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Drug Consumption Rooms in the Netherlands

2018 Update

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Netwerk Infectieziekten
& Harm Reduction

MAINline
DRUGS & GEZONDHEID



Trimbos-instituut
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¹ This is a translation of the 2018 report “Gebruikersruimten in Nederland, update 2018”. The text has been slightly adjusted to better serve the interests of readers from abroad. Some topics that were described in the original document were excluded from this version, but are available upon request.

Colophon

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With thanks to:

Staff at the drug consumption rooms!

Tessa van Doesum (Trimbos Institute)

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Introduction:

A new inventory of drug consumption rooms

In the Netherlands, for many years drug consumption rooms (DCRs) are one of the harm reduction interventions run by addiction treatment and social relief services. The first formal drug consumption room was run by an addiction treatment service² and opened its doors 10 June 1994 in Maastricht. Since then, the number of drug consumption rooms increased, primarily aiming for the reduction of drug-related nuisance in the streets and public spaces. In the 21st century, the need for specific drug consumption rooms decreased, due to the many initiatives that took place in the field of housing of homeless people who use drugs (PWUD) (such as hostels and 'around the clock (24/7) shelters'). Changes in the objectives of DCRs were noted over time, as more facilities now have included health promotion for PWUD as a main target. And since the 2010s, addiction care services are shifting their objectives towards recovery, which includes societal, social and personal recovery.

When describing and defining a DCR, a number of key aspects always pop up: safer drug use, nuisance control and reduction of adverse health effects. In this inventory, we use the following definition: "Drug consumption rooms are facilities where (homeless) people struggling with a drug addiction can use their drugs in a hygienic and quiet environment, with social workers present in the background. Drug consumption rooms aim to reduce nuisance in the neighborhood and to reduce the adverse health effects of drug use" (Standard of Care Opiate Addiction³, 2017) (Zorgstandaard Opiaatverslaving, 2017). Aside from drug consumption rooms, there are also a number of alcohol consumption rooms in the Netherlands, aiming to reduce nuisance caused by drinking in public. However, in this report we focus on DCRs.

Drug consumption rooms in the Netherlands were last monitored in 2013 (Laghaei et al., 2013). In 2013, for the first time since the monitoring of DCRs since 2000 (Linssen et al, 2002), a decrease in number was noted; 31 DCRs in 2013 compared to 37 in 2010 (Havinga & Van der Poel, 2011). In order to keep track of DCR developments over the years, a periodic inventory is needed. Therefore, Trimbos Institute, Mainline and Correlation/ European Harm Reduction Network initiated this new inventory.

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- 2 There have been several informal drug consumption rooms in the Netherlands, starting from the early seventies, such as HUK in Amsterdam, but in this report we focus on formal, official DCR's.
 - 3 In recent years, scientist, practitioners and patients jointly developed many so-called Standards of Care for mental health and addiction care. These standards describe in general terms from the perspective of the patient what good care and support entails for people with a certain mental disorder during the entire care process: the patient journey. A standard of care provides the (national) norm that multi-disciplinary, integral care for mental disorders must meet. Besides opiate addiction, there are standards of care for e.g. problematic alcohol use and addiction, depression, psychoses (see <https://www.ggzstandaarden.nl/>).

Aim and method

Aim

The aim of this inventory is twofold:

1. To give an update of the current number of drug consumption rooms in the Netherlands, and
2. To provide insight into the DCRs' main features such as opening hours, objectives and services on offer.

Method

Existing drug consumption room overviews from Trimbos Institute, Mainline and Correlation were merged into one list. This list was presented to members of the Network Infectious Diseases & Harm Reduction⁴ and the DIMS –network⁵, who were asked to check the list at local level and provide updates or changes if needed.

Thereafter, the listed facilities were approached to check their operational status. All DCRs received a questionnaire covering topics such as services on offer, number of visitors and occurrence of (fatal or non-fatal) overdose. In such a way we inventoried 24 drug consumption rooms operating in the Netherlands in 2018.

Definition

We excluded two types of drug consumption rooms, either because they are part of heroin-assisted treatment (and thus only accessible for those who receive this treatment, or DCRs in (sheltered) housing projects (and thus only accessible for residents) .

