Scientific Institute of Public Health
Unit of Epidemiology

2004 NATIONAL REPORT TO THE EMCDDA by the Reitox National Focal Point

"BELGIUM"

New Development, Trends and in-depth information on selected issues

REITOX

IPH

Belgian national report on drugs 2004

Epidemiology Unit, Scientific Institute of Public Health, October 2004; Brussels (Belgium)

IPH/EPI REPORTS N° 2004 - 22

Deposit number: D/2004/2505/19

BELGIAN NATIONAL REPORT ON DRUGS 2004

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Acknowledgements

The report was made possible thanks to the contribution of many public and private professionals, health professionals and social workers who participated in the data collection. Their essential contribution is gratefully acknowledged.

We would like to especially thank for their very active contributions:
Andries C. (VUB)
Bastin P. (Infor Drogues)
Deblaere P. (Federal Police, Road traffic division)
De Pauw W. (Federal Public Service Justice)
Dessoy AC. (Federal Public Service Justice)
De Smet P. (FARES/VRGT and ULB)
Garlement P. (Federal Police, Drug programme)
Gillard C. (Federal Public Service Justice)
Lambrecht P. (VUB)
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Belgian National Report on Drugs 2004

SUMMARY

The Federal Drug Policy Note published in 2001, became the cornerstone of the national drug policy. The document enlightened three main priorities of the Federal Government being, the reduction of the number of drug users, the reduction of the physical and mental effects related to drug use and the reduction of the consequences of drug issues on society. In order to realise a global and integrated policy, a General Coordination Unit (which gathers all the representatives of the Federal Government, Communities and Regions) received a legal framework in May 2003 but is not yet operational. A Health Policy Drug Unit was already set up in May 2001 and participates since then in the organisation of the drug health policy.

In addition to these coordination tools, a cooperation agreement was signed in September 2002 between the Federal Government and the federate entities. The French and Flemish Communities have promulgated this agreement through decrees respectively in July 2003 and March 2004.

In 2003, a new law modified the legal framework (more specifically the Narcotic Drug Act of 1921), cannabis is being differentiated from the other illegal substances. The new status of cannabis authorises the public prosecutor not prosecute in the classic way the cannabis possessor if there is no evidence of a problematic drug use or of public nuisance. The public prosecutors are expected to follow guidelines published in a ministerial circular. Some professionals involved in the drug field disagreed with the text of the new drug law and some associations introduced an annulment before the Court of Arbitration. The concepts of “problematic use” and “public nuisance” were seen as ambiguous and vague, among other critics. End October 2004, the Court of Arbitration cancelled the concerned article.

In line with the legal basis promulgated in August 2002, the first Royal Decree enacting the substitution treatments was published in March 2004. Buprenorphine as well as methadone was introduced as a possible substitution substance.

Recent legal acts promulgated in the Communities emphasized the importance of implementing doping prevention activities in sports clubs.

In 2004, the results of the research “The Belgian Drug Policy in numbers” were made available. They indicate that the budget dedicated to the drug policy was increased over the last years especially for research, prevention and assistance activities. However, they still remain poorly funded. In average, the contribution to the global public expenditures related to drug policy has amounted to 18.03 euro per inhabitant.

The lifetime prevalence of cannabis use among the general population (15-64 years) was reported to be 10.8% in 2001. Cannabis is the most commonly used among illegal substance by youngsters. The results of the ESPAD 03 survey indicated a lifetime prevalence of marijuana/hashish among the 15-16 years old of 32.2% and a last month prevalence of 16.7%. The lifetime prevalence of “magic mushrooms” use was approximately 5%. All the other lifetime prevalences for illicit substances were found to be below 5%.

Boys tried all the substances at a younger age than girls except for sedatives/ tranquillisers.

Results of a new study among cannabis users in Flanders indicated the mean age at first use of cannabis at 16.3 years.

All studies confirmed a frequently combined use of alcohol with an illegal substance.

- Under the responsibility of the Communities and/or Regions, the prevention programmes in schools target mainly secondary schools. Life skills development is the main objective of these prevention programmes.

Selective prevention in recreational settings is well developed in both Communities. Targeting young people during festivals, cubs and outdoor events or through youth associations or in sports clubs, these activities consist mainly in giving information about the drugs and the risks. Alcohol and drug problems at the workplaces are probably underestimated by companies. Recommendations formulated by researchers emphasised the need of a proactive attitude towards these issues at workplaces.

Few prevention programmes target at-risk families.

- In 2003 no new study on prevalence of problematic drug use was carried out.

Treatment Demand Indicator data were reported separately for each federate entity (Communities or Region) because the data are not comparable between the different entities. A Belgian version of the European protocol is being discussed in order to harmonise the method of data collection.

From non-treatment sources, it seems that the percentage of current injecting drug users (IDUs) seems to decrease. High percentages of users sharing needles are still reported even if the trend is declining.

- The Federal Drug Policy Note (2001) specifies that the treatment offer should be based on a multidisciplinary approach adapted to the complex bio-psychosocial problem of addiction. It is also mentioned that a global and integrated offer should be created by means of regional networks and treatment circuits.

Minors should beneficiate of special care separated from adults. More attention is given to specific populations such as children of alcoholics, migrant populations, addicted mothers/parents with children, … More attention is also paid to the combination of psychiatric disorders and addictions. New pilot projects specialised in dual diagnosis were set up in 2002. A feasibility study on the evaluation of treatment services for patients with dual disorders was carried out in 2003. As a consequence of this study, another one concerning the effectiveness of inpatient treatment programs for dually diagnosed patients was set up.

- Looking at the data on drug-related deaths, from 1987-1997, a sudden rise happened in 1993. From 1993 onwards no significant change could be observed. This rise could be partly due to an improvement of the death certification quality. Almost three out of four drug-related deaths were men and of all cases where the substance itself was mentioned on the death certificate, more than 90% concerned opiates in almost all years.

Diagnosed seropositive persons and AIDS cases are registered at the Scientific Institute of Public Health. In 2003, 1032 new cases of infections were registered. The proportion of all IDUs among HIV cases (cases of HIV with intravenous drug use as risk factor) decreased from approximately 10% in 1985 to almost 4% in 2003.

The prevalence of infection via intravenous drug use was higher among young people, but it becomes comparable the last years to the one observed among older people.

Regarding the percentages of infectious diseases (HIV, HBV, HCV) among treated drug users, self-reported data and biological diagnoses are available. For HIV the trend seems declining. HBV self-reported prevalence in the French Community in 2002 (9%) is lower than in 1997 (23%). In 2002, the prevalence found among patients of De Sleutel (Flemish institution, anti-HBc tested) is around 21%. In this population the percentages remained quite stable over the years. In another sample of patients (Free Clinic) screened for anti-HBc, in 2003, the prevalence is around 62%. The same sample screened for HCV showed a prevalence of almost 79%.

- Prevention activities of drug-related deaths include the dissemination of brochures but also the implementation of an Early Warning System, aiming at exchanging information on new and/or dangerous drugs.

Needles exchange programmes are available throughout the country, except in the German-speaking Community.

Intravenous drug users are not seen as a priority group for the HBV immunisation. Vaccination campaigns target babies and young children in order to have a greater coverage of the population immunised against HBV in the future years.

In 2003, a network dedicated to encourage the screening of drug-addicted patients for HCV was created in Brussels.

Snowbal operations (peer-prevention projects) were extended to three prisons. All the actors integrated in the project positively evaluated these activities.

More attention is given to psychiatric co-morbidity in the framework of treatment institutions. Different pilot projects were set up but are still under evaluation.

- A study was carried out in 2003 in some prisons. The primary aim of the study was to evaluate the detainees' knowledge about the risks related to drug use, the risks of infectious diseases (HIV and hepatitis) related to unprotected sexual relations and other risky behaviours (piercing, tattooing, sharing of injection equipment). The use of hashish was reported in prison was reported by almost 30% of the sample, the use of heroin was reported by 13% and cocaine by 11%. The respondents showed a good knowledge of HIV transmission modes.

- Psychosocial care is offered in addition to medical treatment in the medico-social assistance centres (MSOC). Many in-patient treatment centres have their own after-care programme. Housing, education and employment issues in order to reintegrate (ex)-drug users exist but are linked to local initiatives. The offer varies a lot from one city to another.

In prisons, substitution treatments are available, prevention brochures are made available but no needles exchange programme exist. A new protocol for the detection and the treatment of prisoners infected by hepatitis C is on the agenda.

- The general population sees drugs as quite easily available. Due to its geographical position, Belgium is at the front stage regarding the transit of drugs towards other countries.

Large yearly variations are observed in the quantities seized without clear explanation. It seems however, that the number of seizures has increased in the nineties.

In 2003, the average prices for illegal drugs reported by police services are lower than the years before. Cocaine remains the most expensive illegal drug with an average price of 45 euros per gram.

- In Belgium there is a long tradition of methadone prescription. The reimbursement of Subutex® is newly introduced (since August 2003) but its use seems very limited. Official guidelines for buprenorphine prescription are not yet available, although different associations work on it. It is hoped that more epidemiological information on the patients under substitution treatment (both of methadone and buprenorphine) will be available in future years (as mentioned in a Royal Decree published in 2004).

- Different laws organise the alternatives to prison but none of them targets drug users. In the new drug law (2003), prison is an "ultimum remedium", priority is given to rehabilitation. Justice assistants exercise the control over suspects and convicts in different alternative regimes. These assistants work in Houses of Justice, depending on Courts of Justice. New functions of "Justice case managers" and "therapeutic advisors" were to be provided but are still not fulfilled. They are respectively foreseen to assist the Public Prosecutor to decide about the "drug cases" and to orientate to therapy.

- It seems that data on drug-related public nuisance are rather rare, moreover the concept is not clearly defined. Recently, the fight against nuisance in general is indicated in the Integral Security Framework Note (March 2004) but this note does not specify "drug-related" nuisance. In the Federal Drug Policy Note (2001), the reduction of public nuisance was not mentioned as a separate action point but was included in the idea of "*reducing the negative consequences of the drug issue on society*". Finally, in the Drug Law (April and May 2003), the term of nuisance received a key role, as the presence of public nuisance influences the decision of the public prosecutors. However, the concept was not clearly defined in the legal text.

  A research on "drugs and nuisance" was carried out in 2003; the results showed that nuisance caused by drug users is rarely qualified as a problem apart from the more general nuisance. It was also concluded that drug-related nuisance should be looked at in a broader context of nuisance.

PART A. New developments and trends

CHAPTER 1.
National policies and context

Since 2001, the Federal Drug Policy Note serves as a reference document for the development of the Belgian legal framework.

The authorities of the French and Flemish Communities have promulgated decrees concerning the cooperation agreements signed in 2002 with the Federal Government (see 1.2.a).

In 2004, an important step has been completed with the publication of the first Royal Decree on the substitution treatments. It recognises methadone and buprenorphine as substitution substances (see 1.2.c).

The results of a research related to the expenditures in relation with drug issues, permit to conclude that more funds were attributed to prevention activities and to assistance during these last years. Even if an increase of budget is observed over the last years, funds are not sufficient. More coordination is still necessary in order to succeed in managing a global integrated drug policy (see 1.3.a).

1.1. LEGAL FRAMEWORK

1.1.a Laws, regulations, directives or guidelines in the field of drug issues

Policy Note and Narcotic Drug Act

The Federal Drug Policy Note, presented by the Belgian Federal Government (19 January 2001) formulates the national policy regarding drugs from 2001 onwards. One of the issues of the note is to modify the Narcotic Drug Act (of 24 February 1921[1]). The main priorities of the Federal Government are the following:

- to reduce the number of drug users,
- to reduce the physical and mental effects related to drug use,
- to reduce the consequences of the drug phenomena on the society.

Overall, the note comprises three fields of action, being prevention, treatment and repression. For more details on the policy note, please look at the previous Belgian National Report on Drugs (2002).

One of the major changes of the last years to the legal framework concerning drug issues is the modification of the Narcotic Drug Act (24 February 1921). Some of the most important changes included the new statute of cannabis (being defined as another "category" of drug with its own distinct regulations), the fact that drug use in-group is not seen as punishable *in* se any more (instead, drug use in presence of minors is emphasized). For more information on this subject, please refer to the previous Belgian National Report on Drugs (2003).

Other changes to the legislation

Two decrees, one by the Flemish Government (3 October 2003) and the other by the French Government (4 March 2004) have been published regulating the **trade of seed** for

[1] Full references of laws can be found in the bibliography.

the sowing of “oil-bearing plants and crops”, including Cannabis Sativa. These decrees stipulate conditions, criteria and some formal, conventional provisions.

One Royal Decree (29 June 2003) and a Ministerial Decree (7 July 2003) have been published, obligating all medical and toxicological laboratories to transmit **data of positive drug analyses** (on illegal drugs other than cannabis) to the Belgian Focal Point, even when the analyses were done in the course of a judicial or police investigation. These decrees also sum up which data exactly have to be sent to the Focal Point and through which communication channel.

Finally, a law (7 February 2003) has been enacted changing the existing regulations on **road safety**. The punishment for drunk driving or driving in a similar state due to the use of illegal drugs or medicines is set to a fine of €1.100 to €11.000 and a possible driving ban from one month to five years.

1.1.b Laws implementation

A decree by the government of the French-speaking Community (10 December 2003) determines the **procedures for drug testing in sports**, as well as the substances that are tested for. Among others, included are stimulants, narcotics, cannabinoids (like for instance marihuana) and some hormones are included.

A Royal Decree (11 July 2003) has also been published authorising certain laboratories to perform **tests on blood samples** to determine the levels of alcohol and other drugs with regard to the capability of driving.

1.2. INSTITUTIONAL FRAMEWORK, STRATEGIES AND POLICIES

1.2.a Coordination arrangements

The French-speaking Community has promulgated and published a decree (17 July 2003) approving with the cooperation agreement of 2 September 2002 between the State and the different federate levels on a global and integrated drug policy. The Flemish Community approved the agreement by the decree of 19 March 2004.

1.2.b National plan and /or strategies

In accordance with the Belgian political structure, this section deals with:

- the federal level,
- the federate levels: Flemish, French and German Communities and the Brussels Capital Region as well as the Walloon Region.

➢ Federal level

At federal level, no real new changes are to be mentioned as the government continues the implementation of the Federal Drug Policy Note, started in 2001. In this respect, three pilot projects were initiated in 2002 in collaboration with some federate entities. They concern dual diagnosis treatment offer, crisis intervention and case-management, networks for integrated drug treatment programs.

➢ Federate levels

- *Drug Policy in the Flemish Community*

A drug policy paper (2003-2004) was presented by the Flemish minister of Health in the Health Commission of the Flemish government, but it was not discussed nor voted on, in the light of the new federal elections in June 2004. The 4 axes of the policy paper are: prevention, treatment, harm reduction and repression. The policy paper included the broadening of one of the 5 existing Flemish health objectives from tobacco to alcohol, drugs, psychoactive medicines, gambling. A Health conference should be organised to formulate the health objectives and its concrete indicators for the coming 5 years. Workplace and school are the main areas in which prevention should take place. Co-ordination is needed with the federal level (Cel Gezondheidsbeleid Drugs en Algemene Cel Drugs), with clarification of the role of the police in prevention. There is a focus on harm reduction with the continuation of the syringe exchange programme and with harm reduction in outreach work and prisons.

In the Flemish Community, the cooperation between the government and the co-ordinating agency VAD (Vereniging voor Alcohol- en andere Drugproblemen) continued on the basis of the covenant and the policy plan 2002-2005. The main areas of work are: research and development of evidence-based concepts, information, training, networking and coordination.

At provincial level, there is a prolongation of the provincial networks and the prevention workers pursue their work in the mental health centres.
The needle exchange programme became official through an agreement between the Flemish government and the Medical Social Centres in each province.

- *Drug Policy in the French Community*

Prospects on the next five-year period (2004-2008) include the creation of the “Health Promotion in School” (HPS) crews. The HPS decree (20 December 2001), has replaced the former concept of “School Medical Inspection” by a new one “Health Promotion in School”. The objective is to enlarge the concept of health to a broader definition. This relatively new approach regards health as a whole, including various issues (welfare, life frame, etc.), while the former one focused more on the symptom itself. “Prevent before cure” might be the new motto illustrating this strategy.

- *Drug Policy in the Walloon Region*

A decree (15 May 2003 – "Decree concerning neighbourhood prevention in the Walloon cities and municipalities") provides a subsidy from the Walloon Region to certain municipalities that work out a plan for prevention at city/village level. Among others, these plans should include initiatives to reduce the risks associated with drug addiction. All initiatives are to be integrated in an "umbrella" policy for the city quarters. Each year, the government evaluates these plans in order to decide if the municipalities will continue to receive their subsidy.

- *Drug Policy in the German-speaking Community*

In the year 2003 no new decrees for the drug policy were issued on the part of the German-speaking Community.
Still the government puts value onto the networking of the responsibilities and co-operates with the neighboring foreign countries.

- *Drug Policy in the Brussels-Capital Region*

The Brussels Drug Programme is continued (please refer to the previous Belgian National Report on Drugs).

1.2.c Implementation of policies and strategies

A Royal Decree on the **substitution treatments** was adopted in 2004 (19 March 2004). This document indicates that any practitioner prescribing substitution treatment should be registered in a day centre, a network for drug users or in a specialised centre for drug treatment. This implies that the practitioner agrees to follow scientific recommendations regarding substitution treatments, takes care of a psychosocial dimension and keeps several items in the medical dossier of the patient. The maximum number of patients by practitioner and by year is fixed to 150, except for the practitioners working in a treatment centre.
Methadone and buprenorphine are mentioned as the two substitution substances. The delivery of the substitution treatments are gathered by the Tarification Office and anonymous data on the patient are sent to the Institute of Pharmaco-epidemiology (IPHEB). The Royal Decree is still not fully operational.

In the Walloon Region, a decree (27 November 2003) has been published containing the recognition and funding of treatment centres and networks, specialized in addictions (i.e. not only illegal drugs, but also tobacco and gambling for instance). The decree describes among others the tasks of the networks (consultation between centres, structuring the treatment offer, counselling…), the criteria for a centre to be acknowledged and the funding of the networks. It also states that an Advisory Commission concerning addictions should be created. This commission should gather people from all the fields confronted with the drug phenomenon and delivers advice on drug policy.

This decree organizes for the first time official "Health care-networks" in the Walloon region, but those networks were already in place before the legal framework. One of its objectives for the next years is to provide rural areas with the same health care offer as urban ones.

The Walloon minister in charge of health aims also to clearly identify, in Wallonia, each sector in need of a network, in order to build those in an accurate geographical frame. Once fulfilled, this purpose would prevent drug-users from going from one network to another, using several offers simultaneously. It would also provide them with a broader, multidisciplinary offer (medical, psychological, shelter, etc.) in each single area.

Still, the minister, in the motives that have led to the decree, stresses one point: keeping drug users within the same area (or network, or health-care offer…) mustn't lead to mingle *prevention* and *repression* of drug (ab)use.

In 2003, the French Community has started a new action program, inside sport clubs, on the basis of the decree of March 8, 2001, on Health promotion in sport and the prevention of doping. This one includes information to sportsmen on the new control-procedures and awareness for health-promotion in sport.

Belgium is one of the few countries (less than 20) to have passed legal measures against doping and to apply them. Prevention and proper information inside the clubs were the first "tools" to be applied in the French Community, but the new measures also include more controls. These ones are to take place without warning, especially during the weekends, and include (as prevention and information do) amateur practices, in order to be a real measure of public health.

The sport's federations are in charge of transmitting the list of forbidden substances, and of requiring the sanctions.

It has to be noticed, that this procedure is limited to the French Community and doesn't apply to the *national* federations (as for example the football federation).

In the framework of a decree concerning medically responsible practice of sports, the Flemish government decided to make the names, the suspending periods and the discipline of suspended sportsmen public via the internet[2]. The major goal is to dissuade the use of doping in sports. On the other side it will be easier for organisers and promoters of sports contests to find out which sportsmen are suspended.

1.2.d Impact of policies and strategies

In 2003, there was an amendment of the drug law in Belgium. In the drug law, a distinction is made between cannabis and other illicit substances. The possession of a small amount of cannabis, even for personal use, is still a criminal offence. However, in principle, the public prosecutor will no longer prosecute this type of criminal offence, as long as the possession is not accompanied by problem drug use or by public nuisance.

It is important to note that the criminal law and, as a consequence, the prosecution policy, does not apply to minors. In Belgium, behaviour by minors that is criminalised by law, are not called criminal offences, but "facts described as offences" and minors receive a measure.

[2] http://www.wvc.vlaanderen.be/dopinglijn/paginas/inhoudframe.htm

In the Belgian drug law, the reaction towards the possession of cannabis is based on **expediency principle** by the public prosecutor, which can use its discretionary powers by deciding whether to prosecute or not. Therefore, the ministerial circular of 2003 is important, since it holds guidelines for the public prosecutors' office as to how should be reacted towards the possession (of cannabis) for personal use.

1.3. BUDGET AND PUBLIC EXPENDITURE

1.3.a Law enforcement, social and health care, research,…

The results of the research "The Belgian drug policy in numbers" funded by the Federal Science Policy Office[3] were published in June 2004 (De Ruyver et al 2004). The aim of this study was "*to make a significant contribution by identifying all agencies involved in drugs policy and estimating the cost price of the various aspects of the policy being pursued*"[4]. Three dimensions constitute the research:

- Identification of the actors involved in all levels of the drug policy (federal, regional/community, provincial, local commune),
- Study of public expenditures for all levels of power,
- Population reached among drug users by these actors, qualitative and quantitative description.

Five main sectors related to drug issues have been delimited and defined:

- Research and epidemiology,
- Prevention,
- Assistance,
- Security,
- Policy management.

It is important to notice that the data presented below are based on estimation of budgets thus do not represent the exact budgets.

The data gathered show that the Belgian trend is to increase the funds dedicated to the drug policy. This is especially observed for the research sector, for which the budget was the most increased (multiplied by 7 since 1993). Expenditures for the prevention sector were multiplied by 5 and assistance by 2. However, research and prevention remain very poorly funded.

