Chasing a pot of gold: an analysis of emerging recovery-oriented addiction policies in Flanders (Belgium) and the Netherlands

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# Abstract

Following the paradigm shift to recovery in the Anglophone world, recovery is also gaining momentum in drug policy and practice in Flanders (Belgium) and the Netherlands. Since the meaning of recovery is being debated internationally, broadening the assessment of how the recovery framework is applied in policy discourse and how it is implemented in various international contexts is imperative. This comparative policy analysis aims to assess similarities and differences in addiction recovery vision, implementation, and evaluation in Flanders and the Netherlands. The thematic analysis draws upon a triangulation of different data collection methods in both countries: a focus group (n=14) and interviews (n=21) with key figures in the addictions field, followed by analyses of relevant policy documents (n=9). Our findings show that a holistic vision of addiction recovery is endorsed in both countries. Although differences in policy development occurred (i.e. centrally driven in Flanders versus ‘bottom-up’ in the Netherlands), similar challenges emerged concerning recovery-oriented addiction policies. While policymakers in Flanders and the addiction sector in the Netherlands strongly proclaim recovery, structural implementation, dedicated funding, and systematic evaluation of recovery-oriented policies are lacking. This study suggests that systematic inclusion of experts by experience and aligning government and practice level funding and policies are crucial.

**Keywords**

Addiction; drug policy; recovery; international comparison

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# Introduction

The recovery movement has received renewed and international interest over the last decades, which has been catalyzed by mental health reforms and service user movements since the 1970s, challenging the oppressive dynamics of narrow-minded biomedical systems of care (Berridge, 2012; El-Guebaly, 2012; Pilgrim, 2008; Slade, Amering, & Oades, 2008). Key to this movement was a shift from a focus on improved clinical outcomes (clinical recovery, i.e. absence or reduction of symptoms) as the ultimate goal of treatment, to a more holistic understanding of recovery that recognizes its process-based character and personal recovery, taking into account individuals’ contexts, wishes, and strengths. Parallel to this evolution in mental health care, recovery is increasingly applied as an overarching concept and a new paradigm in alcohol and drug policies and treatment responses (Anthony, 1993; Braslow, 2013; Laudet & White, 2010; Roberts & Boardman, 2013), with mental health and addiction recovery sharing parallel histories and common principles (Davidson & White, 2007). Although consensus on the precise definition of addiction recovery is missing (Witkiewitz, Montes, Schwebel, & Tucker, 2020), it is generally considered as a unique, multi-dimensional, relational, and dynamic process of change and improved wellbeing in different life domains (Ashford et al., 2019; Martinelli et al., 2020; White, 2007). Consequently, abstinence cannot be regarded as synonymous with addiction recovery, as opposed to traditional recovery definitions that have nominated sobriety as a core recovery indicator (Laudet & White, 2010; Witkiewitz & Tucker, 2020). The Betty Ford Institute, for example, sets priority for sobriety as the starting point of recovery (Betty Ford Institute Consensus Panel, 2007). Abstinence can indeed be a potential or chosen route to recovery for some, but recovery includes multiple pathways and can take various forms. According to a holistic recovery definition, other dimensions of recovery need to be considered besides clinical recovery: functional, social, societal, and personal recovery (Best, Bird, & Hunton, 2015; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011; Roberts & Boardman, 2013; Slade et al., 2008; van der Stel, 2012). Rather than searching for a straight-forward definition, in this paper, we refer to the holistic concept of addiction recovery that underscores its idiosyncratic character.

The emergence of addiction recovery is not only gaining ground in research, but it is also increasingly central to drug and addiction policies globally (Lancaster, Duke, & Ritter, 2015; Vanderplasschen & Vander Laenen, 2017). Especially in the Anglophone world, the recovery movement is well established and its principles have become the cornerstones for national drug policies (HM Government, 2017; Laudet & Best, 2015; Roberts & Boardman, 2013; SAMHSA, 2012; The Scottish Government, 2018). For example, in the United States, policies were designed and linked to specific funding mechanisms to foster recovery-oriented systems of care (ROSC), providing an environment that facilitates recovery and a continuum of support options (Sheedy & Whitter, 2013; White, 2008). As a consequence of increasing drug problems and poor treatment outcomes, the recovery framework equally influenced policy and practice in the United Kingdom in the mid-2000s. These recovery-oriented policy initiatives have reinforced peer-led and informal community-based services, as an alternative to professional support (Humphreys & Lembke, 2013).