In this factsheet we use the DCR definition of the Standard of Care Opiate Addiction (2017) and mentioned in the introduction: “Drug consumption rooms are facilities where (homeless) people struggling with a drug addiction can use their drugs in a hygienic and quiet environment, with social workers present in the background. Drug consumption rooms aim to reduce nuisance in the neighborhood and to reduce the adverse health effects of drug use”.

Survey

March 2018, all 24 identified drug consumption rooms were sent a survey containing questions about several DCR features: aim, functionality, managing organisation, funding, opening hours, substances used, number of available slots (for smoking, snorting, injecting), number of visitors (per day and week), criteria for admission, services provided, allowance of alcohol consumption, overdose statistics in the drug consumption room⁶. We received a 100% response; all drug consumption rooms updated their information.

4 <https://www.netwerkihr.nl/>

5 <https://www.trimbos.nl/themas/monitoring-markten-incidenten-drugs/monitoring-drugsmarkt-in-nederland-dims>

6 Not all topics are described in this report, but are available upon request.

Outcomes 2018 inventory

Number of drug consumption rooms

In 2018, 24 drug consumption rooms are operational in the Netherlands. This is a decrease of 7 drug consumption rooms compared to the previous inventory in 2013. The reduced number of DCRs in the Netherlands, first noted after 2010, continued (Figure 1). The current 24 drug consumption rooms are geographically spread throughout the country; in 19 municipalities a drug consumption room is operational (Figure 2). 17 municipalities run 1 drug consumption room, Amsterdam has 3 and Rotterdam hosts 4 drug consumption rooms.

Figure 1. Trend in number of DCRs in the Netherlands.

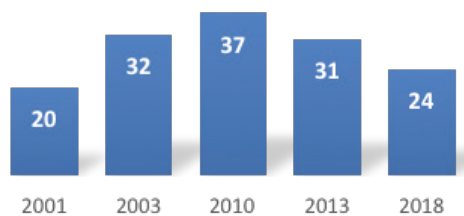


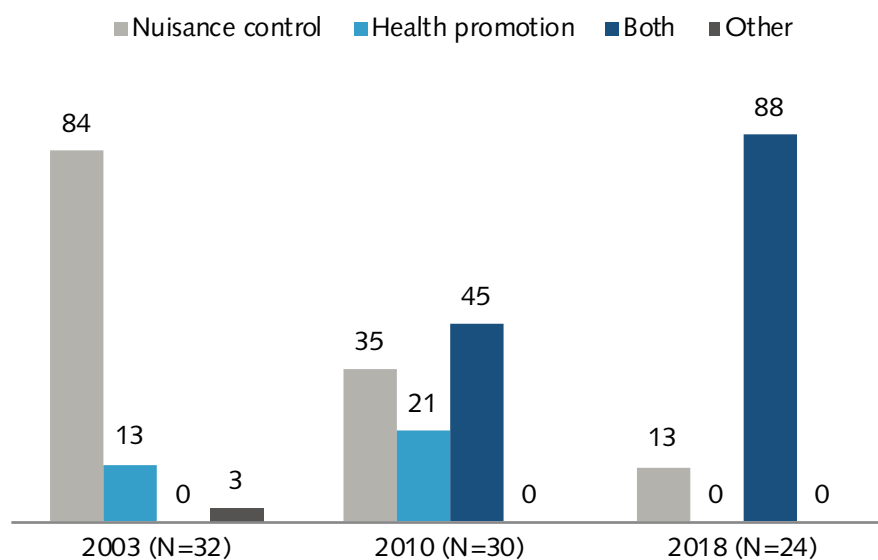
Figure 2. Geographical spread of DCRs (2018).



Objectives

Compared to 2003, a clear shift in DCR goals is visible. Only three DCRs (13%) still name nuisance control as their main objective, while in 2003 this was the main objective of the vast majority of DCRs. In 2018, 88% of DCRs report twofold objectives: nuisance control and health promotion for PWUD (Figure 3).

Figure 3. Objectives of DCRs (in %).



