BELGIAN NATIONAL REPORT ON DRUGS 2014

NEW DEVELOPMENT AND TRENDS
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Lay-out
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CHAPTER 5.
DRUG-RELATED TREATMENT: TREATMENT DEMAND AND TREATMENT AVAILABILITY

Antoine J.

- Since 2011, the number of treatment demands for cannabis as primary drug shows a steep increase and a decrease for opiates. In 2013, patients most commonly reported the use of cannabis (33.5%) for entering treatment.
- A first pilot project on assisted treatment with diacetylmorphine in Belgium recommends to extend diacetylmorphine treatment as a second-line treatment for patients who continue to use street heroin despite treatment with methadone.

1. INTRODUCTION

Due to the sixth state reform, the Communities are to become more competent in political and policy initiatives, which will radically change the drug treatment sector in Belgium. This evolution in the institutional status of the country leads currently to a transitory situation (see chapter 1). This chapter comments on the most recent situation on drug-related treatment in Belgium. First, the common declaration on drug policy is screened regarding treatment information (section 1.1) and organizations working on drug-related treatment field (section 1.2) are presented. Key figures, based on treatment demand indicator data from 2013 (section 1.3) and a description on the different treatment modalities (section 1.4) are described. Trends on the number of treatment demands and on people following a substitution treatment are presented (section 2). Finally, a review of the most recent developments in the field of drug-related treatment (section 3) concludes this chapter.
2. DRUG-RELATED TREATMENT IN BELGIUM

2.1. POLICIES AND COORDINATION

An efficient drug policy requires a global and integrated approach. In 2010, the representatives of all governments in Belgium (Federal Government, Walloon region, Flemish region, French Community, Brussels-Capital Region, German-speaking Community, the French-speaking authorities in the Brussels-Capital Region and the Common authorities in the Brussels-Capital Region) have signed a common declaration entitled “A global and integrated drug policy in Belgium”. The main treatment-related objectives mentioned in this document are:

1) promoting a global and collaborative strategy for help, starting from an approach on health and integrating other dimensions (such as well-being and social integration),
2) providing cure/treatment as well as care and support,
3) providing a large choice of facilities, specifically dedicated to drug users or global health care and services related to well-being,
4) creating a balanced geographic spread of the settings based on the evaluation of needs,
5) guaranteeing the availability of various treatment programmes, including drug-free treatment, withdrawal treatment, substitution treatment, harm reduction initiatives, reintegration and aftercare,
6) promoting integrative treatment with a focus on dual diagnosis, employment, housing, and psychosocial problems,
7) developing a collaborative care/treatment network offering general and specific approaches,
8) training of new health care workers in order to ward off waiting lists,
9) promoting case management focused on individualized support in specific groups.

In the light of this common declaration, a general drug policy cell was created in which 17 representatives of the Federal Government and 18 representatives of the Regional Governments, a national drug coordinator and a vice-coordinator participate. Its main purpose is to formulate well-elaborated recommendations in order to synchronize drug policies.

2.2. ORGANIZATION AND AVAILABILITY OF DRUG TREATMENT

In Belgium, there is a large variety of treatment or help facilities for persons with drug-related disorders. The main objective of these services for drug-users is the promotion of quality of life in terms of global health (physical and psychological) and in terms of welfare and respect of the autonomy of the client.
The primary care network is the first, low-threshold step for organised help. These facilities are the best to detect a substance related problem, to evaluate and eventually to redirect if more specialised help is needed. This network is composed with general practitioners, centres for general welfare, services of domiciliary care, youth advice centres and public centre for social welfare.

Next to primary care, ambulatory or residential specialised treatment are also available and will be described in detail in the following sections.

The federal state is responsible for health care insurance and for defining the basic principles for inpatient treatment (hospitals).

In the health policy sector, the Communities have responsibilities in administrating in- and outpatient care as well as in the field of health education and preventive health care. This implies that the Communities are responsible for laying down rules for institutions that fall under their jurisdiction and for implementing federal regulations. On a regional level, centres for mental health in the Flemish region are coordinated by the Flemish Agency for Care and Health. For their part, the Walloon region (General Directorate Social Action and Health) subsidized specialised addiction centres respecting the recommendations of the addiction decree (B.S./M.B. 25.06.2009). In Brussels, the French Community Commission funds specific projects on treatment, prevention, support and (social) reintegration.