The "security" area receives 54% of the total budget, 38% goes to "assistance"; "research and epidemiology" is the less financed area with only 1% of the total budget.

The following table summarises the financial contribution of all levels involved in the drug policy in 2002 and this, for each of the five sectors previously mentioned.

[3] Formerly named: Federal Office for Scientific, Technical and Cultural Affairs (SSTC/DWTC).

[4] For a summary of the project please refer to the following web site : http://www.belspo.be

Table 1 : Public expenditure for the drug policy in 2002, De Ruyver et al. 2004.

K€ 2002	Policy management	Research and epidemiology	Prevention	Assistance	Security
Federal	3.925.602	1.411.933	2.874.292	64.039.091	78.241.153
Flemish Community/Region	324.113	139.142	1.499.936	3.580.625	0
French Community	20.476	867.709	1.248.393	328.339	0
German speaking Community	1.735	123.272	0	137.218	0
Walloon Region	20.476	0	1.664.393	1.333.258	0
Cocom	105.000	105.000	0	0	0
Mixed community French speaking Brussels	145.873	0	604.876	1.982.488	0
Mixed community Flemish speaking Brussels	356.521	0	43.000	0	0
Provinces	303.023	63.516	362.977	317.304	0
Communes	n.a	n.a	n.a	n.a	19.738.039
Total	5.202.819	2.710.572	8.297.867	71.718.323	97.979.192
%	**3**	**1**	**4**	**38**	**54**

In 2002, the global public expenditures amounted to € 185.908.773. This corresponds to a contribution of € 18,03 per inhabitant.

1.3.b Funding arrangements

As already explained in the previous annual reports and illustrated in table 1, the complexity of the Belgian political organisation has an impact on the design of the budget related to drug issues. There are as many financing modes as there are levels of power. The authors of "The Belgian drug policy in numbers" stressed in their conclusions that in order to reach the objective of a global integrated policy of drugs, all of these actors should find an agreement on the drug policy (De Ruyver et al 2004).

The percentages of the contributions to the drug policy by the different partners are presented in the next figure. By "Federal" it should be understood the Federal Government. "Federate entities" regroup the Communities, Regions, and Provinces. It has to be noticed that for "Security" Federate entities only correspond to Communes and cities (figure 1).

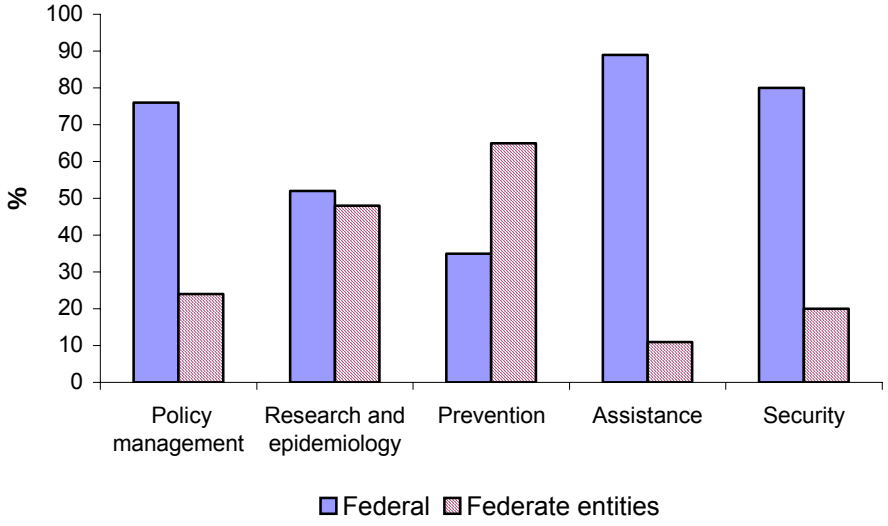

Figure 1 : *Percentage of financing for each sector by the Federal Government and the other entities in 2002 (De Ruyver et al 2004).*

With respect to the "prevention", the figure 1 reflects that the policy is under the responsibility of the federate entities. Concerning the "research and epidemiology", the financing is almost at the same level for the Federal government and the other entities. The Federal Government largely finances the three other sectors.

The prevention, financed by the Federal government, may be characterised as prevention of nuisances or prevention of drug related crime. The prevention activities financed by the federate entities are well-being and health oriented.

In 2002, the different entities financed the prevention activities following the repartition presented below.

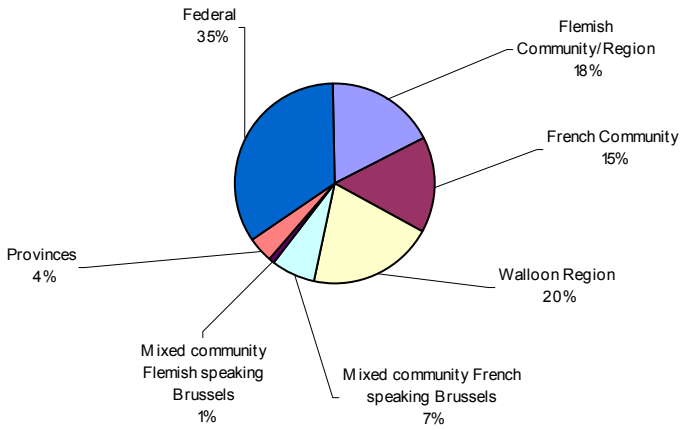

Figure 2 : *Repartition of the budget for prevention activities 2002 (De Ruyver et al. 2004).*

➢ **Communities and Regions**

As presented in previous annual reports, below are given the budgets for the drug demand reduction activities. These numbers could not be compared with the results of the previously mentioned study. Moreover, as not shown in figure 2, the German Community finances prevention activities since 1997 with the creation of the ASL as an independent organization.

In 2003, the annual budget supported by each Community is the following:

Flemish Community: € 2. 644.537

French Community: € 1.351.213,98

German Community: € 371.154,50

Walloon Region: € 1.390.242

Mixed Community Commission of the Region of Brussels Capital: € 210.000

French-speaking Community Commission of Region of Brussels Capital: € 3.319.000

This last budget only concerns the institutions financed for 5 years by the mentioned Commission however additional subventions exist.

1.4. SOCIAL AND CULTURAL CONTEXT

1.4.a Public opinions of drug issues

► VRIND

Since 1996, a survey on public opinion on social issues and policies is regularly carried out among the Flemish population (Administratie Planning en Statistiek 2004). In 2003, a representative sample aged between 18-85 years was questioned (1500 persons from the Flemish Community and from the Flemish speaking part of Brussels). The results show that "drug problem among the youngsters" is the first problem mentioned before the unemployment, insecurity in the streets,… In 2000, "drug problem" was ranked in the second position after "environmental pollution".

Table 2 : Percentage of respondents stating drug use as a top 5 problem, VRIND 2003.

N = 1437	**1996**	**1997**	**1999**	**2000**	**2003**
Use of drugs by youngsters	41.6	37.9	39.7	40.4	40.2

Half of the sample among the 35-44 years considers the use of drugs by the youngsters as the problem number one. For the two younger age groups (18-24; 25-34 years), the drug problem is considered as an important issue but they seem to be more concerned by the problem of unemployment. The lowest percentage is raised among the 45-54 years 32.4%), considering the drug use as less important than other age groups. From a gender perspective, it seems that more women than men think that the drug problem is a very important issue.

► Drugs and nuisances

A recent study on "Drugs and Nuisances" has given some information on the perception of the population on drug laws (Decorte et al. 2004).

Some drug users consider the drug laws as obsolete. Legal texts are thought to be vague with rather unclear defined concepts. This group for three main reasons also mentions feelings of injustice. First of all, the penal answers for drug use are perceived as too severe compared to other infractions. The second reason is linked to a perception of hypocrisy regarding the consequences of legal drug use, especially alcohol. Finally, some think the use of drugs is a life style not necessarily to be associated with delinquency, so they should not be criminalised.

The aforementioned study focuses more on drug-related nuisance, however "nuisance" is found to be a very vague term; moreover, drug-related nuisance can hardly be distinguished on streets from (global) nuisance. It is a very subjective concept.

When asked about the cause of nuisance, only 4% of the respondents mentioned drug users. When asked about the cause of *drug-related* nuisance (i.e. drugs are now deliberately mentioned), 12% (i.e. three times more) of the respondents indicate drug users as the cause of this nuisance. Generally speaking, especially the youngsters in general are considered as producing most nuisances while only very few see specifically the drug users or alcoholics involved. Occupation of public spaces by youngsters / drug users is perceived as the most important nuisance-related phenomenon.

Remarkable also is that a lot of people think the Commune does not do enough effort to reduce or handle drug-related nuisance. This dissatisfaction is even larger when asked about the police's policy.

Drug users themselves see the present policy as a policy that aims at tackling nuisance instead of aiming at the fundamentals of the drug problem. They fear that treatment will become inferior to the fight against nuisance.

1.4.b Debates and initiatives in parliament and civil society

► Harm reduction sittings (Assises réduction des risques)

On the 4th and 5th December 2003, a NGO "Modus Vivendi" organised sittings on harm reduction related to drug use. Historically, harm reduction was developed in the 1990's, aiming at preventing the spread of AIDS. But the concept of harm reduction has been extended to other diseases and risks (hepatitis, tuberculosis, overdose) as well as to all drug users not only injecting ones. This evolution hasn't been formalised yet. Despite this lack, projects multiply, as well as harm reduction workers, while no real community reflexion has been led in order to find a consensus around the concept of harm-reduction. Harm-reduction is too often reduced to syringe-exchange, and considered as prevention among others.

► Study day VAD (Studiedag VAD)

Each year the VAD organises a congress on new trends and topics in the alcohol and drug field. In 2003, the main issues were benzodiazepines, stimulant drugs, cannabis and costs & benefits of the alcohol and drug policy. The conference was held in Ghent and welcomed over 300 people.

► European Society for Social Drug research

From October 2nd to October 4th 2003 the annual conference of the European society for social drug research (ESSD) took place in Ghent. The 14th edition of the international conference was hosted by The Institute For Social Drug research (ISD). Spread over 3 days participants were invited to exchange on the various methods in social research in the field of drug use.

► In March 2004, the Sub Focal Point of Brussels (CTB-ODB) had organised meetings with the commission Health of the Brussels Parliament. The first one has permitted to update for policy makers the epidemiological indicators, the second one concerned the prevention of health problems related to drug use. These meetings have enlightened the policy makers on the importance of international collaborations but also on difficulties of cooperation within the context of the federal organisation.

► In May 2004, the Health Ministers of Brussels in collaboration with the CTB/ODB have organised a press conference about the main features of the drug policy based on epidemiological conclusions.

► In the parliament, seven different proposals for laws concerning illegal drugs have been introduced.

- One proposal wants to guarantee the right of imprisoned drug addicts who follow substitution treatment, to choose a doctor of his/her choice for this treatment. It also guarantees the continuation of the substitution treatment (i.e. it cannot be suspended by, for instance, a disciplinary measure). (51K0163)
- Two proposals stipulate regulations concerning cannabis: it's production, sale and consumption. (3-538 and 51K0262)
- Subject of a fourth bill is the introduction of a saliva test to see if someone is driving under influence. (51K0391)
- Since the changes made to the Narcotic Drug Act, police officers were not allowed any more to enter and search all places at night in the light of actions against drug traffic. This bill, giving back these permissions, has been approved, although it has not yet been promulgated or published. (51K0768)
- Another bill aims to simplify the pursue of drug offences. Some of the proposals include the incitement of a drug offence and the need for the suspect to prove that certain amounts of money do not originate from drug traffic. (51K0852)
- One bill aims at obliging drug addicts to undergo observation and treatment under certain conditions. (51K1011)
- A last bill proposes more severe punishments for drug dealers, as well as psycho-medical counselling for addicted drug users (51K1233).

Apart from this, there is also a proposal for a resolve concerning the permission to conduct an experiment on controlled heroin distribution (51K1189).

All these proposals can be read in full-text on the sites of the Chamber of Representatives and the Senate[5].

► Five associations have introduced an action for annulment before the Court of Arbitration against the article 16 of the law (3 May 2003) modifying the Narcotic Drug Act. They disagree with a specific phrase mentioned in this article, speaking of "public

[5]The texts can be found by using the code given between parentheses as search term on one of the internet-sites of the Belgian Parliament: all texts can be found at www.lachambre.be, the site of the Chamber of Representatives, with the exception of "3-538" which is a proposal by the Senate and therefore can be consulted at www.senat.be.

nuisance or problematic use". They think the definitions of both concepts are not clear enough and ambiguous. According to them, the actual version of the text doesn't allow the citizen to determine if his/her behaviour will be pursued or not. It is also said that the principle of equality in the eyes of the law is not respected. In late October 2004, the Court of Arbitration cancelled the article 16 of the law.

1.4.c Media representations

The main topics related to drugs and discussed in the media in 2003:

- epidemiological data: general, cannabis, XTC, alcohol,
- young people and drugs: nightlife, young people and drug use, XTC, viagra, cocaine, speed; 'drugdogs' in the school, dealers in the school,
- parents: role of parents in drug use; urine testing,
- heroin deaths and misuse of methadone,
- syringe exchange, users rooms,
- legislation: especially changes in legislation concerning cannabis and finally on the Decree on substitution treatments.

In addition, in the framework of the Belgian Early Warning System, all the warnings are published in the media.

The Flemish community launched a new phase of the campaign, 'Alcohol, give it a sober look', which is a long-term approach on alcohol prevention. Every year, the campaign focuses on a specific age group:

2001: 12-16 years: with 'a cool world': website[6] , flyer on alcopops, contest, …

2002-2003: 17-25 y.: with 'Free drinks': website[7] brochure with information on risks of alcohol misuse, especially short-term effects.

2004-2005: 26-45 years: with 'message in a bottle': website[8] brochures for sport fans, workers, women and people with an alcohol problem and a CD-Rom for GP's and welfare workers on how to deal with motivation, early intervention and referral. There is media coverage of the campaign.

Partywise is a prevention project that focuses on young people (18-25 y.) and chemical substance use in nightlife. The main message is safe partying for all young people. A website[9] was created and other campaign materials, advertisement in specific (party) media, media coverage, etc. A strategy to involve the organisers of parties in a harm reduction strategy was developed.

Press releases report that the legal changes in matter of cannabis don't ensure an efficient management of that issue in the future. Cannabis is, since those changes, tolerated rather than legalized. Nonetheless, articles mentioned that cannabis is perceived as actually legalised by a great majority of the general population, due to a lack of communication from the political field. In 2004, an article published the results of a survey on the public's knowledge about political institutions, about their knowledge about cannabis law, the public's opinion on the communication on the law by the Government

[6] www.acoolworld.be
[7] www.gratisdrank.be
[8] www.boodschapineenfles.be
[9] www.partywise.be

and finally about the method of information consumption by the public (Gelders and Van Mierlo 2004). They concluded "*the respondent's knowledge about the political institutions is in line with similar research. In contrast, the respondent's knowledge of cannabis law is low. Respondents stated that the Government created confusion due to conflicting public declarations".* The study demonstrates that *"the respondent's consumption of information has no significant influence on their knowledge about the cannabis law.*" This confusion due to a lack of clarity was already reported in 2001 (Vander Laenen 2001).

The authorities will, according to the new legal context, tolerate a "personal use" of cannabis if it doesn't involve " public nuisances " or " problematic use " (May 3, 2003 Act, Art.16).

These terms are, according to press campaigns which reflect specialists' opinions, creating confusion, since they are never clearly enough defined. Hence a risk of inequality between consumers, one being arbitrarily considered as "problematic" or creating "public damages", while the other isn't. In 2003 started a research on the notion of "problematic drug use", financed by the Belgian Science Policy Office (BELSPO). Results will be published by the end of 2004.

It has also been stressed that cannabis stays "totally" forbidden (which means not even "tolerated") for people under 18, while that specific group represents a great deal of the consumers. For them, nothing changes.

Another issue presented in the press, was the signing of the "worldwide anti-doping code", approved (and signed) by 73 countries and 200 sport's federations. But many think that the "World Anti-doping Agency", which wrote the code, doesn't have the means to enforce the recommendations this one contains.

In the first place, the Agency doesn't have a public status, and intends to stay a private foundation. This has led the signing countries to elaborate their own declaration, wherein they recognize its *action*, but not the foundation in itself. This should be an obstacle on the way to translating that code into national or regional laws (even if some countries, as Belgium, have already done so).

In the German Community, the results of the study carried out on risky behaviors among pupils of the Euregio were presented to the press. These results are now a basis for a new press campaign "0 per mille under 16 years".

CHAPTER 2.
Drug use in the population

The most recent results from the National Health Interview Survey (HIS) among the adult population (HIS 2001, see 2.1) shows that the use of cannabis is by far the preferred substance, especially among the youngsters. The level of urbanisation seems to have an impact on the use of illegal drugs, urban areas gathering higher lifetime prevalences than rural ones. The use of illicit substances (cannabis, XTC amphetamines) decreases in older age groups. The new HIS is already launched and ondergoing.

The results of the first ESPAD 03 survey carried out in the country are in line with the conclusions of other Belgian school surveys. The use of cannabis is by far the first illegal substance used or at least experienced by teenagers. From another study, among Flemish schools (VAD 2004), it appears that the lifetime and last month prevalences of cannabis did not increase in comparison to the previous year neither among boys as among girls.

From the first ESPAD 03 survey, it seems also that the lifetime prevalence of illicit use of sedatives or tranquillisers reaches 9.3%.

Except for sedatives and tranquillisers, boys use more frequently drugs than girls. The 'typical user' starts at a young age (younger than 18, or even younger than 15 years old).

Polydrug use among youngsters is a common phenomenon, being apparent through the combined use of alcohol or cannabis with other substance(s) (see 2.3.a; 2.3.b).

As mentioned previous years, comparison between the different sources of information should be done with caution as the methods of data collection and processing may vary considerably.

2.1. DRUG USE IN THE GENERAL POPULATION

In 2001, the first module on illicit drugs was included in the National Health Interview Survey (HIS 2001). Since the results were presented in the last year annual report they will not be repeated in this edition. The new data collection in the framework of the HIS 2004 started in January 2004. The module on illicit drugs was improved. The questions concern the lifetime, last year and last month prevalence of cannabis use, the frequency of use during the last month and finally the type of substance. The results are foreseen for the end of 2005.

2.2. DRUG USE IN THE SCHOOL AND YOUTH POPULATION

2.2.a Espad

From March 2003 to May 2003 for the first time the "European School Survey Project on Alcohol and other Drugs" (ESPAD) has been carried out in Belgium (Lambrecht et al 2004). This nationwide study is the fruit of the collaboration between the Flemish and French speaking Universities of Brussels, financed by the Scientific Institute of Public Health. 2320 questionnaires were processed for data analysis focusing on the 15-16 years old (those born in 1987) and eliminating incomplete and useless questionnaires.

The lifetime prevalence of any illicit drug use is reported to be 32.6%, with a higher percentage for boys (37.2%) than girls (28.3%). When marijuana or hashish are not included, the lifetime prevalence of any other illicit drug is 7.9% and respectively 9.1% for boys and 6.7% for girls. The lifetime prevalence of any drug used by intravenous way is for the three prevalences below 1%. 0.9% for lifetime prevalence, 0.7% for the last year prevalence and 0.5% for the last month. Except for the last month prevalence, the result is higher among boys than girls.

The following table shows the lifetime, last year and last month prevalences for some substances.

Table 3 : Prevalences (%) of illicit drug use, ESPAD 03, (standard table 02, 2004).

N = 2320		lifetime prevalence	last year prevalence	Last month prevalence
Marijuana or hashish	Boys	36.8	31.9	20.3
	Girls	28.1	21.9	13.4
	Total	**32.2**	**26.7**	**16.7**
Not prescribed tranquillisers or sedatives	Boys	8.6	2.5	1.0
	Girls	9.9	3.7	1.8
	Total	**9.3**	**3.1**	**1.4**
Inhalants	Boys	8.9	5.2	2.6
	Girls	5.1	2.9	1.3
	Total	**6.9**	**4**	**1.9**
Magic Mushrooms	Boys	7.6	3.9	1.6
	Girls	2.8	1.2	0.4
	Total	**5.1**	**2.5**	**1.0**
XTC	Boys	5.1	3.2	1.5
	Girls	3.7	2.3	1.1
	Total	**4.4**	**2.7**	**1.3**
LSD or other hallucinogens	Boys	4.3	2.4	1.0
	Girls	1.2	0.9	0.4
	Total	**2.7**	**1.6**	**0.7**
Cocaine	Boys	3	1.1	0.6
	Girls	2.1	1.2	0.8
	Total	**2.5**	**1.1**	**0.7**
Amphetamines	Boys	2.5	1.3	0.5
	Girls	1.9	1.3	0.9
	Total	**2.2**	**1.3**	**0.7**

5.1% of the respondents indicate to have used magic mushrooms at least once in their lifetime. XTC has been used by 4.4% of the respondents during the whole lifetime. The last month prevalence for these two substances amounts to 1.0% and 1.3% respectively. LSD and other hallucinogens, cocaine and amphetamines are reported by 2.2% to 2.7% of the pupils; the last month prevalence drops below 1% for all these substances. Non-prescribed use of tranquillisers or sedatives is reported by 9.3%, although last year prevalence and last month prevalence drop sharply to 1.7% and 1.4% respectively. Note that the last month prevalence for the use of tranquillisers and sedatives, cocaine and amphetamines is higher among girls than among boys.

For every illicit substance questioned, most of the respondents among all those that admitted having used it at least once, report a frequency of use of 1 or 2 times in their whole life. It seems that cannabis and crack are the only substances used ten times or more by at least 10% of the respondents. One or two times of intravenous drug use (n=20) is reported by 40% while 25% said to have injected 40 times or more.

Table 4 : Frequency of use during lifetime, all respondents that admit having used the substance at least once in their life (%), ESPAD 03, (standard table 02, 2004).