Following the paradigm shift in the Anglophone world, the notion of recovery also gained ground in Belgium and the Netherlands (Flemish Government, 2016; Mental Health the Netherlands, 2013). These neighboring European countries share a common policy shift away from a traditional mental health care model based on large-scale psychiatric institutions towards a community-based mental health care system (European Union, 2017; Fakhoury & Priebe, 2007; Novella, 2010). Mental health care reforms in the Netherlands have inspired Belgian policymakers and endorse a pivotal role for community-based support (Kroneman et al., 2016; Ravelli, 2006). Under Belgium Law, this development is supported by a clause of the Act on hospital legislation from 2010, the so-called Article 107, which is a statutory provision allowing state subsidies for residential care to be re-allocated for community-based support (Federal Administration, 2010; Nicaise, Dubois, & Lorant, 2014). Whereas previously, in Belgium and the Netherlands, addiction treatment was mainly organized separately from general mental health services, it is increasingly integrated into the mental health care system as addiction is generally categorisedas a mental health problem, with the notion of recovery intersecting both fields. This has resulted in both drug-specific services and integrated services with varying funding mechanisms (Bartram, 2019; Flemish Government, 2015, 2019; Gagne, White, & Anthony, 2007; Mental Health the Netherlands, 2009, 2013).

Besides these similarities, important differences can be observed regarding drug and recovery-oriented policies in Belgium and the Netherlands. As Belgium is a federal state and responsibilities for different policy domains, such as addiction treatment, are divided among the national authorities and the regions (Flemish Parliament, 2020), we will refer to Belgium/Flanders respectively. First, the Netherlands has a longer and more established history of drug research and policy innovations. Already in the late 1960s, the Netherlands deviated from international drug standards by framing drugs as a public health and social issue instead of a criminal offense, and subsequently introduced a distinction between ‘soft’ and ‘hard’ drugs (Barendregt & van de Mheen, 2012; Korf, Riper, & Bullington, 1999). Consequently, Dutch drug policy has been more frequently the subject of research, monitoring, and evaluation compared to Belgium. Second, the concept of addiction recovery as a policy vision was put forward approximately five years earlier in the Netherlands than in the Dutch-speaking part of Belgium (Flanders). The origins of the addiction recovery movement in the Netherlands go back to the establishment of the Black Hole Foundation, a national board of addiction client representatives, that facilitated the adoption of the Charter of Maastricht (2010). All major addiction treatment organizations that signed the Charter agreed to feature the notion of recovery in their services (The Black Hole Foundation, 2010). Interestingly, drug policy initiatives in Belgium have often been influenced by good practices from the Netherlands (De Ruyver, Vander Laenen, & Eelen, 2012), which was also the case with the adoption of the Flemish Green Paper on recovery-oriented addiction care (Flemish Government, 2016).

Third, in the Netherlands, the new recovery discourse has been initiated and advocated by a client movement and was implemented on the ground with minimal government interference. In Flanders, however, service providers, scholars, and policymakers played a prominent role in initiating a recovery-oriented addiction policy. Following the sixth reform of the Belgian state, several authorities for important aspects of mental health and addiction care were transferred from the national to the regional level (i.e. communitarisation) (Vander Laenen, 2016). As a consequence and due to language and cultural differences, a recovery framework in alcohol and drug services was introduced in the Dutch-speaking but not in the French-speaking part of Belgium (Flemish Government, 2015, 2016). Notably, the concept of recovery was first introduced in the Belgian mental health care system, thus at the national policy level, in 2010 (Federal Administration, 2010).

As described above, recovery was adopted differently in national addiction policies in both countries. Comparing these variations in policy development and enactment may provide important insights for developing and implementing recovery-oriented policies elsewhere. So far, extensive research on recovery-oriented drug policies is mainly limited to the Anglophone world (e.g. Best et al., 2010; Duke, Herring, Thickett, & Thom, 2013; Humphreys & Lembke, 2013; Lancaster et al., 2015). Few policy analyses have been performed in countries where the notion of addiction recovery was adopted more recently, such as in Flanders (Belgium) and the Netherlands. Recovery is currently gaining momentum in national policies and practices, however, its meaning is still being debated internationally (Slade et al., 2012; White, 2007). Various authors argue that addiction recovery is a polyvalent and contested concept, as different interpretations of the term are enacted and tensions arise between different recovery perspectives amongst various stakeholders. As such, these scholars underscore that a policy consensus on the ambiguous notion of addiction recovery cannot be assumed (Lancaster, 2017; Pilgrim, 2008). Indeed, recovery as an overarching framework to drug and addiction policies has been the subject of polarized discussions in the United Kingdom and Australia (e.g. Anex, 2012; Duke, 2012; Lancaster et al., 2015; McWade, 2016; Rose, 2014). Consequently, adding different international contexts to the discussion is valuable to extend the evidenced discussions occurring in Anglophone countries. Therefore, this study will contribute to the ongoing scientific debates on the policy framing of addiction recovery and the enactment of recovery-oriented policy and practice.

The purpose of this comparative policy analysis is to critically examine the role of recovery (i.e. similarities and differences) in the drug and addiction policies of two countries, Flanders (Belgium) and the Netherlands, that have recently adopted a recovery-oriented policy framework. More specifically, the current study aims to assess to what extent recovery is adopted in addiction policy discourse (i.e. the communication of thoughts and ideas about recovery) and practice (i.e. the intended realization of the recovery framework). For this, we aim to identify: (1) how recovery is defined and put forward in addiction policies, (2) how the recovery-oriented policies are operationalized and implemented, and (3) how their implementation is being evaluated in these two countries.