Since the 80’s, conventions are concluded between specialised centres for the treatment of addictions and the National Institute for Health and Disability Insurance (NIHDI) in order to stimulate new initiatives in this field. In 2013, 29 conventions were signed with ambulant or residential centres working on specific medical and psychosocial treatment. These centres represent a large (but not exhaustive) and diversified part of the treatment offer for drug users in Belgium. Conventions with revalidation centres for drug users financed by the NIHDI will be transferred to the Communities in the near future.

### 2.2.1. Outpatient network

An overview of the available outpatient treatment facilities is presented in Table 5.1 and 5.2, describing a definition of the different types of centres and their importance in terms of number of illicit drug treated patients respectively. General practitioners may play an important role in the treatment of drug users, however these are not mentioned in the tables because of the current lack of this information.
### Table 5.1 | Network of outpatient treatment facilities (total number of units)

<table>
<thead>
<tr>
<th>Type of centre</th>
<th>Total number</th>
<th>National definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised drug treatment centres</td>
<td>34</td>
<td>Day care centres are specialised centres that reach a large group of people with drug-related problems (ranging from new users to persons with severe substance-related disorders) and their relatives or friends. Psychosocial, administrative, judicial support is offered on an individual basis or as part of group therapy. During these programmes, total abstinence is not mandatory, however clients cannot be under the influence during the activities. Substitution treatment (e.g. methadone or buprenorphine) is also available in these centres. The emphasis is put on the guiding process during the transition towards a better structured life. Day care centres are present in the Flemish region (6), in the Brussels-Capital region (9) and in the Walloon region (19).</td>
</tr>
<tr>
<td>Low-threshold agencies</td>
<td>9</td>
<td>Medical and Social Care Centres (MSCC) are low-threshold agencies that offer social, psychological and health care services to persons with a substance-related disorder. Their main objective is to get into contact with people normally excluded from the standard treatment facilities. A large part of their daily work comprises medical and social care, harm-reduction and substitution treatment. Some of them also offer a needle exchange programme. In the Flemish region, there are 5 centres (known as ‘Medisch en Sociaal Opvangcentrum’, MSOC). In the Walloon and Brussels-Capital regions, there are 3 and 1 centre(s) respectively (known as ‘Maison d’Accueil Socio-Sanitaire’, MASS).</td>
</tr>
<tr>
<td>Mental health care</td>
<td>31</td>
<td>Some mental health centres are also specialised in the treatment of substance-related disorders with the reduction of consumption or even total abstinence as the ultimate goal of their services. A variety of treatments is available within these centres: from an individual approach to group, relational and family therapy. Clients that present more complex problems – such as dual diagnosis of substance use – are admitted to an adapted, specific treatment offer. In the Flemish region there are 20 centres (known as ‘Centra voor Geestelijke Gezondheidszorg’, CGG). In the Walloon and Brussels-Capital region there are respectively 8 and 3 centres specialised in addiction (known as ‘Service de Santé Mentale’, SSM).</td>
</tr>
</tbody>
</table>

Source: BTDIR, 2014

### Table 5.2 | Total outpatient treatment provision for illicit drug treatment demand (number of clients) in 2013

<table>
<thead>
<tr>
<th>Type of centre</th>
<th>Total number of clients entering treatment</th>
<th>Coverage of monitored treatment facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialised drug treatment centres</td>
<td>2,975</td>
<td>24 centres / 34 in total</td>
</tr>
<tr>
<td>Low-threshold agencies</td>
<td>1,795</td>
<td>9 centres / 9 in total</td>
</tr>
<tr>
<td>Mental health care</td>
<td>1,073</td>
<td>21 centres / 31 in total</td>
</tr>
</tbody>
</table>

Source: BTDIR, 2014
2.2.2. Inpatient network

Inpatient treatment structures are mostly represented by hospitals. Besides these general structures, there are also specialised centres for drug users in crisis situations (crisis intervention centres) or in a more stabilized phase (long-term residential centres, including therapeutic communities). An overview of the available inpatient treatment facilities (Table 5.3) and provision (Table 5.4) is presented below.

