (2007; 2010), for example. The authors argued that the relative harms of substances correlate poorly with the UK national drug classification and that this called for a reconsideration of said policy (Nutt et al., 2010; Tran, 2009). However, in both the Dutch drug policy and the Opium law, the criteria to establish whether a substance is harmful are only vaguely described using the terms 'health damage' or 'addiction' (only liver and kidney damage are explicitly mentioned in relation to XTC use: Nota 1995: p.17). More prominently, the number of people that use a certain drug and the number of people that are addicted to it, are considered an indicator of the harmfulness of that drug by Dutch drug policy. These numbers are also considered an indicator of drug policy success (or failure):

> "However different views on drug policies may be, there is broad consensus on the ultimate criterion by which to assess the effectiveness of any national drug policy. This is of course the magnitude of and changes in the number of hard drug addicts and in particular the number of hard drug users under the age of 21." (Nota 1995: p.7)

While the number of 'hard drug addicts' was considered relatively low in 1995, as stated in the document, it was considered a 'major societal and administrative problem' bothering communities (Nota 1995: p.9). This nuisance is caused by 'large numbers of property crimes to acquire money for the purchase of drugs' and 'an extremely maladaptive lifestyle of which stray behaviour, (poly) drug use and crime are mutually reinforcing elements' (Nota 1995: p.9). However, the document also explains that nuisance is often incorrectly attributed to persons with drug addiction and that nuisance is actually part of a wider problem of social marginalization. Here, one could even say that the Dutch drug policy performs an analysis of the problematization of drug addiction herself. The document argues that the proposed underlying assumption of this problem, namely nuisance by persons with drug addiction, is incorrect. Regardless, 'nuisance from hard drug users' is still presented as part of the problem of drug addiction. The accommodation of both pointing out and recognizing social marginalization as an underlying assumption for nuisance and at the same time ascribing blame to 'drug addicts' in this policy may be the result of the typical Dutch *polder model.* This political mechanism, is described as a pragmatic recognition of pluriformity (Kuipers, 2015) and refers to a broader practice of cautious governance where different stakeholders try to reach outcomes that are acceptable for all. It can be seen as an alternative to authoritarian governance and emphasizes the role of the government as *primus inter pares* - important, but not imposing (Delsen, 2000; Uitermark, 2004).

Proposed solution to the problem of addiction

In response to the nuisance problem, Dutch drug policy aims to "condition the behaviour" of persons with drug addiction by 'sanctioning deviant behaviour' and 'rewarding correct behaviour', although without explicitly stating how this will be achieved (Nota 1995: p53). This approach implies an interpretation of drug addiction as rational choice behaviour, whereby the problem subject is in control of and responsible for his or her behaviour, which is assumed conditionable. This interpretation is underlined in the policy document when two 'key concepts' for drug treatment are discussed, namely (1) responsibility and (2) reciprocity:

> "Addicts need to accept responsibility for their own behaviour. Being addicted is no excuse for causing nuisance to others. The second concept, reciprocity, means it is expected that in

> return for the help provided, the addict at least adheres to what was agreed upon with support services." (Nota, 1995: p.26)

The policy document simultaneously calls for the need to offer "*opportunities to also address aspects such as social disadvantage, housing and social skills*", in the context of demand-oriented addiction treatment (Nota, 1995: p.26). This latter statement proposes that the problem of addiction is about more than hard drug use and rational choice behaviour, and that structural inequalities and social disadvantages are also underlying to the problem of drug addiction. Here again, multiple problem representations on the same subject are proposed. This may be the result of more *poldering,* as opposing views on how much responsibility can be attributed to behaviour of individuals can differ across political spectrums (Brewer & Stonecash, 2015). In the Netherlands, with a multi-party government and house of representatives, such opposing viewpoints on individual responsibility also exist between parties (Berg et al., 2021). Generally speaking, right-wing parties attribute more responsibility to individual behaviour compared to left-wing parties. We shall discuss some of the implications of the described problematization of drug addiction in the *concluding thoughts*, after addressing the problematization of addiction in practice-level policy.

Problematization of 'Addiction' in Practice-level Policy

As stated in the introduction, Dutch practice-level addiction policy developed without much interference from the governmental Drug policy. While both policies address the problem of drug addiction, they do so from different starting point and within different contexts (see Figure 1).

Problematization of drug addiction by the addiction services
The problem represented in Dutch practice-level policy is that drug addiction constitutes a broad range of health, social, societal, and personal harms to individuals. Moreover, this problematization is not limited to illicit drugs, but also addresses problematic use of legal substances, such as alcohol, and behavioural addictions. No specific substances are problematized more than others or are left unproblematized. Thus, unlike in the Dutch drug policy, cannabis use is considered equally problematic as other substances in the practice-level policy documents. Problematized subjects are those who have gotten into 'serious problems' because of their addiction or who cause harm to their environment. Furthermore, a future focus on the following 'vulnerable groups' is stated: 'young people, people with mild mental disabilities, the elderly and people with comorbid problems' (GGZ Nederland, 2013, p. 29).

The practice-level policy also performs divisive practices by making a distinction between substance *addiction* and *abuse*, similar to how substance 'use, misuse and dependence' are distinguished in Australia's National Drug Strategy (Renae Fomiatti, 2020, p. 4). In the Dutch practice-level policy, abuse is described as continued heavy use of substances that causes problems and is considered to be a pre-stage of addiction and easier resolvable compared to addiction. This justifies the need for different levels of treatment intensity and duration.

Furthermore, the document criticizes a societal trend and government policy for being 'permissive' towards substance use:

> "The addiction services sector wants to increasingly counter the permissive attitude that has been outlined over the past decades – also by the Dutch government." (GGZ Nederland, 2013, p. 11)

By criticizing a 'permissive attitude' towards substance use, this statement implies that the document has different notions as to what harms or risks are acceptable compared to Dutch society and government. It suggests that a more strict or intolerant (opposed to 'permissive') attitude towards substance use is necessary. By producing the public's and government's attitude as a problem, the statement proposes that a certain public attitude can influence the emergence, continuation or even

worsening of addiction problems. This assumption is similar to the 'normalization thesis' that followed after the 1980s dance/rave boom in the UK which argued that (recreational) use of some drugs (e.g. cannabis, XTC and amphetamines) had become so common for youth, that it was no longer considered deviant behaviour and was *normalized*. The original authors (Parker, Measham, and Aldridge 1995: p.26) went on to predict that '*non drug-trying adolescents will be a minority group'*. This theory was soon criticized for exaggerating the extent of drug use, simplifying choices young people make and ignoring the meaning that drug use had for them (Shiner & Newburn, 1997). Similarly, assuming that a permissive public attitude leads to more addiction problems may be a simplification of reality.

Another proposed problem of addiction in the practice-level policy document, is that addiction makes people who suffer from it think and behave in a deviant way, particularly affecting their agency. It proposes that substance use is the underlying cause of this, as addiction is described as: "a response to physical, psychological and social adaptations that occur after regular and/or excessive use of a psychoactive substance (or regular and excessive performance of behaviours) with non-functional and harmful consequences", and where deregulation of brain activities is evident (GGZ Nederland, 2013, p. 15). The document goes on by stating that addiction is characterized by the loss of autonomy, for example the autonomy of free choice over continuing or stopping substance use. More serious effects, according to the document, include a persons' behaviour and thinking being completely fixed on using substances, limiting social and psychological functioning. At the same time, it states that recovery is always possible and "*many are able to change their behaviour and thus their addiction, for the most part without professional help*" (GGZ NL 2013: p.17). In critical literature on the brain disease model of addiction, the high prevalence of 'natural recovery' (Granfield & Cloud, 2001), or recovery without professional help, is often presented as an argument that addiction is *not* a clinical brain disease (Heather et al., 2018). The Dutch practice-level policy is explicitly impartial about such understandings of addiction, stating that definitions of addiction as either a brain disease or a 'cultural problem' contain "a core of truth, but they fall short as a description of the problem" (GGZ Nederland, 2013, p. 17).

Furthermore, the document states that it is crucial that any support aimed at resolving addiction should start "*from an unconditional respect for the autonomy of the individual and from the fundamental insight that self-determination and free will are inherent in human existence*" (GGZ NL 2013: p.17). The presentation of addicted persons as disordered subjects with affected agency (and a deregulated brain) on the one hand, but also in control, autonomous and self-determined on the other hand is also found elsewhere in recovery policy research. Fomiatti et al. (2017), for example, argue that various treatment philosophies, as well as medical and scientific knowledge, produce incoherencies about the nature of addiction and those defined as addicted. These symptom-focused and clinical problematizations of addiction are often criticized by the addiction recovery movement (Davidson & White, 2007). In the Netherlands, the national service user representative organization (Black Hole foundation) argues that clients in the addiction services should not be seen as an object of care, but instead as a subject of care (Black Hole Foundation, 2015). Seeing clients as objects means seeing addiction services as the treatment of addiction symptoms first and foremost. However, seeing clients as subjects means seeing addiction services as offering service to autonomous individuals first and foremost, which may include treating symptoms of addiction.

Lastly, the practice-level addiction policy implicitly presents a structural and societal problem of addiction: stigma. The document states that many persons with addiction only seek help after long periods with problems or when they 'get stuck', after which recovery is more difficult. The cause of this is described as "*denial, trivialization, taboo and shame"* (GGZ Nederland, 2013, p. 6). On one hand, these aspects are personal and concerned with individual behaviour, (lack of) personal insight, coping strategies, or self-stigma, but on the other hand, this is linked to public stigma and

discrimination (Wakeman & Rich, 2018). There is no further discussion of stigma in the practice-level policy documents.

Recovery vision: proposed 'solution' to the problem of addiction
In the practice-level document (GGZ Nederland, 2013), the *layering* of the problem of addiction is highlighted, as addiction is presented as a problem of biological, psychological, social and cultural levels. Accordingly, the existence of many definitions of recovery is recognized. As such, four interrelated aspects of recovery, also described by van der Stel (2014), are assumed: clinical, personal, functional and societal recovery. The practice-level policy does not just problematize substance use and its consequences, but also problematizes personal and social issues that persons with addiction may encounter. Ultimately, the problem of addiction, according to practice-level policy, is about loss or lack of quality of life, wellbeing, and autonomy.

Problematization of drug addiction by the forensic addiction services
Another practice-level sector concerned with drug addiction treatment in the Netherlands are the forensic addiction services. The main difference with regular addiction services is that forensic treatment programs are court-ordered and mandatory for their clients and are therefore always linked to a committed crime and a repressive criminal justice framework. However, forensic addiction service policy also tries to find solutions within that criminal justice framework to preserve autonomy and enhance people's lives. The problem representation of drug addiction in the forensic addiction service sector can be described as pragmatic. The guiding principle is the effect that addiction has on (the risk of) criminal behaviour. In other words, drug addiction is a *problem* if the consequences lead to crime or recidivism.

> "Abstinence is and remains the treatment goal to be pursued for every client, but the relationship between substance use and criminal behaviour is the starting point. If substance use is permissible within the treatment goals (and therefore the risk of recidivism is not increased), controlled use is acceptable." (Expertise Center Forensic Psychiatry, 2020, p. 11)

Problematized subjects are described broadly: any adult (18 years or older) client who uses substances with risk of criminal behaviour. This target group is described as often having other mental health problems as well, such as psychiatric disorders or intellectual disabilities. This comorbidity is highlighted as an important part of the *problem* of addiction. Because of the focus on crime risks, the presented problem is extended to any substance use or behaviour that is potentially related to crime, not just addiction. Furthermore, no distinction is made between hard drugs and cannabis, as is done in the governmental Dutch drug policy.

In the forensic addiction practice-level policy document, several leading underlying principles and models are described that can be applied simultaneously or whenever most appropriate: the *What Works* principles (or *Risk-Need-Responsivity* model) (Andrews & Bonta, 2010), the *Good Lives* model (Ward & Stewart, 2003), the recovery model (Anthony, 1993), the rehabilitation model (Pieters & Peuskens, 1995) and the biopsychosocial model (Engel, 1977). For the recovery model, the document refers to the model used in the practice-level document of addiction services (GGZ Nederland, 2013; van der Stel, 2013). These models, especially when applied together, address much more than substance use or addictive behaviours. The underlying assumption is that many aspects of life are related to addiction and crime and that recovery is more like a way of living than a clinical reduction of symptoms.

Discussion

In the analysis of government and practice-level policy we aimed to show how drug addiction is problematized in two types of policy that address drug addiction in the Netherlands. The goal was to understand how the recent adoption of addiction recovery in addiction services practice fits within

the unchanged older governmental drug policy. In practice-level policy, recovery is the leading principle of addiction treatment and entails personal, clinical, societal, and functional recovery. Without explicitly referring to the concept of addiction recovery in any of the governmental Dutch drug policy documents (including in the more recent 'letters to parliament'), the national drug policy touches upon some elements of recovery nonetheless. The discussion of abstinence-based vs harm reduction approaches addresses clinical aspects of recovery. Furthermore, by recognizing the role that inequalities and social marginalization play in drug addictions and by appreciating the therapeutic effects of heroin-assisted treatment, societal and functional aspects are acknowledged. However, something similar to personal recovery, which particularly characterizes the recovery movement historically (Deegan, 1988; van der Stel, 2013), is lacking in the current governmental drug policy. Thus, while providing a nuanced and comprehensive problem representation of drug addiction, a crucial link with recovery in practice is currently lacking in the governmental policy.

The lack of recovery in national drug policy has not hindered the development of recovery-oriented practice-level policies in the Netherlands substantially. The Dutch recovery movement was able to gain ground and influence the mental health and addiction services bottom-up, without the need for a governmental program or policy vision (Bellaert et al., 2021). Consequently, the concept of recovery in practice-level addiction policy was less subject of political debate and interpretation in the Netherlands compared to other countries where the concept was introduced. In the US, UK and Australia, scholars and harm reduction advocates have criticized governmental recovery policy documents because they helped enforce conservative neoliberal values, making addiction recovery the responsibility of individuals, because they problematised all drug use, and because they coincided with budget cuts (Duke, 2013; Humphreys & Lembke, 2014; Lancaster et al., 2015). Perhaps more similar to the Netherlands, Irish political leaders and civil servants pragmatically avoided such debates between recovery advocates and their critics by initially using the term 'rehabilitation' rather than 'recovery' in the development of their drug policies (Mayock & Butler, 2021). In the Netherlands, addiction services consequently adopted a recovery vision that was less influenced by political debate and more influenced by developments in the broader mental health field, which in turn was influenced by lived experience advocates. An explanation may be that the long history of viewing drug addiction as a public health issue in the Netherlands, has made the introduction of recovery more like a continuing development of addiction services rather than a paradigm shift.

Even though the Dutch addiction service practice features recovery throughout, recovery is not adopted in government policy. A possible explanation is that governmental drug policies, that often originated from international conventions (such as the dominant United Nations conventions on Narcotic Drugs), primarily frame criminal justice and law enforcement, even in the Netherlands where drug policy is historically health orientated. Because addiction recovery principles do not strain the boundaries of these frameworks, there may be less urgency to change the Dutch drug policy. This is different for some harm reduction measures, for example. In the Netherlands, the tolerance policy for cannabis and the regulation of heroin-assisted treatment methods were included in governmental drug policy, because they require – contested (Csete & Grob, 2012) – interpretation of the international UN Conventions (United Nations, 1988; *Single Convention on Narcotic Drugs, 1961, as Amended by the 1972 Protocol Amending the Single Convention on Narcotic Drugs*, 1961). In the case of recovery, such international standards are not hindering implementation. Inclusion of recovery principles in drug policy may therefore be less pressing.