Substance	N	1-2x	3-5x	6-9x	10-19x	20-39x	40x or more
Marijuana or hashish	743	28.0	18.8	10.6	10.6	9.3	22.6
Amphetamines	50	58.0	10.0	8.0	6.0	4.0	14.0
LSD or other Hallucinogens	61	57.4	9.8	11.5	4.9	4.9	11.5
Crack	46	41.3	15.2	8.7	10.9	4.3	19.6
Cocaine	58	63.8	12.1	3.4	5.2	1.7	13.8
Ecstasy	100	44.0	20.0	12.0	9.0	4.0	11.0
Heroin	32	50.0	18.8	6.3	6.3	0.0	18.8
"Magic mushrooms"	117	54.7	19.7	7.7	3.4	6.8	7.7
Not prescribed tranquillisers or sedatives	213	55.4	17.8	9.4	5.2	4.7	7.5
Inhalants	159	54.7	16.4	7.5	6.9	4.4	10.1
Anabolic steroids	15	40.0	13.3	20.0	0.0	6.7	20.0

About one out of three respondents indicating that they have used the substance during the last year, admit to have used it 1 or 2 times. Still almost 16% of the respondents say to have used marijuana or hashish 40 or more times. Inhalants were mostly used once or twice during the last year among the respondents admitting to have used these substances during the last 12 months.

Table 5 : Frequency of use during the last 12 months, all respondents who admit having used the substance at least once in their life (%), ESPAD 03, (standard table 02, 2004).

Substance		**Frequency of use (%)**					
	N	1-2x	3-5x	6-9x	10-19x	20-39x	40x or more
Marijuana or hashish	611	35.5	18.0	11.0	10.0	9.8	15.7
Inhalants	92	57.6	17.4	5.4	7.6	7.6	4.3

Among the respondents who indicated to have used the substance at least once during the last month, more than one third says to have used cannabis once or twice, while almost 8% says to have used cannabis 40 times or more. Inhalants were mostly used once or twice although still 9% indicate their last month frequency of use as being forty times or more.

Table 6 : Frequency of use during the last 4 weeks, all respondents that admit having used the substance at least once in their life (%), ESPAD 03, (standard table 02, 2004).

Substance		Frequency of use (%)					
	N	1-2x	3-5x	6-9x	10-19x	20-39x	40x or more
Marijuana or hashish	383	37.1	20.6	13.1	14.1	7.6	7.6
Inhalants	44	54.5	11.4	9.1	9.1	6.8	9.1

For about all the substances, the age 14 and 15 years old seems to be the age at which more respondents indicate to have used an illicit substance for the first time (among all the respondents having used the substance at least once in their lifetime).

Table 7 : Distribution of age at first use, all respondents that admit having used the substance at least once in their life (%), ESPAD 03, (standard table 02, 2004).

Substance		Age					
	N	-11	12	13	14	15	16
Marijuana or hashish	621	2.1	7.4	17.6	36.4	32.2	4.3
Amphetamines	61	4.9	6.6	11.5	29.5	42.6	4.9
LSD or other hallucinogens	70	2.9	4.3	15.7	18.6	51.4	7.1
Crack	48	8.3	4.2	14.6	31.3	29.2	12.5
Cocaine	51	3.9	3.9	11.8	15.7	51.0	13.7
Ecstasy	98	3.1	0.0	10.2	36.7	43.9	6.1
Heroin	34	8.8	2.9	8.8	17.6	47.1	11.8
"Magic mushrooms"	118	4.2	2.5	11.0	30.5	46.6	5.1
Not prescribed tranquillisers or sedatives	187	11.2	10.2	19.8	26.2	26.7	5.9
Inhalants	132	14.4	15.9	22.7	30.3	12.1	4.5
Anabolic steroids	20	20.0	15.0	15.0	20.0	25.0	5.0
Drugs by injection	23	13.0	8.7	13.0	13.0	39.1	13.0

More girls seem to use at a younger age sedatives or tranquillisers than boys; while it is the inverse for all the other substances.

Table 8 : Distribution of age at first use by sex, all respondents who admit having used the substance at least once in their life (%), ESPAD 03, (standard table 02, 2004).

	Boys						Girls					
	-11	12	13	14	15	16	-11	12	13	14	15	16
Marijuana or hashish	3.1	8.9	17.3	33.4	32.0	5.3	0.8	5.3	17.9	40.5	32.4	3.1
Amphetamines	11.1	14.8	11.1	33.3	29.6	0.0	0.0	0.0	11.8	26.5	52.9	8.8
LSD or other hallucinogens	4.3	6.5	21.7	17.4	43.5	6.5	0.0	0.0	4.2	20.8	66.7	8.3
Crack	12.9	6.5	12.9	35.5	25.8	6.5	0.0	0.0	17.6	23.5	35.3	23.5
Cocaine	6.3	0.0	12.5	18.8	43.8	18.8	0.0	10.5	10.5	10.5	63.2	5.3
Ecstasy	5.5	0.0	12.7	32.7	43.6	5.5	0.0	0.0	7.0	41.9	44.2	7.0
Heroin	10.0	5.0	5.0	10.0	55.0	15.0	7.1	0.0	14.3	28.6	35.7	7.1
"Magic mushrooms"	5.9	3.5	11.8	24.7	47.1	7.1	0.0	0.0	9.1	45.5	45.5	0.0
Not prescribed tranquillisers or sedatives	10.7	13.3	12.0	29.3	32.0	2.7	11.6	8.0	25.0	24.1	23.2	8.0
Inhalants	14.8	17.3	21.0	29.6	9.9	7.4	13.7	13.7	25.5	31.4	15.7	0.0
Anabolic steroids	30.8	7.7	15.4	7.7	30.8	7.7	0.0	28.6	14.3	42.9	14.3	0.0
Drugs by injection	18.8	6.3	12.5	18.8	25.0	18.8	0.0	14.3	14.3	0.0	71.4	0.0

2.2.b Flemish Community study

Since 1999 VAD conducts a large study in the secondary schools in the Flemish Community. The study uses its own protocol. During the school year 2002-2003, 9074 students were questioned (VAD 2004, Standard table 2, 2004). From these, a sample of 1576 questionnaires, representative for grade (age), sex, type of education and type of institution was analysed.

The results of the study show that the lifetime prevalence of illegal drugs use corresponds to 23.6%. In addition, the last year prevalence of illegal drugs amounts to 12.3%.

Also, as shown in the following table, the frequency of use varies by sex: boys use more frequently illegal drugs than girls (table 9).

Table 9 : Last year prevalence and frequency of use of illegal drugs (%), VAD, 2002-2003.

	Prevalence	
	boys	**Girls**
Not used last year	85.6	89.9
<1x/week	7.4	7.5
>=1x/week	7.0	2.7

Cannabis appears to be the most popular illicit drug used by the Flemish students. Only 2.8% of the students have reported the use of illegal drugs other than cannabis (Table10).

Table 10 : Last year prevalence of cannabis use versus other illegal drugs (%), VAD, 2002-2003

		Use of illegal drugs other than cannabis	
		Not last year	**Last year**
Use of cannabis	Not last year	87.5	0.3
	Last year	9.7	2.5

Generally speaking, the use of cannabis, XTC, amphetamines and solvents is higher among boys than girls. However, there are some exceptions. In 2002-2003, results indicate that the lifetime prevalence of cannabis use among the girls aged between 17-18 years is higher than among boys. This is also the case regarding the lifetime prevalence of amphetamine use (table 11).

In comparison to the previous school year (2001-2002), the lifetime prevalence as well as last year prevalence of cannabis use has decreased in the younger age group (15-16 year) both for boys and girls. For the 17-18 year olds, it seems that a slight increase in lifetime prevalence occurred, which is not reflected in the last year prevalence, which slightly decreases (Figures 3,4).

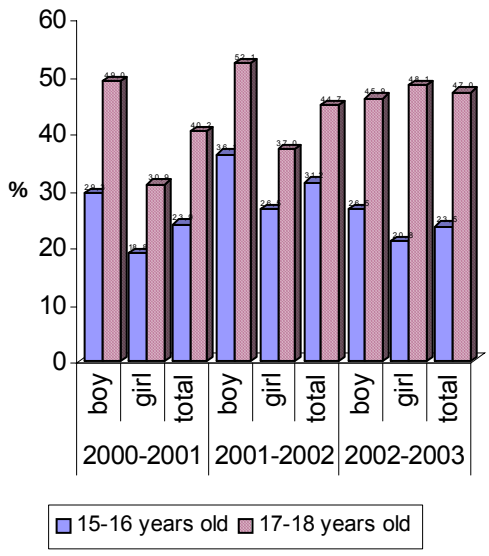

Figure 3 : *Lifetime prevalence of cannabis Flemish secondary school students, VAD 2000-2003.*

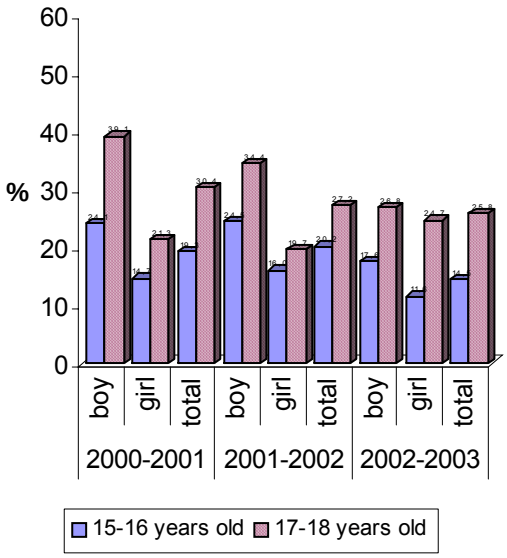

Figure 4 : *Last year prevalence of cannabis Flemish secondary school students, VAD 2000-2003.*

The prevalence of XTC use decreased a little among the 15-16 year olds students, but stayed more or less stable in the oldest group.

The lifetime and last year prevalence of amphetamines kept decreasing in both age cohorts. In contrast, the lifetime and the last year of solvents use maintained a slight increase (table 11).

Table 11 : Lifetime and last year prevalence of illegal drugs (%), by gender and age, VAD 2000-2003.

			2000-2001		2001-2002		2002-2003	
	Age	Gender	Lifetime prevalence	Last year prevalence	Lifetime prevalence	Last year prevalence	Lifetime prevalence	Last year prevalence
Cannabis	15-16	boy	29.3	24.1	36.1	24.5	26.5	17.6
		girl	18.8	14.7	26.5	16.0	20.8	11.6
		total	***23.9***	***19.3***	***31.2***	***20.2***	***23.5***	***14.5***
	17-18	boy	49.0	39.1	52.1	34.4	45.9	26.8
		girl	30.9	21.3	37.0	19.7	48.1	24.7
		total	***40.2***	***30.4***	***44.7***	***27.2***	***47.0***	***25.8***
XTC	15-16	boy	4.8	3.6	4.9	2.3	3.3	1.7
		girl	2.5	1.6	3.5	1.3	2.3	1.2
		total	***3.6***	***2.6***	***4.2***	***1.8***	***2.8***	***1.4***
	17-18	boy	11.6	8.4	11.1	6.3	9.1	4.3
		girl	4.9	3.2	5.5	2.0	8.6	3.7
		total	***8.2***	***5.8***	***8.4***	***4.2***	***8.9***	***4.0***
Amphetamines	15-16	boy	6.7	4.8	4.9	2.0	3.3	0.4
		girl	4.0	2.4	3.3	1.3	1.9	1.6
		total	***5.3***	***3.6***	***4.1***	***1.6***	***2.6***	***1.0***
	17-18	boy	13.2	8.5	9.3	4.1	4.8	2.7
		girl	6.3	3.6	5.0	1.7	6.2	1.9
		total	***9.8***	***6.1***	***7.2***	***2.9***	***5.5***	***2.3***
Solvents	15-16	boy	4.4	2.4	8.1	2.9	9.2	4.2
		girl	3.2	1.9	5.8	1.9	4.2	2.3
		total	***3.8***	***2.1***	***6.9***	***2.4***	***6.6***	***3.2***
	17-18	boy	4.8	2.7	10.5	2.5	10.7	3.7
		girl	2.3	1.1	6.0	1.2	8.6	0.6
		total	***3.6***	***1.9***	***8.3***	***1.9***	***9.7***	***2.3***

2.2.c Study on youngsters and their well-being

From March 2003 to May 2003, a collaborative study between the French University of Brussels and the Rodin Foundation has been carried out among youngsters from 10 years to 18 years old. The sample was constituted by 2009 face-to-face interviews dealing with the use of Cannabis, XTC, alcohol and tobacco (Patesson et al. 2003).

The results indicate 13.7% as lifetime prevalence of cannabis among the 10-18 years old, respectively 18.4% for males and 13.9% for females. Among the 13-18 years, the prevalence is 28.3% for males and 21.3% for females. The last year prevalence for cannabis is 19% for males and 13.3% for females among the 13-18 years. The lifetime prevalence of XTC is 1.4% for the total sample (10-18 years).

2.2.d GOA parties

According to a survey carried out by the police, it appears that since 2001 GOA parties are more frequently organised in Belgium. GOA refers to a place in India where hippies went by the 60-70's and where the use of XTC was combined with techno music during "Full moon parties" (Tersago, Weyts 2004). GOA is an international movement, inspired by a Hindu philosophy. The current guru is "Goa Gil" and lives in the United States.

The Belgian GOA parties gather a public aged between 14-30 years old. There is a European dimension in these parties as lots of participants come from the bordering countries. The GOA culture is recognisable through the style of the participants, their linguistic codes and the music. In addition these parties are secretly organised, the meeting places are revealed at the latest minute. This contributes in creating a sort of fascination. The conditions for drugs dealers are quite attractive as the fear of police controls is quite low, the public is selected and it is difficult to get in.

According to the police services, the use of licit or illicit drugs is very common during the GOA parties.

The police services have accomplished some controls at the occasion of five parties. Among 309 individuals, 162 were already known by police services. Among those, 118 were known for drug related facts.

It seems that the parties are mainly organised in the North of the country but this is not verified.

2.3. DRUG USE AMONG SPECIFIC GROUPS

2.3.a Study on Cannabis users

In 2003, a snowball study among cannabis users in Flanders was carried out by the Ghent University (Decorte et al. 2003). The eligibility criteria applied are:

- At least 5 times of cannabis consumption,
- to be older than 18 years.

The 369 interviews were based on a semi-structured questionnaire.

The mean age is 24.6 years old. The sample is constituted by 69.4% males and it was noticed that females (23.60) are younger than males (25.03).

The mean age at first use of cannabis is 16.3 years and this first experience generally happened in presence of friends or of a more intimate partner. This consumption occurs usually during parties in a context of confidentiality. A major part of users described their first experience as pleasant; however, more than a third says they didn't feel a real effect. Almost a half of the sample chooses marijuana for its taste or its effects and in relation to its easier use. A minority prefers hash, because of a better effect or less negative secondary effects and for its better taste. The variety "white widow" is quoted by more than a half of the respondents as their preferred one. Men seem to use harder varieties than women. Alcohol and tobacco were used for the first time around 13-14 years. The first experience of other illegal drugs was reported to be just before 18 years.

When alcohol and tobacco are not taken into account, 21.9% of the sample has not experienced another illicit drug than cannabis.

Among the others, the lifetime prevalence of LSD is 52.3%, XTC is 49.6%, amphetamines 40.1% and cocaine 35.0%.

More than a half of those experiencing other illegal drugs, combined them “often” or “always” with cannabis.

2.3.b Study among party scene in Flanders

A non-representative study among party people (a-select) was performed during the summer 2003 in Flanders by the VAD (Van Havere et al. 2004). The researchers went to clubs, dance events and rock festivals. 645 interviews were based on a structured questionnaire.

The mean age of the sample was 22 years and constituted by 64% of males.

The most used drug was alcohol, with in second place cannabis and third XTC. The last year prevalence of alcohol use was 94% and the last year prevalence of cannabis use is reported to be 45.5%. Both drugs were used on a regular basis.

XTC was used by 18.9% of the respondents in the last year, but more occasionally than the above-mentioned substances.

Three out of four respondents having used illegal drugs during the past year combined them with alcohol.

Almost half stated a combined illegal drugs use. Among 252 respondents the following mix of substances was reported:

- one illegal drug with alcohol : 85.2%
- one illegal drug with cannabis : 75.8%
- one illegal drug with XTC : 35.2%
- cannabis with alcohol :65.5%
- cannabis with XTC : 22.5%
- XTC and alcohol : 21.5%

2.3.c Drug users in recreational settings in the French Community

Through harm reduction activities carried out by the NGO “Modus Vivendi”, data are collected in various locations of the French Community (Hariga 2004). Between 1996-1999, only one festival was covered, but since 2000, 15-20 different events per year are targeted. Festivals (rock, techno, hip hop, house music), megadancings, city parades, traditional events are the main places where questionnaires are filled in. Differences in the methodology of the data collection have to be taken into account in the data interpretation.

For example:

- the sample size in one location may be very small,
- the method of recruitment of the respondents varies in function of the event,
- over the years some modifications have been introduced in the questionnaires.

However, the biases have been reduced as often as possible. For example, data were not taken into account when less than 10 questionnaires were collected.

The data remain an excellent indicator:

- To evaluate the adequacy of the action with the public of the event

- To adapt the action according to changes/evolution in drugs uses and behaviours
- To facilitate the contact with the public
- To monitor the characteristics of the population met through harm reduction activities

The next table gives an indication of the prevalences of drug use among the respondents interviewed by "Modus Vivendi". Data of all the events from 2000 to 2003 are pooled.
In 2003, 41% reported a drug use during the event. Since 2001, 2% of the respondents declared a lifetime IDU use.

Table 12 : Percentages of "current"* drug use in recreational settings, French Community, 2000-2003.

	2000	2001	2002	2003
	N=1628	N= 926	N= 1568	N= 919
Any illegal drug	70	67	46	44
Amphetamines	20	10	8	11
Cannabis	67	62	43	35
Cocaine	21	10	7	8
Crack	6	1	1	2
GHB	NA	1	2	2
Heroin	7	2	1	3
Ketamin	NA	2	1	2
LSD	14	11	3	4
Hallucinogens Mushrooms	28	30	9	5
XTC	31	23	14	19
Benzodiazepines	7	2	0	4

*In 2000, current = last 6 months prevalence, after 2001 current = last month prevalence.

Data presented in table 12 show lower percentages of use in 2003 than in 2000. It is difficult to confirm if it is a real phenomenon or if the results are biased by contextual reasons. For example, music festivals gain in popularity, their public increases and is more heterogeneous. Police services are more visible during recreational events and more controls are done.

2.4. ATTITUDES TO DRUGS AND DRUG USERS

In the 'leerlingenbevraging' pupils between 12 and 18 years old are asked why youngsters use drugs (Kinable et al. 2003). Most reported answers are: just for the kick, to act tough, curiosity and pressure from friends. Little differences were noticed in the answers of boys and girls. When asked 'why youngsters don't use drugs' the most reported answers are: 'afraid to get addicted', 'afraid for the reaction of their parents', 'illegal drugs are dangerous', 'illegal drugs are expensive'.

When asked for the reaction of their best friend when he/she tries/uses cannabis, almost 60% of the youngsters think the friend would reject his/her use. About 30% thinks it doesn't matter and almost 10% believes that the friend would approve his/her behaviour. When the same question was asked with the reaction of the parents the percentages changed dramatically. 95% thinks his/her parents would reject the use of cannabis. 3.5% thinks they can live with it and 1.7% says that his/her parents would approve the use of cannabis.

In 2003 a study was done in the Ghent region studying the perception of students from second and third year of secondary school on drugs, drug use and the drug policy at school (Vander Laenen and De Ruyver 2003).

In Flanders, drug policy at school has been a priority for over a decade now. So far, however, pupils' expectations and points of view insufficiently got a chance within the policy development. The present study used focus group research to study the perception of pupils on the drug problem in and outside the school and on the drug policy at their school. To this end, seven focus groups were conducted from the second and third year of secondary school in the city of Ghent.

Drugs, both licit and illicit, are a reality for nearly all pupils, inside and out of the school. Sooner or later they come into contact with drugs, whether or not they experiment themselves. Contrastingly, schools still are struggling to adapt their policy on drugs to this social reality. On the one hand, the drug policy is overall limited to crisis management, in reaction to actual drug use. On the other hand, drug policy in schools is still mostly limited to a one-way direction, predominantly aimed at the transfer of information from the school to the pupils.

CHAPTER 3.
Prevention

The Federal Government is not responsible for the prevention policy, which is managed by the Communities governments. More details are given in chapter 1.

In the Flemish Community and the German-speaking Region, VAD and ASL were respectively designated as official structures for the coordination of the respective prevention policies. A similar structure does not exist in the French Community.

The universal prevention among the school population targets mainly the secondary schools but policies encourage prevention activities in the whole range of schools. The prevention activities become more and more numerous and varied. In 1996, a registration programme "Ginger" was created in the Flemish Community to monitor all prevention activities. One of the recent observations in this area of the country is a small increase of the participation of parents associations in prevention activities (Rosiers 2004). The main objective of the activities is the development of life skills.

Prevention targeting families is not restricted to parents of drug using children. Activities targeting large communities are initiated like for example a project in the French Community (see 3.1.c). About one sixth of the callers to the specialised telephone help-lines are women. Questions concerned cannabis in 40% of the cases but questions on cocaine seem to increase (see 3.1.c).

In recreational settings, mainly young people are targeted. Activities are available in the whole country. Partnerships with sports organisations on prevention activities start developing. More companies seem to be aware of drugs and alcohol problems at work places and want to develop an alcohol and drug policy. One prevention project "Bubbels and Babbels" in the Flemish Community is specifically addressed to (ex)-drug dependent parents.

3.1. UNIVERSAL PREVENTION

3.1.a School

Prevention activities among youngsters in schools are identified in the Federal Drug Policy Note as essential. This document stresses also the importance to continue to develop the prevention in this area. It is also recommended to organise a coordination of these activities as actors are at different levels and are numerous.