Function

A function expresses what a DCR stands for, what it intends to do. Does a DCR want to serve as a sweeper, a safety net or a springboard? As a 'sweeper', a DCR primarily intends to get people off the street, people who do not 'fit into public space'. As a safety net, a DCR is dedicated to accommodating PWUD, offering them the opportunity to use drugs more safely and to provide the most necessary medical and social care. As a springboard, a DCR strives to improve living conditions, guidance to other facilities and the engagement of third parties for further re-socialisation.

29% of the DCRs fulfill only one of the functions, while 71% aspires to the implementation of multiple functions (Table 1). As in previous years, most DCRs regard the safety net function to be the most important one. A DCR is primarily a place where people can use their drugs quietly and more safely without being rushed. Most DCRs are both a safety net and springboard (38%). Overall, the sweeper function has become less important over the years.

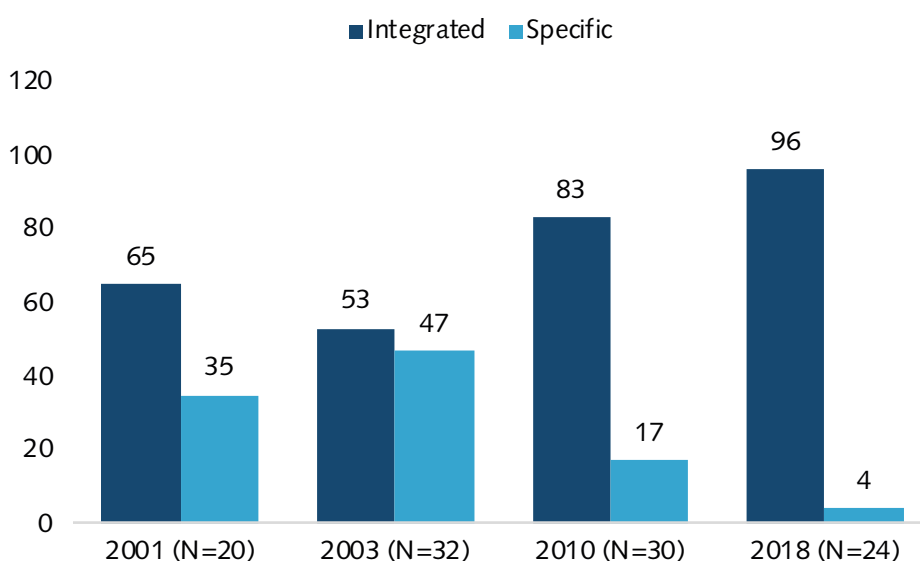
Table 1. DCR functions.

	2003 (N=32)	2010 (N=30)	2018 (N=24)
Sweeper	*	0%	0%
Safety net	*	23%	25%
Springboard	*	3%	4%
Total 1 function	25%	27%	29%
Sweeper, safety net and springboard	31%	33%	25%
Safety net and springboard	22%	30%	38%
Sweeper and safety net	22%	10%	8%
Total several functions	75%	73%	71%

Management and funding

There are so-called integrated drug consumption rooms and specific drug consumption rooms. Integrated DCRs form part of a, usually long-standing, low-threshold drop-in center. Specific DCRs stand on their own. They are not linked to an existing facility in terms of access. In 2018, all but one are integrated DCRs (Figure 4). This specific DCR is managed by a social relief service. The integrated DCRs are managed by social relief services (n = 11) or addiction treatment services (n = 10). Two DCRs are each managed by two or three institutions / organisations jointly, including addiction treatment and social relief services. All 24 DCRs are funded by their local municipality.

Figure 4. integrated and specific drug consumption rooms (in %).