Lastly, one of the goals of our policy analysis was to consider the impact of policies on recovery experiences of individuals, as stated in question 5 from the WPR-approach ('*What effects are produced by this representation of the problem?*' see also Table 1). In the Netherlands, the wish to develop recovery-oriented addiction services emerged from (ex-)service users (Charter of Maastricht, 2010). A more equal relationship between service user and provider and stigmatization were

important drivers for the Dutch recovery movement. As we have shown in the current paper, patient emancipation and stigma are both addressed in the problematization of drug addiction in the practice-level documents, but not in the governmental drug policy. This may mean that the problematization of drug addiction in governmental drug policy produces negative effects for people with drug addiction, as it does not address patient emancipation and stigma. Stigma in particular represents one of the biggest barriers to recovery (Room, 2005; van Weeghel et al., 2019). Recovery principles, as proposed in the Dutch practice-level policy, represent a wellbeing and strength-based approach to addiction which views persons with drug addiction as a heterogenous group of autonomous individuals who are more than their condition and who can recover. If government drug policy would also embrace such principles and introduce more consistency in the problematization of drug addiction (opposed to the current *poldering*), it may also positively contribute to patient emancipation and public destigmatization.

Governmental drug policy has allowed room for practice level recovery policies to develop. However, some practical barriers for this development are also described (Bellaert et al., 2021). Structural implementation of recovery-oriented practices was hindered by the rigid and fragmented financial structures in the Netherlands, in which social support comes from municipal budgets, while clinical care is provided through health insurance, for example. In practice, this means that implementation of recovery-oriented practices is still mostly pilot- and project-based, primarily operationalized through employment of *experiential peer experts* (Bellaert et al., 2021). Thus, for individuals with drug addiction, this means that recovery-oriented support, as it is conceptualised in the practice-level addiction policy documents, is not fully available.

Limitations

There are some limitations to this study that merit mention. First, there may have been selection bias regarding the documents that we analysed for this study. While the Dutch drug policy white paper used in this study is not the most recent governmental drug policy publication, it is the most recent comprehensive document and, moreover, still reflects the current policy. We also scrutinized more recent governmental documents for potential relevance to this study but discovered no significant changes in drug policy. Furthermore, some private addiction services are not part of the national association that published the practice-level policy documents. However, these private services represent only a small part of addiction services in the Netherlands. Finally, the WPR-approach is not concerned with addressing how policy problems unfold in practice (Clarke, 2019). Next to discourse, other factors, such as particular actors, also shape policy development. This would require other forms of data collection and analyses, such as *situated practices* as described by Rabinow (2009).

Concluding thoughts

In this paper we analysed how drug addiction is problematized in two distinct types of policy using Bacchi's *What's the Problem Represented to be* (WPR) approach. We argued that both government-level and practice-level policies apply divisive practices to produce a particular problem of drug addiction. First, government drug policy mainly problematizes the nuisance to communities caused by people that use *hard* drugs and their health problems, particularly emphasizing that the harm is related to the type of drug that people use. The proposed solution is a focus from law enforcement and harm reduction services on particular groups of people with drug addiction. Second, practice-level policy problematizes the negative impact of addiction on a person's agency, wellbeing, and surroundings, regardless of the type of substance or addiction, and distinguishes levels of severity of the impact of addiction. Here, the proposed solution is to organise the intensity of treatment and support around the needs of the person with drug addiction.

We compare the two types of Dutch policies discussed in this paper regarding their problematization of drug addiction, however, the dates on which they appeared are far apart. The Dutch drug policy document is 26 years old, while the practice-level document is more recent (2013). Since the

addiction recovery approach is relatively recent, especially in the Netherlands, it makes sense that this is not included explicitly in the older drug policy document and the developments in practice-level policy may also represent a historical development regarding views of drug addiction which the Dutch government has simply not consolidated in a new drug policy yet. As we have shown in the problem analyses, the comprehensive and nuanced Dutch drug policy partly overlaps with and leaves room for a recovery-oriented approach to drug addiction, regardless of whether it mentions recovery explicitly. Still, it could raise the question whether it is time to update the Dutch drug policy. A recent 'manifest for a realistic drug policy' published and signed by prominent Dutch drug scholars, treatment specialists and (former) politicians (Bakkum et al., 2020) suggested to do so. Reasons for the update included substantive issues such as regulation of illicit drugs, and formal issues such as the age and lack of scientific base of the current drug policy. The misalignment of how drug addiction is addressed in governmental drug policy and practice-level policy is not mentioned in the manifest but could be another reason for updating the Dutch drug policy, as treatment providers experience some practical barriers to provide recovery-oriented support (Bellaert et al., 2021).

While both types of policy in this study address drug addiction, they have fundamentally different starting points. Governmental policy deals with large societal issues, including crime, international relations, law enforcement, public health, and prevention, while practice-level policies deal primarily with treatment, prevention and public stigma (see also Figure 1). Thus, that these types of policies present the problem of drug addiction differently may not be surprising. However, it is notable that in the Netherlands the practice-level policy developed independently from government policy to a large extent. Despite different priorities and problematizations of drug addiction, it seems that the comprehensiveness of the Dutch governmental drug policy, partly as a result of the pragmatic *polder model,* ensures that conceptually, both types of policies can co-exist without strain. Moreover, the independent development may also be the reason that addiction services were able to incorporate a vision on addiction recovery that was less subject to political debate as it was in other countries where it was adopted earlier (Duke, 2013; Lancaster et al., 2015). The Dutch recovery movement did not need the government or political parties to get a foot in the door. Nevertheless, practical limitations and barriers for implementation and execution of recovery-oriented practices still exist, which may be the result of that same lack of government involvement (Bellaert et al., 2021).

In conclusion, integrating recovery in governmental drug policy may have benefits, as it can help reduce stigmatization of individuals with drug addiction and lay the ground for a structural implementation of recovery-oriented addiction services. However, governmental adoption of recovery may also have the unwanted effect of enforcing certain political values upon the conceptualisation of addiction recovery, and of causing ideological and organisational conflict, an effect that the Dutch practice-level sector has been able to avoid so far. This delicate situation of constructive ambiguity is important to consider if one attempts to integrate these two visions of how to handle drug addiction.

Endnotes

[1] Tolerance ('gedogen' in Dutch) means that a person will not be prosecuted even though possession of cannabis is officially prohibited by law. In practice, sale of cannabis in coffee shops (under strict conditions), home growing (up to five plants) and possession (up to 5 g) is tolerated. However, to commercially grow cannabis is not allowed, nor tolerated. This means that coffee shop owners are currently forced to supply their shop illegally. By tolerating the small-scale sale of cannabis and cracking down on the trade in hard drugs, the aim was to separate the cannabis and hard drugs markets. The idea was that the risks of cannabis were estimated to be less serious than those of hard drugs. In the 1970s, the sale of cannabis to consumers occurred primarily through home dealers, from the end of the 1980s this mainly took place in coffee shops.

[2] A few areas in the Netherlands had turned into open drug markets, such as the area around the Zeedijk in Amsterdam, the Hoog Catharijne tunnel in Utrecht and Perron Zero in Rotterdam. People who use drugs began to gather in these areas and drugs were sold and used in the open air. Nuisance, caused by petty crime and sometimes the mere appearance of the people who use drugs caused some local residents and shopkeepers to insist that authorities intervene. Several measures were taken, such as area prohibitions which gave police the power to expel people from the area for up to eight hours if they were caught consuming drugs, in possession of a drug-using device, or if they gathered in a public place in groups of Martinelli et al. 15 four or more. For people who use drugs and who repeatedly committed (petty) crime, legal and penitentiary measures were introduced, including the SOV (Measure for the Criminal Care of Addicts).

[3] The Dutch government is responsible for the accessibility and quality of the healthcare system in the Netherlands, but is not in charge of its management. The health insurance system consists of private organizations that operate within strict government determined conditions. Healthcare, including addiction treatment, is funded through mandatory health insurance fees and taxation of income.

[4] In Standards of Care general recommendations for the prevention, recognition, diagnosis and treatment of psychological complaints and disorders are outlined. They are based on scientific knowledge, professional knowledge and experiential knowledge of patients. The standards provide a solid basis for joint decision-making and optimal care and function as guidelines for mental health care.

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7. Language and stigmatization of individuals with mental health problems or substance addiction in the Netherlands

An experimental vignette study

Martinelli TF, Meerkerk G, Nagelhout GE, Brouwers EPM, Weeghel J, Rabbers G, et al. Language and stigmatization of individuals with mental health problems or substance addiction in the Netherlands: An experimental vignette study. Health Soc Care Community [Internet]. 2020 Sep 10;28(5):1504–13. Available from: https://onlinelibrary.wiley.com/doi/10.1111/hsc.12973

ABSTRACT

Persons with mental health problems and/or substance addictions (MHPSA) are stigmatised more than persons with physical conditions. This includes stigmatisation by care professionals. Stigma is considered one of the most important barriers for recovery from these conditions. There is an ongoing debate that use of language can exacerbate or diminish stigmatisation. Therefore, we conducted an experiment examining how four different ways of referring to a person with (a) alcohol addiction, (b) drug addiction, (c) depression and (d) schizophrenia are related to stigmatising attitudes by care professionals in the Netherlands. We partially replicated two studies performed in the United States and used surveys with vignettes containing either 'disorder-first', 'person-first', 'victim' and 'recovery' language, which were randomly assigned to participants (*n* = 361). No significant differences between language conditions were found for any of the vignettes. Our findings suggest that subtle differences in language to refer to persons with mental health problems or substance addictions have no effect on stigmatising attitudes by care professionals in the Netherlands. However, more research is needed to determine the effect of language use on other groups, such as individuals with MHPSA.

Introduction

There are various ways to refer to individuals who experience mental health problems and/or substance addictions (MHPSA), which is often done arbitrarily in public (including media) as well as in professional settings. Terms like 'substance abuser', 'drug addict' or 'a person with a substance use disorder' are often used interchangeably. This is similar with mental illness, e.g.: 'schizophrenic' or 'person with schizophrenia'. However, implicit assumptions that are linked to some of these terms are believed to contribute to the stigmatization of these individuals. There are many examples of 'terms to use' and 'terms to avoid' in the addiction and mental health field (Botticelli & Koh, 2016; Harris & Felman, 2012a; Rose et al., 2007). The issue raises questions on whether language matters and on what terms should be used (Edwards et al., 1981; Richards, 2018; W. White, 2004). We know that stigmatization can harm individuals with MHPSA and act as a barrier for recovery (Lasalvia et al., 2013; Plooy & van Weeghel, 2009; Thornicroft, Brohan, Rose, Sartorius, Leese, et al., 2009), so it is important to examine how to prevent or reduce this. However, debates concerning the effect of language on stigmatization are rarely based on empirical investigation (John F. Kelly & Westerhoff, 2010a). Therefore, we conducted an experiment, to examine how language to refer to persons with MHPSA is associated with various degrees of stigmatizing attitudes by care professionals that work with individuals with MHPSA.

Stigmatization can be described as a process that involves labelling, segregation, stereotyping, prejudice and discrimination and is socially discrediting (Link & Phelan, 2001). In his classic work, Goffman states that stigma can reduce a "whole and usual person to a tainted, discredited one" (p. 3: 11). Theories on stigma around MHPSA have described the impact on individuals in two major ways. First, individuals with MHPSA can perceive themselves as failing and not living up to normative standards, which can lead to negative self-regarding attitudes, such as shame (Flanagan, 2013). This is also referred to as self- or internalized stigma. Second, there is also an interpersonal source, namely public stigmatization (Matthews et al., 2017), which can lead to discrimination.

Persons with MHPSA can experience (social) dysfunctions and loss of opportunity related to particular symptoms of their condition. The negative impact on a person's quality of life is often worsened by public stigma (Corrigan et al., 2000; Rüsch et al., 2005). Even if they recover and manage their disorder well enough to function in society, it is still likely that they will struggle because they are being discriminated against as a result of stigmatization (Jenkins & Carpenter-Song, 2008). Stigmatization not only negatively impacts a person's social network, employment situation and confidence, but also his or her access to and availability of care and support (Livingston & Boyd, 2010). For substance addictions, stigma is even cited as one of the major reasons why people do not access treatment, which is linked to delayed recovery (Substance Abuse and Mental Health Services Administration, 2008).

Studies have shown that care professionals also engage in stigmatization of patients with MHPSA (Rao et al., 2009; Ronzani et al., 2009; Rüsch et al., 2005; van Boekel et al., 2015; Vistorte et al., 2018). For persons with substance addictions, this can contribute to poor mental and physical health, non-completion of treatment, delayed recovery and increased involvement in risky behavior (Livingston et al., 2012; van Boekel et al., 2013). For persons with mental illness, studies have demonstrated that stigmatization by care professionals can act as a barrier to social participation, successful vocational integration, and seeking effective treatment (Lasalvia et al., 2013; Plooy & van Weeghel, 2009; Thornicroft, Brohan, Rose, Sartorius, Leese, et al., 2009).

These consequences not only negatively impact *clinical* recovery, but also impact *personal* recovery, which is described as a process that has impact on multiple life domains, such as (mental) health, legal issues, and social- and economic functioning and wellbeing, and includes subjective outcomes such as self-esteem, empowerment, and self-determination (Anthony, 1993; W. L. White, 2007). This paradigm of recovery is endorsed in the mental health and the addiction field. In their scoping

review, van Weeghel and colleagues named stigma as one of the most important barriers for personal recovery (van Weeghel et al., 2019).

Concerns over language to refer to individuals with MHPSA are not new. More than 40 years ago, the WHO published a paper on substance-related terminology (Keller, 1977). It was then believed that the diagnostic term 'abuse' should be avoided (p.32, 28) because of negative connotations. In 2004, the U.S. Substance Abuse and Mental Health Services Administration stated that 'abuse' was stigmatizing because it blames the individual, and demeaning because it labels a person by his/her illness and ignores human dignity (SAMHSA, 2004). Nevertheless, the term 'abuse' was widely used. The DSM-5 (American Psychiatric Association, 2013), for example, has only recently replaced the distinction between 'abuse' and 'dependence' by 'substance use disorders', and in 2016 the government of the United States issued a document named 'Changing the language of Addiction' (Botticelli & Koh, 2016) in which they promote the use of person-first language. A similar effort was made by the American Psychiatric Association which provides instructions for journalists on how to report about mental illness and suicide (American Psychiatric Association, 2015).

Despite long-going advocacy against using stigmatizing language to refer to persons with MHPSA, empirical investigations in this area are rare. In the field of substance addiction, Kelly and colleagues (John F. Kelly, Dow, et al., 2010; John F. Kelly & Westerhoff, 2010a) conducted two empirical (vignette) studies concerning language used to describe persons with substance addictions: one among clinicians and one among participants from a broader convenience sample (with mostly healthcare professionals). Individuals in these vignettes were labeled as either 'a substance abuser' or as 'having a substance use disorder'. A questionnaire assessed perceived causes of the problem, social threat and whether the individual should receive therapeutic versus punitive action. In both experiments, participants' exposure to either substance abuser or substance use disorder terminology elicited systematically different judgements (John F. Kelly & Westerhoff, 2010a, 2010b). Compared to substance use disorder, substance abuser was linked to more willful misconduct, greater social threat and more deserving of punishment. In the field of mental health, there are studies that have examined aspects of language and stigmatization, such as labelling of mental health problems as mental illness (Angermeyer & Matschinger, 2003) and types of information that can reduce stigmatization (Jensen et al., 2013). Furthermore, person-first language has been advocated in this field (Penn et al., 1994). However, no similar (empirical) studies that examine the specific effects of wording on stigmatization exist to our knowledge.