For the three Communities, the strategies are based on the following elements:

- long term perspective,
- global integrated approach,
- data collection (Ginger data base for the Flemish Community[10]),
- adult "multiplicator",

[10] Due to the growing number of prevention workers in the Flemish Community of Belgium, the need for a general monitoring of prevention activities on a community base became clearer. Since 1996, Ginger was developed. Each year, more than 65 prevention workers export their registration data to VAD. The bundled data are analysed. Each year, a monitoring report based on the results is published by VAD. In 2003, 5568 activities were registered.

- same prevention strategies for all the substances.

Within the French Community, there is no official co-ordination structure (however, co-ordination exists at local level). In the Flemish and German speaking Community, VAD and ASL work respectively as official co-ordination structures.

Faced with the use of legal and illegal drugs, more and more schools take an interest in the idea of a drug policy at schools. This school drug policy should help schools to face drug related problems and creates a framework for preventive actions and co-operation with external organisations.

In the French Community, circulars[11] are set up to encourage schools to implement prevention projects.

In the Flemish Community, the "drug policy at schools" is a prevention concept based on three parts: 'plan', 'education', and 'intervention'. The plan indicates the limits of what is acceptable and describes the strategy the school could develop to handle drug use. Education focuses on information, attitudes and social skills as well as on the school climate.

The approach in kindergarten and primary schools is integrated within the framework of health education and health promotion, in which life skills training and a supporting class- and school- environment are the most important elements.

Secondary education is based on the same framework, but is also characterized by more drug specific activities and teaching packages. To motivate and facilitate healthy behaviour, repetition is necessary.

In the part 'intervention', attention is given to the creation of networks around the school - including school, parents, school health service, prevention workers, social workers - and to the training of teachers in early intervention methods and referral.

A drug policy at school should be set up by all partners involved in the school setting: students, teachers, principal, other school personnel, parents (associations), school health service, etc.

Training is offered to all these parties to support them in dealing with the different aspects of a drug policy launched at school.

Involving students (and parents) in a drug policy at school is not very easy. In the Flemish Community, a questionnaire was developed to collect information on pupils' attitudes towards drugs, their actual drug use and their opinions about the drug policy of the school. The results may stimulate the communication between teachers, pupils, parents etc.

The results confirmed the importance of the involvement of all the partners (school health service, prevention workers, parents,...).

Overall, it is very important to pay continuous attention to the policy, to keep it as a continuous process, without breaking the dialogue among the different partners. Also important is to evaluate the prevention projects on a regular basis.

➢ Models of interventions

In the French Community, interventions in schools are managed by specialised associations or by internal services of the schools. The specialised associations offer two main training types: adult "multiplicator" training and training to the youngsters (for more detailed info see Standard Table 19, 2003).

[11] http://www.agers.cfwb.be/org/circulaires/assuetudes.pdf

As mentioned before, the programmes are integrated within the framework of health promotion and are not only limited to drugs prevention. An initiative of the Red Cross sensitises directors of schools to this problem.

There are two models of interventions in schools in the Flemish Community:

1. School advisory services give free and multidisciplinary support to students, parents teachers and schools. These services are active in four domains: preventive healthcare (health promotion of which drug prevention is one aspect), learning and studying, study career and psychological & social functioning. Advisory services negotiate policy agreements with schools to determine the responsibilities of both schools and advisory services in these four domains.
2. Specialised health organisations offer a broad range of interventions from training, education & support (for pupils, teachers and parents) to ready-made didactical packages and educational projects. These packages and projects are often grounded in different prevention models.

In the German speaking Community, on voluntary basis, preventive activities are carried out in schools with the collaboration of the local police or of the ASL, as for example with a smoke-free week etc…

Prevention programmes are listed in the standard table19 (standard tables 2003).

- **Evaluation studies and results**

French Community

All health promotion projects funded by the French Community must have an evaluation built in the project. In addition, the French Community is funding two departments in universities (Promes in ULB and Ceres in ULG) to provide technical support and to advise the promoters of the projects.

However, most evaluations are process evaluation and internal evaluations. Funding for impact evaluation is most limited.

Flemish Community

In 2003, monitoring data from the Ginger program show that about a third of all prevention activities took place in the educational sector (Rosiers 2004). It is by far the most reached sector. Two third of the activities in the educational sector were organised in **secondary schools**. The general curriculum (ASO) as well as technical (TSO) and professional (BSO) study branches are the most reached. The smaller branches are less reached, but when considering their proportional impact on the student population, the only conclusion is that they were never underrepresented during recent years. Even more, the smaller branches are in 2003 even more represented than in previous years. Prevention activities consist mostly in training students and teachers, and consultation with teachers and the school board.

Elementary schools are the second best reached, with participation in one out of six activities. Prevention lessons in MEGA, a DARE-based prevention program for pupils in 5th and 6th year (age: 11 - 12 years), are manifestly present.

Higher education is better reached than in 2002, which is a positive evolution considering that this is a potentially important branch for prevention activities:

- it hosts a large group of students (almost 170.000),
- the varied study curriculum and the multidisciplinary team of lecturers are interesting conditions for prevention,
- social services in most institutions are important partners in prevention,
- a lot of study programs host future intermediaries,
- the student population is characterized by specific risks in substance use, such as binge drinking and the use of stimulating medication during the exams.

Parents associations still are rarely targeted by prevention activities, even though they know a continuous increase of their share. Over the last five years, prevention activities in the educational sector in cooperation with parent associations rose from 0,6% to 3,2%.

German Community

The ASL euro-regional survey has showed that prevention activities had an impact on the prevalence of lifetime drug use. This prevalence was lower in schools where prevention activities have been organised. The same study showed that a serious alcohol problem exists among young people of the area. Therefore, the government of the German-speaking Region arranged a new project called “0/000 under 16 years”!

3.1.b Family

Prevention interventions are not restricted to parents using drugs and/or children. It is open to all parents with a broad objective to develop “life skills”.

French Community

Besides this, various types of treatment programmes include the issue “drug addicted parents” as part of their programme. These programmes want to provide assistance to drug addicted mothers, and improve the relationships mother-child as well as the living conditions for the children (“Kangourou project”).

In 2003, modules of training on "Dependence and parenthood" continued to be organized targeting the personnel of the pre and postnatal consultations of the ONE (medico-social workers: nurses, welfare officers). These modules were organized by the therapeutic Community Trempoline (Kangourou project) in Brussels and in the provinces of the Walloon Brabant and Hainaut.

Flemish Community

'Hole in the fence[12]' is a prevention programme aimed at children in early childhood. Pre-school children listen to a story about the adventures of a group of vegetables. Throughout the story the children learn about the importance of life skills. Teachers or parents can tell the story and the word 'drug' is not mentioned in the story.

‘Lindestraat 14’ is a manual for trainings sessions about alcohol and illegal drugs. The concept is set up for parents with experimenting children. The shooting script for the

[12] Het gat in de haag', De Sleutel.

training was updated in 2002. Especially the figures, legislation, and product information were adapted.

Drugs etc is a concept on product information that was developed in 2003. It is a set consisting of a brochure, fact sheets, folders and didactical materials. The set also holds a cd-rom with texts and pictures of legal and illegal substances. It is an instrument to inform parents, teachers, youth workers, … about the different types of products and to enlarge their expertise and communication skills on drug use and gambling.

A few years ago VAD started a working group 'consult' regrouping healthcare and prevention workers in the field of alcohol and drugs (De Bock 2004). This group developed a work map with guidelines for counsellors of consult groups for parents with drug using children. In 2003, they prepared a training for social workers and prevention workers on 'how to give consult to parents with drug using children'. They also made an inventory of the 24 existing consult and self-help groups in the Flemish community for parents with children using drugs.

Few initiatives for children of alcoholics also exist. One of them is 'KOAP', more information on the project is available in 3.2.c.

German-speaking Community

For several years the ASL offers education-trainings for interested parents. In this project the parents are used to multiply the training's contents by wide spreading it on their part. The ASL cares for several groups of people who bring up their children alone and it arranges activities and holiday-trips with these groups. A self-help group for parents of addicted adults or teenagers was created in 2002.

3.1.c Community

French Community

For the first time in 2003, a specialized centre (Zephyr), Bipass service, the schools and the cultural and psychosocial sector of Sambreville (youth movements, directions of schools, teachers, pupils, PMS centres, etc), launched a project "Souffle la vie" in Auvelais (Province of Namur). This project aimed at giving opportunities to teenagers and to young adults to create a humanistic project as an alternative to drugs consumption. During three months the participants work together, with the main goal to organise a thematic procession in the streets of the city centre. Participants have to consider "The community of life", "the communication with others", "to be creative". Although launched at the initiative of a specialised centre, this project wants to be addressed to the largest possible audience so that each one can be recognized there.

Flemish Community

The concept of a global alcohol and drug policy for local communities was developed during the European Drug Prevention Week '98. At that time, the project 'A local alcohol and drug policy: Join in!' was launched. With this project, all local key persons (Youth leaders, supervisors in the workplace, owners of hotels and catering business,…) join in a local alcohol and drug policy and they get supported in this. Anybody can play a part in stimulating discussions about alcohol and drug problems, in trying to prevent them, in

assisting in their treatment. Publications were developed for the facilitators and partners in a local alcohol and drug policy and for other interested field workers.

To keep the concept of a local alcohol and drug policy alive, the exercise book 'Evaluation. A theme in the spotlight' was added in 2003 to the publications. Evaluation was set in a broader prevention perspective. Basic topics are: starting points of prevention, the importance of evaluation, evaluation in the context of local prevention work, evaluation methods and instruments and a practical application of 'Ginger' (Flemish monitoring system for prevention activities).

Also in 2003 the sector brochures 'education', 'work', and 'police' have been updated.

Telephone help-lines

"Infor-Drogues" and "Druglijn" are respectively the drug help-lines for the French and Flemish Communities (Infor-Drogues 2003, Druglijn 2003).

Results indicate that females constitute the larger part of callers.

Cannabis is the product in both communities for which questions are the most asked.

As mentioned in earlier reports, the lack of clearness and the confusion created by the new measures concerning the cannabis legislation probably explain the high rate of calls about this substance over the last years, as being suggested in the study published by Gelders and Van Mierlo (2004). Still, with the political debate and media attention on the topic of cannabis legislation dropping, the Druglijn gradually noticed a decrease in the number of calls. Another important trend in the calls of the Druglijn in 2003 was the increase in calls on cocaine. In association with this, Druglijn also noticed a large increase in calls concerning legal information.

The calls received do not necessarly come from substance users (a majority of callers are non-users). The figures presented correspond to the substances for which questions were raised.

In 2003, the cannabis remains, by far, the first source of contact with Infor-Drogues. Questions on cocaine increase in an important way, thus confirming a tendency already observed now for 6 years. One notes also the increase in legal drugs like psychoactive medicines. There is on the other hand a significant fall of the questions on XTC and amphetamines.

Table 13 : Frequency of substances in related calls (%), Infor-Drogues, Druglijn 2002-2003

	Infor-Drogues		**Druglijn**	
	2002	**2003**	**2002**	**2003**
Number of calls	5149	5579	6527	5779
Males (%)	40	35.6	37	39
Females (%)	60	64.4	63	61
Involved substances in calls				
Cannabis	38,3	40.4	42	40.9
Cocaine	12,6	15.7	11.3	14.2
XTC (mdma)	7,4	5.6	10.7	8.0
Heroin	8,7	8.3	6.2	6.1
Alcohol	10	10.0	18.4	18.6
Psychoactive medicines	6,8	7.3	7.7	7.2
Methadone	4,6	3.9	1.4	1.7
LSD	2,2	1.1	0.9	1.1
Amphetamine	3,1	2.4	11.5	11.0

Through these calls at **Infor-Drogues**, 9570 demands were registered (2002: 7299; +31%) related to: information 34 %; prevention activity 3 %; advice 21 %; listening 5 %; help need 30 %; counselling service 4 %; no explicit demand 4 %.

Callers consist of: 22 % users themselves, 44 % relatives of users (81 % are members of the family), 11 % professionals, 8 % students, 12 % "other" persons and 3 % unknown.

Druglijn received 8743 calls in total. Among them, 2640 were outside the opening hours (mon-fri 15-21h and sat 15-21h); 324 were hoax calls, leaving 5779 effective calls (compared to 6527 in 2001; being –11%).

About one in four callers (23%) are users and ex-users; 31% are parents; 19 % family members, partners and friends; 20% intermediaries; 7% are simply "interested" persons.

Six calls out of ten concerns information on specific substances: mostly about effects and risks, blood- and urine testing, legal information, indications of drug use and withdrawal symptoms.

One call out of two was related to prevention or treatment questions. Most referrals made by Druglijn are towards ambulatory settings.

In eight calls out of ten some kind of emotional or relational problems were treated (mostly child-parent-relations, problems with own use, partner-relations).

The following table shows the repartition of callers by class age. It is noted with caution (because of the high percentage of unknown data), that there is a difference between the two help lines according to the distribution by age categories.

Table 14 : Frequency by age of callers (%), Infor-Drogues, Druglijn 2003

Class age	Infor-Drogues	Druglijn*
Under 18	3.2	7.5
18-25	10.7	20.4
26-35	16.0	19.5
36-50	33.2	36.3
50 and older	11.5	16.3
Unknown	25.4	0*

* Since this year the age is not asked to every caller (only 1 in 3 callers is asked). So the results are these of the sample group. But these results are representative for all callers. This explains why the unknown = 0.

In the German speaking part of the country, a special drugs telephone help-line, such as in the Flemish and French Communities, does not exist.

17140 calls were registered by the general telephone help-line in 2003. Only 3% concerned drugs.

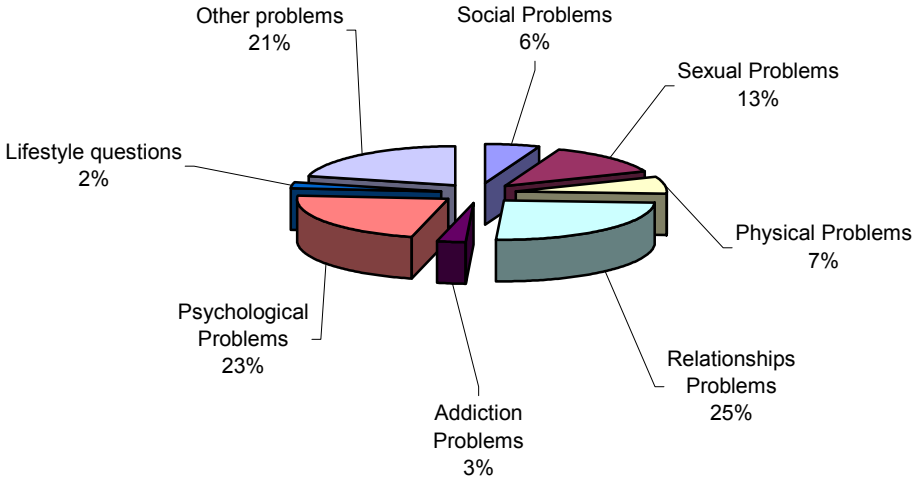

Figure 5 : *Main topics registered by the telephone help-line; German speaking Community, 2003 (Telefon Hilfe 2004).*

3.2. SELECTIVE/ INDICATED PREVENTION

3.2.a Recreational settings

In the French Community, activities are carried out in outdoor events, festivals, clubs,…. Information, brochures on specific substances are distributed, targeting young drug users. In large events, activities include water distribution, bad trips management and needles exchange.

About one out of ten prevention activities in the Flemish community take place in recreational settings (Rosiers 2004). Youth associations (youth services centres, youth clubs, scouting…) are the best-reached branches, followed by prevention activities with youngsters in a non-institutional context (on the streets and squares, in bars and dancings, at music festivals…). There are also several prevention activities in sports clubs.

Prevention activities in this sector mostly consist of consultance with professional intermediaries. Training and education activities, mostly concerning product information and discussions on attitudes towards alcohol and drugs, are also frequently organized towards young people as well as towards professional intermediaries in the recreational settings.

Sports

The VAD continued in 2003 two parallel projects for the sports sector in co-operation with the Belgian Football Association and the Flemish Sports Federation. In 2003, 10 information sessions (KBVB and SPORTAC) have been carried out. The target group are coaches and policymakers. The aims are to explain the role of sports and sport clubs in prevention and reflect on the issue of implementing a drug prevention policy in the sport club.

The project with the Belgian Football Association has been finished in the spring of 2003. VAD wrote an evaluation report and based on the results VAD and the Belgian Football

association decided to continue their collaboration. A first concrete prevention initiative is a training session for security officers of clubs who are playing in the first and second soccer league. It is planned for the beginning of 2004.
The project in co-operation with the Flemish Sports Federation will be continued in 2004.

Since 2003, the ASL organises pedagogy classes for addiction-endangered adolescents with another organisation from Luxembourg. About 8 youngsters coming from the DG took part in this kind of adventure pedagogy class. Sports activities, karaoke and theatres were components of the programme.

Partywise

VAD-de DrugLijn worked out a new global prevention concept for nightlife called Partywise. Partywise focuses on the quality of going out in a realistic way, meanwhile realising that drugs are part of nightlife. Partywise does not aim to deny nor to promote the use of illegal drugs in night life but simply believes that not taking any drugs at all is the safest option. Partywise aims to enhance party people' sense of responsibility and to make them really change their attitudes. For this reason, Partywise has worked out initiatives on two levels. On campaign level, Partywise focuses on six topics: overheating, importance of the peer group, first aid, combinations of recreational drugs, drinking water and the promotion of partying. In co-operation with media partners, advertising in youth and music magazines, sampling on location, posters, flyers and video clips they want to make the party people susceptible to the topic. On Informational level, Partywise worked out a website (www.partywise.be) which provides objective information on going out 'wisely' in a playful way. Besides the six main topics, six subcategories can be found: safe sex, precaution, traffic, healthy food, law and party tourism. No going around the bush, but straightforward information in a fun way on this website. Partywise is also meant for professionals, because party people have the right to safe and healthy party conditions and because they are the best partners to make drug prevention work. That is why Partywise permanently wants to inform on drugs and wants to draw up guidelines to integrate prevention initiatives in the organization. On Informational and educational level professionals from the prevention, youth and party sector receive direct mail to get to know Partywise. A first formation initiative was 'First Aid in case of Drug Incidents' (FADI). VAD-de DrugLijn organized a first pilot training in 'De Vooruit' in Gent. We would also like to get the sector more involved by means of a quarterly electronic newsletter, informing on the Early Warning System (EWS) and going out, news from the media and an overview of prevention initiatives in nightlife. On a organizational level, Partywise wants to create a safe and healthy environment to go out (e.g. overcrowding, air conditioning en free water supply, measures to lower the risks in and around the location (e.g. prevention messages before and during the going out, FADI and road safety), preventive control and supervision (e.g. door policy, dealing with drugs and communication of preventive controls) and a proper alcohol and drug policy.

3.2.b At-risk groups

Drugs at the workplace: social economy

A recent research revealed that the total social burden of harmful alcohol consumption at the workplace in Belgium is estimated on 2,2 billion euros which is 1/3 of the social cost in the Belgian society (Pacolet et al., 2003). Other research study, the first of its kind in Corporate Belgium, shows that companies are very poorly aware and tend to

underestimate the size of alcohol and drug problems at the workplace (Tecco & Annemans, 2003):

- 92% of Companies have no A&D programmes even though 70% of companies consider firing an employee as an appropriate consequence of being 'drunk at work'
- 11% of companies have been carrying out employee tests for alcohol - only 3% do likewise for illicit drugs.
- In contrast the perceived abuse is above the average in those companies that adopt a permissive attitude to alcohol in the workplace, where there are large numbers of operational/front-line staff and where there are education programmes in place.

The study suggests changes of attitude, changes in company cultures, and change to a more proactive policy approach in areas such as prevention, pre-emption and positive intervention are now a 'sine qua non' for corporate survival (Tecco & Annemans, 2003).

In Flanders figures concerning the use and the problematic use of alcohol and illicit drugs in what is called the 'sociale economy' do not exist. In 2003, an increasing interest in this type of organisation is noticed for the implementation of an alcohol and drug policy. These organisations have to deal with specific 'groups at risk' especially in terms of low education and unemployment. Tailored programs and specialized advice is highly recommended. VAD and its partners in the field support these initiatives.

In 2003 collaborators of the Flemish alcohol and drug field asked more attention for at risk groups and especially those people who are not easy to reach trough prevention work: e.g. foreigners, newcomers and asylum seekers, underprivileged, less verbal youngsters.

In 2003 VIBOSO (Flemish institute for promotion and support of community structure) organised training for community workers. Central topic was to trigger the debate on the use and misuse of alcohol and illegal drugs.

In Gent there is an organisation 'De Eenmaking' that concentrates on migrants.

They do drug prevention in prisons, counselling, trainings and they ask attention for a diversity policy in institutions.

3.2.c At-risk families

There are only a few initiatives for children of alcoholics in Belgium and also in Europe. Although in the literature and research you find that children of alcoholics have more risks to develop mental and physical problems. Children of alcoholics are two to four times more likely than other children to become addicted to alcohol themselves so it is important that health care workers also have attention for children of alcoholics.

In 2001 "Broeders Alexianen in Tienen" and the Catholic University of Leuven and VAD developed a prevention program that helps children of alcoholics to understand and to deal with the addiction of the client/parent and the consequences in the family. This program has 4 important issues:

- Psycho education
- Cognitive and social skill training
- Coping with stress and mixed feelings
- Look after yourself

In 2003 the VAD organise a training about this issue. The aim of this session is to sensitise health care workers and counselors to involve the children of the clients in the treatment.

Bubbels & Babbels is a prevention project funded by the Flemish government *(Stedenfonds*) in Antwerp (Belgium) focusing on the problems of children of (ex) drug dependent parents. Participation of the target group is on a voluntary base. The main issue of the project is to provide all the essential support to the parents regarding the welfare and the basic needs of the child. Bubbels & Babbels is trying to support the family by providing information and encourage a better collaboration between the various services and disciplines engaged in the family by case management.