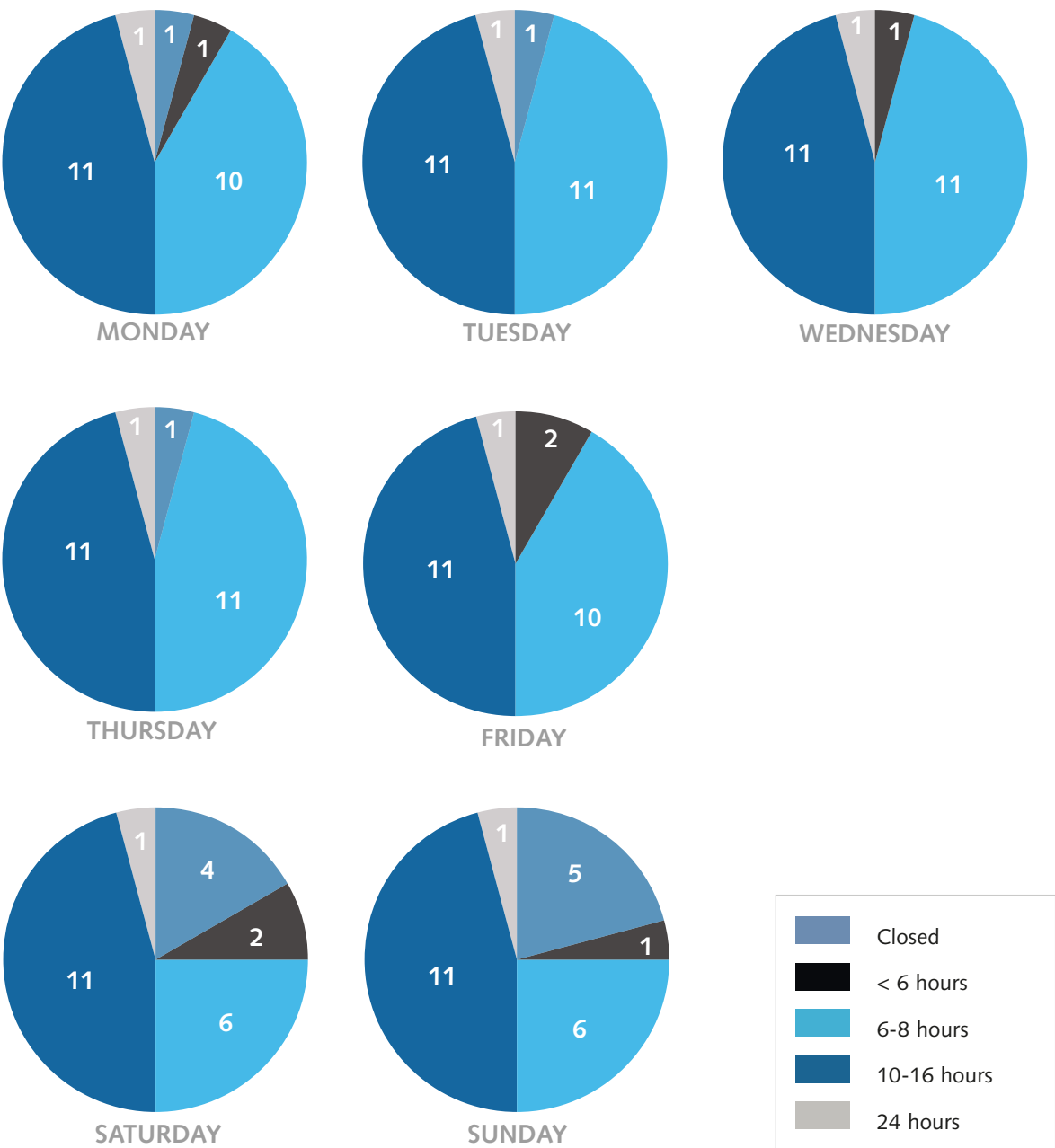


The 23 integrated DCRs were asked about the other facilities with which they are integrated. 9 only offer a living room or drop-in service in addition to the drug consumption room. A variety of facilities or services are mentioned at the other 14 integrated DCRs: accommodation, night shelter, living room, daytime activities, methadone maintenance treatment, budget management, medical consultation by a specialized medical doctor, computer use, alcohol consumption room and heroin-assisted treatment.

Opening hours

In 2018, most of the DCRs are opened daily (n = 18), 14 of which have the same opening hours every day. We further found that 2 DCRs are opened 6 days a week, 3 are opened 5 days a week and o1 DCR is opened 3 days a week. The number of hours that DCRs are opened varies between 3 and 24 hours a day; one DCR is open 24 hours a day). In 2018, DCRs are opened for an average of 10.6 hours a day; in 2010 this was an average of 8 hours a day (varying from 3 to 15 hours a day) and in 2003 it was an average of 9.4 hours a day.

Table 2. DCRs: days opened and hours opened per day (2018).