**Table 5.3 | Network of inpatient treatment facilities (total number of units)**

<table>
<thead>
<tr>
<th>Type of centre</th>
<th>Total number of centres</th>
<th>National definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital-based residential drug treatment</td>
<td>120</td>
<td>Among all hospitals in Belgium, psychiatric hospitals as well as psychiatric units in general hospitals have a limited capacity to treat patients with substance use. In some hospitals, there’s a special programme for drug users. The range of care options can be very extended in hospitals. In order to evaluate the number of hospitals where drug users can be treated, the number of hospitals with specific psychiatric beds were considered (Classified as beds A, T, K). There are 67 hospitals in the Flemish region, 16 in the Brussels-Capital region and 37 in the Walloon region. Nevertheless, not all psychiatric beds are used to treat substance users.</td>
</tr>
<tr>
<td>Crisis intervention centre</td>
<td>8</td>
<td>Crisis intervention centres are short-term residential treatment centres that guarantee the unconditional and rapid support in case of a crisis situation. They promote a physical detoxification and motivate for further abstinence or guide patients towards the best fitted treatment programme. There are 5 crisis centres in the Flemish region, 1 in the Brussels-Capital region and 2 in the Walloon region.</td>
</tr>
<tr>
<td>Therapeutic communities or other long-term residential centres</td>
<td>15</td>
<td>Therapeutic communities were the first treatment initiatives for drug users in Belgium. Other long-term residential centres are also presented here. They are drug-free environments with a strong focus on self-help and peer support. A hierarchical community structure and group therapy sessions are the key lead to detox and to reintegrate patients into the society. There are 8 therapeutic communities in Belgium: 5 in the Flemish region and 3 in the Walloon region. A recent European publication gives a more detailed picture of therapeutic communities in Belgium and more generally in Europe (Vanderplasschen et al., 2014).</td>
</tr>
</tbody>
</table>

Source: BTDIR, 2014

**Table 5.4 | Total inpatient treatment provision for illicit drug treatment demand (number of clients) in 2013**

<table>
<thead>
<tr>
<th>Type of centre</th>
<th>Total number of clients</th>
<th>Coverage of monitored treatment facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital-based residential drug treatment</td>
<td>2,119</td>
<td>42 hospitals / 120 in total</td>
</tr>
<tr>
<td>Crisis intervention centre</td>
<td>727</td>
<td>8 centres / 8 in total</td>
</tr>
<tr>
<td>Therapeutic communities</td>
<td>380</td>
<td>15 centres / 15 in total</td>
</tr>
</tbody>
</table>

Source: BTDIR, 2014
2.3. TREATMENT DEMAND DATA

The Treatment Demand Indicator (TDI) registration in Belgium was officially approved by the Inter-ministerial conference on Public Health in 2006 (B.S./M.B. 03.05.2006). Consequently, a national TDI protocol was adopted in 2010 based on the EMCDDA Protocol version 2.0. On this basis, the TDI registration was launched at national level in specialised centres in 2011. Prisons and general practitioners are currently not part of the registration. This system registers both patients entering treatment for illegal drugs as well as alcohol as a primary substance. A new European protocol was adopted in 2012 and had to be implemented in EU member states. At national level, a new protocol was adopted in September 2013 and will be the basis for the TDI registration from 2015 onwards.

The specialised residential and ambulatory centres are using an online application since 2011 to encode their clients or are sending their data through a repository module. In 2013, around 100 specialised centres participated in this TDI registration.

In 2013, a total of 9,192 drug users entered treatment in the centres that report data. Around 73% and 45% of the specialised out- and inpatient centres in Belgium are reporting data.

More or less 2 patients out of 3 (64.0%) were registered in outpatient centres and 36.0% in inpatient centres.