Case management is the central activity of Bubbels & Babbels and can be seen as a method for managing the delivery of multiple services to target populations, i.e. drug dependent parents and their children. Main issues of this method are planning, coordinating, monitoring, and evaluating services to meet clients' needs and follow up to ensure that appropriate services are accessed. The case manager can't take any action without the permission of the parent(s).

Others:

In 2003, Bubbels & Babbels has followed up 22 families affected by drug abuse. In addition to the client work, Bubbels & Babbels is engaged in the ENCARE-Network, an European Network regarding children at risk. Bubbels & Babbels has created a website with relevant information about the target group and published four newsletters. The project had published a policy report about working with this target group. At last, Bubbels & Babbels has organized training sessions about drug abuse and pregnancy/parenthood and answered more than 50 questions of social workers about this theme.

CHAPTER 4.
Problem Drug use

The prevalence of problematic drug use was estimated in 1995 and 1997 by using the prevalence of HIV among problematic drug users and data related to drug users from the national HIV/AIDS register. In 2002, a feasibility study on the "capture-recapture" method was carried-out. The results underlined the difficulty to use this method in Belgium.

Information on the profile of clients are not extracted from the TDI (explanation is given in 4.2), but conclusions of specific studies are presented. One of the study deals with a group of patients under methadone treatment (see 4.2.c).

From non-treatment sources, the results of snowball surveys are given. They indicate that the percentage of current IDU's seems to decrease. The share of needles seems also to decline however the percentage remains very high (47% in 2003), the share of other injecting materials is even higher (54% in 2003). The users' profile of a needles exchange programme is a male, polydrug user although heroin remains the most used drug. A drug treatment was already initiated in the past or is currently going on. The share of injecting materials is more common with sex-partner than with others.

4.1. PREVALENCE AND INCIDENCE ESTIMATE

In 2003 no new Belgian studies on prevalences or incidence estimates have been published.

4.2. PROFILE OF CLIENTS IN TREATMENT

In Belgium, no national treatment reporting system exists. However, Treatment Demand Data are registered via more than ten different registration systems, often with already a long history.

Like the past two years, the National Focal Point decided not to present these data in the National report, since they cannot be pooled to provide national figures.

In November 2003 the report of the study "Implementing the 'Treatment Demand Indicator' in Belgium: registration of drug users in treatment" was published.

The objectives of this study were to:

- provide an overview of the different treatment reporting systems in Belgium and their characteristics;
- compare the Belgian situation related to drug treatment registration to the guidelines in the European TDI Protocol;
- be a starting point for further discussion with all partners involved, in order to continue the steps that have already been taken towards the search for valid and reliable national figures.

Meanwhile the discussions have resulted in the development of a Belgian version of the European TDI protocol. A draft version of this protocol was made and sent to different experts for comments. A few difficult issues are still being discussed, before finalising this Belgian TDI protocol.

When finalised, the Belgian protocol will be sent to the Inter-Ministerial Commission of Health, where a decision will be made according to the implementation and the outcome of this protocol.

4.2.a Charleroi

The results presented below concern a sample of drugs users in treatment in the region of Charleroi (Walloon Region).

Since 2000, it appears that the proportion of "ever injecting" heroin users seems to decrease (Depaepe 2002) and the number of heroin "current injectors" seems to remain stable. Current injecting is defined as injecting during the last month.

In 2002, 32% of the cocaine users have reported past injection as well as a current one (Depaepe, personal communication 2003).

Table 15 : Percentage of injecting users in Charleroi, 1995-2002 (sample size between brackets)

Drug	Ever injecting								Current injecting			
	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**1999**	**2000**	**2001**	**2002**
Heroin	53 (554)	55 (481)	50 (531)	56 (588)	53 (660)	41 (571)	44.4 (172)	40 (607)	17	20	35	28 (343)
Cocaine	37 (286)	31 (320)	37 (350)	43 (465)	41 (547)	34 (533)	33 (101)	32 (465)	11	21	33.3	32 (221)
Medicines	1.2 (163)	1.3 (233)	1.8 (226)	5.4 (93)	2.6 (230)	1.2 (453)	-	3.6 (166)	-	-	-	2.2 (89)

It has to be noticed that among the current injectors of cocaine, almost the same percentage consume it only by injecting (16.7%) as those both injecting and non injecting (14.9%).

4.2.b Study on personality profile

A study on the personality profile of substance users was carried out at the Brugmann Hospital in collaboration with the Liège University and the Research Centre on biodiversity from the Université Catholique de Louvain (Le Bon et al. 2004).

Three groups were compared. They were composed by:

- 42 heroin dependent patients under methadone maintenance programme, seeking detoxification under anaesthesia.
- 37 patients with alcohol dependence under detoxification cure.

- Finally, 83 control subjects' representative of the Belgian population with respect to sex, age, geographical area, educational level, having completed in 1997 a family survey.

Personality was measured by Cloninger's Temperament and Character Inventory (TCI). Temperament dimensions are:

Novelty seeking: behavioral activation, defined as tendency to respond actively to novel stimuli leading to the pursuit of rewards and escape from punishment.

Harm avoidance: behavioral inhibition, tendency to inhibitory response to signals of aversive stimuli leading to avoidance of punishment and non-reward.

Reward dependence: behavioural maintenance, tendency for a positive response to signals of reward to maintain or resist behavioural extinction.

Persistence: linked to reward dependence.

Character dimensions are: self-directedness, cooperativeness and self-transcendence.

Self-directedness is defined as the ability of someone to control, regulate his/her behaviour to fit with individually chosen values/goals.

Self-transcendence refers to identification with everything conceived as an essential and consequential part of a unified whole.

Results of the study have shown that:

- Novelty seeking was significantly higher in both substance users groups than in the control population. Heroin users were significantly more novelty seekers than alcoholics, especially on exploratory excitability.
- Harm avoidance was higher in both patients groups than in a general population. Alcoholics showed significantly more fear of uncertainty and a trend towards more anticipatory worry than heroin users.
- Self-directedness was lower in both groups than in the control group.
- Self-transcendence was significantly higher in both patients groups and showed drug users to be more distant from the controls than the alcoholics.
- Heroin users have more anti-social profile than alcoholics. Heroin users seek more sensations, are less apprehensive, more responsible and disciplined, are more self-transcendent than the alcoholics group. Heroin patients may show lower dopamine responsivity than alcoholics.

4.2.c Study on methadone delivery by pharmacists

A recent research was focused on the delivery of methadone in Belgian pharmacies (Ledoux 2004)[13]. This study contains a qualitative evaluation of the patients by the pharmacists and an epidemiological analysis of the methadone prescription. 408 respondents have participated; they were recruited in 167 different pharmacies. The data collection occurred between October 2002 and April 2003. The mean age of these patients under substitution treatment was 31.5 years and mostly male representatives (74.3%).

Heroin is currently used by 44.5% of the respondents (currently is defined by during the last three months). Among those, 18.1% uses heroin every day, 37% more than once a

[13]The full report is available at :http://www.belspo.be/belspo/home/publ/rappdrug1_fr.stm

week but not everyday, 30% more than once a month and finally 15% less than once a month. Among the current heroin users, 15.6% (26/167) use it by intravenous way.

Cocaine is reported to be currently used by 29%. One fourth of them use it by intravenous way. The intravenous users of cocaine use cocaine more frequently.

Only 10% have not used a drug for the last three months. A half used more than three substances.

Cannabis is reported to be currently used by 60.8%, **XTC** is reported to be currently used by 7.2% of the respondents.

The first use of **heroin** was situated at the age of 20.39.

The **intravenous drug use** starts approximately one year after the first drug experience.

Intravenous drug use was experienced at least once by 45% of the respondents.

The first use of methadone is recorded at 25.7 years and the mean age for the first treatment was found to be 22.7 years. The mean latency period for the first treatment is 2.5 ($p<.01$). The mean latency for the first use of methadone is calculated as 5.0 ($p<.001$).

Among those patients, 23% have not been in treatment before.

4.3. MAIN CHARACTERISTICS AND PATTERNS OF USE FROM NON-TREATMENT SOURCES

4.3.a Substance used

- **Snowball survey (French Community)**

Snowball surveys were carried out yearly since 1996 to investigate drug use, its pattern knowledge and attitudes (Hariga, personal communication). The users have been interviewed in different regions (Brussels, Charleroi, Liège, Namur, Verviers and Wavre) but these regions may vary each year.

Among others, the table 16 shows that almost one fourth of the sample reported the use of methadone during the last month.

Table 16 : Percentage of current drug use, French Community, 1999-2003, Snowball surveys.

	Current use*				
Drug	**1999**	**2000**	**2001**	**2002**	**2003**
N	928	574	1051	787	607
Heroin	81	69	69	68	65
Cocaine	69	64	62	57	62
Amphetamines	23	30	28	23	14
Methadone	28	36	27	27	24

*1993-2000: current means during the last 6 months;
since 2001 current means during the last month.

4.3.b Injecting use

➢ Snowball survey (French Community)

Due to large variations from one year to another, there is no clear pattern in the proportion of current (last 6 months) IDU among drug users (table 17). Clustering may also be a non-negligible source of bias.

In 2003, 60% of the sample have at least once injected a drug and 47% are current injectors. A declining trend in the proportion of IDUs sharing syringes is observed but the percentage remains high (47% in 2003). Sharing other injection material, such as a spoon, cotton, water, happens more frequently.

Table 17 : Percentage of lifetime and current IDUs and of sharing of syringes among current IDUs, Snowball surveys, French Community, 1993-2003

	1993-94	1994-95	1996	1997	1998	1999	2000	2001	2002	2003
Number of users	457	1123	1294	1395	1243	928	574	1051	787	607
Mean age			27	28	28	28	29	29.5	30	31
% males			66	69	67	70	70	65	67	66
Lifetime IDUs/drug users (%)			68	74	65	68	60	61	63	60
Current* IDUs/drug users (%)	69	57	53	56	43	52	40	46	46	47
Sharing/IDUs (%)	48	60	60	59	53	52	43	44	44	47
Sharing injecting materials /IDUs (%)	-	-	-	-	-	-	-	48	52	54

*1993-2000: current means during the last 6 months; since 2001 current means during the last month.

The next table indicates that over the last five years, the trends for injecting heroin and cocaine are stable. The trends of amphetamines and methadone seem to increase, more especially for methadone.

Table 18 : Percentage of current* IDUs by drug, Snowball surveys, French Community, 1999-2003.

Drug		1999	2000	2001	2002	2003
Heroin						
	N	755	397	416	535	395
	%	54	50	56	53	53
Cocaine						
	N	644	367	362	448	376
	%	58	46	55	54	52
Amphetamines						
	N	211	171	62	181	85
	%	19	19	21	21	27
Methadone						
	N	208	208	65	212	146
	%	12	16	25	20	27

*1993-2000: current means during the last 6 months; since 2001 current means during the last month.

- **Injecting and Polydrug use at a Festival (French Community)**

More details on the methodology, the context of data collection and results are given in 2.3.c.

The next table shows the results of the data gathered only in one particular festival covered since 1996.
In 2003, current drug users represent 55% of the sample and 3 % are IDUs users.

Table 19 : Percentage of IDUs, Rock festival, French Community, 1996-2003

	1996	1997	1998	1999	2000	2001	2002	2003
Number of interviews	123	167	157	686	479	454	172	160
Current drug use	87	96	88	88	83	87	78.5	55
IDUs / users	25	13	13	4	4	5	3	3

As already explained in the other section (2.3.c) several reasons could explain the lower percentage of IDUs observed since 1999.
First, the population has changed as the musical programme changed from a mainly rock oriented festival to a more “house” festival. Secondly, in 1999 and 2000, the survey was carried out in the whole festival, not only around the stands and not at the camping only.

The next table indicates that in 2003, 26% of the respondents has used one drug at least once in their life, while 52% reported a use of 3 drugs or more. The percentage of polydrug use has increased these last years.

Table 20 : Lifetime of polydrug use, Rock festival, French Community, 1996-2003

	1996	1997	1998	1999	2000	2001	2002	2003
Number interviews	12	167	157	686	435	454	172	160
Only 1 drug (%)	47	40	25	33	30	22	23	26
3 drugs or more (%)	32	45	36	36	40	35.5	51	52
Total : at least 1 illicit drug (%)	87	93	88	88	83	93	92	89

Information on these behaviours should be considered as an indication of the prevalence of these behaviours among some selected groups of drug users. Indeed, there is a selection bias and a clustering effect.

A survey on drug use is repeatedly conducted during a very popular Rock Festival (Hariga, personal communication).
The figure below shows the evolution of the use of different illegal substances at this festival. The observed variation in the substances used may be explained by several influencing factors such as the size of the audience, the presence/activity of police services, …

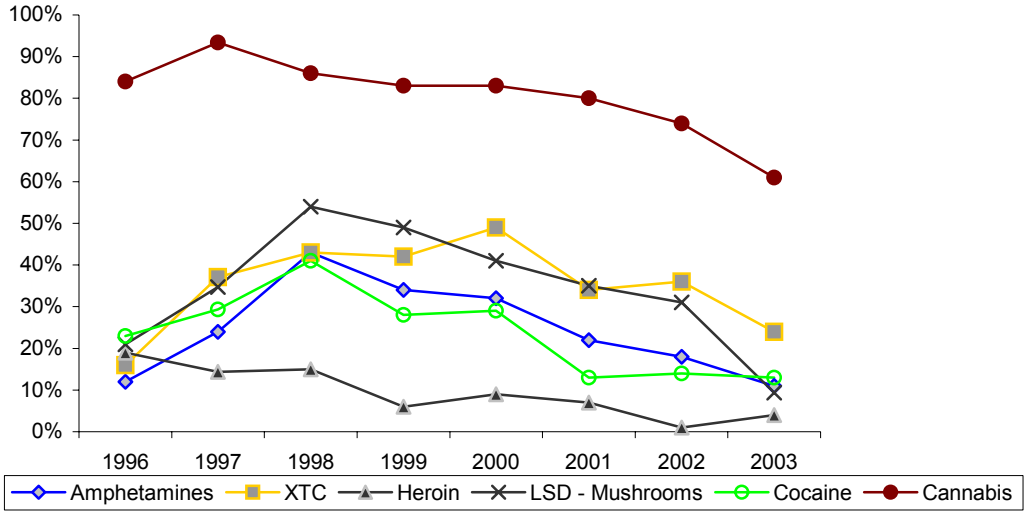

Figure 6 : *Evolution of the current drug use by substances, Festivals, French Community, 1996-2003.*

➢ Needles exchange programmes

In the Flemish Community, 155 IDU's using the needles exchange facilities were interviewed (Windelinckx 2004). The most important results are presented below.

1. Socio-demographically:
   - 78.6% are male,
   - 85% are over 25; amongst those 42% are older then 35;
   - 49% live alone, 7% are homeless, 7% live together with friends.

2. Drug use
   - Polydrug use is common; on the average they use 5 illegal substances;
   - Heroin is still the most injected drug in 76% of the cases, followed by cocaine (57%) and amphetamines (29.6%);
   - The combined use of heroin and cocaine is clearly prevalent in the Flemish cities, 26.4% are injecting these speedballs;
   - The exchange programme reaches more speed and/or cocaine users than last year;

3. Risk behaviour
   - The majority (62.6%) of the IDUs interviewed didn't share injection materials in the last month;
   - Sharing occurs more easily with sex partners than with strangers or friends;
   - Frontloading and back loading are not common;
   - 47% of the IDU's share the spoon; in a cross table with cleaning the spoon with the alcohol pads we notice that the IDU's who never share their spoon are mostly cleaning their spoon (70%), the IDU's with high risk behaviour,

who frequently share their spoon are not likely to clean their spoon (86% doesn't always clean the spoon).
- 63% never share their filter;
- 35% share water;
- 14% use syringes that the get from a container, that other IDU's use to throw away their syringes;
- 31% still use their syringes more than once.

4. Evaluation syringe exchanges
   - Syringe exchanges, pharmacists and drug services are most commonly used to get syringes;
   - 8% are even getting their syringes from their dealer;
   - 31% also get syringes for friends, 26% for their sex partners;
   - syringes that are not brought back to the exchange programme or drug services are mostly discarded by using a plastic bottle, breaking the needle or flushing it down the toilet or sewer. 1 person said he or she is throwing them on the street;
   - most of the interviewed IDU's got their information about the exchange from drug services (68%), 5% from media. In comparison to the last year less IDU's got the information from street corner work (outreach) or from user association;
   - 87.4% had no problem to buy syringes from pharmacists;
   - 52% prefers day time opening hours;
   - Monday, Friday, Saturday and Sunday are the preferred opening days.

5. Health
   - 66% had been tested for HIV in the previous year, 0.8% tested positive;
   - 70% had been tested for HBV in the previous year;
   - 72% had been tested for HCV in the previous year;
   - 67.5% had been tested for TBC in the previous year, 1.8% tested positive;
   - 30% of the IDU's interview did use syringes in prison;
   - most of the interviewed IDU's already had drug treatment in the past, mostly in residential institution;
   - 63% were still in a drug treatment while contacting the syringe exchange, 68% followed a methadone programme;

6. Free-base cocaine (interview only in Antwerp)
   - 86 IDU's were interviewed;
   - 55 (67%) are using freebase-cocaine;
   - most of the users clean their cocaine with ammoniac;
   - 75% of the interviewed IDU's are both injecting cocaine and using freebase cocaine.

In the French Community, the syringe exchange programme set up in Charleroi, in September 2001, is composed by mobile and fixed settings. The programme was evaluated after one year (see BNR 2003, pp.37-38) and a second evaluation was carried out from September 2002 to August 2003. 4993 contacts sheets were collected through the street and the fixed exchange setting and analysed (Hariga et al. 2003).

In total, 766 different users (70% more than in 2001-2002) attended the programme, including 70% within the fixed exchange location. Among them, 414 were for the first time users of a needles exchange programme (78% came for the first time at fixed exchange service). The average age of the users is 30 years. The women represent nearly a quarter of them.

These contacts allowed the distribution of almost 47000 syringes (increase of 50% compared to 2002-2003), including 31% in street. The exchange allowed the recovery of 38 573 used syringes. These figures correspond to a rate of recovery of 82%.

The water vials for injection and the cups with Stericup® cottons, are much less distributed (approximately half of the number of syringes).

This evaluation highlights the important increase in the activities of the exchange progamme.

CHAPTER 5.
Drug-related Treatment

The Federal Drug Policy Note (2001) specifies that the treatment offer should be based on a multidisciplinary approach adapted to the complex bio-psychosocial problem of addiction. It is also mentioned that a global and integrated offer should be created by means of regional networks and treatment circuit.

Minors should beneficiate of special care separated from adults ones. More attention is given to specific populations such as children of alcoholics, migrant populations, addicted mothers/parents with children, … More attention is also paid to the combination of psychiatric disorders and addictions. New pilot projects specialised in dual diagnosis were set up in 2002. A feasibility study on the evaluation of treatment services for patients with dual disorders was carried out in 2003. As a consequence of this study, a new study concerning the effectiveness of inpatient treatment programs for dually diagnosed patients was set up.

A newly adopted decree on substitution treatment introduced buprenorphine as a possible substitution substance in addition to methadone. A consensus on methadone was first published in 1994 and this substance is largely prescribed throughout the country.

5.1. TREATMENT SYTEMS

5.1.a Availability, financing and organisation

In Belgium a large diversity of treatment possibilities exists for people with drug problems. Not only in regard to the types of treatment centres, but also regarding the specific methods of treatment that are used. Furthermore, due to the organisation of the Belgian state structure with its different *policy levels* (the federal level, the communities and regions), not all types of treatment centres fall under the same legislation or the same financial regulations. Treatment centres might fall under different policy levels, but also under different *policy domains* (e.g. public health, internal affairs). Moreover, often several authorities are involved at the same time and consequently the division of competencies between them is not always clear.

In first instance a number of treatment centres specialised in (illegal) substance abuse treatment have gradually entered into a so-called 'revalidation agreement' with the National Institute for Invalidity and Health Insurance and consequently fall under the authority of the federal policy level. These centres are often referred to as the *'specialised substance abuse treatment centres with RIZIV/INAMI[14] convention'*. Most of these centres are exclusively oriented towards people with illegal drug problems. Some of them have added a clause in their agreement that allows them to take up a limited number of people with primary alcohol problems.

By the end of the year 2000, 28 centres (possibly with different units or treatment modules) were working within the framework of such a financial agreement with the RIZIV/INAMI. Within this group of treatment centres a distinction has to be made between four different types of treatment centres: long-term residential programmes (the

[14] The *"Rijksdienst voor Invaliditeit en Ziekteverzekering"* (RIZIV) and *"Institut National d' Assurance Médicale et Invalidité"* (INAMI) are the respective Dutch and French terms for the National Institute for Invalidity and Health Insurance in Belgium.

therapeutic communities); the residential crisis intervention centres; the ambulatory centres and the medical–social reception centres. In 2000, 14 long-term residential treatment centres, 8 crisis intervention centres, 7 ambulatory centres and 8 medical–social reception centres had entered in an agreement with the RIZIV/INAMI (INAMI, 2001). This number of centres stayed stable until 1 April 2003, when a new medical-social reception centre entered in an agreement with the RIZIV/INAMI.

A second group of services where people with drug problems can turn to are the *psychiatric hospitals* and the *psychiatric wards in general hospitals*. These treatment centres are as such not exclusively oriented towards people with illegal drug problems; on the contrary, a variety of psychiatric problems are treated. On the other hand, due to the specific characteristics of their client population, it is possible that certain psychiatric hospitals or psychiatric wards in general hospitals have decided to create a specialized substance abuse unit. Naturally, all of these treatment centres follow the same general regulations as other hospitals and are therefore mostly subject to federal legislation. The policy level of the communities has however certain competencies on the matter (e.g. quality assurance).