Admission criteria

In 2018, there are on average 6.5 admission criteria in place for access to the DCR, varying from DCRs that work with 2 criteria to DCRs that have 12. In 2018, two “new” criteria were prompted, namely: ‘legally staying in the Netherlands’ and ‘being in possession of a valid ID’. In total 15 criteria could be ticked in the survey. In 2010, DCRs worked with an average of 6 criteria, out of the 13 listed at the time (see Table 3).

The previously discussed noticed shifted in main objectives of the DCR (Figure 3) are reflected through the changes in admission criteria (Table 3). In 2001, two thirds of the DCRs had ‘causing nuisance’ as a criterion for admission, the most frequently used criterion in that year. In 2018, nuisance still is a criterion for one third of the DCRs. One DCR (4%) requires to ‘be known to the police’, compared to a quarter of all DCRs in 2003.

Moreover, there is a noticeable increase in the share of DCRs that requires a statement of ‘compliance to the house rules’ (88% in 2018). Less DCRs require their visitors to ‘be registered with the municipality’ (54% in 2018). And since 2010, ‘homelessness’ is no longer one of the top 3 admission criteria; after a dip in 2010, about two thirds of the DCRs now set this as a criterion.

The integration of facilities may be reflected in the 13% that require an ‘a nurse’s or doctor’s referral’ as an admission criterion (spontaneously named under ‘other, namely’).

In 2010, tuberculosis (TB) control was still a criterion for around a quarter of the DCRs, which decreased to 4% in 2018. A possible explanation is that TB controls are no longer carried out specifically in DCRs, but elsewhere in the wider integrated facilities (or the Municipal Health Service).

Table 3. DCR admission criteria.

	2001	2003	2010	2018
	N=15	N=30	N =30	N=24
Signing of contract (statement of agreement with house rules)	40%	-	67%	88%
Minimum age (range 18-26 years)	47%	80%	90%	79%
Registered as a client with the managing organisation	60%	67%	67%	68%
Being homeless	60%	77%	43%	63%
In possession of drugs while entering the DCR	33%	-	53%	58%
Registered in the municipality	27%	63%	70%	54%
Registered as a client of the local organisation	47%	50%	37%	46%
Residing legally in the Netherlands	-	-	-	46%
In possession of a valid ID	-	-	-	38%
Having caused public nuisance	67%	47%	40%	33%
Residing in the vicinity of the DCR	20%	-	20%	21%
Signing of a disclaimer	40%	-	20%	21%
Poor physical and mental condition	47%	47%	17%	17%
TB-control	-	-	23%	4%
Known to police	-	27%	13%	4%
Other:				
Nurse's or doctor's referral	-	-	-	13%

- = unknown: not asked or not reported

Blue = top-3 criteria in that year

Routes of administration and number of visitors

Data gathered about route of administration and number of visitors were and therefore we cannot elaborate in detail on these aspects. What we can report is that in all 24 DCRs smoking as route of administration is allowed, in 19 DCRs drugs injected is allowed and snorting is allowed in 13 DCRs. DCRs differ though in how they have organized the route of administration in their daily practice:

- Only smoking
- Smoking and injecting in separate rooms
- Smoking and snorting in separate rooms
- Smoking and injecting in the same room
- Smoking and snorting in the same room
- Smoking, injecting and snorting in the same room

The number of DCR visitors per day that smoke varies from 2-10 (n=10 DCRs), to 11-20 (n=5), to 21-35 (n=4), based on data of 20 DCRs. The number of DCR visitors per day that inject varies from 0 (n=6 DCRs), to 1-2 (n=8), to 6-8 (n=2), based on data from 16 DCRs. Categories that were most mentioned in 2018 are 2-10 smokers and 0-2 injectors per day.

Due to incomplete data, we cannot calculate an average and cannot compare the average numbers with previous years. However, looking at these numbers and averages of earlier years, it seems that – in general – the number of visitors in 2018 has decreased. In earlier years, we did not ask for the number of smoking and injecting visitors, but for the number of visitors in general for integrated and specific DCRs. In 2003 there was an average of 45 visitors per day of integrated DCRs and an average of 27 visitors per day of specific DCRs. In 2010, these averages were 22 and 24 for integrated and specific DCRs respectively. In 2003 and 2010 there were some large DCRs with 60, 80, 150 visitors per day. These high numbers were no longer reported in 2018.