# Methodology

## *Research context*

This comparative policy analysis was performed in the context of the European Recovery Pathways (REC-PATH) study (2017-2020). The goal of the REC-PATH project was to map and assess pathways to drug addiction recovery, as well as to focus on individual, social, and societal factors that positively or negatively influence recovery processes (see Best et al., 2018; Martinelli et al., 2020). The current policy analysis contributes to the latter aim to investigate the structural context in which people initiate and sustain their recovery journeys.

## *Study design*

This policy analysis critically examines the current recovery discourse in addiction policies and its enactment in practice in Flanders (Belgium) and the Netherlands. A triangulation of different data collection methods was adopted in both countries, consisting of two main phases. In the first phase, the recovery vision put forward by the country/region’s government and that of other stakeholders in the addictions field was analyzed (i.e. discourse) through document analyses of the most relevant addiction and recovery-oriented policy documents (Flanders: n=5 and the Netherlands: n=4). During the second phase, we examined the development and implementation of recovery-oriented addiction policies with how it is endorsed in policy documents in each country (i.e. practice). Therefore, we set up a focus group regarding the development and implementation of the recovery agenda including several key informants (Flanders: n=6 and the Netherlands: n=8), as well as individual interviews with civil servants and other key figures in the addictions field in Flanders (n=10) and the Netherlands (n=11). The focus groups were useful in determining the shared or conflicting perspectives of various group members. The interviews allowed us to explore topics more in-depth and created space for participants to talk more openly, as opposed to group discussions which potentially lead to a dominance of outspoken participants and risk group thinking (Gill, Stewart, Treasure, & Chadwick, 2008; Vander Laenen, 2015). Combining focus groups and individual interviews contributed to data richness (Lambert & Loiselle, 2008).

### *Focus groups*

Two focus groups were conducted in February 2018 in Flanders and the Netherlands to start the policy analysis. Recovery(-oriented addiction policy) was discussed regarding its current state and development, and its integration into policy. Both focus groups included civil servants of the Departments of Public Health and representatives of treatment services. In the Netherlands, client representatives were also included, however, no such organization was involved in Flanders in the absence of a national/regional board of addiction client representatives. Three topic areas were addressed during the focus groups, based on the research questions: (1) the participants’ policy vision on recovery and the goals and action points formulated for addiction recovery, (2) the implementation and evaluation of recovery-oriented policies, and (3) the political and socio-economic context in which the development and implementation of current recovery-oriented policies take place. In each country, the researcher acted as a moderator to guide the discussion between participants and to stay on track in relation to the topics, while a co-researcher assisted in taking notes (Gill et al., 2008; Nyumba, Wilson, Derrick, & Mukherjee, 2018). The duration of the Flemish and Dutch focus group discussion was about two hours. Both focus groups were audio-recorded and transcribed verbatim.

### *Individual interviews*

Interviews with key informants were conducted between November 2018 and April 2019. To take into account various administrative levels and local differences, key experts from different domains, including political, practice, research, and service user actors, were recruited. Based on the advice of focus group participants, a group of stakeholders who were considered influential in the development of addiction and recovery-oriented policies was identified (see Table 1). There was some overlap between the Flemish focus group and interview participants (n=3), as these individual conversations enabled us to gain more in-depth information. In the Netherlands, there was no overlap.

< Insert Table 1. Profile and number of interview respondents in Flanders (n=10) and the Netherlands (n=11) >

Three topics were discussed during the semi-structured interviews: vision, implementation, and evaluation of recovery-oriented addiction policies, similar to the focus group discussions and in line with the research questions. Participants were asked to define what the concept of addiction recovery meant to them and why recovery was included in policy documents and discourse, or not. Furthermore, we asked how recovery-oriented policies are being implemented and what governmental finances are available to support this. Lastly, we inquired whether and how the implementation of the recovery-oriented policy is monitored and evaluated. We also invited respondents to elaborate on the challenges they encountered concerning the development and implementation of a recovery-oriented addiction policy and about their expectations for the future. The duration of the interviews ranged from 30 to 77 minutes.

### *Recovery-oriented policy documents*

The focus groups and interviews were supplemented by document analyses of key addiction and recovery-oriented policy documents. We selected policy and vision documents that discuss the role of recovery in general mental health and addiction policy, due to its integration and based on recommendations from the focus group and interview informants. Six addiction-specific policy documents (Flanders: n=3 and the Netherlands: n=3) and three general mental health care policy documents (Flanders: n=2 and the Netherlands: n=1) were analyzed to grasp the Flemish and Dutch policy context more comprehensively. Table 2 outlines these documents.