A third group of treatment centres that plays a significant role in the treatment of substance abuse problems are the *Centres for Mental Health Care (CHMC)*. As well as the psychiatric hospitals and the psychiatric wards in general hospitals, these centres treat a large number of psychological or psychiatric problems. Certain Centres for Mental Health Care have however developed a certain specialisation in the treatment of drug problems. According to the principles of the Belgian state structure, where the communities are responsible for certain attributed person–related matters, the Centre for Mental Health Care can be situated exclusively under the competences of this policy level. Due to historical and pragmatic reasons however, the responsibility for the CHMC in the French-speaking part of Belgium has been transferred to the Walloon Region instead of the French Community (COCOF for the Brussels Region).

Although these three groups of treatment centres can be considered to take up a large part of drug users starting treatment in Belgium, the group of other treatment facilities for persons with drug problems should not be ignored or underestimated. Other types of treatment or guidance than the ones mentioned above are: initiatives in the general health or social welfare sector, general practitioners, self-employed psychologists or psychiatrists, emergency wards in general hospitals, outreach work, non-subsidized initiatives, half way houses, sheltered living, temporary projects, self-help groups, etc.

Certain types of treatment centres run parallel in the different parts of Belgium since they are subsidized at the federal level. Other services are organised or represented in a different manner. General practitioners for example tend to play a larger role in substitution treatment in Brussels and the French Community than in the Flemish part of Belgium (EMCDDA, 2002).

When describing this diversity of treatment possibilities, the focus was on the different treatment centres, but one should be aware of the recent evolutions concerning care circuits and the used concepts. When looking at different treatment possibilities in the context of a care circuit, we rather look at the different modules that can be offered than to the distinction between treatment centres.

A care circuit forms the complete offer of care of a network, for a certain target group in a certain region. Such a circuit consists of units of care that offer certain modules. These modules represent the necessary care routes for that specific target group and offer the guarantee of continuity in care and care adapted to the specific needs of the client

(Nassen et al., 1999). In the French Community, instead of a care circuit, the concept of network has been introduced by a decree of the Walloon Region (details are given in 1.2.c).

In mental health care and youth assistance, as in the assistance for drug users, the organization of care by networks in the form of care circuits, becomes more and more of a frequent thought. Care adapted to the client, continuity of care, collaboration and more effective and efficient care are central concepts (Vanderplasschen et.al., 2001b). A specific intervention that is aimed at promoting coordinated and continuous care at individual level is case management.

In 2004 a dissertation concerning these last subjects was published. The dissertation "*Implementation and evaluation of case management for substance abusers with complex and multiple problems*" of Wouter Vanderplasschen focussed on the organisation of substance abuse treatment in a specific region (Ghent) and on an alternative approach to optimize the quality of treatment and service delivery for substance abusers. In particular the study aimed at:

- evaluating aspects of coordination and continuity of care in agencies that addressed this target population in this region;
- implementing and evaluating a model of case management for assisting substance abusers with multiple and complex problems;
- integrating this intervention in the network of available services (Vanderplasschen, 2004).

In November 2003, a research project, financed under the research programme "*Supporting actions to the federal policy document on drugs*", started concerning "Case management in the substance abuse treatment- and criminal justice system". The aim of this study is on one hand to come to a conceptualisation of case management, focusing on occasional differences between case managers operating within the criminal justice system and those connected to substance abuse treatment, and on the other hand to identify conditions for the implementation of case management within the criminal justice- and substance abuse treatment system. The results of this study will be available by the end of 2004.

In pursuit of the Federal Drug Policy Note, the Flemish steering group mental health care started in 2004 the project care coordination substance abuse (Overleg Vlaamse zorgcoördinatoren middelengebruik en de Vlaamse overlegplatforms GGZ 2004). Care coordinators have to facilitate consult with regard to a care circuit for people with substance related disorders. The available care offer and the extent of cooperation are different for each province, so a differentiated approach is necessary. To find some inspiration and to tune the care coordinators meet at a regular basis.

In the Walloon Region, in the area of Charleroi, a network of several institutions: (Diapason, Unisson, Trempoline and Coordination drogue), called "DUTC" was created (other networks exist in the Walloon Region). The aim of the DUTC is to create a work in network complementary to other existing networks in order to improve the work of assistance offered to the user (Trempoline 2003).

5.1.b Evaluation results, statistics, research, training and quality insurance

In 2003, for the first time in the French-speaking Community, on the initiative of the therapeutic Community "Trempoline" a training on "EuropASI[15]" was organised.
In the continuity of this training, the follow-up of patients was based on this tool, this allowing to evaluate the stay in the institution.

The service of prevention and formation "Re-Sources" (Trempoline) launched a cycle of 10 days training targeting institutions working with drug users, on the basis of " integrated system approach " (George De Leon, pH D). This training was organized in close cooperation with the therapeutic Community De Kiem and the department of orthopedagogy of the University of Ghent.
There are specific training and education programs organized by the VAD for the different aspects of treatment. One of the training is a two years programme for health workers, working in treatment centres.

In some institutions "evaluation" is conceived like a philosophy of work directed towards the patient, they permanently seek to improve the processes of work by implementing tools of analysis. Some of them work with external evaluators.

A new Decree of the Walloon Government (promulgated on January 22, 2004) specifies the list of information and the anonymous epidemiological data to be collected by the mental Health services and to be provided to the Administration of Walloon Region.
In the Walloon Region, 7 out of 56 mental Health services are identified as specialized in drug dependence among all the mental health services financed by the Region.
But this doesn't reflect the reality. Indeed, the Walloon League for the Mental health specifies that almost all the mental health services deal with drug dependent patients without being subsidised specifically for this mission (Ligue Wallonne pour la Santé mentale 2002).

Establishment of a "research platform substance abuse" by the VAD, which aims at bringing research and practice in the Flemish alcohol and drug field closer to each other.

A study at the initiative of the Centre of reference related to drug dependence and addiction, was carried out in the Walloon Brabant among professionals (from 2001 to 2003). The study aimed at evaluating the interest of the various professionals involved in the field of health and assistance to drug users (GP's, pharmacists, communes, social assistance and mental health institutions) on the implementation of a structured network.
In total, 474 interviews were carried out (Centre de référence relatif aux assuétudes et à la toxicomanie en Brabant Wallon 2003).

Difficulties and needs for the professionals
75% of the GP's and 65% of the pharmacists estimate that they should be more recognized like partners on the level of the assumption of responsibility and the prevention. 50% of the professionals of the mental health and 81% of the professionals of the social sector said to be badly equipped to face the follow-up of the people suffering from dependence. This figure goes up to 78% in mental health concerning the management of the crises. All the professionals show a great interest with regard to

[15] EuropASI = European Addiction Severity Index.

several possible initiatives such as interactive and interdisciplinary meetings, telephone permanence, supervisions, place of emergency reception, and trainings in the field.

Positioning compared to the installation of a network

According to the sector, between a half and 2/3 of the sample agree to be integrated in structured network related to drug-addiction issues. Those who refused invoked: a lack of time, lack of training, the problem of safety and labelling near the doctors and the pharmacists, the participation in other networks, and those which are not concerned by these issues.

5.2. DRUG FREE TREATMENT

5.2.a Inpatient treatments

Therapeutic Communities psychiatric units of hospitals and units of psychiatric hospitals (see 5.1.).

5.2.b Outpatient treatments

Most of the outpatients units are not drug free but it is difficult to generalize, as the type of treatment is adapted individually to the patient. Centres for mental health (CGG) are drug free outpatient treatment centres in Flanders.

5.3. MEDICALLY ASSISTED TREATMENT

5.3.a Withdrawal treatment

The goal of withdrawal therapy (detoxification) is to stop taking the addicting drug as quickly and safely as possible. Detoxification may involve gradually reducing the dose of the drug or temporarily substituting other substances that have less severe side effects. For some people it may be safe to undergo withdrawal therapy on an outpatient basis. Other people may require placement in a residential treatment centre or an addiction unit in a psychiatric hospital or general hospital. Withdrawal from different categories of drugs produces different side effects and requires different approaches.

5.3.b Substitution treatment

The legal basis of substitution treatments was enacted in August 2002. Since then, a Royal decree on the substitution treatment was adopted in 2004 (see 1.2.c). Methadone and buprenorphine are both mentioned in the text as substitution substances. Methadone is being prescribed throughout Belgium, through a consensus reached amongst partners concerned (1994 and updated in 2000). In the Flemish region, most methadone (maintenance) programmes are being provided by low threshold drug services. In smaller towns and rural areas, if existing at all, methadone is being prescribed by GPs under the

supervision of drug services. In certain urban areas the demand outweighs the availability of methadone (maintenance) programmes.

In the French Community, a broad range of services (low threshold services, GPs, outpatients specialised units, mental health facilities) offer an access to methadone. However, an important part of the substitution treatment, in the French speaking part of Belgium, is offered by GPs.

A substitution treatment aims to prescribe, administer, dispense to a drug addict patient drugs delivered as medicines, with the objective, within the frame of the treatment, to improve health, quality of life and if possible to attain abstinence (Law 22 August 2002).

Methadone treatment should be used in case of heroin or other opiates addiction. The patient should be at least 18 years old and dependent for more than one year.

The MSOC's, a few day centres, low threshold programmes and GPs offer methadone programs. The number of general practitioners who prescribe methadone is unknown. Beside methadone, burprenorphine is also used to a lower extent as substitution for heroin.

Since august 2003, buprenorphine is newly reimbursed by the social Security, however data on its prescription are not yet available.

It is recommended to start treatment with a methadone dosage of about 30mg/day and to check the effect on the patient. It is also mentioned not to prescribe take home dosages at least during the first 6 weeks. Generally speaking, substitution refers only to the use of methadone or buprenorphine.

It is stated that psychosocial counselling and assistance to patients are factors improving the results of methadone treatment. Substitution treatment should be part of a medical-psychological-social approach; this is stated to be an essential component to make substitution treatment work.

In 2002, several research projects, financed under the research programme "*Supporting actions to the federal policy document on drugs*", two were related to the evaluation of substitution treatments. Results were published end 2003[16].

- Action research on methadone provision through community pharmacists in Belgium.

This study, carried out by the Belgian Pharmaceutical Association, was patient-oriented, proposing to community pharmacists to evaluate patients buying prescribed methadone in their pharmacy.

In November 2003 a second phase of this study was started, to continue the evaluation of the patients, registered in the first phase of this study. The results of this second phase will be available by the end of 2004.

- Cure through substitute treatments in Belgium: development of a model for assessment of types of care and patients.

This study examined the different means for accessing to substitution treatment in non-residential institutions. The study started in 2002 and a follow-up of the project is currently ondergoing. The results of this project will be available by the end of 2004.

Another project financed within this framework is related to:

[16]Some of the final reports are available on the following website:
http://www.belspo.be/belspo/fedra/prog.asp?l=fr&COD=DR#docum

- Prognosis value from an integrative model of vulnerability based on a French and Dutch adaptation of ASAM criteria in the choice of treatment method for drug addicts.

The objectives of the study are to adapt an integrative model of vulnerability in the case of substance-dependent persons and to validate the model in order to highlight subsequently the links between diagnoses and therapeutic choices.

201 subjects were assessed with a mean duration of the interview of 114 (+/- 43) minutes. The PPC-2R algorithm generated a placement matching report for 167 patients (83%). One month outcomes showed that patients who received treatment in settings corresponding to a PPC-2R match or higher level of care (n=140) were rated as significantly better than patients (n=27) who were mismatched to a lower level of care than recommended. This study showed the applicability of the ASAM PPC-2R outside the US in 2 different languages and the usefulness of the system in matching patients to an optimal level of care.

5.3.c Other medically assisted treatment

- A new project, financed by the Belgian Science Policy, concerns the « Délivrance d'héroïne sous contrôle: étude de faisabilité et de suivi (DHCo) ». The aim of the study consists of the following parts:

- literature study concerning the experiences with controlled delivery of heroin in finished or still ongoing projects;
- to realize a quantitative analysis on the available data;
- to do a feasibility study with regard to the legal and administrative area;
- to develop different protocols with regard to the impact on the existing assistance, the criminological aspects and the economical aspects (cost-benefit).

Results of the study will be available in 2005.

- Rapid detoxification under anaesthesia (RODA).

From March 1999 till April 2003, patients were treated under anaesthesia in a hospital of Liège (Pinto et al. 2003). The sample was constituted by individuals older than 18 years, motivated for detoxification, included in a network of health care. 27 patients were selected for the treatment among 53 patients generally referred by GP's. Those patients were mainly addicted to Heroin with methadone (33.3%). The mean number of the attempts of detoxification is 2 times.

The results of the follow-up indicate that after:

- 6 months : 63% were abstinent,
- 12 months : 46% were abstinent,
- 18 months : 43% were still abstinent.

It may be concluded that results are promising and are in line with results of other studies, however evaluation studies are still necessary to ensure the efficacy of the method and to determine which factors increase the success.

- The influence of social Networks on retention in and Success after therapeutic Community Treatment (Soyez. 2004).

The study aims at understanding the family counselling activities in therapeutic communities (TC) to implement a brief intervention with social network members of TC residents in the beginning of the treatment. This is in order to improve treatment success.

The hypothesis is that involving significant others at this crucial moment in treatment, will contribute to success.

Four TC (long term residential settings) located in Dutch-speaking part of Belgium participated to the study.

Among 267 admissions from 1 May 2000 till 31 April 2002, 218 clients agreed to participate. Each of these institutions has a counselling service. Data were collected within the first month after admission by means of the EUROPASI, CMRS, GKS-II< and in-depth interview on social network construction and social support. Follow-up interviews were done between 12 and 18 months after clients had left treatment.

The results of the study have shown that the involvement of social networks during the treatment is important for retention.

It is also said that it is worthwhile to invest as much in intensive, though well-considered, network counselling in the beginning of the treatment.

It has been noticed that many TC already make efforts to involve network members into treatment and to provide clients and some of their network members family counselling but these efforts mainly happen between 6 months and 1 year after admission.

The intensity of family counselling should also be increased at the start of the integration period. It was also noticed that parents are the most frequently involved as network member in the social network intervention.

Analyses reported that network members of clients experiencing more social support, having more alcohol problems, reporting less family and social problems, were more likely to participate in and complete the social network intervention offered.

- A Belgian study on socio-economic disparities in psychiatric in-patient care was published in 2003 (Lorant et al. 2003). All psychiatric admissions are registered in a database called Minimum Psychiatric Summary (MPS) since 1996. A sample of 144 754 discharges were analysed for the period 97-98.

“Socio-economic status” (SES) was defined by a combination of educational status, occupational level and activity status.

Differences in psychiatric in-patient care were assessed for the three following domains: admission setting, treatment received and outcome of the stay.

“Less favourable” admission was indicated by: the mode of admission, hospital type, hospital performance in relation to the length of stay and the average severity of patients cared.

Patients with substance-related disorders (diagnosis on axis 1 DSM IV) represented 33.3% of all the inpatients considered by the study.

It was noticed that among those patients with substance abuse related disorders, a slight under-provision of withdrawal surveillance was observed for the lowest socio-economic status group (OR= 1.10).

Overall, the study has shown that psychiatric hospitalization is associated with socio-economic differences in terms of access to more favourable settings, adequate treatment and outcome. Indeed, for example, lower SES groups were less likely to be admitted in a general hospital or in a teaching hospital, in addition, compulsory admission was more likely the case. Lower SES achieved less improvement in their functioning and psychological symptoms. According to these findings, the whole delivery of psychiatric care as well as the distribution of resources should be examined. It could be also concluded that the promotion of equality of treatment in psychiatric in-patient care should be improved.

CHAPTER 6.
Health Correlates and Consequences

The National Institute of Statistics provides mortality data from which are extracted the drug related deaths; no other databases on drug-related deaths at national level exist, though these could be useful to validate the data gathered through the general mortality register.

Delays in data updates of the mortality register are due to the complexity of administrative procedures.

Data available on drug related death concern young people (people 20-34 years) and males mostly. A sudden rise appeared in 1993. Trends, over the period 1987-1997, vary slightly from one Region to another.

Figures available through the Belgian database of HIV and AIDS cases indicate a declining trend of HIV cases among IDU's.

If compared, prevalences of HCV are by far higher than those of HBV. In 2002, the prevalence rates for HBV vary from 9% to 21% according to the reporting method used.

Reported results on HCV (self-reported and biological tests) vary from 43% to 79%.

Although data on drug-related driving accidents are not available, some information on the substances used by drivers is available. In 2002, a "Road safety action plan" launched by the Federal Police pointed out the need to increase the number of controls focusing on drivers under influence of alcohol and drugs. It seems that among the drivers controlled by the police services and for whom a blood test was performed, around 58% had used cannabinoids, 17% amphetamines and almost 10% amphetamines with cannabinoids.

6.1. DRUG-RELATED DEATHS AND MORTALITY OF DRUG USERS

6.1.a Direct overdoses and indirect drug related deaths

No eligible registers were found to estimate direct overdoses and indirect drug-related deaths.

6.1.b Mortality and causes of deaths among drug users

The Belgian general mortality register contains data coded according to the ICD-9. Data on deaths that occurred in 1998 or later are coded according to the ICD-10, although these data are not yet available at national level (Jossels and Sartor 2004).

The EMCDDA's "Selection B" was used for case extraction from the general mortality register. This selection, from the EMCDDA's "DRD Standard", describes a drug-related death as follows:

- "when their underlying cause of death was drugs psychoses, drug dependence, nondependent drug abuse, accidental poisoning, suicide and self-inflicted poisoning, and poisoning with undetermined intent"; furthermore,
- "cases will be included when the death was due to a standard list of specific drugs: opiates, cocaine, amphetamines and derivatives, cannabis, and hallucinogens".

Using these criteria, 890 drug-related deaths were extracted from the general mortality register during the period 1987-1997.

Table 21 : Number of drug-related deaths, National Definition (Selection B), Belgium, 1987-1997, (Standard table 06, 2003).

	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
N° DRD	17	33	26	50	63	64	123	122	132	137	123

The number of drug-related deaths increases suddenly in 1993 with nearly twice as much cases as the year before. From 1993 onwards no remarkable change could be observed.

More men than women died of drug-related causes, with 651 men (73.1%) as opposed to 239 women (26.9%, all 11 years added together).

Table 22 : Percentage of drug-related deaths by gender, Belgium, 1987-1997 (n=890) (Standard table 06, 2003).

Year	Men	Women
1987	58.8	41.2
1988	54.5	45.5
1989	57.7	42.3
1990	76.0	24.0
1991	69.8	30.2
1992	78.1	21.9
1993	68.3	31.7
1994	75.4	24.6
1995	72.0	28.0
1996	78.8	21.2
1997	78.9	21.1

Most of the years, about 7 out of 10 drug-related deaths concerned men. Only during the period of 1987 through 1989 more than a third of the deaths were women. Note however that the total number of drug-related deaths in these three years is very low, which results in slight variations in absolute numbers but relatively high variations in percentages.

A distribution of the number of drug-related deaths by five-year age categories results in the following:

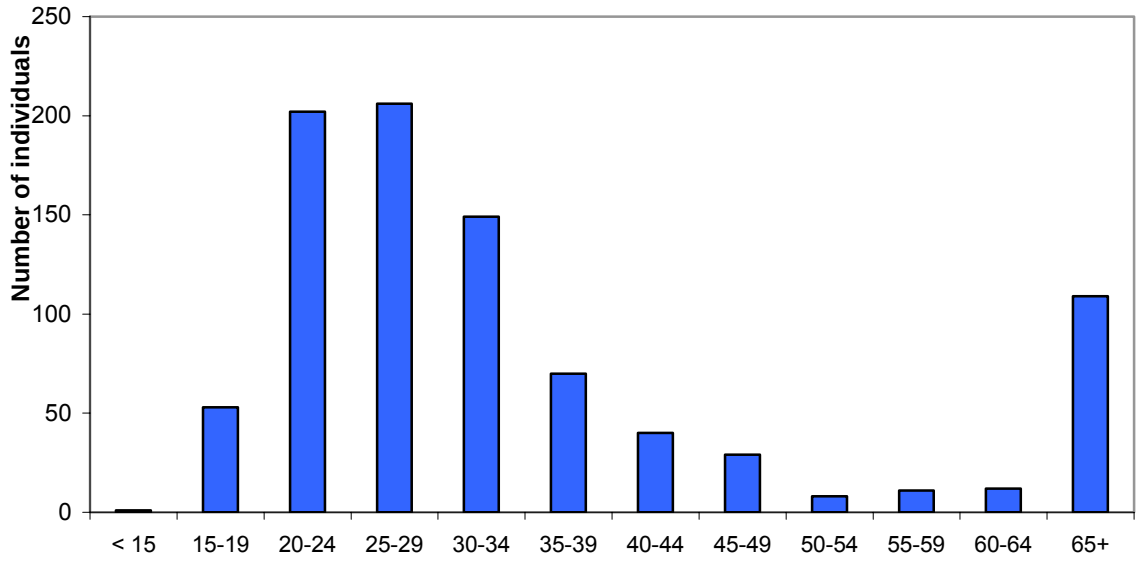

Figure 7 : *Number of drug-related deaths by age group, Belgium, 1987-1997 (n=890).*

Most drug-related deaths (62.5%) concern people aged between 20 and 34 years old (figure 7). Almost no persons (1 individual) below the age of 15 have been reported to have died due to drug-related causes; in 11 cases the deceased person has not yet reached the full age of 18 years old. Once past the age of 25-29 years old, drug-related mortality steadily decreases. For the period 1987-1997, the mean age at death is 35.5 years old while the mode is 23 years old; the median amounts to 29 years old.

Remarkable, however, is the high number of cases observed in the age group of people of 65 years or older. In the majority of these cases, the death was coded as “nondependent abuse of drugs – other, mixed or unspecified substance”.

The evolution in drug-related mortality is not the same throughout Belgium; differences can be observed when distributing the number of drug-related deaths by region[17] (figure 8).

[17] Please note that by “region”, the region of residence of the deceased person is meant.