Drugs consumed

Heroin and freebase cocaine are used by visitors in every DCR (Table 4). Amphetamines and cocaine (HCL) snorting and / or injecting is done in about half of the DCRs. Other drugs are not commonly used in Dutch DCRs.

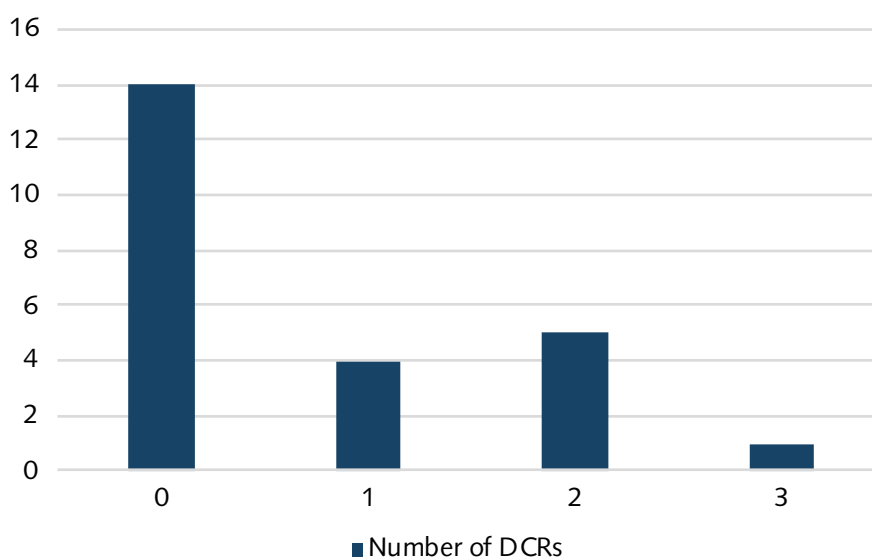
Table 4. Drugs consumed in DCRs (2018).

	# DCRs
Heroin	24
Freebase cocaine	24
Amphetamines	15
Cocaine (snorting)	12
Cocaine (injecting)	11
Cannabis/soft drugs	9
GHB	3
Benzodiazepines	3
Ecstasy	1

Overdoses

In 2018, it was the first time the survey addressed the number of overdoses that occur in DCRs. In 10 DCRs, a total of 17 overdoses were noted in the 12 months prior to the survey (Figure 5), including 1 fatal overdose. The fatal overdose occurred on the toilet, out of the range of the DCR-employees' supervision. A formal investigation into this event concluded that the DCR could not be held accountable for this death, and that this could have happened anywhere⁷.

Figure 5. Number of overdoses in DCRs (March 2017- March 2018).



⁷ For reasons of privacy, no further information can be shared about this incident.

Services provision in DCR

In the survey, DCRs were asked which services within the walls of the facility are available for DCR visitors.

In 2003, there were differences in the range of services between specific and integrated DCRs. Specific DCRs often only offered basic services, whereas integrated DCRs provided a wider range of services (including practical support, health education and medical care, and daytime activities). In 2010, most differences had disappeared except for one aspect, which is the medical care that was present in almost all integrated DCRs as opposed to the specific DCRs, where medical care was not included. In 2018 there are hardly any specific DCRs (n=1), so we do not report on differences between the two types of DCRs. At the 24 DCR locations, between 8 and 22 different services are offered. On average that is around 16.

We highlight a few noteworthy observations (see also Table 5):

- Visitors can use the basic services at almost all locations. The number of locations that offer recreational activities has increased (92% in 2018).
- Health education is being given at two thirds of the locations in 2018. Previously this was lower (around one third in 2001-2003) or higher (90% in 2010).
- More locations offer nursing services (67% in 2018), but fewer locations offer GP consultations (46% in 2018).
- In 2018 one survey question addressed STD and infectious diseases testing and (referral to) treatment. One fifth of the locations indicated to offer such services. Condoms are provided at 83% of DCRs. 13% administer naloxone in case of an overdose.
- In 2018, between 67-96% of the locations offer (referral to) care/treatment and daytime activities/work. We see an increase in locations that offer work /reintegration projects in 2018 (88% in 2018).

