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Commentary

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Addiction Medicine and Psychology in the French-Speaking Community of Belgium: A Balancing Act between Progress and Challenges

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In a recent paper [1], members of the European Federation of Addiction Societies (EUFAS) proposed an overview of the current training related to addiction medicine and psychology in 24 countries, using a questionnaire built through a Delphi process. Results showed a large heterogeneity across countries. Some offer recognized specialization, involving long-term training with a comprehensive theoretical and practical education (e.g., Austria, Norway). Conversely, others do not offer specific training (e.g., Poland, Romania), which led the authors to conclude that massive discrepancies exist between European curricula. This situation may lead to important inequalities between European citizens regarding the access to and quality of treatments for addictive disorders.

This paper generated important insights on the current shortcomings of addiction training in Europe and rightly underlined the need to develop and harmonize such training across countries. However, the limits inherent to the panel associated with the Delphi method generated pessimistic numbers for Belgium. For both addiction medicine and psychology, Belgium was described as presenting no specific training and as having only four academics working on addictive disorders. Moreover, the paper offered no figures regarding the number of addiction specialists currently active in the country (notably due to the absence of a national register of addiction specialists). The presented figures are most probably erroneous for the Dutch-speaking part of the country, but they are particularly misleading for the French-speaking community, which has a different healthcare system than the Dutch-speaking one considered in the paper.

To deepen this work and to offer a more realistic description of the situation related to addiction medicine and psychology training in Belgium, we contacted members of the faculties of medicine and psychology of the five French-speaking universities (UCLouvain, Free University of Brussels, University of Liège, University of Mons, and University of Namur) and addressed them the questions included in the initial survey. Our results

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cannot be considered comprehensive, but they indicate that the situation in the French-speaking part of Belgium, while remaining suboptimal, is less dramatic than described in the paper. First, three universities (UCLouvain, Free University of Brussels, and University of Liège) have research groups or units focusing on addiction research in psychology, neuroscience, and neurobiology, encompassing at least eight academics and more than 25 PhD students or post-doctoral researchers. These groups published more than 200 peer-reviewed papers in international journals during the last decade. Second, courses related to addiction are routinely provided to medicine and psychology students in all mentioned universities, offering a minimal theoretical and practical background. Some universities (e.g., University of Liege) even propose master's options focused on addictive disorders (up to 20 ECTS). Third, two 1-year inter-university diplomas fully dedicated to addictive disorders are available for medical doctors, psychologists, social workers, and nurses. They are respectively focused on alcohol use disorder (10 ECTS) and tobacco use disorder (15 ECTS). They encompass theoretical and practical courses and include non-pharmacological and pharmacological therapy, basic procedures, and medical/neuropsychological contents. They deliver a formal university-level certification following an examination and a written thesis. Fourth and finally, official figures [2] indicate that a dense network of care for addictive disorders is available in the French-speaking part of Belgium, including 22 psychiatric hospitals with detoxification units and 31 general hospitals with psychiatric units, but also many outpatients' clinics, day centers, crisis intervention centers and long-term treatment programs (e.g., therapeutic communities). These structures employ several hundreds of caretakers (psychiatrists, psychologists, nurses) presenting various levels of expertise in addictive disorders, from basic skills in general psychiatry clinics to high-level expertise in specific detoxification units.

Despite these strengths and the availability of up-to-date training, the French-speaking part of Belgium still faces massive challenges regarding the education of caretakers specialized in addiction and the quality of the treatment offered to people suffering from such disorders. First, while the network of care for addictive disorders is well-integrated and connected, and while the number of caretakers working in the addiction field is high, these professionals constitute a heterogeneous group in terms of organization, knowledge, and capacity to treat substance use disorders. In the absence of any official diploma in addiction medicine or psychology, there is no formal requirements for continuous training, which is a critical problem that maintain a gap between academic researchers and clinicians, and delay knowledge dissemination and implementation of new potential treatments (e.g., neurocognitive remediation, evidence-based therapy). Second, like in other countries [3, 4], persistent treatment gap and delay in care seeking [5] hamper the early diagnosis of addictive disorders and their efficient handling, notably because primary care structures are still under-prepared to detect and treat addictions, or to refer to the right specialized services. Stigma and dehumanization issues may also contribute to this persistent gap [6, 7]. Third, at the broad societal level, drug consumption remains high in Belgium. This is particularly true for alcohol consumption that is higher than the European mean, with elevated rates of consumption per capita, heavy drinking and alcohol use disorders [8].

Several paths can be proposed to solve these issues, centrally (1) the improvement of continuous training in addictive medicine/psychology, but also its extension towards other healthcare professionals (e.g., nurses, social workers), to develop a comprehensive and evidence-based training combining theoretical courses with clinical practice and leading to a degree in addictology (or possibly to different levels of degrees) certified by the Government. Of note, recent legislative changes in Belgium have taken the first steps towards such improvements. Since 2015 [9], a mental health care law regulates clinical psychology practice, notably by making continuing education compulsory. In the same vein, since 2020, a reimbursement for "first-line" psychological care has been implemented, helping the orientation of patients with addictive disorders to specialized care units; (2) the reduction of the treatment gap, by training general practitioners and emergency departments to detect addictive disorders and to orient patients towards specialized care, but also by developing outreaching strategies and peer support training, which might favor the early orientation of patients towards treatment; (3) the strengthening of the preventive laws and policies limiting illicit drug use and excessive legal substances consumption, including restrictions on availability, increased prices policies, and regulations on advertising. Importantly, such legislative evolution should avoid stigmatizing or criminalizing drug users, but rather promote consumption reduction and risk prevention. Finally, while our commentary focuses on the situation in the French-speaking community, a crucial way to improve addiction treatment in Belgium is to foster interactions and collaborations between French- and Dutch-speaking clinicians and researchers, in order to generalize good practices and to unify the Belgian healthcare network.

In conclusion, we share the view that substance use disorders are not sufficiently diagnosed and could be better treated in Belgium, notably because the training/expertise level of practitioners working in addiction treatment units remains heterogeneous, and because the healthcare system is not sufficiently coordinated. As proposed by Bramness and colleagues [1], high-level training should thus urgently be extended for medical doctors and psychologists, and the care pathway of patients with substance use disorders should be improved. However, we argue that such evolution will not start from a blank page as it will capitalize on already existing training programs, on active research teams in universities, and centrally on an installed network of caretakers in addictive disorders.

Conflict of Interest Statement

The authors have no conflicts of interest to declare.

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Author Contributions

P.M.: writing – original draft. S.C., E.Q., M.D., Y.K., and P.d.T.: writing – review and editing.

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