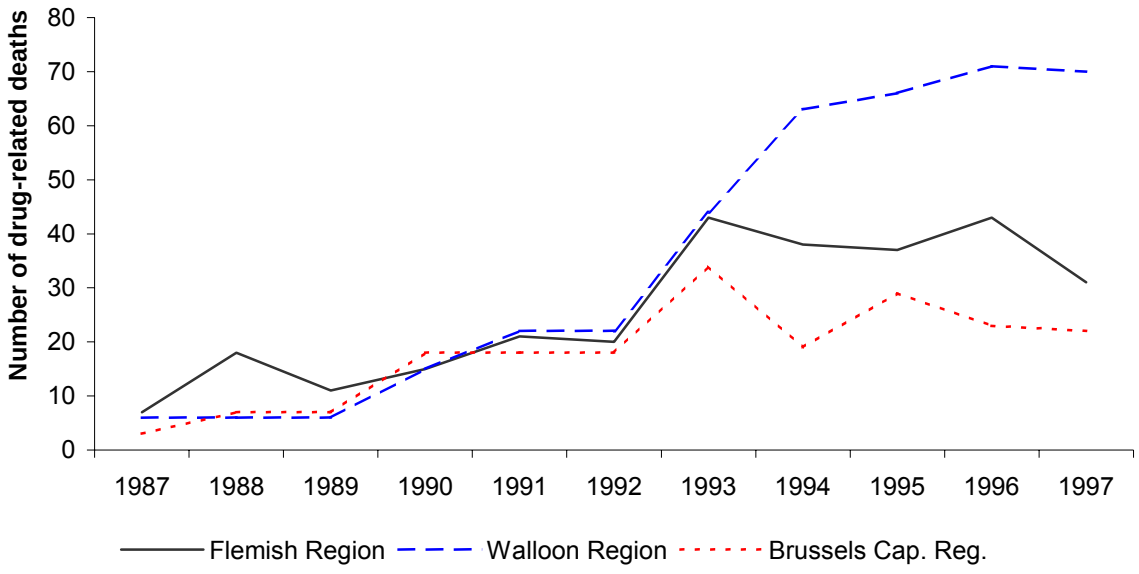

Figure 8 : *Number of drug-related deaths by region, 1987-1997 (n=873)*[18].

Until 1993 the number of drug-related deaths seems to be more or less the same among all three regions and the same trend can be observed. However, while the Flemish Region and the Brussels Capital Region seem to have reached their highest point in 1993, drug-related mortality keeps rising further in the Walloon Region.

From 1990 onwards, the number of deaths in the Walloon Region keeps growing, claiming a larger share of the total number of drug-related mortality in Belgium (30% of the drug-related deaths in 1990, rising to 56.9% in 1997).

[18] In 17 cases, the region of residence of the deceased person was unknown.

6.2. DRUG RELATED INFECTIOUS DISEASES

6.2.a HIV/AIDS

6.2.a.1 Injecting drug use among HIV/AIDS patients

In Belgium, diagnosed seropositive HIV persons and AIDS cases are registered in two integrated databases at the Scientific Institute of Public Health in Brussels[19].

From the beginning of the epidemic till December 2003, 15803 HIV infected patients have been registered. Among these, 3173 have reached the clinical stage of AIDS. The number of females newly diagnosed increased over the last years, reaching 45% in 2002. Between 1997 and 2002 an increase of new diagnosed cases of HIV infection was observed. In 2003, 1032 new cases of infections were registered (Sasse; Defraye 2004).

Information on the risk factor status is globally available for 60 % of the cases.

The proportion of all IDU's among HIV cases (cases of HIV with intravenous drug use as risk factor) was amounted to around 10% in 1985 and decreased to approximately 4% in 2003.

Infection via intravenous drug use was higher among young people, but it becomes comparable the last years to that observed among older people. Among infected people aged between 15 and 24 years, the number of new cases stating IDU was 3 cases in 2002 and 8 in 2003. Approximately one third of HIV new cases with IDU as risk factor are aged between 15-24 years old (Figure 9).

[19] Approximately 550,000 blood samples are yearly screened for HIV antibodies with the ELISA assay, excluding testing related to blood donations. Seven reference laboratories are recognised by the Ministry of Public Health to confirm the results of these positive ELISA tests. Since they are the only laboratories subsidised for this confirmation, their reporting on new positive HIV individuals gives the number of newly diagnosed seropositives in the country. Data on age, sex, nationality, residence, and possible route of transmission are collected through a standardised form sent by these laboratories to the physician of each new HIV patient. On the other hand, the newly diagnosed AIDS cases are notified in an independent way by clinicians on a standardised form. They are validated by a Commission of experts referring to the definition of the Centers for Diseases Control, adopted by the European Centre for the Epidemiological Surveillance of AIDS. A follow-up survey is conducted each year to collect data on last consultation and possible death of reported AIDS cases. Since a common code is used to record each case, whether HIV-positive or AIDS, it is possible to avoid multiple counting and also to link the two databases.

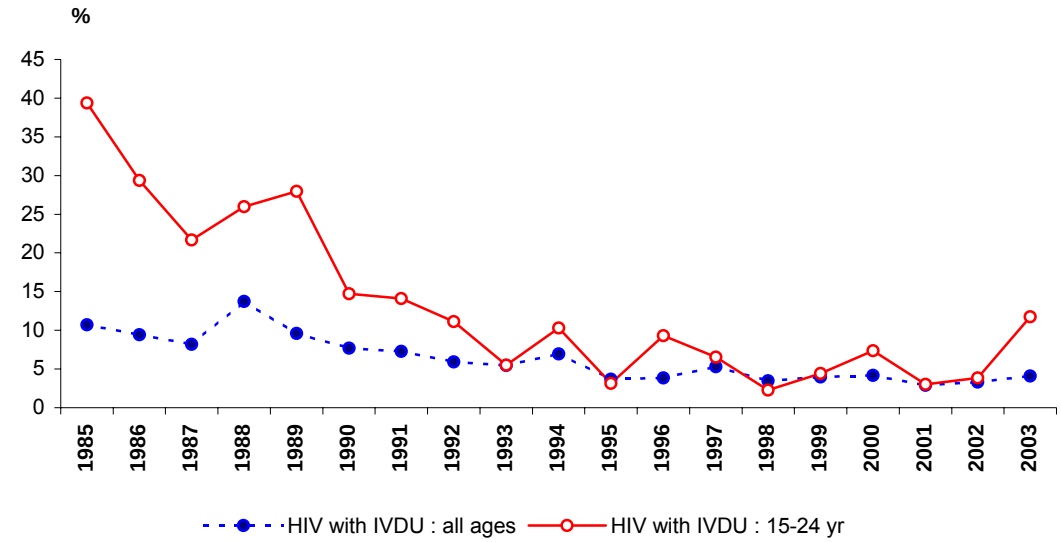

Figure 9 : *Percentage of IDUs among new HIV-cases from 1986 to 2003 in Belgium (Sasse and Defraye 2004).*

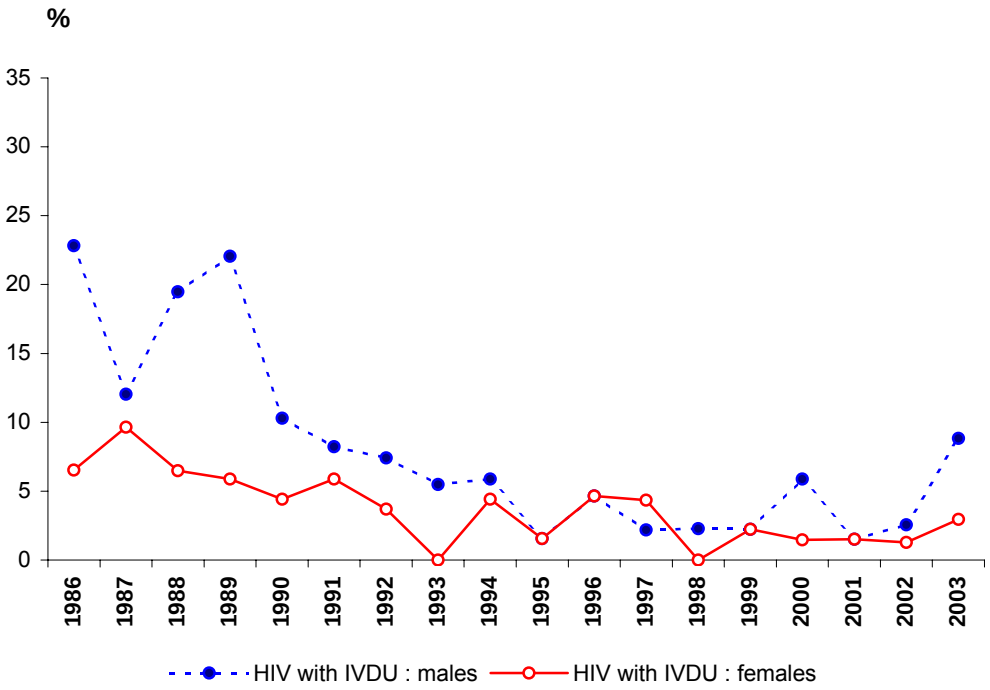

Figure 10 : *Percentage of IDUs among new –cases aged between 15-24 years from 1986 to 2003 in Belgium, according to sex (Sasse and Defraye 2004).*

Trends of IDU's among HIV new cases according to gender are quite similar since 1995 the trend of IDU among HIV. In 2003, on the 8 new cases: 2 were females and 6 were males.

6.2.a.2 HIV seropositivity among drug users

The results of the snowball survey[20] (already described in 4.3.a) showed that in 2003, 47% of the sample reported to be current injectors (injection during the last month).

Among these current injectors, 4% of 299 respondents declared to be HIV positive. (Hariga , Modus Vivendi, personal communication).

6.2.a.3 HIV seropositivity among treated patients

The next table gives information gathered by two different sources. For the French Community, the data on HIV are self-reported and collected through the CCAD/EUROTOX monitoring system. On the other hand, biological data on HIV are made available through "De Sleutel", a Flemish institution composed by several ambulatory and residential treatment centres. This biological testing is only performed for the clients seen by a doctor. A doctor follows all clients in substitution and / or other medication treatment. Criteria for seeing a doctor are not influenced by the type of drugs or by their modes of consumption.

The self-reported data indicate a declining trend since 1994 for HIV seropositivity among IDU's and the same trend is observed since 1997 in the data of De Sleutel (table 23).

Table 23 : Percentage of self-reported HIV-seropositivity among IDUs asking for treatment in centres of the French Community and De Sleutel, 1993-2002, Standard table 9, 2004

Year	1994	1995	1996	1997	1998	1999	2000	2001	2002
French Community									
Number of treatment demands from IDUs	607	550	666	620	505	697	412	579	761
Number of IDUs self-reported	270	255	314	294	255	217	128	267	180
% HIV + (self-reported)	7,4	3,1	1,3	2,7	2,7	2,3	3,1	3,4	-
De Sleutel (Flemish institution)									
Number of treatment demands from IDUs				236	75	352	303	241	306
Number of IDUs tested				120	56	186	161	118	62
% HIV+ (tested)				0,8	5,4	0,5	1,2	1,7	1,6

In the outpatient centre "Free Clinic" (medico-social centre) all attending patients are offered a blood screening on a regularly basis. In 2003, 565 individuals visited the centre, 408 (72,2 %) of them were male and 157 (27,8 %) were female. The age distribution in this population varied between 25 and 58 years old. The mean age was 35 years old. 78 % of the individuals reported to have used drugs by intravenous way at least once in their live.

In 2003, 16 patients were tested positive for HIV (table 24).

[20] In total, 607 drug users were interviewed.

Table 24 : Percentage of sero-prevalence of HIV in an outpatient centre, Antwerp, Standard table 9, 2004

IDU	2001	2002	2003
Number of IDUs	333	340	408
Number of IDUs tested	254	259	287
% HIV+ (tested)	5.9	6.2	5.6

6.2.a.4 HIV seropositivity among prisoners

In 2003, the study (fully described in 8.3) gives some results of HIV seropositivity among prisoners. A sample of 3691 medical files issued from 10 prisons was examined. It results that 252 prisoners/patients were tested, and 2% were found HIV positive. (Hariga et al. 2004). Results should be interpreted with caution as the prisoners are not systematically tested but were only tested when they were identified as being at risk.

6.2.b Hepatitis B and C

In Belgium, current hepatitis C prevalence in the general population is estimated to be around 1% (Beutels et al. 1997).

Injecting drug use seems to be the first cause of HCV contamination at this time (Delwaide et al. 1997). The other sources of transmission, such as transfusion of blood and its derivates, mother-child exchanges, sexual and family contamination and medical care are less frequent. No information is available in Belgium on transmission through sniffing of drugs.

6.2.b.1 HBV- and HCV seropositivity among treated patients

The sources of information used for HBV-HCV are the same as for HIV which are presented in the related section.

Although based on different methods, prevalence rates for HBV vary from 9% to 21 % in 2002.

The prevalence of self-reported HBV infection in surveyed lifetime IDUs registered in the monitoring system of the French community increases with age. The same trend is also observed in the results of the tested patients in “De Sleutel”.

Data on prevalence of HBsAg are available from “De Sleutel”: they show an increase from 0 % (0/116) in 1997 to 7.4 % in 1999 but a decrease to 4.9 % in 2002 (standard table 9, 2004). One should be cautious in interpreting these data because biological testing is performed only for the clients seeing a doctor and there are no guidelines with criteria specifying the patients to be tested.

Table 25 : Percentage of hepatitis B infected among IDUs asking for treatment, in centres of the French Community and De Sleutel, 1997-2002

HBV	1997	1998	1999	2000	2001	2002
French Community						
Number of treatment demands from IDUs	620	505	697	412	579	761
Number of IDUs (self-reported)	115	240	195	127	275	184
Number of hepatitis B + (self-reported)	27	57	39	20	38	17
Prevalence rate (%)						
All IDUs	**23**	**24**	**20**	**16**	**14**	**9**
Males	21	22	27	16	15	10
Females	28	29	19	15	7	7
<25 years	14	18	10	7	5	-
25-34 years	25	22	21	16	14	12
>34 years	33	35	26	22	18	7
IDUs using opiates	23	24	21	16	11	11
IDUs not using opiates	25	18	17	15	21	6
De Sleutel (Flemish institution)						
Number of treatment demands from IDUs	236	75	352	303	241	306
Number of IDUs tested	73	54	155	123	89	47
Number of hepatitis B +(anti-HBc+)	15	13	37	27	14	10
Prevalence rate (%)						
All IDUs	**21**	**24**	**24**	**22**	**16**	**21**
Males	23	23	28	22	14	22
Females	8	33	7	20	25	14
<25 years	11	7	12	8	0	10
25-34 years	27	21	26	26	21	50
>34 years	57	50	44	42	32	44
IDUs using opiates	24	29	34	-	18	21
IDUs not using opiates	13	8.3	-	-	0	27

Among lifetime IDUs, i.e. IDUs having injected at least once, hepatitis C is more prevalent than hepatitis B. Between 1997 and 2002, the number of lifetime IDUs registered through the monitoring system of the French Community, reporting to be positive for hepatitis C, has increased from 47% to 67%. In 2002, around 43 % of tested lifetime IDU patients of "De Sleutel" have antibodies against hepatitis C (table 26).

The prevalence of HCV infection among tested IDUs (having injected at least once) registered in the French Community as well as in De Sleutel's data, increases also with age (table 26).

Table 26 : Percentage of hepatitis C infected among IDU asking for treatment, in centres of the French Community and De Sleutel,1997-2002, Standard table 9, 2004

HCV	1997	1998	1999	2000	2001	2002
French Community						
Number of treatment demands from IDUs	620	505	697	412	579	761
Number of IDUs (self-reported)	115	240	195	127	275	184
Number of hepatitis C + (self-reported)	54	124	100	66	182	124
Prevalence rate (%)						
All IDUs	**47**	**52**	**51**	**52**	**66**	**67**
Males	46	49	49	52	66	68
Females	48	60	57	52	67	64
<25 years	41	47	32	27	55	29
25-34 years	46	49	57	54	65	68
>34 years	67	58	54	57	74	73
IDUs using opiates	44	53	56	48	66	59
IDUs not using opiates	62	39	59	63	67	82
De Sleutel (Flemish institution)						
Number of treatment demands from IDUs	236	75	352	303	241	306
Number of IDUs tested	114	56	195	164	120	65
Number of hepatitis C + (biological testing)	45	26	74	59	43	28
Prevalence rate (%)						
All IDUs	**40**	**46**	**38**	**36**	**36**	**43**
Males	40	40	39	34	33	42
Females	39	100	30	47	53	50
<25 years	25	21	14	16	16	19
25-34 years	53	52	51	45	42	50
>34 years	77	62	63	60	56	85
IDUs using opiates	47	50	50	-	34	48
IDUs not using opiates	21	33	-	-	50	33

The following data are the results of the blood testing diagnosis (the context is already described in 6.2.a.3). Around 79% of the patients tested at Free Clinic were tested positive for Hepatitis C, no change has been observed in the percentage over the last three years. In 2003 concerning HBV anti-HBc, almost 62% of the tested patients were positive (table 27).

Table 27 : Percentage of hepatitis B and C infected among IDU asking for treatment, in Free Clinic, 2001-2003, standard table 9 2004.

Free Clinic Antwerp	2001	2002	2003
HBV			
Number of treatment demands from IDUs	332	340	408
Number of IDUs tested	249	255	281
Number of hepatitis B + (biological testing) (anti-HBc+)	107	168	174
Prevalence rate (%)			
All IDUs	**43**	**65.9**	**61.9**
Males	42.4	67.9	64.6
Females	46.3	63.2	56.5
<25 years	66.7	33.3	33.3
25-34 years	39.3	58.2	54.9
>34 years	45.5	72.2	67.4
HCV			
Number of treatment demands from IDUs	333	340	408
Number of IDUs tested	252	259	287
Number of hepatitis C + (biological testing)	201	206	227
Prevalence rate (%)			
All IDUs	**79.8**	**79.5**	**79.1**
Males	80	80.1	81.5
Females	79.3	78.4	73.9
<25 years	66.7	33.3	50
25-34 years	77	77.6	76.9
>34 years	82.4	82.5	82.4

Results of the hepatitis B surface antigen (HBs-Ag) were amounted to 6.3% in 2001, 4.6% in 2002 and 3.9% in 2003 (Standard table 9, 2004).

6.2.b.2 HBV- and HCV seropositivity among prisoners

In 2003, the study (fully described in 8.3) gives some results of HBV and HCV among prisoners. A sample of 3691 medical files issued from 10 prisons was examined.

254 prisoners were tested for HBVag and 18 were positive (7%). 73 prisoners (25% on a sample of 292) were tested positive for HCV (Hariga et al. 2004). Results should be interpreted with caution, as the prisoners are not systematically but were only tested when they were identified as being at risk.

6.2.b.3 Hepatitis among drug users- Snowball survey (French Community)

According to the **snowball survey,** for which details are given in section 4.3.a, (Hariga F., Personal Communication), additional information on hepatitis is also available for the French Community. In 2003, among 293 injectors tested for hepatitis, 197 reported to be positive (68%). The following table gives more details on these results.

Table 28 : Percentages of self-reported positive results among tested IDU's for hepatitis, Snowball surveys, French Community, 2002-2003.

	2002	**2003**
N	273	293
HAV +	12	10
HBV+	29	29
HCV +	55	52
HDV +	5	1

6.2.c Tuberculosis

In 2003, 1128 tuberculosis cases were registered (incidence rate: 10.9/100.000 inhabitants) (Fares/VRGT in press). Among them 7 cases stated intravenous drug use : 1 case in Brussels, 1 in Flanders and 5 in the Walloon Region.

6.3. PSYCHIATRIC CO-MORBIDITY

Pilot projects on "intensive care for patients with a double diagnosis" started in 2002. Epidemiological data are not available at the moment.

6.4. OTHER DRUG-RELATED HEALTH CORRELATES AND CONSEQUENCES

6.4.a Somatic co-morbidity, non-fatal drug emergencies, other health consequences

No information is available.

6.4.b Driving and other accidents

In October 2002, the Federal Police has launched a "Road safety action plan". This plan is aimed to reduce by half, the number of deaths and injured people on the roads by 2010. Driving under influence of alcohol and drugs is one of the key points of this new action plan. In practice, the frequency and the number of controls by police services are increased. Places and moments of those controls are published (Federal Police Press release 8/4/2003).

The following table shows the results of the controls done by the federal police on the motorways. It concerns only the actions led by the Federal police.

Table 29 : Results of the controls in the framework of the "Road safety action plan", Deblaere, Personal Communication 2004.

		2003
Controls		275
Urine tests	**Positive**	108
	Negative	31
	Total	*139*
Blood tests		108
Refusal		7
PV's		115
Driving license revocation		18

The law of 16 March 1999 and the different subsequent legal acts, have mentioned 5 groups of substances to be controlled within the framework of road safety. These substances are the following: cannabis, amphetamines, metamphetamines, morphine, and cocaine (Deblaere 2003).

The methods of control are divided into two phases: detection and observation.

The detection follows standardised tests on physical and attention signs. If after the completion of all the tests, several of them have been positive, a urine test is done. If this result is also positive; then a blood test is requested. Policemen should have followed a theory training of 2 days and 8 hours of practical tests before participating in such tests.

Several reasons (among them, the difficulty to organise these controls) lead to the set up of specific actions for drugs controls among drivers.

The next figure presents the results of the blood analysis performed in 2003. Blood samples have been taken during police road controls (both local and federal police services). In total, 616 blood samples have been analysed by the National Institute for Criminalistics and Criminology (NICC). On 616 tests, 525 were positive and 91 were false positive.

Cannabinoids represent 58.3% of the substances detected in the samples, amphetamines 17.1% and a mix of cannabinoids with amphetamines 9.7%.