Table 5. Provision of services in DCRs (2018).

	2001 N=14	2003 N=32	2010 N=30	2018 N=24
Basic services				
Provision of drug paraphernalia	80%	91%	100%	100%
Coffee/tea, bread ^a	100%/93%	97%/81%	97%	96%
Needle exchange	66%	84%	93%	96%
Personal care (e.g. shower and washing clothes)	60%	75%	90%	96%
Recreational activities	73%	75%	67%	92%
Hot meals	60%	56%	83%	88%
Provision of condoms	-	-	-	83%
Practical support				
Possibility to use telephone	- ^b	-	87%	100%
Social support/ legal assistance	-	-	-	75%
Support with financial/ administrative issues	-	-	77%	71%
Lockers	50%	62%	57%	67%
Postal address	57%	50%	40%	54%
Education and medical care				
Health education	27%	31%	90%	67%
Office hour nurse	-	-	57%	67%
Office hour general physician (GP)	33%	41%	63%	46%
Testing / treatment of STDs / infectious diseases	-	-	-	21%
Administration of naloxone in case of overdose	-	-	-	13%
Care and daytime activities				
Referral to care/treatment facilities	-	-	93%	96%
Work/re-integration projects ^c	66%	75%	73%	88%
Referral to work/re-integration projects elsewhere	-	-	77%	79%
Care/consultation on location	-	72%	67%	67%

^a In 2001 and 2003 coffee/tea and bread were separate items in the questionnaire

^b The dash means that the specific item was not added to the questionnaire in that year

^c In 2001 and 2003 this item was referred to as 'activities'

Conclusion

In 2018, 24 drug consumption rooms were counted in the Netherlands: 1 specific and 23 integrated DCRs. After an initial increase in the number of DCRs in the early 2000s, we have witnessed a decrease in the number of DCRs since 2010. Further, we see a decreasing trend in the number of visitors per day. There are DCRs that have separate rooms for the different methods of administration, but there are also DCRs where smoking, injecting and/or snorting take place in the same room. Heroin and freebase cocaine are – still – the most used drugs.

Compared to other countries inside and outside of Europe, the Netherlands still has many DCRs (EMCDDA, 2018). It has recently been reported that there are more than 100 DCRs in Europe (particularly in Switzerland, Spain and the Netherlands), Australia and Canada (Beletsky et al., 2018). In response to issues concerning nuisance and public health (such as related to infectious diseases and overdoses), it is expected that many DCRs will continue to be opened in various countries. For instance, in Canada in response to the opioid crisis, in addition to the thus far only existing DCR in Vancouver which opened in 2003⁸.

Objective and function

In the course of time, the proportion of specific DCRs has decreased. In 2018, all but one DCR are integrated facilities, which means that they form part of a, usually long-standing, low-threshold drop-in center. At the premise of the DCR many other services, as well as support and care are provided. This development runs parallel to changes in the objectives and functions of DCRs. In 2018, the vast majority of DCRs has a twofold objective: nuisance control and improving the health of PWUD. More and more DCRs are both a safety net (offering a safe place and necessary medical and social assistance) as well as a springboard (striving towards improvement of living conditions and resocialization). The sweeper function (getting people off the streets) has become less important over the years. The criteria for admission and supply of services at the DCRs follow this trend. As such, the admission criterion 'causing nuisance' is used less than before. On the other hand, in recent years, 'being homeless' has become a criterion for more DCRs again. For those who are not homeless, other facilities are in place, such as housing projects where use of drugs is allowed. With regard to the DCR services, a comprehensive set of services is available: basic services, practical support, medical care and referral to other care.

The abovementioned developments go hand in hand with another trend in the field of addiction treatment, a trend towards 'recovery, participation and re-integration'. The Dutch addiction treatment services described 'recovery' in their vision as consisting of four coherent forms (clinical, functional, societal and personal (Dutch Association of Mental Health and Addiction Care, 2013). Working on recovery implies a focus on the daily life, on development

8 See: <https://www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/federal-actions/overview.html>

of motivation, on positive experienced identities, and on self-regulation. These matters are at the heart of the Standard of Care Opiate Addiction (2017). In this standard, DCRs are mentioned as part of Psycho-social treatment, with aims at among others the improvement of living conditions of PWUD. It is important to pay attention to recovery in all its facets.