< Insert Table 2. Overview of recovery-oriented mental health and addiction policy and vision documents in Flanders (n=5) and the Netherlands (n=4) >

## *Data analysis*

focus group and interview as it is a foundational method to identify patterns in the data in relation to the three topics under studyand The Flemish transcripts were coded using the software package NVivo and the Dutch transcripts were hand-coded. Table 3 provides a detailed overview of the thematic analysis outcomes. The findings were summarized in focus group and interview reports for each country. policy same topic areas

< Insert Table 3. Overview of (sub)themes coded for the topics under study in each country >

Based on reports drafted for the focus group, interview, and document analyses in each country, a country comparison was conducted regarding the three main topics around recovery-oriented policy discourse and practice (i.e. addiction recovery vision, implementation, and evaluation). LB analyzed and compared the country reports, assisted by FVDL, in close consultation with TM. Designing the study, data collection, and data analysis followed different stages in an iterative process. The different educational and country backgrounds, levels of expertise, and experiences with research, policy, and practice of the authors contributed to dealing with potential biases by continuously discussing the study approach via online meetings and the interpretation of the findings through sharing feedback on the country reports. As the respondents were guaranteed confidentiality, potential identifiers were removed from the extracts that are used to illustrate the results.

# Results

## *Addiction recovery policy visions*

A holistic vision of addiction recovery is endorsed in policy and vision documents in the Netherlands and Flanders (Belgium). In the Netherlands, the Charter of Maastricht (2010), initiated by the national client representative board, defines recovery as follows:

Recovery is an individual process that people with addictions engage in to regain control over the achievement of realistic and concrete goals and meaning in their own lives. Treatment is part of the recovery process for people who cannot realize this on their own. Societal recovery requires the commitment of other institutions in broader life domains such as housing, work, and well-being. (The Black Hole Foundation, 2010, p. 5)

Similarly, the Flemish Government aims to create a policy framework for recovery-oriented addiction care with its Green Paper (2016) describing recovery as:

an individual process of positive change, in terms of health, daily functioning, social participation, and personal development. This concerns recovery on a clinical, functional, social, and personal level. Addiction care should support the recovery of people with an addiction problem and improve their quality of life. This is done in close collaboration with actors from adjacent sectors and in collaboration with the informal and natural network of the persons involved. (Flemish Government, 2016, p. 4)

Both documents refer to addiction recovery as being about more than the reduction of or abstinence from substance use (i.e. clinical recovery) but also about functional, social, societal, and personal recovery, which was equally emphasized during the Dutch and Flemish focus groups and interviews. Notably, some Dutch interviewees put forward the suggestion that these four dimensions of recovery do not only describe recovery processes accurately but also take away some of the tensions between clinical and personal recovery that exist in Anglophone countries. Moreover, throughout the interviews and focus group discussions, as well as in the policy and vision documents, empowerment, shared decision-making, quality of life, and a strengths-based approach were raised as important aspects of recovery-oriented addiction support in both countries. The Dutch Vision Note ‘Addiction and addiction care: focus on prevention and rehabilitation’, for example, underscores that service users need to be in charge of their treatment (Mental Health the Netherlands, 2013), which is in line with the statement of a Dutch interview participant: ‘a more equal relationship between the treatment provider and patient - emancipation - was an important driver for the recovery movement’. In sum, the conceptualization of addiction recovery as a unique, individual, and multi-dimensional process of change and empowerment is similar in both countries.

Yet, different nuances regarding the holistic recovery vision, underscored in policy documents, emerged during the focus groups and interviews in both countries, as these data collection methods enabled a more critical and in-depth examination of stakeholders’ perspectives. For example, the Dutch vision documents, which have been developed by addiction treatment organizations, originate from the boards of directors. According to some Dutch participants, there generally is agreement on a holistic addiction recovery vision. However, when you dig deeper, different levels of actors often focus on different dimensions of addiction recovery ‘resulting in a trichotomy of visions’ between: (1) persons with substance use problems (who may prioritize personal recovery), (2) clinicians and other ground-level professionals (who may prioritize clinical recovery), and (3) the boards of directors and funders (that may prioritize measurable recovery aspects). Similarly, in Flanders, most respondents endorsed the holistic addiction recovery vision as defined in the Green Paper (Flemish Government, 2016). However, some underlined the value of societal recovery, as expressed in the following quote: ‘Recovery is ensuring that people can participate in our society starting from their strengths and possibilities’, while others underscored factors linked to personal recovery (e.g. individual choice). Some interviewees argued that although taking responsibility is an important part of recovery, there is a tendency to use this aspect of the recovery vision to make people more responsible for their problems by emphasizing individuality while ignoring structural external conditions. Hence, even though a policy vision exists in terms of addiction recovery, different interpretations prevail in practice in both countries.