Aims

With this study, we want to contribute to empirical investigation of the relation between different ways of referring to persons with MHPSA and stigmatizing attitudes. We do this by partly replicating the studies conducted by Kelly and colleagues in the United States (John F. Kelly, Dow, et al., 2010; John F. Kelly & Westerhoff, 2010a). We recruited a similar convenience sample, consisting mostly of health care focused professionals, but from the Netherlands. Like the original studies (John F. Kelly, Dow, et al., 2010; John F. Kelly & Westerhoff, 2010a), we used vignettes in which the term to refer to a person with MHPSA was different in each condition. In the Netherlands, both mental illness and substance addictions can typically be described using disorder-first language (e.g. schizophrenic or addict), person-first language (e.g. person with schizophrenia or individual with an addiction) or victim language (e.g. person who is suffering from depression). A recently emerging way to describe someone with MHPSA is through recovery language (e.g. person who is recovering from depression), which has not yet been studied in this context. Thus, different than the replicated studies (John F. Kelly, Dow, et al., 2010; John F. Kelly & Westerhoff, 2010a), we used four language conditions, instead of two. Furthermore, we expanded on these studies that only included vignettes about persons with substance addictions, by including vignettes about persons with mental illness, because debates about stigmatization and language are similar in this field.

We presented four vignettes to our participants representing different MHPSA: drug addiction, alcohol addiction, depression and schizophrenia. Drug addiction was chosen because it is the most stigmatized disorder and we chose alcohol addiction because it is the most common addiction (Room et al., 2001; van Boekel et al., 2015). Schizophrenia was chosen because it is the most stigmatized mental illness, and depression was included as it is the most common mental disorder overall (Lasalvia et al., 2013; Thornicroft, Brohan, Rose, Sartorius, & Leese, 2009). Our aim is to analyze whether there are systematic differences in stigmatizing attitudes of (mental) health care and support professionals associated with the four language conditions in any of the vignettes. Based on literature and previous empirical studies, we hypothesize that person-first and recovery language is associated with less stigmatizing attitudes and higher recovery expectations among professionals, than disorder-first or victim language.

Method

This study is a partial replication of two studies performed by Kelly and colleagues (John F. Kelly, Dow, et al., 2010; John F. Kelly & Westerhoff, 2010a). We performed a similar experiment using surveys with either one of the four language conditions followed by items that measure attitudes related to stigmatization, combined in subscales. We used a similar convenience sample, aiming primarily on (mental) health professionals (professionals that worked with patients with MHPSA). Furthermore, we included items on demographics and several measures that were used in the original studies. However, we also included items not used in the original studies that were more appropriate for our expanded scope that included mental illness and recovery expectations. In Supplementary Table 1, exact methodological comparisons are presented between the current study and the studies by Kelly et al. (John F. Kelly, Dow, et al., 2010; John F. Kelly & Westerhoff, 2010a).

Study population and protocol

Participants for this study were recruited from February to March 2019 and constituted a convenience sample of primarily addiction, mental health and social care professionals. We approached various (mental) health and addiction care organizations, shelters, probation organizations, general practices and university Medical and Health science faculties in the Netherlands, in order to target care professionals that work with persons with MHPSA. Organizations were asked to spread recruitment messages linking to an online survey among their employees or students. Furthermore, we used social media, newsletters, magazines and printed flyers handed out at conferences. The only eligibility criterium included in the call was that participants worked, or could potentially work, with persons with MHPSA. Participants self-reported their gender, age, education level, professional field and work experience. A pilot study (n=10) was performed among researchers and students, which led to minor adjustments in the vignettes and questions. A raffle of coupons (two coupons of 100 euro) was used as an incentive. Participants were not compensated in any other way and ethical approval was obtained through the Ethics Review Board (ERB) of Tilburg University in the Netherlands (reference: EC-2018.EX119).

To prevent biased responses, it was important that the participants were not aware of the focus of the study on *language* and *stigmatization*. For this reason, we used a message with minimal general information stating that the research focused on ”expectations of and experience with patients/clients with mental illness and substance addictions”.

The survey started with questions on demographics. Subsequently, four persons were described in separate vignettes with drug addiction, alcohol addiction, depression or schizophrenia, respectively. Each vignette was followed by questions that measured stigmatizing attitudes (described below). The different language conditions were randomly and evenly assigned to participants (n=361). The key advantages of this method were (a) to control for known and unknown factors and minimize

covariate effects so that the participants across all conditions were statistically comparable, (b) to eliminate both intentional and unintentional human bias during the experiment, and (c) to evaluate error effects because of the sound probabilistic theory that underlies randomization (Salkind, 2010). Median completion time of the survey was 16.5 minutes and the completion rate was 66% (n=361/547) and was not found to significantly differ between conditions.

Measures

Independent variables

Each survey contained vignettes with either 'disorder-first' (DFL), 'person-first' (PFL), 'victim' (VL) and 'recovery' (RL) language, which were randomly assigned to participants. The four language conditions represented the four independent variables (DFL, PFL, VL or RL). Each participant was presented a version of the survey containing the same language condition in each of the four vignettes (see for translated example Fig. 1). The vignettes were based on real and anonymized cases of clients of an addiction and mental health care organization in the Netherlands. Information that could influence stigmatizing attitudes were removed as much as possible. Previous studies showed, for example, that having no work or causing nuisance was linked with highly stigmatizing attitudes (Oudejans & Spits, 2018; Perkins et al., 2009).

For the recovery language condition, we used language pursuant to the recently developed conceptual framework of personal recovery from mental illness or addiction (Anthony, 1993; W. L. White, 2007). In this framework, recovery is described as a process, rather than an outcome. Still having symptoms of mental illness or addiction does not exclude a person from being 'in recovery'. Accordingly, we described the persons in the vignettes in the recovery language condition as being 'in recovery from ..', referring to the process.

Figure 1. Example of a study vignette for a person with alcohol addiction

'Disorder-first language' (DFL)

Ben is a 38-year-old alcoholic. He is married but sometime has issues with his partner. He experiences a lot of responsibilities at home. It is not the first time that Ben is an alcoholic, he has had treatment before. Now, he drinks, at least half but usually a whole, bottle of wine daily. The general practitioner has referred him to addiction treatment again.

'Person-first language' (PFL)

Ben is 38 years old and has an alcohol addiction. He is married but sometime has issues with his partner. He experiences a lot of responsibilities at home. It is not the first time that Ben has an alcohol addiction, he has had treatment before. Now, he drinks, at least half but usually a whole, bottle of wine daily. The general practitioner has referred him to addiction treatment again.

'Victim language' (VL)

Ben is 38 years old and suffers from an alcohol addiction. He is married but sometime has issues with his partner. He experiences a lot of responsibilities at home. It is not the first time that Ben suffers from an alcohol addiction, he has had treatment before. Now, he drinks, at least half but usually a whole, bottle of wine daily. The general practitioner has referred him to addiction treatment again.

'Recovery language' (RL)

> Ben is 38 years old and is in recovery from an alcohol addiction. He is married but sometime has issues with his partner. He experiences a lot of responsibilities at home. It is not the first time that Ben is in recovery from an alcohol addiction, he has had treatment before. Now, he drinks, at least half but usually a whole, bottle of wine daily. The general practitioner has referred him to addiction treatment again.

Descriptive variables

Gender, age, education level, professional field and years of work experience were collected. Furthermore, information about familiarity with MHPSA was measured by asking 'do you know anyone with mental illness and/or substance addiction in your personal environment?' 'have you worked with clients/patients with mental illness and/or substance addiction?' to which participants could answer: yes, someone with (a) drug addiction, (b) alcohol addiction, (c) depression, (d) schizophrenia, (e) maybe I'm not sure, or (f) no. We also asked if participants had experienced mental illness and/or substance addiction themselves at any time in their life to which they could answer: (a) yes, but not anymore, (b) yes, and I still do, (c) no never, (d) maybe, I'm not sure, (e) I don't want to answer. In table 1 the 'yes' categories were combined.

Dependent variables

The survey presented 24 Likert-scaled (9-point) items that asked levels of agreement with various statements for each type of MHPSA: 6 questions formulated by the authors, 6 questions represented the blame and control scale (2 subscales) that covers attributions by clinicians to patients with MHPSA (Kloss & Lisman, 2003), 8 questions from the Attribution Questionnaire (AQ-8: 14), 3 questions obtained from the studies by Kelly et al. (John F. Kelly & Westerhoff, 2010a) and 1 question based on a semantic differential scale by Corrigan et al. (Corrigan et al., 2015). A higher score meant a higher level of agreement. The questions formulated by the authors were based on the widely endorsed conceptual framework for personal recovery in mental health called CHIME, which is an acronym of Connectedness, Hope and optimism about the future, Identity, Meaning in life and Empowerment (Leamy et al., 2011; van Weeghel et al., 2019).

Analysis

Survey data were processed and analyzed through SPSS 25. Our relatively large participants to item ratio (>15:1) allowed us to do exploratory factor analyses (EFA) to derive subscales and reduce the number of statistical comparisons and type 1 error rates. Because of the assumption that the factors would correlate, as most factors do in social sciences (A. B. Costello & Osborne, 2005), we chose an oblique Promax rotation that allows correlation. The blame and control subscales by Kloss & Lisman (2003) were excluded from these factor analyses. The rest of the items (n=18) were analyzed for each of the four vignettes. There was a strong overlap in the outcomes of the factor analyses among the four vignettes, which yielded four interpretable factors labeled for which reliability analyses (Table 2) were performed: (1) social threat (α=0.70-0.79), (2) unpredictability (α=0.75-0.84), (3) discrimination (α =0.57-0.66) and (4) recovery expectations (α=0.53-0.68).

Six Pearson's chi-squared tests were performed as randomization checks across conditions on demographic variables. Means were calculated for each subscale and one-way analyses of variance (ANOVA) were performed on each subscale to test for differences between the four language conditions.

Results

Participants had a mean age of 40 and three-quarters were women (77.6%), almost half had a higher vocational degree (49.3%) and more than one-third a university degree (35.5%). The most reported professional field was 'addiction treatment' (32.4%), followed by 'mental health care' (25.2%) and social care (16.1%). The mean years of work experience in their current field was 12 years (SD=10.0). Almost all participants had work experience with patients with MHPSA (98.6%) or had personal contacts with someone with MHPSA (87.8%). More than two-fifths reported to have or have had MHPSA themselves (43.5%). Groups did not differ on any characteristics ($p > 0.18$) between conditions (Table 1).

Table 1: Sample characteristics by language condition (n=361)

	Total %	DFL (*n*=96)	PFL (*n*=95)	VL (*n*=88)	RL (*n*=82)	Test of difference between conditions
Gender, % (*n*) women	77.6 (280)	81.3 (78)	80.0 (76)	68.2 (60)	80.5 (66)	χ^2=7.41, p=0.285
Age, mean (SD)	40.4 (12.5)	38.0 (12.6)	41.0 (12.1)	40.9 (13.1)	41.7 (12.1)	F=1.63, p=0.183
Education level, % (*n*)						χ^2=8.60, p=0.476
High School	5.5 (20)	8.3 (8)	6.3 (6)	4.5 (4)	2.4 (2)	
Secondary Vocational	9.7 (35)	8.3 (8)	9.5 (9)	9.1 (8)	12.2 (10)	
Higher Vocational	49.3 (178)	43.8 (42)	49.5 (47)	46.6 (41)	58.5 (48)	
University	35.5 (128)	39.6 (38)	34.7 (33)	39.8 (35)	26.8 (22)	
Profession, % (*n*)						χ^2=18.00, p=0.803
Addiction treatment	32.4 (117)	32.3 (31)	36.8 (35)	33.0 (29)	26.8 (22)	
Mental Health Care	25.2 (91)	27.1 (26)	23.2 (22)	25.0 (22)	25.6 (21)	
Social Support	16.1 (58)	12.5 (12)	14.7 (14)	13.6 (12)	24.4 (20)	
Nurse Practitioner	5.5 (20)	4.2 (4)	3.2 (3)	8.0 (7)	7.3 (6)	
Probation	4.2 (15)	3.1 (3)	5.3 (5)	2.3 (2)	6.1 (5)	
General Practitioner	1.4 (5)	2.1 (2)	1.1 (1)	1.1 (1)	1.2 (1)	
Student	8.9 (32)	11.5 (11)	9.5 (9)	9.1 (8)	4.9 (4)	
Other	6.4 (23)	7.3 (7)	6.4 (6)	8.0 (7)	3.6 (3)	
Years of work experience in the field of MHPSA, mean (SD)	12.2 (10.0)	10.6 (10.0)	12.3 (10.0)	13.7 (11.2)	12.5 (8.6)	F=1.47, p=0.221
Personal contact with MHPSA, % (*n*) yes	87.8 (317)	87.5 (84)	89.5 (85)	83.0 (73)	91.5 (75)	χ^2=3.22, p=0.360
Work experience with MHPSA, % (*n*) yes	98.6 (355)	99.0 (95)	97.9 (93)	97.7 (86)	100 (82)	χ^2=2.10, p=0.551
Has or had mental illness and/or addiction, % (*n*) yes	43.5 (157)	39.6 (38)	49.5 (47)	46.6 (41)	37.8 (31)	χ^2=3.40, p=0.334

Abbreviation: DFL, disorder-first language; MHPSA, mental health problems and/or substance addictions; PFL, person-first language; RL, recovery language; VL, victim language.

One-way analyses of variance (ANOVA) revealed no significant differences between disorder-first language (DFL), person-first language (PFL), victim language (VL) or recovery language (RL) on all subscales for any of the vignettes. The only exception is the 'blame' subscale (F=3.11, p = 0.026) in the vignette about drug addiction (Table 2). Tukey's HSD test revealed that PFL scored significantly higher on 'blame' than DFL (p = 0.027) in the vignette about drug addiction.