In all types of centres, patients most commonly reported the use of cannabis (33.5%) for entering treatment (see Figure 5.1), next to opiates (30.7%), cocaine (15.6%), stimulants other than cocaine (11.3%) and misuse of hypnotics and sedatives (6.1%). Characteristics of patients and addiction profile of patients entering treatment for the different substances are described in Table 5.5.
Figure 5.1  Proportion (%) of treatment demands by primary drug in 2013

![Proportion (%) of treatment demands by primary drug in 2013](image)

Source: BTDIR, 2014

Table 5.5  Characteristics of patients entering treatment in 2013 by type of primary drug

<table>
<thead>
<tr>
<th>Characteristics of patients</th>
<th>Type of primary drug mentioned for entering treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Opiates</td>
</tr>
<tr>
<td>Women (%)</td>
<td>19.6</td>
</tr>
<tr>
<td>Mean age (years)</td>
<td>34.7</td>
</tr>
<tr>
<td>Ever injected (%)</td>
<td>41.5</td>
</tr>
<tr>
<td>Daily users (%)</td>
<td>58.6</td>
</tr>
<tr>
<td>Use of only one substance (%)</td>
<td>18.0</td>
</tr>
<tr>
<td>First time in treatment (%)</td>
<td>16.0</td>
</tr>
<tr>
<td>Mean age at time of first use (years)</td>
<td>21.2</td>
</tr>
</tbody>
</table>

Source: BTDIR, 2014

Remarkably, the majority of the group of persons in treatment for hypnotics are women. On the opposite, women are the least represented in the group of cannabis users in treatment. The mean age of patients in treatment is higher for people in treatment for hypnotics and opiates than in the group in treatment for cannabis and stimulants. The proportion of people that ever injected a substance is the highest in the group of people in treatment for opiates. Patients in treatment for hypnotics or cannabis are using less other substances (alcohol included). The registration shows that most patients using opiates already went into treatment in the past. The mean age of first time use is the lowest for cannabis users.
2.4. TREATMENT MODALITIES

2.4.1. Opioid substitution treatment

In Belgium, methadone and buprenorphine are the two substances authorized for opioid substitution treatment (OST). The provision is organised by both specialised centres and general practitioners. Since April 2009, prescriptions for methadone and buprenorphine are registered in the Pharmanet-system of the NIHDI. The objective of this registration is to avoid multiple prescriptions and allow warnings among involved practitioners as requested by the Royal Decree of March 19th 2004 (B.S./M.B. 30.04.2004). This database contains information from public pharmacies, hospital pharmacies and specialised centres. Substitution treatments provided in prisons are not included in this database.

Currently, there are big regional differences concerning the administration: in the Flemish Community, substitution treatment is often prescribed by specialised centres whereas in the French Community, general practitioners are more involved. A daily delivery of the treatment can be arranged in specialised centres or alternatively, in a pharmacy under the supervision of a pharmacist.

In 2013 there were 17,482 persons registered in the Pharmanet register (see Table 5.6). Among them, only 13.5% were in treatment with buprenorphine. The patients were mainly men (77.0%) and had a mean age of 39.3 years. Methadone and buprenorphine are more often prescribed in the French Community (2/3 when counted together) than in the Flemish Community (1/3).

Table 5.6 | Characteristics of patients receiving methadone or buprenorphine in 2013 by type of substance

<table>
<thead>
<tr>
<th></th>
<th>Methadone</th>
<th>Buprenorphine</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total amount (N)</td>
<td>15,112</td>
<td>2,370</td>
<td>17,482</td>
</tr>
<tr>
<td>Women (%)</td>
<td>22.9</td>
<td>23.5</td>
<td>23.0</td>
</tr>
<tr>
<td>Mean age</td>
<td>39.5</td>
<td>37.9</td>
<td>39.3</td>
</tr>
<tr>
<td>Region (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flemish</td>
<td>29.9</td>
<td>49.4</td>
<td>32.6</td>
</tr>
<tr>
<td>Brussels-capital</td>
<td>15.3</td>
<td>11.6</td>
<td>14.8</td>
</tr>
<tr>
<td>Walloon</td>
<td>54.8</td>
<td>39.0</td>
<td>52.6</td>
</tr>
</tbody>
</table>

Source: NIHDI, 2014

2.4.2. Dual diagnosis patients

Over the past few years clinicians have noted increasing numbers of patients subjected to dual diagnosis (De Hert et al., 2010). Such patients are particularly vulnerable and currently lack any form of provision. Therefore, a pilot project was launched in 2002, setting up two specific units (one in the Flemish region and one in the Walloon region) (Sabbe et al., 2008). These units provide intensive and integrated treatment for both problems (drug use and mental disorders).
The aim is to stabilise patients after a period of intensive treatment to then refer them to other services to continue treatment.