## *Implementation of recovery-oriented policies*

Concerning implementation, several similarities emerged between the Flemish (Belgian) and Dutch context, based on the focus group discussions and interviews. In the Netherlands, policy around addiction treatment is generally developed outside of the Ministry of Public Health (e.g. Charter of Maastricht). Respondents asserted that this means that addiction services, health insurances, and local governments are responsible for developing and implementing care strategies, as ‘the Government is not taking direct action at the moment’. In the Dutch situation, addiction treatment is financed as specialized care by the central government through health insurance, whereas many other types of care and support that also fall within the scope of recovery (e.g. resolving debts, housing, and community support) are financed locally through the municipalities. As a result, many locally organized recovery-oriented initiatives and pilot projects, so-called ‘testing grounds’, exist in which these different stakeholders (have to) collaborate. Furthermore, organizations often recruit experts by experience in addiction services as a form of recovery-oriented support. However, these initiatives have not (yet) transcended the local level to more structural arrangements.

The lack of structural arrangements in the Netherlands corresponds with the Flemish policy context. Although the Flemish Government has developed a Vision Note (Flemish Government, 2015) and Green Paper (Flemish Government, 2016) on recovery-oriented addiction treatment, it only provides a rather general overview of future action points that is not sufficiently detailed and does not describe concrete measures to take. One civil servant added: ‘At the moment we have very few tools in our hands and there is very little to say to organizations like: implement this or that and do it this way’. As such, implementation efforts depend heavily on individual treatment services. Some Flemish interviewees argued that the extent to which a particular vision or decision is supported often depends on local political and treatment authorities in which power mechanisms play a significant role (i.e. the political position of the person in charge for locally implementing policy is often either oriented on repression or welfare). Consequently, several recovery-oriented policy initiatives were mentioned by interviewees as (local) implementation examples of recovery (e.g. Recovery Colleges), but these are not structurally embedded or are general mental health, and thus not addiction-specific, initiatives. Furthermore, one respondent suggested that, although policy visions are available, recovery should mainly be developed and implemented ‘bottom-up’: ‘Policy will provide an important framework and provide funding opportunities, but as it is such a complex issue involving so many areas of life, drug policy must come from bottom-up’. Another participant mentioned that this focus on ‘bottom-up’ recovery-oriented practices should be given a boost at the legislative level. In sum, various local and regional recovery-oriented initiatives exist in both countries, but implementation efforts are rarely structurally embedded, nor is the recovery policy vision endorsed in concrete legislation and regulations, which is in line with a ‘bottom-up’ policy approach.

Regarding the implementation of recovery-oriented policy objectives into practice, the role of experts by experience is highly prominent in both countries. For instance, the parties that signed the Dutch Charter of Maastricht (2010) agreed that: ‘experiential knowledge is recognized as a third source of knowledge besides scientific and professional knowledge’ (The Black Hole Foundation, 2010, p. 5). Similarly, the Flemish Government points out in the Green Paper (2016) the aim: ‘to motivate organizations in the care sector to implement an adapted volunteer policy and to include people with a psychological vulnerability or experience with addiction problems’ (Flemish Government, 2016, p. 22). During the interviews and focus groups, the operationalization of the recovery vision was equally linked to shared decision-making and input from experts by experience at the organizational and policy level in both countries. It was discussed that experts by experience are already employed in various forms throughout addiction services in the Netherlands and Flanders, either as volunteers, as trained and paid professionals, or in the form of patient boards. The following quote illustrates their involvement in recovery-oriented policy as viewed by a Dutch participant: ‘In some treatment organizations, the implementation of a recovery-oriented policy is synonymous with the employment of experts by experience’. At the policy level, a notable difference emerges between both countries based on the accounts of respondents. In the Netherlands, various actors such as addiction client representatives participated in policy development, while in Flanders (Belgium), client participation at regional and national policy level was only introduced recently (e.g. two experts by experience were involved in drafting the Vision Note on recovery-oriented addiction care in 2015). Despite the higher level of involvement of (ex-)service users in the Netherlands compared to Flanders, structural funding and organization of experts by experience are still lacking and are viewed as a challenge in both countries. Moreover, some Dutch interviewees critically disputed the professionalization of experts by experience: ‘What you see is that an expert by experience is reeled in and turned into a professional. That is not the essence of their expertise. You are just turning them into another social worker’.

With regard to funding of the implementation of the recovery vision, vague descriptions were recorded in policy documents (i.e. they are not readily operationalized) in both countries. In Flanders, for example, no statement is made about the budget that will be needed to achieve the objectives outlined in the Green Paper (2016). Dutch and Flemish focus group and interview respondents could not provide a clear picture of how recovery-oriented policies are financed. In the Netherlands, interviewees asserted that fragmented and decentralized financial flows have led to barriers and local variations between treatment services. The idea behind decentralization was to bring mental health service users closer to society instead of institutionalizing them. However, according to participants in the focus group, ‘budgets were cut but not reinvested enough’, which meant that mental health care providers were delivering more with less money and ‘as a result, care providers have had little to no possibilities to be creative or innovative, and to implement more recovery-oriented policies’. Correspondingly, Flemish respondents could not specify the concrete amount of funding attached to initiatives that attempt to implement recovery. In sum, we found that implementing addiction recovery means that stakeholders have to deal with fragmented and project-based financing. Consequently, little prospect of integrated and dedicated financing was offered that would make effective and efficient recovery-oriented addiction care feasible and accessible.