Table 2: Means comparisons and One-way analyses of variance (ANOVA) between language conditions for each MHPSA and reliability analyses for each subscale[a]

	DFL (N=96)	PFL (N=95)	VL (N=88)	RL (N=82)	ANOVA (F-values)	Cronbach's α
Social threat						
Drug addiction	2.30 (1.15)	2.18 (1.03)	2.04 (1.04)	2.06 (1.00)	1.19	0.748
Depression	1.59 (0.74)	1.52 (0.65)	1.66 (0.82)	1.56 (0.62)	0.60	0.698
Alcohol addiction	1.96 (1.11)	1.82 (0.86)	1.87 (1.20)	1.81 (0.86)	0.43	0.794
Schizophrenia	2.63 (1.30)	2.54 (1.24)	2.56 (1.15)	2.45 (1.08)	0.34	0.765
Unpredictabiliy						
Drug addiction	4.04 (1.52)	4.02 (1.53)	4.03 (1.58)	4.22 (1.50)	0.32	0.762
Depression	3.10 (1.16)	3.08 (1.31)	3.15 (1.39)	3.28 (1.32)	0.42	0.753
Alcohol addiction	3.67 (1.64)	3.47 (1.49)	3.45 (1.60)	3.68 (1.59)	0.57	0.799
Schizophrenia	5.01 (1.74)	5.28 (1.65)	5.32 (1.74)	5.22 (1.59)	0.61	0.838
Discrimination						
Drug addiction	3.85 (1.35)	3.97 (1.24)	4.06 (1.24)	3.77 (1.14)	0.94	0.646
Depression	3.06 (1.21)	2.99 (1.06)	3.00 (1.15)	2.97 (1.22)	0.09	0.595
Alcohol addiction	3.67 (1.33)	3.64 (1.27)	3.78 (1.28)	3.64 (1.39)	0.22	0.659
Schizophrenia	3.67 (1.13)	3.79 (1.09)	3.66 (1.11)	3.71 (1.11)	0.25	0.574
Recovery expectations						
Drug addiction	3.83 (1.43)	3.65 (1.39)	3.92 (1.44)	3.80 (1.24)	0.61	0.533
Depression	3.72 (1.48)	3.44 (1.45)	3.72 (1.52)	3.57 (1.32)	0.85	0.609
Alcohol addiction	3.73 (1.43)	3.88 (1.48)	3.76 (1.36)	3.76 (1.36)	0.85	0.611
Schizophrenia	5.27 (1.62)	5.43 (1.65)	5.54 (1.69)	5.23 (1.39)	0.72	0.675
Blame						
Drug addiction	5.14 (1.38)	5.70 (1.35)	5.36 (1.44)	5.20 (1.27)	3.11*	0.636
Depression	3.80 (1.54)	3.85 (1.56)	3.86 (1.54)	4.05 (1.46)	0.43	0.739
Alcohol addiction	4.73 (1.74)	5.16 (1.75)	5.04 (1.74)	5.14 (1.84)	1.17	0.827
Schizophrenia	2.44 (1.33)	2.26 (1.30)	2.58 (1.46)	2.49 (1.42)	0.90	0.827
Control						
Drug addiction	5.06 (1.40)	4.94 (1.58)	4.82 (1.59)	4.74 (1.67)	0.74	0.637
Depression	4.71 (1.58)	4.61 (1.63)	4.38 (1.70)	4.67 (1.56)	0.71	0.739
Alcohol addiction	4.78 (1.69)	4.95 (1.76)	4.75 (1.78)	4.78 (1.65)	0.27	0.741
Schizophrenia	2.79 (1.48)	2.87 (1.39)	2.96 (1.52)	2.90 (1.43)	0.22	0.806

* $p < 0.05$

[a] A higher score represents a higher level of agreement

Spearman correlations showed significant correlations between the subscales (factors) yielded from the factor analyses (Supplementary Table 2). Two high (r>0.5) positive correlations were found between 'discrimination' and 'unpredictability' for the drug and alcohol addiction vignettes, which were *medium* (r=0.3-0.5) for depression and schizophrenia (Cohen, 1988). Another high positive correlation was found between 'control' and 'blame' in the schizophrenia vignette, which was medium for the other vignettes.

Discussion

This study examined the effect of four randomly assigned language conditions on perceptions and expectations of care professionals about persons with drug addiction, alcohol addiction, depression and schizophrenia. Exposure to either of the four language conditions was not found to be associated with systematically different judgments regarding perceived social threat and unpredictability, attribution of blame and control, expectations of recovery or levels of discrimination. The blame subscale was the only variable found to differ significantly in the experimental conditions in the vignette about an individual with drug addiction. This effect came solely from the item 'To what extent do you feel that Michael could have avoided the problems he has?', in which a 'drug addict' was perceived less likely to be able to prevent his problems compared to 'a person with a drug addiction'. However, since there was no difference in items that measured similar concepts, we do not consider this single finding convincing enough to draw conclusions from and want to avoid capitalization on chance. Based on these results, we cannot conclude that referring to a person with MHPSA with specific language elicits systematically different attitudes related to stigmatization in care professionals in the Netherlands.

Assumptions on stigmatizing effects of language are common (American Psychiatric Association, 2015; Botticelli & Koh, 2016; Keller, 1977; John F. Kelly, 2004; SAMHSA, 2004), however we did not find such effects in this empirical study. An explanation could be that the differences between the vignettes were too subtle. Almost all participants had professional experience with persons with MHPSA and also for quite some time (the mean years of work experience in the field was 12 years). Having such experience may explain why professionals are unaffected by changing some words in a case vignette. Perceptions of persons with MHPSA likely have already been formed. Thornicroft et al. (Thornicroft et al., 2010), for example, describe something called *physician bias*: because professionals tend to spend the most time with patients who have difficulties to recover or relapse, they tend to have a more pessimistic look on treatment outcomes. In our study, however, stigmatizing attitudes were not particularly high in any of the subscales measured in this study. Furthermore, a study in the Netherlands showed that social distance to persons with addictions is a good indicator for stigmatizing attitudes (van Boekel et al., 2015). Participants in this study can be considered to have a small social distance to persons with MHPSA: almost 90 percent has or had personal contact with persons with MHPSA and more than 40 percent (currently) has or (ever) had MHPSA themselves.

However, in the two American addiction-focused studies (John F. Kelly, Dow, et al., 2010; John F. Kelly & Westerhoff, 2010a) that were replicated in this study, the same minimal stimuli and participants with small social distance to MHPSA applied. Contrary to our results, these studies do report significant differences between two language conditions: 'substance abuser' elicited more negative judgements compared to 'a person with a substance use disorder'. One of the studies among clinicians only found a small effect regarding the degree to which punitive action should be taken, and whether an individual with a substance-related condition is more culpable for his problems (John F. Kelly & Westerhoff, 2010a). The other study with a broader convenience sample (mostly healthcare professionals), reported more negative judgements on all subscales in vignettes where 'substance abuser' was used compared to 'substance use disorder' (John F. Kelly, Dow, et al., 2010). This raises the question whether American professionals are more sensitive to language than Dutch professionals or that differences in culture or language account for our different findings. Anthropologist Hall (Hall, 1976) described ways how human communication styles differ across cultures. He distinguished low-context and high-context cultures. In low-context cultures, meaning is more explicitly expressed either verbally or orally, while in high-context cultures meaning is best conveyed through context, such as gestures and social customs ('what is said' (low-context) versus 'how it is said' (high-context)). Although both the U.S. and the Netherlands are typically described as

low context cultures, it is possible that care professionals in the U.S. are lower on the 'high-low context' continuum, since an effect of language was found in the American studies.

Another explanation for our different findings can be the timeframe in which the American studies were performed (2008 and 2009). Although relatively recent, there have been many efforts in the last ten years to promote awareness and reduce stigmatization of persons with addictions and mental illness. The personal recovery paradigm (Anthony, 1993; W. L. White, 2007), which has particular attention for stigma, is still increasingly being endorsed in the mental health and addictions field in the Netherlands. A general reduction in stigmatizing attitudes could have contributed to the reduction of sensitivity for language.

Our findings suggest that subtle differences in language to refer to persons with mental illness and/or substance addictions, has no effect on stigmatizing attitudes by care professionals in the Netherlands. This means that if reducing stigmatization by professionals in the Netherlands is the goal, language is not the most effective focus. This does not mean, however, that language does not matter at all. Language potentially affects other groups than professionals. A similar study among the general public, for example, could yield different results. Moreover, a recent Dutch publication highlights the importance of language *from professionals to clients* and warns for the negative effect disorder-first language can have on clients (Oosterkamp et al., 2016). While there is no empirical study to support this, research has shown, for example, that the framework of addiction (disease model versus psychological and social conceptualization) that is conveyed to clients by professionals impacts their agency in relation to substance use (Wiens & Walker, 2015). In other words: what professionals say to their clients about their condition has an impact on clients. Further exploration of this focus in relation to language and stigmatization is recommended.

Limitations

The sample used in this study was a convenience sample, the study was performed online, and the sample consisted mostly of highly educated mental health and addiction care professionals which limits the generalizability of our findings. We were not able to analyze non-response. The incentive to attract respondents also may have attracted persons outside our target group, which we were not able to verify. However, our recruitment strategy targeted specific organizations, professional LinkedIn groups, and e-mail newsletters which increased the chances that participants were authentic. Furthermore, we were limited in the way that we could measure relevant concepts extensively. The target group of mental health and social care professionals often has a high work pressure and is not easily reached for surveys. Thus, it was important to keep the survey short. Another limitation was that participants potentially recognized the language manipulation. We received two e-mails from participants complaining about the 'stigmatizing' language we used in our survey. Furthermore, the experimental differences between vignettes were very minimal. However, we did expose participants to the language conditions twice in each vignette, as opposed to Kelly and colleagues (John F. Kelly, Dow, et al., 2010; John F. Kelly & Westerhoff, 2010a) who only used the experimental terms once.

Additionally, while vignettes are a commonly used tool in research to investigate how care professionals make decisions that affect their patients, concerns are also raised regarding limitations in construct and external validity. It is indeed hard to assess to what extend a written stimulus and participants' responses to it, measures and represent 'real world' future behavior. However, in the context of this experiment, it is not ethical to use real persons. The vignettes allowed us to combine the strengths of survey and experimental methodologies and to isolate key aspects of stigmatizing attitudes. It was also notable that the completion rate of the survey was quite low (66%). Reasons may include that the survey was repetitive and time-consuming, which could have been perceived as boring. Furthermore, given the high work pressure of mental health and social care professionals, participants potentially ran out of time or did not find the survey interesting enough to complete.

Because of these limitations of vignette surveys, it is also important to study stigmatization of persons with MHPSA through multiple research methods and disciplines. Qualitative studies could provide more insights into 'how' and 'why' stigmatization of certain conditions or illnesses by professionals take place.

A limitation in our replication of the two American studies was that we were not able to use the same wording. In the United States, 'substance abuser' is a commonly used term as is 'someone with substance use disorder'. In the Netherlands, literal translations of these terms are not commonly used. Therefore, it is possible that similar results were not found because of the nature of the language conditions being different. However, the labels used in our study reflect common language better and were therefore more appropriate to examine in a Dutch setting. A strength of our study is that we expanded the focus of these experiments by adding mental illness and recovery language as extra variables to the study.

We did not find similar results as the American studies. We think that this fact makes this paper important to publish. An Open Science Collaboration (Open Science Collaboration, 2015) showed that only 36 percent of replication studies in psychological science found significant effects versus 97 percent of the original studies. Reporting 'null findings' lies at the heart of science. It provides us with equally important insights as studies with significant findings.

Conclusion

Attitudes of care professionals in the Netherlands in relation to stigmatization were not influenced by the language used in the vignettes. This may mean that perceptions of persons with mental illness and or substance addictions are determined more by other things than language or terminology (e.g. personal or professional experience with persons with MHPSA). This suggests that if the goal is to reduce stigmatization by care professionals, a focus on language is not the most effective approach. However, despite the lack of empirical evidence of the effect of language in our study, there seems to be consensus about not using disorder-first language to refer to persons with mental illness or substance addictions because of the negative connotations (Botticelli & Koh, 2016; Harris & Felman, 2012b; Rose et al., 2007; Thornicroft et al., 2007). Even if it does not help to reduce stigmatization among professionals, using more accurate (or person-first) language may contribute to lessening public stigmatization by drawing attention and awareness to the person instead of the disorder. Language can represent the notion that a person is not defined by his or her disorder and person-first language carries more neutral connotations and distinguishes the person from his/her diagnosis or perceived membership in a group (Botticelli & Koh, 2016). Empirical studies are needed to also determine the effect of language use on individuals with mental illness and/or substance addictions. The fewer stigma they perceive, the fewer barriers they will experience for their recovery.

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8. Discussion

8.1 This thesis

Drug addiction is a serious and widespread phenomenon and is often characterized as a chronic relapsing disorder or illness (McLellan et al., 2000). Despite this persistent characterization, emerging evidence consistently shows that recovery from drug addiction is likely and prevalent (Kelly et al., 2017; White, 2012). An increasing body of knowledge has generated insights into different aspects of the recovery process. However, notions about how to understand and facilitate recovery are still debated among professionals, policymakers, scientists and the general public. Knowledge about recovery is also skewed towards perspectives of what professionals can do to help people recover and is lacking information about how people with drug addiction experience recovery themselves (van der Stel, 2020). Furthermore, the vast majority of insights on addiction recovery are based on studies about alcohol addiction, while information about drug addiction recovery pathways is more scarce. To shed more light on this, in this dissertation, we addressed the following main research question:

> *What does drug addiction recovery entail for those who experience it, for recovery support services, and for policy?*

The secondary research questions were:

1. How do recovery outcomes compare between people in different stages of their recovery process?
2. How do various mutual aid groups support drug addiction recovery?
3. How is drug addiction recovery experienced from a first-hand perspective?
4. What role does language play in the stigmatization of people with drug addiction by care professionals?
5. How is recovery adopted in Dutch policy and what are the notions of drug addiction and recovery which underlie that policy?
6. Are factors associated with drug addiction relapse different before and during the COVID-19 pandemic?

First, we will present the main findings for each secondary research question, followed by a critical reflection on the main results. Second, we will discuss the most important methodological considerations that are crucial for interpreting the findings. Third, we will provide recommendations and considerations for future research and implications for policy and practice, which may help to improve the facilitation of recovery for people with drug addiction.

8.2 Main findings

Chapter 2

In our analyses of the Life in Recovery survey among persons in recovery from drug addiction, conducted in the Netherlands, Belgium and the UK, we found that persons with more time in recovery report better outcomes on life domains that are known to be important markers for recovery, compared to persons who started their recovery process more recently. We distinguished three stages of recovery: early (less than one year), sustained (one to five years) and stable (more than five years). Persons in later recovery stages had lower risks of having housing problems, being involved in crime, and using illicit hard drugs and higher chances of having work or education. This may mean that recovery markers progress over time in recovery, that better recovery markers help people stay in recovery, or that both these mechanisms apply and reinforce each other. In line with other recovery research, these findings suggest that drug addiction recovery is a long-term process that continues to evolve years after its onset.

Chapter 3

Recovery pathways may involve a variety of (combinations of) treatment and support. In the REC-

PATH baseline sample, also conducted in the Netherlands, Belgium and UK, a majority (69%) of persons in recovery reported that they were a member of a (or multiple) mutual aid group(s) at some point in their lives. This included Twelve Step groups (e.g. Narcotics Anonymous and Cocaine Anonymous), as well as alternative groups, such as SMART-groups. We found that compared to non-members, members of mutual aid groups had more resources that are known to be supportive for addiction recovery: they reported higher rates of changes and participation in social networks, greater levels of recovery capital, and a stronger commitment to sobriety. These results suggest either that mutual aid groups support addiction recovery through multiple mechanisms of change in favor of recovery, or that mutual aid groups are attractive for persons with more recovery resources.

Chapter 4
Using all three prospective REC-PATH measurements, we explored how the recent COVID-19 pandemic may have impacted risk factors for return to problematic substance use for persons in drug addiction recovery. We found that rates of problematic use did not differ between the period before and during the COVID-19 pandemic. However, factors associated with problematic use differed between these periods. During the COVID-19 pandemic, those with less commitment to sobriety had higher risks of problematic substance use. The COVID-19 pandemic has limited access to environmental and social resources that can have a protective effect on relapse. Consequently, people in recovery may have been more dependent on themselves and their internal resources to prevent relapse.

Chapter 5
Through a qualitative inquiry of first-hand experiences of drug addiction recovery, we generated insights into *how* recovery is experienced. A data-driven thematic analysis of 30 in-depth interviews revealed five main themes that involved learning: (1) to recognize and understand addiction; (2) that recovery is about more than quitting (or reducing) drug use; (3) to give meaning to experience and to reconsider identity; (4) that recovery is a gradual process and; (5) how universal life processes shape recovery. The findings highlight that drug addiction and recovery are entwined with many aspects of one's life and that although drug addiction may have specific impacts that need to be addressed, recovery processes also include universal processes that anyone can go through.