2.4.3. Crisis and case management
Emergency departments play an important role in offering first aid to persons with substance use-related disorders. These facilities inform patients on the treatment options and refer them to specialised treatment. They increase motivation for treatment and changing their behaviour. In Belgium, crisis care can be situated within two projects. First, a national pilot project exists for the crisis and case management of patients with substance use-related disorders (8 centres in Belgium offer four crisis beds with a maximum stay of five days). Second, the so-called Crisis Intervention Centres (CICs) (also described in chapter 7) intervene in crisis situations and arrange quick admission or support. On the other hand, they assist in physical detoxification and motivate to continue treatment. An important supportive strategy that may facilitate crisis management for persons with substance use-related disorders is case management. Case management has been implemented in Belgian substance abuse treatment since 1999. It has been institutionalized as part of the federal pilot project ‘Crisis and case management for persons with substance use disorders’. However, little is known about the effectiveness of this intervention, nor is there consistency concerning its application (Bruffaerts et al., 2010).

2.5. QUALITY ASSURANCE OF DRUG TREATMENT SERVICES
Different legal documents or conventions are available, describing the type of treatment or the type of functioning that should be applied in centres dealing with patients with a substance-related use problem:

- All low-threshold agencies (MSCC) have signed a convention with the NIDHI precisely describing the expected medical or social activities and the way their organization is to be arranged. For the other residential or ambulant centres with this type of convention, the document describes specific objectives for each facility. In this way, a diverse panel of therapeutic solutions is made available.
- Centres in the Walloon region that request funding for specialised addiction treatment activities, need to fulfil the missions and the functioning stated in the regional decree of 30 April 2009.
- For the French-speaking centres in Brussels, a decree (B.S./M.B. 08.05.2009) describes directions for all ambulatory services working on social action and amongst them the drug addiction facilities.
- Centres for Mental Health in the Flemish region recognized by the Agency for Care and Health have additional rules to respect on quality of care and organization to get the agreement.
3. **TRENDS**

Currently, trends in treatment offer and demand are only studied based on the TDI data registered by the specialised centres that participate in a convention with the NIHDI. These centres are indeed obliged to complete this registration since 2011, while this is not yet the case for the other types of centres. These centres represent around 70% of the TDI registrations for 2013 for treatment demands for illicit drugs (10 out of the 34 day centres, 9 out of the 9 low-threshold centres, 8 out of the 8 crisis centres and 15 out of the 15 long-term residential centres).

Since 2011, a decrease is observed in the number of clients entering treatment for opiates. At the same time, there has been an increase for clients in treatment for cannabis, cocaine and stimulants. In 2013, cannabis is the main substance for entering treatment. (see Figure 5.2). This trend is due to a shift in the group of new patients (see Figure 5.3). Indeed, when looking at the trends concerning the primary drug used among people entering treatment for the first time a steep increase in cannabis patients and a decrease in opiates patients are noticed. This decrease of the proportion of treatment demand of opiates as primary drug is also notable in all European countries (EMCDDA, 2014). Concerning cannabis, the increased proportion is also partially explained by a high(er) proportion of judicial referral for treatment.

![Figure 5.2](image-url) **Figure 5.2** | Trends in numbers of clients entering treatment for the first time, by primary drug in the centres with a convention with the National Institute for Health and Disability Insurance between 2011 and 2013

Source: BTDIR, 2014
Figure 5.3 | Trends in number of all clients entering treatment, by primary drug in the centres with a convention with the National Institute for Health and Disability Insurance between 2011 and 2013

Source: BTDIR, 2014

Figure 5.4 | Trends in number of clients receiving methadone or buprenorphine between 2009 and 2013

Source: NIHDI, 2014
4. NEW DEVELOPMENTS

4.1. CANNABIS USE DISORDER IN TROUBLEYOUTH – THE INCANT PROJECT

The INCANT trial was performed in 5 European cities (Berlin, Brussels, Paris, Geneva, The Hague) and included a comparison of Multidimensional Family therapy (MDFT) with individual therapy among 450 youngsters aged 13 up to 18 showing problematic patterns of cannabis use. The project followed the adolescents and their relatives for 12 months to determine both information about mental and behavioural characteristics (Rigter and Dekker, 2014).