## *Evaluation of the recovery-oriented policies*

In our policy document analyses, as well as in the focus groups and interviews, we found no systematic evaluation of recovery-oriented policy in place, nor is such an evaluation foreseen. For example, one evaluation instrument that is mentioned in the Green Paper (2016) on recovery-oriented addiction care in Flanders is the Recovery Oriented Practices Index (ROPI), an instrument to determine to what extent a team provides recovery-oriented support (Flemish Government, 2016). This tool has been applied as part of a study and has not structurally been embedded, as one interviewee explained that it is not mandatory for mental health care organizations to use it. Moreover, a respondent remarked: ‘It is not easy to measure recovery goals, because recovery is a very individual story. If you want to support personal recovery, you must be given some space to do things, instead of predefining things. So you have to be careful with measurements’.

In the Netherlands, ‘testing grounds’ (cf. supra) were part of the Charter of Maastricht (The Black Hole Foundation, 2010) and were designed to develop and assess the implementation of recovery initiatives. Evaluation of these testing grounds in 2013 led to the conclusion that the addiction services sector was still in the beginning phase of a communal learning process (Schippers, Barendregt, de Haan, & Wits, 2013). Furthermore, Dutch focus group participants mentioned several instruments that currently exist or that are being developed and that could potentially be used for evaluating recovery-oriented policies. However, they asserted that a lot of what is being measured and evaluated in addiction treatment is (still) pathology-oriented, as these instruments are mainly concerned with clinical recovery, like Routine Outcome Monitoring (ROM) tools and the National Alcohol and Drug Information System (LADIS), in which treatment demand data from alcohol and drug services are registered. As the mental health and addiction sector already encountered some fundamental (privacy) issues with ROM, a new system is currently being developed. This new system is described as a ‘further development that is more aligned to the work field’ and is already included as a quality indicator in the care guidelines for recovery-oriented support (Akwa Mental Health Service, 2017). Hence, the Netherlands has experimented more with various evaluation tools, while in Flanders no systematic evaluation takes place, not even at the project level.

# Discussion

The context of this comparative policy analysis is the recent shift to recovery-oriented policy and practice in Flanders (Belgium) and the Netherlands, following the emergence of the recovery movement in the Anglophone world (Best et al., 2018). The development of an addiction recovery policy vision evolved ‘top-down’ in Flanders (Belgium), as the Flemish Government drafted a Green Paper on recovery-oriented addiction care (2016), while in the Netherlands the driving force behind the integration of the recovery paradigm within addiction care was the client movement that initiated the Charter of Maastricht (2010). In light of these differences in policy development and origins, this study aimed to compare: (1) recovery-oriented policy discourse, (2) its implementation, and (3) to what extent evaluation is undertaken. Similarities and differences between both countries regarding these three aims will be discussed, considering contemporary international debates and challenges around the notions of addiction recovery and recovery-oriented policies.

Analysis of the recovery policy vision in Flanders (Belgium) and the Netherlands shows that both countries share similar views on the notion of addiction recovery, broadly described as a personal process and holistic concept that involves multiple life domains. This is in line with, and likely inspired by, scientific conceptualizations of mental health and addiction recovery that broaden the focus from (abstinence-oriented) clinical recovery to personal, social, societal, and functional dimensions (e.g. Best, Gow, Taylor, Knox, & White, 2011; Neale et al., 2015; van der Stel, 2012; White, 2007). In comparison to some Anglophone recovery discourses, it can be argued that the Flemish and Dutch recovery frameworks are less focused on normative ideas of recovery as an outcome. Although UK drug policy has, for example, featured recovery as its organizing concept for addiction services and policies earlier compared to Flanders and the Netherlands, its recovery-oriented policy discourse has been criticized for being overly abstinence-oriented (e.g. Duke, 2012; McKeganey, 2014). UK policy refers, for example, to ‘full recovery’, which means to support ‘every individual to live a life free from drugs’(HM Government, 2017, p. 7). Hence, the concept of recovery in policy documents and/or practice is defined differently internationally, despite similar origins.

Although a holistic recovery vision is endorsed in Flanders and the Netherlands, the policy document analyses, focus group discussions, and interviews underscored that different interpretations and priorities prevail about how recovery should be operationalized. This fits into concerns that recovery has become a floating signifier (i.e. an umbrella concept interpreted in many different ways) that is extensively used but represents divergent views (Hopper, 2007; Pilgrim, 2008). Additionally, Duke et al. (2013) argue that the multiplicity of the recovery concept makes its adoption politically attractive as it can be framed differently in diverse contexts, depending on the perspectives and intentions of various stakeholders. Due to this polyvalence, Davidson and Roe (2007) argue that recovery (within the mental health field) is increasingly becoming the expectation for people with psychological vulnerabilities, although little consensus exists about the meaning of recovery. This expectation of recovery in Flemish and Dutch policy documents is defined as an ‘individual process’ that involves ‘taking back control over one’s life’ (Flemish Government, 2016; The Black Hole Foundation, 2010).