Chapter 6
To investigate whether the Dutch recovery vision is coherent with its governmental drug policy, we applied Bacchi's *What's the problem represented to be?*-approach to analyze problematizations of 'drug addiction'. We analyzed two influential practice-level recovery policy documents and one governmental drug policy document. We found that governmental policy addresses the harms and public nuisance of drug addiction, while practice-level policy addresses the well-being of persons with addiction. Despite these different starting points, the Dutch recovery vision seems coherent with both problematizations of drug addiction. The adoption of recovery in Dutch policy was less subject to political debate compared to other countries where it was introduced earlier. This may be a result of recovery being driven by bottom-up efforts without government intervention, leading to a situation of constructive ambiguity between government- and practice-level policies.

Chapter 7
Stigma is considered an important barrier for recovery. There is an ongoing debate that use of language can exacerbate or diminish stigmatization. Replicating a US experiment, in which person-first language was found to reduce stigmatization by care professionals, we found that using different terms to refer to persons with mental illness or substance addiction in a vignette had no effect on stigmatizing attitudes by care professionals in the Netherlands. Although we found no effect of language among care professionals, using accurate (person-first) language may contribute to lessening stigmatization by other groups than care professionals.

8.3 Reflection on findings

Defining addiction and recovery

General understandings and criteria of addiction, continue to be contested and evolve. Historically, addiction has been framed as 'moral failure' (Siegler & Osmond, 1968), a disease (Jellinek, 1960) and a biopsychosocial phenomenon (Engel, 1977), among other definitions. In the 1990s, advancements of the fields of genetics, molecular biology, and behavioral neuropharmacology have generated a now dominant understanding of addiction as a chronic relapsing brain disease (Leshner, 1997; Volkow & Li, 2005). This brain disease model of addiction, is currently being challenged by others (Heather et al., 2018, 2022), who argue that addiction is *not* a brain disease, but rather "a disorder of a person, embedded in social context" (Levy, 2013, p. 1). Furthermore, clinical diagnostic criteria (DSM) offered by the American Psychiatric Association (2013) and the World Health Organization (1992) have been revised multiple times over the years as evidence accumulated.

This discussion about addiction is also relevant for the discussion of recovery, because the way in which *the problem* of addiction is conceptualized, also influences thoughts about how to address this problem. In other words: how one defines addiction, influences how one would organize treatment or other pathways to resolve addiction. To illustrate, a certain definition of addiction may determine whether the focus of treatment and interventions should be on medical, psychiatric, legal or social aspects. Vice versa, insights into recovery, such as presented in this thesis, may in turn influence understandings of addiction. In this section we reflect on what may be learned about addiction from recovery.

First, the studies in this thesis underline that sustained recovery from drug addiction is possible. This is in accordance with evidence pointing at a high prevalence (for example, about 9% of the US adult population has resolved a significant alcohol or drug problem) of recovery from addiction (Kelly et al., 2017; White, 2012). Additionally, studies have estimated that it takes a low number of recovery attempts to successfully recover from a drug or alcohol addiction (a median of two attempts) and that many people never relapsed after initiating recovery (Kelly et al., 2019; Mcquaid et al., 2017). These data about recovery oppose the idea of addiction as a *chronic relapsing* disorder. In this thesis, we also found that people with more time in recovery report better outcomes that indicate participation in society and socioeconomic wellbeing. Additionally, Hibbert and Best (2011) showed that people in long-term recovery may even function better than before they became addicted, and that their quality of life reaches levels above population norms. This underscores that recovery is more than just remission of symptoms from a disorder. Furthermore, we found that participation in peer-based mutual aid groups was associated with having more resources for recovery. Although we could not prove a causal relationship, this is in accordance with studies that consistently find that peer-support, changes in social networks (often exchanging 'substance use networks' for 'recovery supportive networks') and social identity are crucial predictors of positive recovery outcomes (Best et al., 2016; Kelly, 2017; Longabaugh et al., 2010). Combined, these findings suggests that recovery is embedded in a social context beyond the brain and that a model that includes such a context, such as the biopsychosocial model of addiction (Buchman et al., 2010), may fit best with the current knowledge of recovery.

What does addiction recovery entail?

The Betty Ford Institute Consensus Panel (2007) distinguished three subsequent stages that indicate stability of recovery: early recovery (1–12 months), sustained recovery (1–5 years), and stable recovery (5 years or more). While studies show that reaching stable abstinence is a long-term process (Dennis et al., 2007; Langendam et al., 2000; Schutte et al., 2001; Shah et al., 2006; Vaillant, 2003, 2012), they provide little information on what happens in this process beyond reduced substance use. The study in Chapter 2, in which we showed that people with more time in recovery report better recovery markers (lower risks of having housing problems, being involved in crime, and using illicit hard drugs and higher chances of having work or education) adds information on what is

happening in the recovery process and expands the scope to a population with drug addiction, for whom recovery shows similar patterns as those with alcohol addiction (Best et al., 2015; Laudet, 2013; Mcquaid et al., 2017). These findings suggest that recovery may entail a long-term process of several years in which multiple life domains are likely to gradually improve and the chances of relapse diminish. For recovery services and policy makers, this means that resources for addiction treatment and services should facilitate broad and long-term recovery goals. This is currently not the case in most treatment settings, as interventions are often short-term and lack long-term approaches covering several years of recovery (Best & Colman, 2019; Laudet & White, 2010; Vanderplasschen & Vander Laenen, 2017). Considerations about how to address this discrepancy between recovery knowledge and practice are discussed later in this chapter (*Implications for practice*).

Besides the developmental character of recovery, information on how these pathways are shaped by various types of support is increasingly available, including evidence of the benefits of attending non-professional peer-delivered mutual aid groups (Best et al., 2020; Costello et al., 2019; Humphreys, 2004; Kaskutas, 2009; Kelly et al., 2020; White et al., 2020). Mutual aid groups are found to support people in recovery by providing social bonding, norms and role models, improving social networks, self-efficacy and coping skills, and supporting motivation over time (Kelly, 2017; Moos, 2008). So far, this evidence is primarily based on studies that look into the most popular mutual aid group '*Alcoholics Anonymous'* (AA), while in Europe there is a variety of addiction-related mutual aid organizations which vary markedly in their histories, structures, philosophies, procedures, and membership (Humphreys, 2004). The findings from the mutual aid group study described in Chapter 3, suggest that the mostly social mechanisms that are found to work in AA, may also apply to persons in *drug* (opposed to alcohol only) addiction recovery and to non-Twelve Step groups. Our findings further show that either members of mutual aid groups are better equipped to sustain recovery compared to never-members, or that mutual aid groups self-select for persons with more recovery resources. This suggests that mutual aid groups can complement professional treatment by appealing to a different target group or by providing a different kind of support. Qualitative studies of mutual aid groups, for example, suggest that peers in these groups provide a feeling of connectedness, as they can fulfill long-term and flexible supportive (or even friendship-like) roles (Dekkers et al., 2020). Additionally, research finds that mutual aid groups can particularly complement professional treatment if combined with compatible treatment with a similar philosophy (Best et al., 2020).

The findings from the mutual aid study in Chapter 3 also highlight that drug addiction recovery entails more than just addressing drug use. In line with the analyses of recovery stages in Chapter 2, the qualitative study described in Chapter 4 and the longitudinal analyses of problematic substance use in Chapter 7, we found how recovery, but also return to problematic use, are associated with various recovery domains. Van der Stel (2013) outlines these as: personal, clinical, functional and societal recovery domains. This is in accordance with findings from US studies of alcohol recovery on which much of our study design (and outcomes of interest) is built (Kaskutas et al., 2014; Kelly, 2017; Laudet, 2007, 2013). Recognizing and understanding that recovery may also entail needs in a variety of life domains other than substance use, can help recovery support services and policymakers improve their responses to drug addiction, by expanding their scope and offer support on multiple life domains coherently. If less emphasis is put on substance use alone, this may lower the threshold to enter treatment for people who are unwilling or unable to stop or reduce their substance use, but who may seek help in other areas. This broad recovery approach is similar to how *harm reduction* services 'meet people where they are' (G. Alan Marlatt et al., 2001) and emphasizes how 'any positive change' (as coined by the Chicago Recovery Alliance) should be a goal for people with addiction problems.

At the same time, broadening the goals of recovery support to include certain social, functional and societal roles, should not imply that every person in recovery should live up to a set of normative

standards (Lancaster et al., 2015). Our qualitative study in Chapter 5 showed that drug addiction can have a variety of underlying problems, including trauma and comorbid mental health issues. For people with particular underlying issues, it may be unrealistic to strive for certain normative goals, including (meaningful) jobs, independent housing and strong social networks. As achieving such broader recovery goals may be too difficult or impossible, this could be experienced as failing recovery, while positives changes may still be possible. Research shows, for example, that a recovery-oriented approach aimed at positive change for people with disabilities, is still possible when recovery goals are tailored to each person's possibilities as well as needs (Trustam et al., 2022, p. 259). Tailoring recovery support to the *person* instead of to the *disorder*, may also help to uncover and recognize the commonness and universal processes of recovery that we found in Chapter 4. By looking at a patient as a whole person (with preferences and priorities) first, it may become easier to identify issues or needs outside the context of addiction and rather in the context of a life course.

Recovery, problematic use and the pandemic

During the course of the REC-PATH study, a quickly spreading coronavirus (causing COVID-19) placed enormous burdens on society and individuals. Governments launched impactful measures such as quarantine, lockdowns, and social distancing. These measures slowed the spreading of the coronavirus, however, there are worries that they have negatively affected people's wellbeing and that they have decreased access to public health services, including to addiction recovery support services (Marsden et al., 2020). In Chapter 4, we explored how the pandemic may have impacted recovery stability of the REC-PATH cohort. In line with another study focused on alcohol recovery (Gilbert et al., 2021), we found no evidence that people in recovery used substances problematically more often during the pandemic, than in the period before the pandemic. However, we found that the relation between return to problematic substance use and commitment to sobriety differed between the two periods. Marlatt's model of relapse distinguishes both personal (internal) and environmental (external) factors that may impact risks of relapse (G. A Marlatt & Gordon, 1985). It seems that during the pandemic a positive personal factor (commitment to sobriety) was protective for problematic use. This suggests that in events like the pandemic when environmental factors are cut off, personal factors, such as motivation, are more important for recovery stability. Given that access to external resources (e.g. professional and social support) was limited during the pandemic (Bergman & Kelly, 2021; Blanco et al., 2020), internal resources, such as motivation and commitment, may have gotten more important to rely on. Therefore, personal factors and internal resources may serve as suitable intervention targets as they can be trained and developed with therapy (Kelly & Greene, 2014). However, finding ways to keep environmental resources available during difficult times, similar to the COVID-19 pandemic, is also crucial.

Furthermore, relapse is currently the most commonly used and well-known term to concisely describe setbacks, breaks in the recovery process, or return to problematic use. However, it is also a contentious concept. As we have explained in Chapter 1, definitions of relapse may vary. Generally, it refers to a binary judgement in which two situations or behaviors are distinguished: you are either in recovery or you have relapsed. The latter, also known as "falling off the wagon", is almost synonymous with failure of recovery (White, 1998). However, according to Miller (1996), imposing such a binary decision on a *flow* of behavior (e.g. the recovery process), vastly oversimplifies what is really happening. For example, relapse implicitly suggests that a violation of abstinence or other personal recovery rule inevitably has serious adverse effects. However, this is not always the case. To illustrate, Witkiewitz and colleagues (2018) found that people who returned to heavy drinking after treatment, which is often seen as relapse, scored equally well on a range of outcomes measuring recovery as participants who were abstinent. Additionally, two recent reviews show that relapse is often poorly defined in research and conclude that there is no widely accepted consensus on its definition (Moe et al., 2022; Sliedrecht et al., 2022). Therefore, it is important for future studies to consider this ambiguity of relapse(-like experiences) and to be more precise in operationalizing what

is studied and why. In Chapter 4, we used a subjective measure of problematic substance use (according to the participant), for example. This outcome is more concrete than the term 'relapse', imposes less implicit assumptions about (failure or success of) recovery, is more true to the experience of the participant, and still allows to gain insights into which factors shape resilience and stability during recovery.

Recovery: an organizing principle or an empty shell?

Our analysis of recovery policy in Chapter 6 shows how the emerging recovery paradigm has functioned as a vehicle for the empowerment of people in recovery: the recovery movement challenged academic and medical hegemony. By putting the personal recovery experience central, instead of the externally perceived pathology of addiction and its symptoms, the recovery movement questioned the dominant vision of treatment professionals about medical labelling, recovery goals and about people with addiction (e.g. as passive). Compulsion or 'automation-like' processes characterized by lack of autonomy, for example, are commonly seen as explanations of why addiction occurs (Heather, 1998). However, recovery-oriented addiction treatment starts from the opposite premise that people with addiction actively make choices and have goals, will and volition. The mere existence of the recovery movement is illustrative of the fact that people with addiction do not lack such things.

In Chapter 6, we also showed how the adoption of recovery in drug policy is a political process, influenced by local context. Several international authors have criticized the emergence of new recovery policies in the US, UK and Australia. First, Braslow (2013) argues that because recovery is person-centered, it seems to resonate with sociocultural values of neoliberalism that highlight each individual's responsibility for their own (mental) health and wellbeing. Duke (2013) adds to this and expressed worries that such neoliberal ideas about recovery helped to justify budget cuts, damaging or limiting access to addiction services in the UK, justified by the idea that recovery is mostly a personal process. Second, Lancaster and colleagues (2015) expressed concerns that drug policies in Australia apply the concept of recovery to all illicit drug use, expanding focus beyond addiction. This frames all drug users in need of 'curative attention', ignoring the fact that many drug users do not experience problems that require recovery. These policy analyses illustrate that recovery (but also other addiction-related paradigms) can become instrumental in enforcing moral political agendas that are not necessarily concerned with the wellbeing of people with drug addiction. It is important to be attentive to these processes in the development of or research into drug and addiction policies.

Research finds that policy debates around the subject of drugs are often moralized (McKeganey, 2011). The 'war on drugs', for example, is driven by the notion that consuming illegal drugs is immoral (Holland, 2020). The contentiousness of such debates, makes it more challenging to settle disagreements by introducing facts or evidence, compared to less controversial policy areas (Rein & Schon, 1993). To illustrate, a 2013-experiment presented two problems with the exact same datasets to participants and tested their ability to draw valid causal inferences from the empirical data. The authors found that when the dataset was presented as being from a controversial subject (gun-control policy), participants used their quantitative reasoning capacity selectively to conform data interpretation to the result most consistent with their political outlooks. This did not happen when it was presented as a dataset from a non-controversial subject (skin-care products) (Kahan et al., 2013). The experiment illustrates that controversial subjects can lead to multiple interpretations of evidence and thus to different policy realities. Therefore, merely introducing evidence to shape drug and addiction policies is unlikely to settle existing disagreements. Instead, it is important to take into account the underlying assumptions and historical development of drug policies.