Recovery is a unique and individual process in which one works towards a valued and meaningful existence – despite the limitations that an opiate addiction may cause. It is therefore also about mental and social functioning and being able to participate and contribute to society, according to one's capabilities and desires.

-- Standard of Care Opiate Addiction (2017)

Future

The set up and organisation of DCRs are in line with developments in the field. Each DCR inventory provides new (aggregated) knowledge and insights. We therefore recommend periodically repeated DCR inventories in the Netherlands. Further, we recommend a new inventory of alcohol consumption rooms as a follow-up to the 2015 inventory (Zijlstra-Vlasveld & Van der Poel, 2016) and also research into substance use and DCRs in (sheltered) housing projects.

New studies should focus on the number of DCRs, the number of slots and visitors, and how drug and/or alcohol consumption rooms and other services are integrated. A qualitative study among visitors and staff could provide insight into experiences (at different levels), success factors as well as obstacles. One of the questions could be in what way and to what extent integrated services - among which DCRs - contribute to the aim of recovery, participation and re-integration of people suffering from an alcohol or drug addiction. By answering this question, an important step forwards would be taken, providing insights in the need for and necessity of harm reduction services within the new paradigm that is called recovery.

References

Bransen E, Van 't Land H, Wolf J. Drug consumption rooms in the Netherlands. Trends and developments 2001-2003 [in Dutch: Gebruiksruimten in Nederland. Trends en ontwikkelingen 2001-2003]. Utrecht: Trimbos-instituut, 2004.

EMCDDA. Perspectives on drugs. Drug consumption rooms: an overview of provision and evidence. Lissabon, EMCDDA, 2018. <http://www.emcdda.europa.eu/topics/pods/drug-consumption-rooms>

Dutch Association of Mental Health and Addiction Care [in Dutch: GGZ Nederland]. A vision on addiction and addiction treatment services: focus on prevention and recovery [in Dutch: Een visie op verslaving en verslavingszorg: focus op preventie en herstel]. Amersfoort: GGZ Nederland, 2013.

Havinga P, Van der Poel A. Drug consumption rooms in the Netherlands. Update of the practical guide for organisation and set up [in Dutch: Gebruiksruimten in Nederland. Update van de handreiking bij organisatie en inrichting]. Utrecht: Trimbos-instituut, 2011.

Beletsky L, Baker P, Arredondo J, Emuka A, Goodman-Meza D, Medina-Mora M, Werb D, Davidson P, Amon JJ, Strathdee S, Magis-Rodriguez C. The global health and equity imperative for safe consumption facilities. The Lancet, 392(18): 553-554.

Laghaei F, Van Wamel A, Van der Poel A, De Gee A. Harm reduction in the Netherlands. Inventory of opiate maintenance programs, consumption rooms and Harm Reduction in the (Flexible) Assertive Community Treatment teams [in Dutch: Harm reduction in Nederland. Inventarisatie van opiaatonderhoudsprogramma's, gebruiksruimten en Harm Reduction binnen de (F)ACT-teams]. Utrecht: Trimbos-instituut, 2013.

Linssen L, De Graaf I, Wolf J. Consumption rooms in sight. Practical guide for the organisation and set up [in Dutch: Gebruiksruimten in beeld. Handreiking bij de organisatie en inrichting]. Utrecht: Trimbos-instituut i.c.w. Landelijk Steunpunt Druggebruikers en Resultaten Scoren, 2002.

Zijlstra-Vlasveld M, Van der Poel A. Alcohol consumption rooms in the Netherlands. Organisation and set up 2015 [in Dutch: Alcoholgebruiksruimten in Nederland. Organisatie en inrichting 2015]. Utrecht: Trimbos-instituut, 2016.

IVO, Resultaten Scoren, Het Zwarte Gat [patient representation], Working group Standard of Care Opiate Addiction. Standard of Care Opiate Addiction [in Dutch: Zorgstandaard Opiatverslaving]. Utrecht: Netwerk Kwaliteitsontwikkeling GGz, 2017.