The focus on individual responsibility to change is criticized in recent recovery literature, as it brings the risk that recovery is narrowed down to personal recovery, ignoring societal recovery and absolving the state from the responsibility to intervene, which was equally suggested by some respondents in our focus groups and interviews. These critics argue that this is linked to a broader neo-liberal agenda that highlights individual responsibility, neglecting structural and societal factors (e.g. Fomiatti, Moore, & Fraser, 2019; Harper & Speed, 2012; Lancaster, 2017; Price-Robertson, Obradovic, & Morgan, 2017; Vandekinderen, Roets, & Van Hove, 2014; Vander Laenen, 2016). Moreover, in the aftermath of global economic recessions in 2008 and subsequent public sector funding cuts, some argue that the shift to recovery in policy discourses was used as a covert means of cost reduction (Duke, 2012), by placing more responsibility on individuals instead of structural support. The translation of recovery-oriented addiction policies into successful organizational models, however, can only be realized if the necessary resources are provided (SARWGG, 2016), which may also need substantial investments initially. As such, financial haziness and a lack of structural funding in Flanders and the Netherlands pose risks to implementing the holistic recovery visions as described in policy documents.

For operationalizing recovery, Flemish (Belgian) and Dutch policy documents and respondents mainly referred to the role and inclusion of experts by experience. The addition of lived experience and experts by experience in addiction and mental health services is indeed put forward as an important part of the international recovery movement (Davidson, Chinman, Sells, & Rowe, 2006; Sheedy & Whitter, 2013), to model recovery and share a message of hope (Laudet & Humphreys, 2013; Smith-Merry, Freeman, & Sturdy, 2011). Emerging evidence suggests that this facilitates individuals’ recovery processes (Best et al., 2015; Repper & Carter, 2011). However, to employ paid experts by experience is a challenge for most addiction services in Flanders and the Netherlands as they are not yet fully recognized as staff by the government and insurance companies. Consequently, in practice, they mostly work as volunteers as there is almost no funding for their positions unless they also have qualifications as trained professionals. In this regard, Rose (2014, p. 218) debates that experts by experience ‘are a subsidiary labor force commanding neither the respect nor the financial remuneration of mainstream staff’. In both countries, systematic involvement and integration of experts by experience are currently lacking at the organizational and policy level. Moreover, the mere presence of experts by experience does not necessarily imply participation, let alone influence or structural change, at the treatment service or policy level (Neale, 2013). Hence, it can be questioned to what extent experiential knowledge is implemented and valued in reality compared to professional and academic knowledge (Vander Laenen, 2016).

Additionally, shared decision-making is advocated in Flanders and the Netherlands as an essential aspect of recovery-oriented policy implementation. Since recovery is viewed as a personal process, service user input based on their own experiences and knowledge of coping with addiction problems is promoted (Smith-Merry et al., 2011). The importance of shared decision-making is linked to the emergence and emancipation of the recovery movement as a critique of the patriarchal and unilateral power relationships with practitioners about treatment decisions. Recovery-oriented support should therefore promote individuals’ capacities for self-determination, within their care process and their own lives (Davidson & Roe, 2007; Davidson, Tondora, Pavlo, & Stanhope, 2017). In Flanders and the Netherlands, the shift towards recovery has culminated in a policy framework that seeks to underscore the importance of service users’ input and choice. Davidson et al. (2017) consider shared decision-making as only one component of recovery-oriented care. They argue that this ‘tool’ should be integrated into a global person-centered process, i.e. an approach to care that is holistic, individualized, and empowering (Marchand et al., 2019).

Variations in local implementation efforts of the recovery policy discourse were found in both countries. Although the adoption of recovery in policy documents evolved differently in both countries (i.e. ‘bottom-up’ by the Dutch addiction sector and ‘top-down’ by the Flemish Government), Flanders (Belgium) and the Netherlands both adopted recovery-oriented policies that are not very directive, leaving room for a ‘bottom-up’ approach in developing and implementing a recovery framework. In this light, the shift to recovery is said to ‘intersect neatly with the emphasis on devolving responsibility to the local level’ (Duke et al., 2013, p. 972). The idea behind decentralization is that policy can be more tailor-made and adapted to local variations. This points to the dynamic nature of policy implementation and the need for flexibility, as policies cannot specify all objectives and measures (Sausman, Oborn, & Barrett, 2016). However, decentralization also implies that implementation depends on local initiatives and engaged stakeholders. This means that recovery-oriented policy at the local level is vulnerable in both countries, which can lead to differences between various municipalities and regions.