In Chapter 6 we focused on how recovery policy in the Netherlands has come about. To start, the Netherlands only adopted recovery in practice-level policy and not in governmental drug policy, which may have had an effect on how recovery was implemented. These practice-level policies

primarily address treatment, prevention and public stigma (GGZ Nederland, 2013) and their conceptualization of recovery is more similar to the concept of recovery found in the mental health field (Anthony, 1993), than to the normative 'conservative' and 'neoliberal' recovery found in the US, UK and Australia (Duke, 2013; Lancaster et al., 2015). While recovery principles are now widely embraced in Dutch practice, structural implementation, dedicated funding, and systematic evaluation of this new approach is still lacking (Bellaert et al., 2021). This raises the question whether it is desirable to adopt recovery principles in Dutch governmental policy. On one hand this could help structural implementation and set clear goals that can be evaluated for effectiveness. On the other hand, this means that recovery may become subject of political debate, potentially invoking moral political agendas as has happened in other countries.

The history and current situation in the Netherlands around drug policy may contain some hints about how a governmental adoption of addiction recovery may play out. Debates about Dutch drug policy are often characterized as a clash between pragmatism and ideology (de Kort & Cramer, 1999). Since the 1970s, Dutch drug policy is based on the pragmatic outlook that a drug-free society is not realistic. Therefore, a repressive prohibitionist approach towards drugs was considered an unfeasible and counterproductive effort that leads to undesired side-effects in the areas of public health and crime. Instead of viewing drug use as a moral problem, the Dutch have historically been more concerned with whether a particular intervention is an effective and efficient way of limiting risks related to drug use. Such pragmatism may help to steer governmental implementation of recovery towards improving the support for people with drug addiction. In more recent years, however, a more moral and ideologically driven approach around drug policy has emerged in the Netherlands. Several politicians have been promoting the idea that people who use drugs need to realize that they are maintaining a system of organized crime, leading to death and destruction in society (Hollemans, 2019). There has been an uptake of policy documents and letters to parliament, from both the Ministry of Justice as well as the Ministry of Health, that make a moral appeal on the responsibility of people who use drugs. Two Christian conservative political parties even suggested to criminally prosecute people for using drugs (de Jong, 2019), something that is currently impossible in Dutch law. The pragmatic outlook that accepted drug use as a reality and aimed to reduce risks, now seems to be shifting towards an intolerant view that judges drug use as morally wrong. A recent Dutch 'Manifest for a realistic drug policy', signed by prominent Dutch drug scholars and professionals, underlines these worries about the shifting drug policy debate, illustrated by statements like: "Abandon the pursuit of a drug-free world through repression. It is a wicked road" (Bakkum et al., 2020, p. 3). Considering these recent developments, the Netherlands may risk a morally driven implementation of recovery in governmental policy. This means that recovery may be used to enforce political agendas that see drugs and drug use as phenomena that are wrong and that need to be reduced through punishment and prohibition.

8.4 Methodological considerations: strengths and limitations

The research questions in this thesis were addressed using quantitative and qualitative methods. Specific strengths and limitations for each separate study are discussed in chapters two to seven. In this section, we will discuss the main considerations regarding the entire body of work.

The use of mixed methods, inclusive research design (offering offline surveys and telephone and face-to-face assistance to participants), involving and consulting an ex-service user organization (from the start), and inclusion of multiple countries were strong points of this study. It allowed us to study the recovery process from different perspectives. We collected multiple waves with longitudinal quantitative information on a broad set of (short- and long-term) outcomes that are known to be related to addiction recovery. The measures included recovery domains that extend beyond the typically studied measures of abstinence or drug use and map different mechanisms that are important in recovery pathways. Using the qualitative interview method we were able to shed light onto how recovery is experienced from a contextualized first-hand perspective. Lastly, the

policy analysis method and the experimental study method about stigmatization by professionals allowed us insights into structural factors that may influence drug addiction recovery.

Inclusion criteria of the REC-PATH study were that participants had to be in recovery from drug addiction or problematic drug use for three months or more. We did not require (a minimal period of) abstinence or completion of a particular intervention, as is often the case in addiction research (Laudet & White, 2010). This means that participants defined what being in recovery means themselves. On the one hand this was a strength because this approach does more justice to the personal and idiosyncratic nature of recovery indicated by earlier studies, and it avoids to predefine recovery in one-dimensional inclusion criteria (Davidson & White, 2007; White, 2007). On the other hand, it can be seen as a limitation, because this subjective approach makes it difficult to objectively operationalize addiction recovery in certain characteristics, potentially leading to too much variation within the recovery sample. There may have been various ways in which participants defined their recovery. For some it meant being abstinent. For others it meant that they reduced certain problems related to drug use, for example. We also lack detailed information on addiction severity preceding their recovery. Thus, the nature and severity of the conditions that participants recovered from may vary. Furthermore, we aimed to recruit an equal number of women and men in recovery and to consider gender differences in recovery pathways. In spite of this, findings on gender differences were limited. This may mean that such differences are minor, but it may also mean that we missed certain outcomes that are associated with gender differences.

A general limitation of this thesis is that the data comes exclusively from convenience samples. Because comparable representative data from people in recovery is unavailable, we cannot determine whether our findings can be generalized to all people in recovery from drug addiction. Furthermore, the use of convenience samples appeared to have affected comparability across the participating countries in the study. The Belgium sample, particularly, differed from the Netherlands and UK sample, as participants from Belgium were more often men, younger and more often in early recovery. This may point at differences in recruitment. More established recovery networks exist in the Netherlands and the UK, while in Belgium a large part of the sample was recruited through treatment networks (because of the absence of recovery networks). This may explain why the Belgium sample resembles the population in treatment there (Antoine, 2017). Nonetheless, we controlled for these differences statistically and we found consistent associations when analyzing separate and pooled country models.

Another limitation is that, apart from Chapter 4, we used cross-sectional analyses to examine associations. This means that the direction of these associations cannot be determined and that findings must be considered indicative and the direction of effects should be verified with longitudinal analyses. For the mutual aid study, for example, this means that we cannot confirm whether participation in mutual aid groups led to better recovery outcomes, that mutual aid groups tend to attract persons with better recovery outcomes, or that a third variable explains the better outcomes and mutual aid group participation.

8.5 Implications

Implications for practice

The addiction recovery movement in the Netherlands emerged from the (ex-)service user organization the Black Hole foundation (in Dutch: Stichting het Zwarte Gat). Besides advocating for a more equal relation between addiction service users and providers, one of the core points from the Charter of Maastricht (2010), is that recovery-oriented support should be aimed at societal recovery. In fact, the name of the foundation is inspired by the lack of attention for societal recovery in the addiction services: service users felt that they ‘fell into a black hole’ after leaving treatment. In line with the findings in this thesis, namely that recovery pathways may be enhanced by more attention for social wellbeing, and changes in social networks and social identity, there is also a growing

literature highlighting the potential benefits of community engagement (Best et al., 2017). For example, recreational activities, training and employment, volunteering, mutual aid groups and other peer activities can be important components of so-called 'Recovery-Oriented Systems of Care' (Sheedy & Whitter, 2009). These studies and the research from this thesis can inform such systems in which addiction services and community services collaborate and stimulate a cohesive environment in favor of recovery, offering a range of support for extended periods. This can be achieved in different ways. On the one hand, broader recovery services could be integrated with addiction treatment. This would allow for a demand-based (person-centered) approach, in which pre-conditions and priorities are not imposed by the treatment provider. On the other hand, it may also imply that addiction services collaborate or join forces with other existing (social) service providers that offer help in areas such as work, study, desistance or housing. In doing so, a more long-term continuous model of care can be developed to complement the current acute model of care for addiction.

Furthermore, our study on long-term pathways to recovery in Chapter 2, for example, provides support for implementing long(er)-term recovery support with shifting support needs. This can be achieved through long-term recovery management checkups, through which treatment providers reach out to ex-patients regularly over an extended period of time to ask them whether they have any support needs. These checkups show promising results at helping people to (re-)enter and stay in treatment and improve long-term outcomes (Dennis et al., 2003; Dennis & Scott, 2012; Scott et al., 2005, 2021). A similar model has already been piloted and studied in the Netherlands in four forensic psychiatric hospitals (Schaftenaar et al., 2018). The study found that patients recidivated (into criminal behavior) later and at a lower rate than patients from two control groups without voluntary checkups. Similar positive results may be expected for people in addiction recovery. Additionally, some mental health facilities in the Netherlands offer patients a kind of voucher ("strippenkaart" in Dutch) after treatment, which they can use to request post-treatment support (van den Reek & de Muijnck, 2015). Such vouchers are a low-threshold resource that can help people to seek out (timely) support and prevent relapse.

Lastly, our study of mutual aid groups in Chapter 3 shows how mutual aid groups may complement other types of support that are already available in practice. However, currently there is no structural implementation of or funding for mutual aid groups in the Netherlands. While Twelve-step groups are currently available in most regions, alternative recovery groups are often not available. Some treatment providers currently facilitate mutual aid group participation after treatment, however, this depends on the treatment provider and region. More structural facilitation of mutual aid groups will make it more likely that such services are available to everyone in the Netherlands. This is the case in Germany, for example, where the federal government funds approximately 100,000 support groups for a variety of conditions and problems, including addiction and mental health problems, with around three to four million members (Matzat, 2001).

Implications for future research

Although this thesis provides comprehensive insights into mechanisms and experiences of drug addiction recovery, some aspects of this subject deserve more academic scrutiny. The individual experiences that we examined should also be placed within macrolevel processes, power structures, and systems of cultural meaning (Page & Singer, 2010). This can help answer questions such as: 'how do living conditions (in certain communities or neighborhoods, for example) affect processes of addiction and recovery?' or 'how may having a job benefit people in recovery?'. Although relatively rare, there is some ethnographic research on people who use drugs and on people in addiction treatment that is able to answer such questions. These studies provide important contextualized information on how persons get into that situation and how they deal with it (Agar, 1973; Bourgois & Schonberg, 2009; Fomiatti, 2020). However, such research does not yet exist on experiences outside or after addiction treatment. Such contextualized insights into recovery pathways in everyday life can

add valuable information about how addiction recovery is experienced and how it is affected by larger societal issues, such as socioeconomic circumstances, drug policy and stigmatization. Qualitative research is especially suitable for this inquiry, such as our study described in Chapter 3. However, in addition to single retrospective interviews, future studies should also aim to collect *thick* (Geertz, 1973) ethnographic descriptions of recovery pathways and places where people initiate and support recovery. Adding to the qualitative research based on semi-structured interviews, ethnographic studies are able to examine recovery from a holistic perspective, as the researcher is able to observe macrolevel processes, structures, and systems and is able to talk to persons in multiple settings and over a longer period of time.

Furthermore, stigmatization of people with drug addiction is considered one of the most important barriers to recovery (van Weeghel et al., 2019). Therefore, research into interventions that can reduce stigmatization is valuable. In Chapter 7, we found that stigmatizing language had no effect on the attitudes of care professionals who had many years of experience working with people with mental health problems and addiction. However, longitudinal studies or experiments in which different types of participants are exposed more and longer (than in a single vignette) to certain language conditions may elicit different results. Even if language may not or minimally affect stigmatizing attitudes by professionals, it may affect attitudes from other populations, such as from people with addiction or people in recovery themselves, or from the general public. Such research should also take into account potential effects of gender and ethnicity (and other intersecting identities) of the person with addiction. Additionally, as reducing public stigma remains challenging, studying the consequences of stigmatization is important. While much is known about the consequences of stigmatization in people with mental health problems (see for example, Clement et al., 2015; Webber et al., 2014; Zoppei et al., 2014), much less is known about this for people with substance addictions (van Boekel, 2014). Studying this, may help provide insights in how to mitigate these consequences through addressing structural factors that facilitate stigmatization, and by preparing and making people with addiction more resilient to the effects of stigmatization, as changing such structures may be difficult. We also recommend to monitor stigmatizing attitudes towards people with drug addiction, and to assess the effects of initiatives and interventions aimed at reducing stigmatization with longitudinal research.

Lastly, it is important to determine how the information from research about what recovery entails, such as this thesis, can be implemented into practice. Design studies, for example, can do this by determining which conditions have to be taken into account to enhance the coherency and continuity between addiction services and community services, so that service users are able to continue their (societal) recovery after treatment. Implementation research can complement such endeavors by revealing through which financial structures and preconditions such cohesive and continuous systems of recovery-oriented care can maximize and preserve positive effects on creating a recovery supportive environment for people with addiction.

8.6 Conclusion

For people with drug addiction, recovery may entail a long-term process of several years in which multiple life domains are likely to gradually improve and in which one's identity evolves, while the chance and impact of relapse diminishes. For recovery services and policy makers, this entails aiming goals and expectancies from addiction treatment and services at broad and long-term outcomes, which is currently often not the case. This thesis shows that drug addiction recovery entails much more than just addressing drug use or other clinical aspects of addiction. It supports the existence of multiple recovery domains. Therefore, it is crucial to understand drug addiction as a condition that is embedded in many aspects of someone's life, which should be addressed cohesively. We further showed that drug addiction can have a variety of underlying problems to which many solutions may apply, and thus, to which multiple recovery pathways exist. Recovery may also involve common processes that many people go through, regardless of whether they experience drug addiction. Thus,

without understating the difficulties that people with drug addiction face, it is important to recognize the commonness of the experiences that underly drug addiction and addiction recovery. Additionally, we found that the lack of attention for recovery in governmental drug policy does not have to hinder the adoption of recovery oriented services in practice. However, it does seem to hinder structural implementation, dedicated funding, and systematic evaluation of recovery-oriented policies. Regarding drug use, addiction and recovery, this thesis has demonstrated how contextual understandings of these concepts continue to evolve. Therefore, research into these subjects remains a worthy endeavor. Regardless of whether 'recovery' is the right term to capture the essence of what is needed to support people with addiction, embracing the strengths-based, non-judgmental and open way to "approach the day's challenges" (Deegan, 1988, p. 96) may ultimately help to improve the lives of people with addiction in meaningful ways.

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Summary

Introduction

The phenomenon of drug addiction has been studied for decades from many different disciplines. In the last two decades, insights from the mental health field sparked by a grassroots patient-movement, have inspired an emerging academic and advocacy movement around the concept of addiction *recovery*. This concept can refer to the *process* of recovering from addiction (including related outcomes), as well as a *paradigm* to approach, organize and deliver addiction treatment, support services, and research. Recovering from addiction is described as a long-term process aimed at positive change. It takes place in an interwoven personal, social and societal context, which may include improvements or growth in different life domains and can – but does not necessarily – include abstinence from substance use. So far, a growing body of knowledge has generated important insights into this complex process, particularly around recovery from alcohol addiction but less around illicit drug addiction. Therefore, the aim and main research question of this thesis is to study what drug addiction recovery may entail for persons who experience addiction recovery, for recovery support services and for policy. A multi-country and multi-method approach is used to answer this main research question and the following sub-questions:

1. How do recovery outcomes compare between people in different stages of their recovery process? (Chapter 2)
2. How do various mutual aid groups support drug addiction recovery? (Chapter 3)
3. Are factors associated with return to problematic substance use by persons in recovery different before and during the COVID-19 pandemic? (Chapter 4)
4. How is drug addiction recovery experienced from a first-hand perspective? (Chapter 5)
5. How is recovery adopted in Dutch policy and what are the notions of drug addiction and recovery which underlie that policy? (Chapter 6)
6. What role does language play in the stigmatization of people with drug addiction by care professionals? (Chapter 7)

Methods

Data for chapters 2 to 6 are collected with an international (Belgium, the Netherlands and the United Kingdom) research group collaborating in the project: Recovery Pathways or REC-PATH. Quantitative, qualitative and policy analyses are part of this project in each country. We use the merged quantitative dataset, with data from each country, in chapter 1, 2 and 3. We collected data from a sample of people in drug addiction recovery for at least three months (n=722 in three countries), who were recruited through the Life in Recovery survey (LiR). Participants from the LiR who wanted to be involved in other study components were asked to participate in a subsequent longitudinal survey. From the participants at baseline of this study (n=367 in three countries), we recruited a subset (n=30 Dutch participants) to participate in the qualitative study component. Two follow-up measurement were carried out among the baseline participant of the survey one year (n=311) and two years (n=248) after the baseline survey. For chapter 5, Dutch national policy documents were collected for policy analysis. Finally, a separately conducted study presented in chapter 7 involves data collected from a sample of health- and social care professionals in the Netherlands (n=361), who work with persons with drug addiction and/or other mental health problems.