There is a strong belief among a selection of therapists in Western Europe that forced treatment of teenagers will harm the chances of the therapist to establish a therapeutic alliance with the adolescent and consequently influences the outcome of the treatment. Data from the study however contradict this notion: adolescents coerced into treatment accepted therapy and remained in therapy as long as other teens (Rowe et al., 2013).

Yet, Schaub and colleagues demonstrated that both MDFT and individual treatment reduce the rate of externalising and internalising symptoms and in addition did improve family functioning. However, MDFT proved to be more efficient in decreasing externalising symptoms, especially in coerced adolescents (Schaub et al., 2014).

4.2. HEROIN-ASSISTED TREATMENT – THE TADAM PROJECT

The pilot-project on assisted treatment with diacetylmorphine (TADAM) aimed at comparing the efficacy and feasibility of this treatment with regular approach of methadone treatment. To this order, 36 people in the experimental group and 38 in the control group were observed for one year. The project was finished in 2012 and conclusions were delivered in terms of efficacy of the treatment, socio-economic aspects, criminological aspects and patient satisfaction. The difference in efficacy between the two groups was significant at 3, 6 and 9 months but no longer significant after 12 months. This could be a false negative effect due to experimental conditions (patients of the experimental group knew that the treatment ended after 12 months). The treatment via diacetylmorphine showed less efficacy in socio-economic aspects than the methadone treatment. Due to limited observation time, the study under-evaluate the amount of positive impacts on society. The diacetylmorphine treatment could reduce delinquency of severe addicted persons. The treatment with diacetylmorphine met the expected help better than the methadone
treatment. In conclusion, the extension of diacetylmorphine treatment for people who continue to use street heroin despite treatment with methadone was recommended. This treatment should remain a second-line treatment, only available to patients refractory to methadone. For these patients, treatment with diacetylmorphine has proved to be more effective, but only if its length is not arbitrarily restricted. Recommendations were made on the conditions for the installation of such a centre, the inclusion criteria of the patients, the treatment organization, the infrastructure of the building and the staff (Demaret et al., 2013).

4.3. ANALYSIS AND OPTIMIZATION OF SUBSTITUTION TREATMENT – THE SUBANOP PROJECT

Although substitution treatment has been applied on a large scale for over 15 years now, research on this topic remains limited. In order to gain more insight and optimize current practices of OST in Belgium, the SUBANOP study was set up. There’s a need of a centralized and comprehensive database that allows the mapping of providers of OST as well as the follow-up on evolutions in treatment demand and practice. The combination of treatment-related data (e.g. dosage, type of medication and treatment regimen) with client data (e.g. characteristics, support needs and benefits from treatments) provides valuable information regarding a personalised approach in the allocation of treatment options. Additional research is advised regarding the nature and type of psychosocial support that is required for opiate dependent persons (Vander Laenen et al., 2013).
5. CONCLUSIONS

In Belgium, different institutional partners are in charge of the treatment for addictions which is coordinated by the General Drugs Policy Cell. A large variety of treatment facilities are available in the country providing ambulatory (including low-threshold) or residential services.

In 2013, more than 9,000 patients entering treatment were registered by over 100 centres, mainly in outpatient services. Opiates and cannabis represent the main type of substance for a large majority of the patients entering treatment. However, these two groups of patients are very different in terms of age (older people in treatment for opiate use), sex (less women in treatment for cannabis) and high-risk drug use profile (less ever-injecting drug use for people in treatment for cannabis).

Moreover, a clear evolution is observed in the number of people entering treatment by primary drug. The number of treatment demand for opiates is declining and the number of treatment demand for cannabis is increasing. The latter, however, is partly due to the increased number of treatments referred by justice.

The number of people receiving methadone or buprenorphine remains relatively stable over time and is more often prescribed in the French Community in comparison with the Flemish Community. Buprenorphine remains less often prescribed.

Several studies were conducted on specific aspects of treatment to work towards potential developments in treatment. A remarkable pilot study on assisted treatment with diacetylmorphine concluded that treatment with diacetylmorphine is only more effective than the methadone treatment for a specific target group: assisted treatment with diacetylmorphine is recommended for people who continue to use street heroin despite the treatment with methadone. Recommendations were made on the main aspects (target group, infrastructure, rules,...) for the development of a similar new project. Nevertheless, there are currently no further plans on implementing these results.

Acknowledgements

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