To study the effects of recovery-oriented policies and services, appropriate evaluation methods need to be developed that can further inform policy development and implementation (Frost et al., 2017). The findings of this study suggest, however, that evaluation of recovery-oriented addiction policies is still lacking in Flanders (Belgium) and is in its infancy in the Netherlands. Some respondents linked this to the subjective nature of recovery. Developing standardized evaluation instruments is challenging as defining addiction recovery as a personal experience underscores the ambiguousness of objective measurements of recovery (Slade et al., 2008). Moreover, recovery can be present in many aspects of care and support, from general health care, debt-relief, and social care to addiction treatment (Sheedy & Whitter, 2013). These particular characteristics make it difficult to study the effects of recovery-oriented policy and practice through common (quantitative) methods (Neale et al., 2014), as traditional clinical research tends to focus on outcome measures, mainly focused on substance use and offending (De Maeyer, Vanderplasschen, & Broekaert, 2010; Gossop, Trakada, Stewart, & Witton, 2005; Neale et al., 2015; White, 2008). Still, many different aspects of recovery can be measured and investigated separately through observable and qualitative outcomes (Kaskutas et al., 2014; Martinelli et al., 2020; Scheyett, DeLuca, & Morgan, 2013), in which different life domains are seen as interconnected and reinforcing (Dennis, Foss, & Scott, 2007; Kelly, Greene, & Bergman, 2018; White, 2007).

## *Policy implications*

Although recovery as an organizing concept has increasingly become a core feature of international addiction policy and practice, our findings show that operationalizing recovery remains a significant challenge, even in countries that proclaim addiction recovery as a policy goal. Therefore, we briefly discuss some policy implications regarding the development and implementation of recovery-oriented policies, aimed at bridging the gap between policy discourse and practice.

Policy awareness of the lack of an unambiguous definition of recovery and of the related limitations to measure something undefined is crucial. To address this issue, recovery assessment tools need to be developed, preferably in accordance and collaboration with experts by experience. There is a need for innovative ways of evaluating recovery that take into account individual experiences, needs, and circumstances (Neale et al., 2014). In line with recovery principles, the systematic inclusion of experts by experience at all levels is necessary. An important prerequisite is that these experts by experience are structurally paid, as to recognize the added value of experiential expertise (Boevink, 2018).

Given the long-term nature of recovery processes and support needs of persons in addiction recovery (Martinelli et al., 2020), adequate and cross-cutting funding needs to be facilitated (Duke, 2012). Access to the right support at the right time can be crucial to supporting long-term recovery. Financial structures behind different types of support, such as clinical treatment and community services, can hinder these processes. We argue that national governments are responsible to guarantee access to the highest quality addiction services. Collaboration and agreements between regional and local actors as well as different policy domains need to be supported and improved. Structural and earmarked funding, guidelines, and binding legislation, that still offer possibilities for local adaptation, can facilitate this. To do so, the conditions in which decentralised governments can fill in their addiction policies need to be framed properly. We, therefore, propose to formulate and to (financially) support a national recovery-oriented policy with some key indicators, including long-term outcome monitoring and inclusion of experts by experience. Hence, we opt for a balance, including national management with sufficient autonomy and room for innovation and a tailored approach.

## *Strengths and limitations*

The results of this study should be interpreted in light of several strengths and limitations. A key strength is the mixed data collection approach that provided detailed accounts of both recovery discourse and practice. The engagement of a diverse sample of focus group and interview informants was important to capture the views of a wide range of actors involved in the addictions and mental health fields in the Netherlands and Flanders (Belgium). Still, the representativeness of the focus group and interview sample cannot be claimed, because of the different profiles of the respondents in both countries. Furthermore, discourse analysis was not applied as an analytic framework for the documentary analyses, which could have focused more on the underlying values and assumptions of the language used in policy documents. Moreover, as scientists studying recovery, we interpret policies from a certain perspective and context. The mix of junior and senior researchers and experienced policy experts involved in this comparative policy analysis, however, strengthens the validity of our findings.

# Conclusion

This study shows that the growing emphasis on recovery-oriented addiction policies is not restricted to the Anglophone world. Recovery, as an organizing concept, is also increasingly becoming the ultimate goal of treatment services and the guiding vision of addiction policies in Flanders (Belgium) and the Netherlands. Despite apparent country differences in recovery-oriented policy development (i.e. centrally driven versus ‘bottom-up’), similar challenges emerged when implementing these policies. Policymakers in Flanders and the Netherlands strongly proclaim a comprehensive and holistic definition of recovery. Clear implementation, in terms of content and financing, and evaluation of recovery-oriented addiction policies is, however, missing or just emerging, which is why these policy shifts to recovery could symbolize chasing a pot of gold at the end of the rainbow. This might partly be due to a policy context that is based on decentralization and incremental change, in which a ‘bottom-up’ approach is used to spread new ideas and create a support base. Based on our findings, we argue that if a central policy were to be put in place, it should impose minimal demands, through operationalization milestones and evaluation tools, while simultaneously ensuring sufficient room for innovation and a tailored approach.

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