Findings

In **chapter 2**, we compare the recovery markers of three groups of LiR-participants: early (less than one year), sustained (one to five years) and stable (more than five years) recovery. Cross-sectional analyses show that participants in the sustained and stable recovery stage have lower risk of having housing problems, being involved in crime, and using illicit hard drugs and higher chances of having work or education, compared to participants in the early recovery stage. Thus, participants with more time in recovery report less negative and more positive outcomes that are known to be related to addiction recovery. These findings suggest that drug addiction recovery is a gradual, long-term process unfolding over a period of multiple years and is associated with positive outcomes in various life domains besides substance use.

Chapter 3 describes a study into mutual aid groups, which are an informal source of support for persons recovering from drug addiction. We examine the relationship between membership of mutual aid groups and recovery capital (a variety of psychological, physical, social, and environmental resources for recovery), participation in social networks, and commitment to sobriety. The majority (69%) of participants are or were a member of a mutual aid group. We also found that membership is strongly associated with more participation and changes in social networks, higher levels of recovery capital, and a stronger commitment to sobriety. Together, these findings suggest that mutual aid groups can support addiction recovery through multiple personal and social mechanisms of positive change. Therefore, these groups may be able to complement formal addiction treatment and support recovery.

During the REC-PATH study, a global pandemic suddenly broke out and placed various burdens on society and individuals. In **chapter 4**, we present a study in which we assess some impacts of the COVID-19 pandemic on persons in drug addiction recovery. We assess whether risk and protective factors associated with (return to) problematic substance use differ between the periods before and during the pandemic. Rates of problematic substance use do not differ significantly before and during the pandemic for those who are followed-up. Also, in both periods, persons engaged in psychosocial support have lower risks of problematic use. However, we find that higher commitment to sobriety is only associated with lower risk of problematic use during, but not before the pandemic. The results suggest that the COVID-19 pandemic may not have been followed by significant return to problematic substance use for people in recovery. However, with restricted access to environmental resources, some persons may have been more dependent on themselves and their internal motivation than before the pandemic.

In **chapter 5**, we present the results of a thematic analysis of in-depth interviews with REC-PATH participants about their autobiographic recovery experiences. The analysis focuses on how recovery is experienced, to further understanding of how individuals make sense of the changes they go through while recovering from drug addiction and other issues. We discuss five main themes that involve learning about recovery: (1) to recognize and understand addiction; (2) that recovery is about more than quitting (or reducing) drug use; (3) to give meaning to experience and to reconsider identity; (4) that recovery is a gradual process; and (5) how universal life processes shape recovery. The findings highlight that drug addiction and recovery are entwined with many aspects of one's life and that although drug addiction may have specific impacts that need to be addressed, recovery processes also include universal processes that anyone can go through.

Chapter 6 of this thesis describes an analysis of the Dutch governmental drug policy and practice-level addiction policy. Applying Bacchi's *What's the problem represented to be?*-approach, we

analyze problematizations of ‘drug addiction’ in two influential practice-level policy documents and one governmental drug policy document. The goal is to assess whether the relatively recent Dutch recovery vision is coherent with governmental drug policy. We find that despite different starting points, the recovery vision from the addiction practice policy is largely coherent with the older governmental drug policy, which makes no explicit mention of the concept of recovery. Furthermore, we reveal how the adoption of recovery in Dutch policy was less subject to political debate compared to other countries, where the concept of recovery was introduced earlier. This may be a result of recovery being driven by bottom-up efforts in the Netherlands, without government intervention.

Stigma is considered a major barrier for recovery and there is an ongoing debate that the use of language may exacerbate or diminish stigmatization. Therefore, in **chapter 7** we present a study in which we examine stigmatization through the use of different terms that can refer to persons with (a) alcohol addiction, (b) drug addiction, (c) depression and (d) schizophrenia (e.g. ‘a drug addict’ versus ‘a person with drug addiction’). We replicate an experiment conducted in the United States using vignettes and a survey measuring stigmatizing attitudes, which found that person-first language reduced stigmatization by health- and social care professionals. In our study, however, we find no effect of using different language. This suggests that subtle differences in language have no effect on stigmatizing attitudes among care professionals. However, using accurate (person-first) language may contribute to lessening stigmatization in other groups.

Discussion

Reflecting on the main question of what recovery entails for those who experience addiction recovery, for recovery support services and for policies, we present some emerged points of interest. First, we show what the findings about recovery can add to the debate about the definition of addiction. We argue that people are recovering from addiction and that they can experience broad personal, societal and social growth as part of that process. This suggests that addiction does not have to be chronic and that it is embedded in the broad context of a person’s whole life, beyond merely a neurobiological sphere, which disputes the dominant definition of addiction as a chronic relapsing (brain) disease, for example. Instead, a biopsychosocial model of addiction fits better with the findings on recovery.

Second, we discuss what addiction recovery may entail for individuals and support services. The broad life domains and long-term recovery outcomes examined in this thesis suggest that recovery may entail a long-term process of several years in which multiple life domains are likely to gradually improve and the chances of relapse diminish. For persons experiencing recovery this may help to understand how support needs may continue to exist over a longer period and that this is part of the process. For recovery services, this implies that resources for addiction treatment and services should be oriented at broad and long-term recovery goals attuned to a persons’ (evolving) needs.

Third, we reflect on what our findings on the effects of the COVID-19 pandemic may mean for instability, relapse or problematic use during recovery processes. Results suggest that during the pandemic, a positive personal factor (commitment to sobriety) reduced the risk of problematic substance use. This may mean that in events like the pandemic, when environmental support is less accessible, people rely more on personal factors, such as motivation for recovery stability compared to periods when external support is accessible. Accordingly, personal factors and internal resources may serve as suitable intervention targets as they can be trained and developed with therapy. However, finding ways to keep environmental resources available during difficult situations, like the COVID-19 pandemic, also seems crucial.

Fourth, we discuss what recovery entails in different kinds of policy contexts. We argue that interpretations of recovery vary and are subject to political processes. To understand this, it is important to note that recovery is an abstract concept. Generally, the recovery movement challenges notions from professionals who characterize the personality and behavior of people with addiction through a medical lens as pathological. Instead of focusing on symptoms, a recovery-oriented vision starts from the premise that people with addiction actively make choices and have (positive) goals, will and volition. Such broad and unexplicit ideas about recovery leave room for different interpretations. This is why the governmental endorsement of recovery has been instrumental in enforcing political agendas. To illustrate, the idea that recovery is a personal process is used to make recovery an individual responsibility in some policies. This framing of recovery has helped to justify budget cuts, which damaged or limited access to addiction services. In the Netherlands, the introduction of the concept of recovery has been limited to the practice-level of addiction services and has not yet been adopted or interpreted by the government. However, this lack of government policy may also explain why Dutch addiction services struggle with implementing and stimulating structural recovery-oriented practices that impact people with addiction in meaningful ways beyond the acute treatment of symptoms.

Implications for practice and research

The findings from this thesis can inform recovery-oriented systems. To offer a range of support for the long-term and broad recovery process, addiction services and community services need to collaborate cohesively. A long-term continuous model of care, therefore, is needed to complement the current acute care model for addiction. Long-term recovery management or maintenance checkups, for example, and structural facilitation of mutual aid groups and other types of informal support can help to achieve such a model.

Furthermore, in-depth and contextualized ethnographic research is needed to shed more light on how macrolevel processes, power structures, and systems of cultural meaning affect addiction recovery. This will help to reveal how society and communities can become more supportive for recovery. More research into interventions that can reduce stigmatization, a major recovery barrier, is also necessary. Finally, design and implementation studies can help determine how information from research about what recovery entails, such as presented in this thesis, can be implemented into practice.

Conclusion

In **conclusion**, for people with drug addiction, recovery may entail a long-term process of several years in which multiple life domains are likely to gradually improve and in which one's identity and resilience evolves, while the chance and impact of negative addiction related experiences diminish. For recovery services and policy makers, this entails aiming goals and expectancies from addiction treatment and services at broad and long-term outcomes, which is currently often not the case. It is crucial to understand drug addiction as a problem that is embedded in many aspects of someone's life, and that this problem therefore should be supported cohesively. We further showed that drug addiction can have a variety of underlying problems and recovery pathways. Regarding drug use, addiction and recovery, this thesis has demonstrated how understandings of these concepts continue to evolve. Therefore, research into these subjects remains a worthy endeavor. Finally, we have learned that embracing the strengths-based, non-judgmental and open way to approach recovery may ultimately help to improve the lives of people with addiction in meaningful ways.

Samenvatting

Introductie

Al decennia bestuderen verschillende disciplines het fenomeen drugsverslaving. In de afgelopen twintig jaar hebben inzichten uit de geestelijke gezondheidszorg, geïnspireerd door de patiëntenbeweging, een discussie aangewakkerd over het steeds vaker aangehaalde concept van *herstel* bij verslaving. Dit concept kan verwijzen naar het proces van herstellen van het individu (inclusief bijbehorende uitkomsten), alsook naar een visie over verslavingszorg, ondersteunende diensten en onderzoek. Herstellen van verslaving wordt beschreven als een langdurig proces met positieve verandering als doel. Dit kan onder andere gaan om persoonlijke, sociale en/of maatschappelijke groei. Herstellen kan dus ook – maar hoeft niet noodzakelijk – stoppen met middelengebruik omvatten. Het gaat om positieve veranderingen in de breedste zin van het woord. We weten steeds meer over dit ingewikkelde proces bij alcoholverslaving. Over hoe dit werkt bij verslaving aan drugs is echter veel minder bekend. Daarom is het doel en de hoofdvraag van dit proefschrift om te onderzoeken wat herstel bij drugsverslaving kan inhouden voor personen die het zelf doormaken, voor herstelondersteunende zorg en voor beleid. We zetten verschillende onderzoeksmethoden in meerdere landen in om deze hoofdvraag en de daaruit volgende deelvragen te beantwoorden:

1. Hoe verhouden hersteluitkomsten van mensen in verschillende stadia van hun herstelproces zich tot elkaar? (Hoofdstuk 2)
2. Hoe kunnen steungroepen het herstel bij drugsverslaving bevorderen? (Hoofdstuk 3)
3. Hoe verschillen factoren die verband houden met problematisch middelengebruik van personen in herstel tussen de periodes vóór en tijdens de COVID-19-pandemie? (Hoofdstuk 4)
4. Hoe wordt herstel van drugsverslaving ervaren door personen die het doormaken? (Hoofdstuk 5)
5. Hoe is herstel opgenomen in het Nederlandse beleid en wat zijn de aannames over drugsverslaving en herstel die ten grondslag liggen aan dat beleid? (Hoofdstuk 6)
6. Welke rol speelt taal bij de stigmatisering van mensen met een drugsverslaving door zorgprofessionals? (Hoofdstuk 7)

Methoden

Data voor hoofdstukken 2 tot en met 6 zijn verzameld door een internationale (België, Nederland en het Verenigd Koninkrijk) onderzoeksgroep voor het Recovery Pathways project of REC-PATH. Kwantitatieve, kwalitatieve en beleidsanalyses maken in elk land deel uit van dit project. We gebruiken in hoofdstuk 1, 2 en 3 een samengevoegde kwantitatieve dataset, met gegevens uit elk land. Deze dataset bestaat uit een steekproef van mensen die minstens drie maanden in herstel zijn van drugsverslaving (n=722 in drie landen), gerekruteerd via de Leven in Herstel-vragenlijst (LiH). We vroegen deelnemers uit de LiH die aangaven ook bij andere studieonderdelen betrokken te willen worden, om mee te doen aan een vervolgonderzoek met meerdere meetmomenten. Van de deelnemers aan de nulmeting van dit onderzoek (n=367 in drie landen) nam een aantal mensen (n=30 Nederlandse deelnemers) deel aan een kwalitatieve deelstudie met diepte-interviews. Er zijn hierna nog twee vervolgmetingen uitgevoerd één jaar (n=311) en twee jaar (n=248) na de nulmeting. Voor hoofdstuk 5 zijn de belangrijkste Nederlandse beleidsdocumenten die betrekking hebben op herstel verzameld voor een beleidsanalyse. Tot slot bevat hoofdstuk 7 een apart uitgevoerde studie onder Nederlandse zorgprofessionals (n=361) die werken met mensen met drugsverslaving en/of andere psychische problemen.

Resultaten

In **hoofdstuk 2** vergelijken we indicatoren van herstel tussen drie groepen LiH-deelnemers in vroeg (minder dan een jaar), langdurig (één tot vijf jaar) en stabiel (meer dan vijf jaar) herstel. In onze analyse zien we dat in vergelijking met deelnemers in de vroege herstelfase, deelnemers in de langdurige en stabiele herstelfase een lagere kans hebben op huisvestingsproblemen, betrokkenheid bij criminaliteit en het gebruik van harddrugs en vaker werk hebben of een opleiding doen. Deelnemers die langer in herstel zijn rapporteren dus minder negatieve en meer positieve ervaringen waarvan bekend is dat ze verband houden met herstel. Deze bevindingen kunnen erop wijzen dat herstellen van drugsverslaving een geleidelijk, langdurig proces is, dat zich over een periode van meerdere jaren ontvouwt en gepaard gaat met positieve veranderingen op verschillende levensdomeinen naast middelengebruik.

Hoofdstuk 3 beschrijft een onderzoek naar steungroepen (ook bekend als zelfhulpgroepen): een informele vorm van steun voor mensen die herstellen van een drugsverslaving. We onderzoeken in hoeverre het lid zijn van een steungroep verband heeft met uitkomsten op het gebied van herstelkapitaal (verschillende hulpbronnen van psychologische, fysieke, sociale en maatschappelijke aard die kunnen worden ingezet voor herstel), deelname aan sociale netwerken en motivatie om nuchter te zijn. De meerderheid (69%) van de deelnemers is of was lid van een steungroep. We zien daarnaast dat deelnemers die lid zijn of waren van een steungroep meer deelname aan en veranderingen in sociale netwerken, meer herstelkapitaal en een sterkere motivatie om nuchter te zijn rapporteren. Deze bevindingen kunnen betekenen dat steungroepen het herstel van verslaving bevorderen via zowel persoonlijke als sociale mechanismen. Steungroepen kunnen hiermee dus aanvullend zijn op professionele verslavingsbehandeling en het herstelproces ondersteunen.

Tijdens ons REC-PATH-onderzoek brak er plotseling een wereldwijde pandemie uit met grote gevolgen voor de samenleving en individuen. In **hoofdstuk 4** presenteren we een studie waarin we onderzoeken of en in hoeverre de COVID-19-pandemie impact heeft gehad op personen in herstel van een drugsverslaving. We onderzoeken eerst of problematisch middelengebruik (zowel alcohol als drugs) onder deelnemers vaker voorkomt tijdens de pandemie dan vóór de pandemie, en of factoren die verband houden met problematisch gebruik verschillen tussen de twee periodes. Problematisch middelengebruik komt niet vaker voor tijdens de pandemie onder de deelnemers die aan de studie meedoen. Verder vinden we dat deelnemers die een vorm van psychosociale hulp ontvangen zowel vóór als tijdens de pandemie een lagere kans op problematisch gebruik hebben. We vinden echter ook dat een hogere motivatie om nuchter te zijn alleen verband heeft met een lager risico op problematisch gebruik tijdens, maar niet vóór de pandemie. Dit betekent mogelijk dat de COVID-19-pandemie niet heeft gezorgd voor het vaker voorkomen van problematisch middelengebruik onder mensen in herstel. Echter, met beperkte toegang tot externe hulpbronnen, lijken sommige personen meer teruggeworpen op zichzelf en hun interne motivatie voor herstel.

In **hoofdstuk 5** presenteren we de resultaten van diepte-interviews met REC-PATH-deelnemers over hun autobiografische herstelervaringen. We onderzoeken hoe herstel wordt ervaren, om beter te begrijpen hoe personen betekenis geven aan de veranderingen die ze doormaken tijdens het herstel van drugsverslaving en andere problemen. We bespreken vijf hoofdthema's met geleerde lessen over herstel: (1) je verslaving herkennen en begrijpen; (2) dat herstel meer is dan stoppen met (of verminderen van) drugsgebruik; (3) het geven van betekenis aan de herstelervaring en het heroverwegen van de eigen identiteit; (4) dat herstel een geleidelijk proces is en; (5) hoe universele levensprocessen herstel mede vormgeven. De bevindingen benadrukken dat drugsverslaving en herstel verweven zijn met vele aspecten van iemands leven. Hoewel drugsverslaving een aantal

kenmerkende gevolgen kan hebben, kent het herstelproces ook meer universele processen die iedereen kan meemaken, en niet alleen mensen met een verslaving.

Hoofdstuk 6 van dit proefschrift beschrijft een analyse van het Nederlandse drugsbeleid en van het beleid van de verslavingszorg. We gebruiken Bacchi's *What's the problem represented to be?*-methode om te onderzoeken hoe drugsverslaving wordt geproblematiseerd in beleid. We analyseren twee invloedrijke beleidsdocumenten op praktijkniveau en op overheidsniveau. Het doel hiervan is om na te gaan of de relatief recente Nederlandse herstelvisie van de verslavingszorg coherent is met het drugsbeleid van de overheid. We stellen vast dat de Nederlandse herstelvisie van de verslavingszorg grotendeels aansluit bij het oudere drugsbeleid van de overheid, ondanks verschillende uitgangspunten en ondanks het feit dat herstel niet expliciet wordt genoemd in het drugsbeleid. Verder laten we zien dat – tot nu toe – de introductie van herstel in het Nederlandse beleid minder onderwerp van politiek debat is geweest dan in andere landen, waar herstel al eerder werd geïntroduceerd. Dit kan het gevolg zijn van het feit dat het herstel in de Nederlandse verslavingszorg vooral via inspanningen van de cliëntenbeweging (in de GGZ en verslavingszorg) tot stand is gekomen, zonder tussenkomst van de overheid.

Stigma wordt beschouwd als één van de belangrijkste belemmeringen voor herstel. Er is een voortdurend debat over of het gebruik van bepaalde taal stigmatisering kan verergeren of verminderen. In **hoofdstuk 7** presenteren we daarom een studie waarin we onderzoeken of stigmatisering door zorgprofessionals kan worden beïnvloed door verschillende termen die kunnen verwijzen naar personen met (a) alcoholverslaving, (b) drugsverslaving, (c) depressie en (d) schizofrenie (bijv. ‘een drugsverslaafde' versus 'een persoon met een drugsverslaving'). We repliceren een experiment dat in de Verenigde Staten is uitgevoerd met behulp van vignetten en een enquête die stigmatiserende attitudes meet. In de Verenigde Staten bleek dat *person-first* taal (‘een persoon met verslaving’) voor minder stigmatisering onder zorgprofessionals zorgt dan taal die een aandoening als een identiteit labelen (‘een verslaafde’). In ons onderzoek vinden we echter geen effect van het gebruik van verschillende termen. Dit kan erop wijzen dat subtiele taalverschillen geen effect hebben op stigmatiserende attitudes van zorgprofessionals. Het gebruik van nauwkeurige (*person-first*) taal kan echter mogelijk wel bijdragen aan het verminderen van stigmatisering door andere groepen in de samenleving.

Discussie

In de discussie over de hoofdvraag wat herstel kan inhouden voor personen die het zelf doormaken, voor herstelondersteunende zorg en voor beleid, komen enkele belangrijke punten naar voren. Ten eerste laten we zien wat de bevindingen over herstel kunnen toevoegen aan het debat over de definitie van verslaving. We stellen dat mensen kunnen herstellen en dat zij daarbij brede persoonlijke, sociale maatschappelijke groei kunnen ervaren. Dit suggereert dat verslaving niet chronisch hoeft te zijn en dat verslaving is ingebed in de brede context van iemands leven en dus over meer gaat dan enkel neurobiologische processen. Dit staat haaks op de dominante neurobiologische definitie van verslaving als een chronische (hersen)ziekte. In plaats daarvan past een definitie van verslaving als biopsychosociaal probleem beter bij wat we weten over herstel.

Ten tweede bespreken we wat herstel bij verslaving kan inhouden voor individuen en herstelondersteunende zorg. We onderzochten hoe factoren die gelinkt worden aan herstel in brede levensdomeinen zich over een lange termijn kunnen ontwikkelen en groeien. Dit betekent dat herstellen een langdurig proces van meerdere jaren kan zijn waarin verschillende levensdomeinen,

ondanks mogelijke tegenslagen, geleidelijk verbeteren en de kans op terugval verder afneemt. Voor personen in herstel kan deze informatie helpen te begrijpen dat niet alleen middelengebruik, maar ook andere factoren belangrijk zijn voor duurzaam herstel en dat ondersteuningsbehoeften gedurende een langere periode kunnen blijven bestaan – ook na verslavingsbehandeling. Dit houdt in dat herstelondersteunende zorg in de verslavingszorg en aanvullende ondersteuning gericht moeten zijn op brede, lange termijn doelen, afgestemd op de (veranderende) behoeften van een persoon.

Ten derde bespreken we wat onze bevindingen rondom de effecten van de COVID-19 pandemie op deelnemers kunnen zeggen over instabiliteit, terugval of problematisch gebruik in herstelprocessen. De resultaten suggereren dat tijdens de pandemie een positieve persoonlijke factor (motivatie om nuchter te zijn) de kans kleiner maakte op problematisch middelengebruik. Dit kan betekenen dat bij impactvolle gebeurtenissen zoals de pandemie, waarbij externe ondersteuning in iemands omgeving minder toegankelijk is, mensen – meer dan wanneer deze ondersteuning wel toegankelijk is – worden teruggeworpen op interne persoonlijke factoren, zoals motivatie. Deze interne persoonlijke factoren kunnen in veel gevallen worden getraind en versterkt met therapie en kunnen mensen in herstel dus mogelijk beschermen tijdens moeilijke gebeurtenissen. Het is tegelijk ook belangrijk om manieren te vinden om externe ondersteuning toegankelijk te houden in dergelijke situaties om de nadelige effecten voor mensen in kwetsbare situaties te verkleinen.

Ten vierde reflecteren we op wat herstel kan inhouden in verschillende soorten beleidscontexten. We stellen dat de betekenis van herstel in beleid varieert en gevormd wordt door politieke processen. Om dit goed te begrijpen is het belangrijk om te realiseren dat herstel een abstract begrip is. De herstelbeweging is ontstaan uit een verzet tegen opvattingen van professionals, die de persoonlijkheid en het gedrag van mensen met een verslaving vooral zien door een medische bril en deze beschrijven als abnormaal of pathologisch. In plaats van te focussen op symptomen van verslaving, heeft een herstelgerichte visie het uitgangspunt dat personen met een verslaving bewust keuzes maken en (positieve) doelen, een wil en wilskracht hebben. Deze brede en niet expliciete ideeën over herstel geven ruimte voor verschillende interpretaties. Dit maakt herstel in beleid een kwetsbaar concept dat instrumenteel ingezet kan worden voor bepaalde politieke agenda's. Ter illustratie: het idee dat herstel een persoonlijk proces is, wordt in sommige beleidsstukken gebruikt om van herstel een individuele verantwoordelijkheid te maken. Dit heeft in sommige landen geholpen om bezuinigingen te rechtvaardigen die de toegang tot verslavingszorg hebben geschaad en beperkt. In Nederland zien we de introductie van herstel in beleid alleen op het praktijkniveau van de verslavingszorg en (nog) niet in overheidsbeleid. Dit gebrek aan overheidsbeleid kan ook verklaren waarom het voor de Nederlandse verslavingszorg moeilijk is structurele herstelondersteunende zorg, die verder gaat dan alleen de acute behandeling van de symptomen van verslaving, te implementeren en te stimuleren.

Implicaties voor de praktijk en onderzoek

De bevindingen van dit proefschrift kunnen gebruikt worden om herstelgerichte zorg te helpen ontwikkelen. Om het langdurige en brede herstelproces continu en voor langere periodes te ondersteunen, is het belangrijk dat de verslavingszorg en diensten uit het sociale domein samenwerken. Een langdurig continu zorgmodel is nodig als aanvulling op het huidige acute zorgmodel voor verslaving. Langdurig contact houden met (oud-)cliënten en een structurele facilitering van steungroepen en andere vormen van informele hulp kunnen helpen om dergelijke herstelondersteunende zorg te realiseren.

Verder is diepgaand etnografisch onderzoek, dat rekening houdt met de omgeving waar mensen in leven, nodig om te begrijpen hoe processen op macroniveau, machtsstructuren en cultuursystemen invloed hebben op herstel. Dit is nodig om te begrijpen hoe de samenleving en gemeenschappen meer ondersteunend kunnen zijn voor mensen in herstel. Er is daarnaast meer onderzoek nodig naar interventies die stigmatisering, een belangrijke herstelbarrière, kunnen verminderen. Ten slotte kunnen ontwerp- en implementatiestudies helpen om informatie uit onderzoek over wat herstel inhoudt, zoals gepresenteerd in dit proefschrift, in de praktijk te implementeren.

Conclusie

Voor mensen met een drugsverslaving kan herstel een langdurig proces van meerdere jaren zijn, waarin meerdere levensdomeinen, ondanks mogelijke tegenslagen, geleidelijk verbeteren en waarin iemands identiteit en veerkracht groeit. Dit terwijl de kans op, en impact van, negatieve aan verslaving gerelateerde ervaringen afneemt. Voor herstelondersteunende zorg en voor beleidsmakers betekent dit dat de doelen en verwachtingen van verslavingszorg en andere vormen van ondersteuning gericht moeten zijn op brede en lange termijn resultaten, wat nu vaak niet het geval is. Het is belangrijk om drugsverslaving te begrijpen als een probleem dat ingebed is in vele aspecten van iemands leven en dat deze aspecten dus samenhangend moeten worden ondersteund. We hebben laten zien dat drugsverslaving verschillende onderliggende problemen en mogelijke herstelroutes kent. Daarnaast lieten we zien hoe de concepten drugsgebruik, verslaving en herstel voortdurend evolueren. Daarom blijft onderzoek naar deze onderwerpen belangrijk. We hebben geleerd dat een positieve, niet-oordelende en open begrip van herstelprocessen kan helpen om de levens van mensen met een verslaving op een betekenisvolle manier te verbeteren.

Dankwoord

Ik lees nog steeds liever dan dat ik schrijf. Dus voordat ik hieraan begon, las ik natuurlijk eerst een aantal dankwoorden van collega-promovendi. Velen kijken met ‘veel plezier’ terug op een ‘leerzame’ tijd, maar ook termen als ‘vermoeiend’ en ‘eenzaam’ komen vaak voor. In het dankwoord wordt vervolgens duidelijk wie heeft bijgedragen aan al die plezierige leerervaringen en wie het vermoeiende en eenzame dragelijker hebben gemaakt.

Nou, het promoveren was voor mij ook zeker een plezierig, leerzaam, vermoeiend en heel soms eenzaam proces. Je gaat erop uit en begeeft je in werelden van mensen, met wie je anders nooit in contact was gekomen. Je kan je storten op alle literatuur die je toch al wilde lezen. Om je vervolgens steeds meer een expert in je vakgebied te voelen. Anderen blijken dat dan ook zo te zien. Maar voor een groot deel zit je ook alleen achter je computer. Binnen in het donker te schrijven, terwijl buiten de zon uitnodigend schijnt. Je vrienden vragen zich af wanneer je nu eindelijk eens klaar bent met ‘studeren’. Als ze überhaupt nog aan je denken. Thuis loop je verward de trap af na een dag coderen. Om tijdens het eten in een soort wartaal je theoretische concepten uit te leggen aan je partner. Ze knikt begripvol, maar kijkt ook een beetje bezorgd.

Ja, promoveren is een emotionele achtbaan. Maar ook ik kan niet anders dan degenen bedanken die het leuke leuk(er) hebben gemaakt en het moeilijke dragelijk. Want ook al voelde ik me soms eenzaam, dat was ik absoluut niet! Van alle mensen om mij heen wil ik – zonder anderen tekort te willen doen – de volgende personen bedanken.

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Curriculum Vitae

Thomas F. Martinelli was born on September 4th, 1989, in Oud-Beijerland, the Netherlands. After finishing secondary school, he studied Cultural Anthropology at the Utrecht University. He graduated for a Bachelor of Arts after conducting ethnographic fieldwork on indigenous protests against mining in San Miguel Ixtahuacán, Guatemala, in 2010. In 2012, he volunteered for a Belgian NGO to organize seminars for indigenous groups, about mining activity in Peru and Ecuador. That same year, he started a study in Global Criminology at the Utrecht University, where he graduated for his Master of Arts in 2014. His master thesis reported on qualitative research on pimps, sex workers and sex trade in Mexico City. Back in the Netherlands, he worked as freelance researcher for two years. In 2016 he started working for IVO Research Institute where he is still employed as a researcher. Working at IVO, he collaborated with the Maastricht University, studying the gateway effect from e-cigarettes to combustible tobacco between 2019 and 2021. Starting in 2017, Martinelli and colleague Cas Barendregt founded and organized IVO Kino, a reoccurring movie and discussion night. Martinelli is also an ad-hoc reviewer for several drug, addiction, tobacco control and public health journals. He is a guest-lecturer at several universities and an expert guest-trainer for CEPOL (the European Union Police Academy) and EMCDDA (the EU Drug Agency). Currently, Martinelli uses a variety of research methods at IVO Research Institute to study topics such as addiction, recovery, drug policy, forensic care, crime, and other phenomena that people in vulnerable situations may encounter.

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Overcoming a drug addiction can be a complicated process and is increasingly called recovery. Recovering from addiction can mean reducing substance use problems, but it also refers to positive changes in broader life domains such as health, well-being and social inclusion. In this thesis, we explore what the concept of recovery entails for people who experience it, for recovery support services and for policy.

Thomas F. Martinelli (1989) studied Cultural Anthropology (B.A., 2010) and Global Criminology (M.A., 2014) at Utrecht University in the Netherlands. In 2016 he started working for IVO Research Institute, where he also started his PhD-research in 2018. Martinelli uses a variety of research methods to study topics such as addiction, recovery, drug policy, forensic care, crime and other phenomena that people in vulnerable situations may encounter.