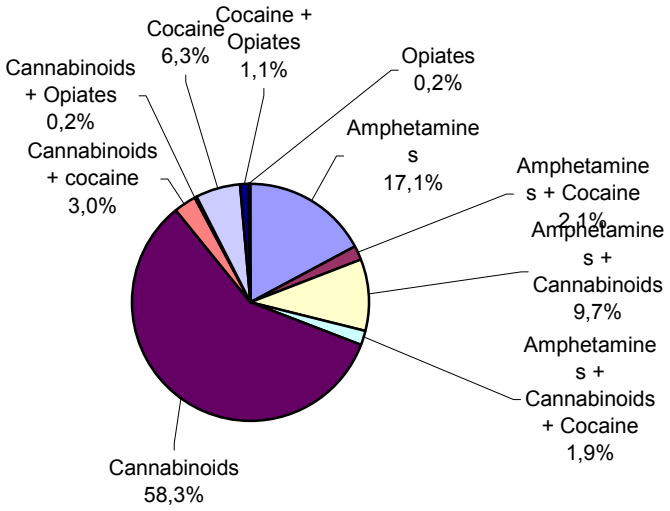

Figure 11 : *Results of positive blood tests in the framework of road controls done by local and federal police services, N= 616, NICC 2004.*

CHAPTER 7.
Responses to Health correlates and consequences

In 1995, the federal government formulated an action plan for illegal drugs, based on a health perspective and on the harm reduction philosophy. In 1998, a law allowed needle exchange (royal decree of 5 June 2000). In the French Community, needle exchange programmes are implemented since 1994. In July 2000 in Flanders, the necessary legislative adaptations were made and in 2001 syringe exchange programmes were also officially implemented.

7.1. PREVENTION OF DRUG RELATED DEATHS

An Early Warning System was developed by the Focal Point aiming at exchanging information on "new and/or dangerous drugs". Dangerous is defined as a "substance that could cause permanent injuries, coma or death". Information on such drugs are disseminated in a broad national "early warning network".

Brochures on overdoses prevention and guidelines are disseminated in the **French Community**.

In the **Flemish Community**, a local training in OD-prevention for drug workers and drug users through the provincial co-ordinators of the needle exchange programmes is set up. Recruitment of drug users is done through advertising and personal contacts in low threshold drug services. In Antwerp it is worked out in close collaboration with the local drug user union (the only one in the Flemish region). An information brochure on OD-prevention is also available and distributed through drug services, street corner workers and needle exchange programmes.

7.2. PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES

7.2.a Prevention

Different types of ***needles exchange programmes*** are available in the country except in the German Community: stationary, street programme and programmes in pharmacists (structured questionnaire 23,2004). Safe injection rooms do not exist in Belgium.

Prevention of sexual transmission: all harm reduction projects have a component on safe sex and provide condoms (lubricants).

Hepatitis B immunisation is poorly available, as intravenous drugs users are not identified as a priority group for Hepatitis B immunisation policy. Therefore, the high costs of the vaccines make its access low. Programmes of vaccination against Hepatitis B are developed but target children.

French Community

The Platform for AIDS prevention has been set-up by a consortium of NGO's to develop general population projects. Modus Vivendi is responsible for the aids prevention activities specifically targeting drug users.

Different services are offered:

Development and diffusion of Information material about aids, hepatitis B and C and other similar risks:

Time table flyer with the addresses of the different needles exchange programmes;

Brochure "Shooter propre", targets intravenous drug users and provides information on how to inject safely;

Brochure "A,B,C des hépatites": information brochures for drug users on hepatitis prevention.

Injection kits: Stérifix

Stérifix is a kit containing 2 syringes/needles, water for injection, disinfectant swabs, and information on the risk of transmission by syringe sharing and HIV screening centres. The package is distributed by pharmacies.

The global budget of public health in the French community includes a vaccination program. Though not specifically dedicated to drug users, it ought to affect them on the long run. A systematic free vaccination is offered to all new-born babies and young teenagers (12-13 years old) in the French community[21]. It is funded at a rate of 1/3 by the French community and 2/3 by the INAMI, and includes the vaccine against hepatitis B since 1999. It has to be noticed that since October 2003 the "hexavalent Infanrix-hexa® " vaccine is provided (a single injection, protecting against 6 different diseases, only used for new-born babies). The programme ensures all the necessary booster injections until the age of 18. The whole young adults population in the French Community should be covered by this immunization within the next 20 years.

From a harm reduction point of view, it is hoped that intravenous drug users, who experience the first injection at an average age of 20 years, will then be more efficiently immunised against Hepatitis B. It is foreseen for the year 2019 onwards. Indeed, according to the « Service Communautaire de Promotion de la Santé ULB-PROMES », the coverage rate of the vaccination campaign would reach about 95% (Dr. Swennen, personal communication).

Nonetheless, some target populations are not concerned by that general action. Let's mention the case of the sex-workers, many of whom are foreigners, and live in a precarious situation. Besides, those who (youngsters or adults) were older than 12-13 years old during the campaign and the inclusion of the Hepatitis B vaccine (1999), could remain at risk.

The '*Operation Boule de neige*', HIV, hepatitis and other risks related to drug use peer prevention project aiming to reach, through a snowball methodology, target groups not easily reachable. (Ex)-drug users in short-term contracts ('jobist'), training them on HIV, hepatitis or overdoses prevention. After training, the "jobists" go back to the " drug scene " to contact drug users, diffuse their prevention messages and material and recruit new candidates jobists. The jobists are assisted in their work by a questionnaire, used also to collect data on patterns of use, use and attitudes. Evaluation of each intervention is made with the "jobists" and is both collective and individual. About 1500 drug users, mainly IVDUs are reached every year in the French Community.

[21]For more information on vaccination in the French Community : http://www.sante.cfwb.be/pg001.htm

Euro Boule-de-neige: with the support of EC-DGV, the project has been transferred in Finland, Greece, Italy, Portugal, Spain, and Slovenia.

In 2003, in addition to the prison of Namur (2002), three other prisons (Lantin (Liege), Jamioulx (Hainaut) and Forest (Brussels)) in the French Community set up the snowball project. These four operations constituted a pilot project intended to evaluate the conditions of feasibility of a snowball operation in prison and the adequacy of this project in such institutions (Modus Vivendi 2004).
27 prisoners jobists were recruited and trained to the methodology and to the aim of the project. They have collected 255 questionnaires from their peers.

The **jobists** declared themselves very satisfied with their participation. The reasons for satisfaction most often evoked relate to the valorisation of the prisoners in several fields (acquisition of new knowledge and competences, position developing of agent of prevention, actor health for themselves and the others warned, a more positive image of the jobists compared to themselves and also compared to the other prisoners and the penitentiary personnel, great motivation of the prisoners). The reward of these prisoners jobists contributed to this feeling of valorisation.

The **directions of the establishments** also expressed their satisfaction. The expressed reasons are as follows: contribution of the project to return to the prisoners a developing identity, a certain dignity, a more positive image of themselves; contribution of the project to the philosophy of humanization of the prisons; operation which constitutes an original and new response to the massive phenomenon of consumption of drugs within the prisons; interest of the directions for an operation which is not too heavy for their establishment insofar as animations are ensured by external actors.

The reactions of **the other actors** present in prison showed the need for integrating well the penitentiary agents in the operation and the facilitator role of the psychosocial services.

In conclusion, the evaluation was very positive. This test constituted a great success. Requests to reorganise such snowball operations in the same prisons and in new prisons were already made but financing still must be found.

Flemish Community

Peer Support networking in collaboration with outreach workers and needle exchange personnel. Training and support of (ex-)drug users for training their peers in safer use, communicable diseases, overdose prevention, etc.

In the Flemish Community, a handbook for syringe exchange programmes was developed and distributed amongst all participants. Its topics are e.g.: the legal framework, good practice, infectious diseases, and health problems related to injecting, alternative ways of using.

7.2.b Counselling and testing

In 2003, a new network “Hepatitis C -drug addiction” was set up in Brussels. This network gathers hepatologists, GP’s and several services actives in the field of drug addiction. The necessity to screen more patients for HCV in Brussels was the first reason for which the network was set up (Mulkay personal communication). In addition, this collaboration inside the network may increase the confidence of the patient and may facilitate the initiation of a treatment.

More information on this initiative will probably be published in future editions of the national report.

The needles exchange programme, Le comptoir, (former CESC) in Charleroi, in partnership with the NGO “Sida MST Charleroi”(HIV reference centre) offers to IDUS the opportunity to be tested for HIV and hepatitis during the opening hours of the needle exchange programme.

7.3. INTERVENTIONS RELATED TO PSYCHIATRIC CO-MORBIDITY

Overall there is more attention to psychiatric co-morbidity. This attention is integrated in treatment. There are a few projects witch focus specifically on this problem e.g. the project “intensive care for patients with double diagnosis”.

In the end of 2002 the psychiatric hospital in Sleidinge started a pilot project 'intensive care for patients with a double diagnosis' (De Cuyper 2003). The main objective of this program is to try out and refraise a care policy for the specific target group. Secondly they develop an integrated care plan that guarantees collaboration and continuity of acute treatment, prevention and aftercare. Therefore the section got extra paramedical assistance. This inpatient unit gives shelter to 10 clients of whom the majority suffers from psychosis and severe use of illegal substances. There are also 5 beds for after care. The intake is voluntary or on judicial compulsion. Each year 25 to 30 patients follow the project. Most of them stay for 6 months in treatment.

The project is authorized and funded by the federal government. The pilot project is under evaluation. In case of a good evaluation the program will be maintained.

7.4. INTERVENTIONS RELATED TO OTHER HEALTH CORRELATES AND CONSEQUENCES

7.4.a Somatic co-morbidity

In the MSOC in Gent every new client is screened on HIV and Hepatitis B & C (Dr. Wilfried Swinnen, personal communication). Another standard test used is the Mantoux test (TBC). With hepatitis B seronegatives the MSOC starts an active immunisation (3 vaccines). Since the start of this immunisation they managed to decrease the active hepatitis B prevalence and incidence in their population.

Hepatitis C seropositives are referred to the university hospital of Ghent. The success rate of this treatment is over 90%.

HIV-positives are also referred to the university hospital of Ghent. The number of HIV-positives is very low (< 0.5%).

7.4.b Non fatal emergencies and general health-related treatment

In general hospitals, individuals with problematic substance use can both be treated in the general services, the emergency department as well as in the psychiatric ward for serious somatic or psychiatric complaints that may be due to problematic substance use but also may not. Because of a non-selective and easily accessible policy, a number of people with problematic substance use can, for instance via the emergency admission, end up in general hospitals. There are no recent data on the specific topic (Geirnaert 2004).

In 2002, a new pilot project started as an implementation of the federal drug note. In each of the five provinces of Flanders there was set up a new crisis unit. The units are part of five general hospitals. Per hospital 4 beds will be reserved for crisis interceptions of alcohol and drug adicts with a maximum stay of five days. Every crisis unit is linked to a case manager who guides the patients who enter the unit. On the other hand the casemanager does the outreach work (Geirnaert & De Maeseneire 2002).

7.4.c Prevention and reduction of driving accidents related to drug use

The Belgian Road Safety Institute (IBSR/BIVV) organised in May 2002 a study day on “Driving under influence of drug”. This event gathered different actors concerned by the issues of road safety. Legal aspects, results of scientific studies and the concept of prevention were presented.

The IBSR/BIVV organises a prevention campaign “BOB” focused on driving under influence of alcohol. In addition, IBSR has published specific drugs prevention brochures (“Rouler drogué, c’est parti pour un mauvais trip”).

7.4.d Other health consequences reduction activities

In June 2002, a charter was signed in Brussels by owners of discos (Gosuin 2002). The signatories of the «Charte du bien-être dans les lieux festifs» agree for example to offer free water in a chill-out place. Dissemination of prevention messages is also organised in these discos.

CHAPTER 8.
Social Correlates and Consequences

The method of registration of infringements was modified these last years, in the framework of the reform of the police services (Federal Police versus Local Police). The new common database is not fully operational and some data are still missing.

It seems that throughout the years, the number of convictions for drug-related offences varies, although from 1998 on, the numbers stay remarkably lower than the years before.

8.1. SOCIAL EXCLUSION

In a recent study on drugs and nuisance (Decorte et al. 2004), drug users were interviewed on their perception of the drug-related nuisance topic. They feel powerless and excluded. This leads to the stigmatisation of an already vulnerable group.

8.1.a Homelessness

No new information.

8.1.b Unemployment

No new information.

8.1.c School drop out

No new information.

8.1.d Financial problems

No new information.

8.1.e Social networks

No new information.

8.2. DRUG RELATED CRIME

A large reorganisation of police forces was initiated in 1998. Indeed, different services (Judicial Police, the 'Gendarmerie/Rijkswacht' and the municipality polices) have been gathered. Meanwhile, a new common registration system, directly linked to a central database for all of the police services disseminated through the country, is still under development.

From 1994 to 1997, six variables were recorded: identification number of the report, identification of the involved unit, type of infringement, tentative or not, location and time of the infringement. The covered variables will be expanded in the future new system.

The interpretation of the national criminal statistics on the seizure of narcotics calls for some explanation. The statistical data on the seizure of narcotics is based exclusively on the positive results of searches or investigations but by no means reflects the number of infringements committed in this field. On the other hand, these figures do not provide any information on the severity of the infringement, nor on the importance of the seizure.

Since 1993, a distinction was made for the first time between the *use* and *the trafficking* of narcotics. The term *use* is applied to narcotics seized from a person who had them in his possession but only for personal consumption. The term *trafficking* is applied to all seizures of narcotics where it appears that they were not only intended for personal use. Meanwhile, it is recognized that categorising of infringements varies largely between police units.

8.2.a Drug offences

Drug possession and personal use **infringements** in Belgium represent in 2000 73.4% of all infringements related to narcotics (Table 30).

Table 30 : Number and proportion (%) of infringements related to narcotics according to the type of infringement, Belgium, 1996-2000 (NIS[22])

Year	Total	Possession/ use	Trafficking	Other
1996	37124	73.2	22.6	4.2
1997	45958	70.5	24.3	5.2
1998	42824	72.5	23.2	4.3
1999	43500	73.5	23	3.5
2000	40561	73.4	23.4	3.2

The evolution of the number of 'arrests' related to illicit drugs registered by police can be an indicator of the activity of the illicit drug market, although it can also be considered as the result of the effort of the police to better control it. The figure below is based on police reports indicating the **number of persons intercepted ('arrest')** by the various law enforcement agencies. Persons that were intercepted were not necessarily arrested, i.e. held in custody.

In 2003, 18683 persons were taken in for questioning for drug use, possession and or traffic by police services (standard table 11, 2004).

[22] http://www.statbel.fgov.be

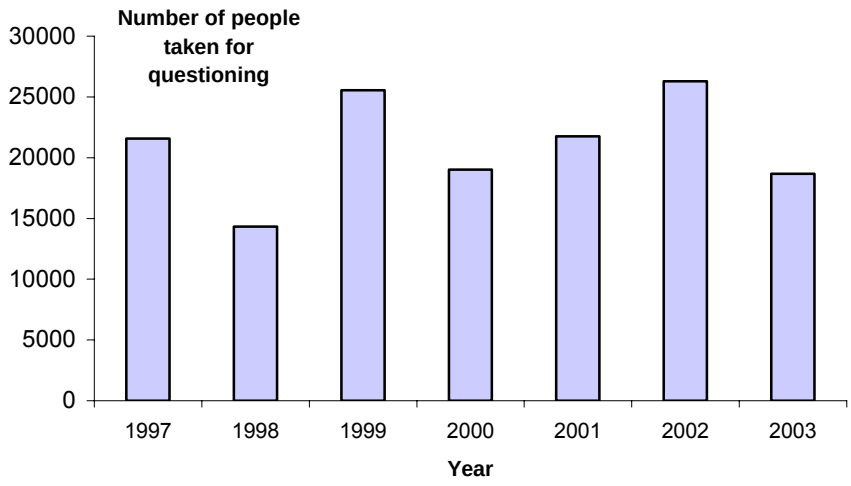

Figure 12 : *Number of people taken in for questioning, Belgium, 1997-2003, standard table 11,2004.*

It has to be noted that the registration method has changed in 2003. Each offence is now considered as a separate record. In the past, when several offences were found, only the main offence was recorded.

Cannabis is the most commonly involved drug of all drug related 'arrests' in 2003 (13884 'arrests' for drug use, possession and or traffic). Moreover, cannabis is also the drug most recorded for drug use and possession as well as for trafficking (standard table 11, 2004).

In Belgium, data concerning **prosecutions** are not systematically gathered. There is, however, a research continuing from 1990 on that gathers information on drug users through the Public Prosecutor. Data[23] show that the age categories of the 18-20 years old and of the 21-24 years old are the most represented. In fact, at least half of the persons receiving a policeman's report for drug use seem to be between the age of 18 and 24.

The substance mentioned most frequently on the forms filled in by the Public Prosecutor's Offices is cannabis (71,8% in 2002), followed by XTC and amphetamines with quite similar use percentages (10,2% and 11,7% respectively in 2002). Heroin, cocaine and LSD show a downward trend since 2000.

[23] Detailed results were given in the last year Belgian National Report, updated data were not available this year.

The Federal Public Service Justice publishes on annual basis a report gathering a summary of the main criminal data. This document, "Justice in numbers 2004" contains among others information on the convictions (Table 31).

Table 31 : Evolution of convictions for drug-related offences*, Belgium, 1994-2002 (FPS Justice 2004).

	1994	1995	1996	1997	1998	1999	2000	2001	2002
N° convictions	5343	4922	5426	5363	4491	3981	4039	3401	3510

* Based on individuals, double countings could occur.

It seems that throughout the years, the number of convictions for drug-related offences varies, although from 1998 on the numbers stay remarkably lower than the years before.

8.2.b Other drug related crime

Please refer to chapter 13 on public nuisance and in chapter 1.4 for the results of the study "drugs and nuisances" [24].

[24] An extended summary of the research is given on the web site: http://www.belspo.be

8.3. DRUG USE IN PRISON

Two NGO's Modus Vivendi and Street Wise, carried out in 2003 a survey on the consumption of drugs in prison. This was undertaken within the framework of a European network for HIV and hepatitis prevention in prison and co-funded by DG SANCO [25], the Ministry of Justice, the Ministry of Heatlh of the French Community. The project was also the second phase of a project funded in 1999 concerning the development of an epidemiologic tool for the monitoring of health risks linked to drug use.

The prisons were grouped in categories, according to their size and type. In each category, a prison was drawn at random. A sample of 10 prisons was settled (5 French-speaking and 5 Flemish-speaking).

In total 886 prisoners filled in the questionnaire. The questionnaire was self-administered, and standardised. It wasn't however a European questionnaire. The detainees were contacted via a call for participation, entrusted to the directions of the various prisons.

The rate of participation was 24%. This rate is weak, even compared to preceeding studies (1997 - rate around 70% in European Network for aids prevention 1998 -; 1999 - rate around 30% in De Maere et al.2001) but these studies were carried out only in one prison.

The primary aim of the study was to evaluate the detainees' knowledge about the risks related to drug use, the risks of infectious diseases (HIV and hepatitis) related to non-protected sexual relations and other risky behaviours (piercing, tattooing, sharing of injection equipment).

The questionnaire asked about "lifetime use", "use in prison" and "first use in prison" among other issues. The "use during the last month" was not surveyed, as fear of suspicion and monitoring specific to the prison, was likely to influence the answers.

The next table deals with the prevalences of drug use in prison.

Table 32 : Percentages of drug use in prison (%), 2003 (Standard table 12, 2004).

	Use in prison	First time used in prison
Heroin	13.3	7.2
Cocaine	11.1	3.3
Speed	11.5	3.7
XTC	10.0	3.7
LSD	4.1	1.5
Methadone	5.8	2.3
Hashish	28.9	11.4
Benzodiazepines	11.8	5.3
Barbiturates	3.9	2.5
Alcohol	6.4	1.3
Others	3.5	0.8
Injection	2.5	0.9

Cannabis comes at the head of use in prison with 28.9% and heroin follows with 13.3%. 2.5% of the prisoners reported an injecting drug use.

[25] Hariga, F., Todts, S., Doulou, M., et al. Drug use in prisons : monitoring of health risks : a survey in 10 prisons in Belgium. European network for HIV prevention in prison, to be published. Personnal communication by HARIGA.F., coordinator for Belgium.

11.4% have reported their first use of cannabis in prison and 7% report a first use of heroin in prison. In addition, almost 1% reported their first use by injection in prison.

Moreover, there is a tendency to polydrug use: while 37% use 1 substance; 13.67% uses 2 substances and 57.56% use 3 substances and more.

More than the half (63.6%) of drug users in prison justified their use as a mean “to relax”.

3.5% of the prisoners reported to share injecting materials in prison, against 4.2% before imprisonment. It seems that certain detainees give up this practice once in prison.

Approximately 80% of the detainees stated not to have received, in prison, written information on the use of drugs, the health risks and prevention messages.

In addition, drug use affects also non-users: 29.5% of them declare to have encountered problems related to the use of drugs, caused by other prisoners. In 46.3% of the cases, these non-users were victims of robbery.

The detainees show a good knowledge of the HIV’s transmission modes. The median number of good answers is 10, out of 13 questions.

On the basis of these questions, the following scale was established: weak, middle or good score HIV. 57.4% of the respondent obtained a "good" score.

The practice of tattooing and/or piercing was rated at 11.3% among prisoners presenting a weak HIV score, for 11.7% of the middle scores, and only 7.6% of the good scores.

Several questions raised their perception on sexual risks:

The prisoners report the availability of condoms:

- At the canteen in 66.7% of the answers
- In the medical department in 43.8% of the answers
- In the places dedicated to the marital visits in 77.2% of the answers

28.4% of the respondent state to have had sexual intercourse during one marital visit at least. Among those, only 9.5% always use a condom.

8.8% of the respondent state to have had sexual intercourse apart from the marital visit. More than the half (53.2%) of those do not use a condom.

8.9% of drug users reported to have followed a treatment involving methadone before the last imprisonment. In more than half of the cases (56.3%), this treatment was stopped at the early arrival in prison.

Concerning the consultations, 51.7% of the drug users did not see a GP during their imprisonment. However, for those who were under treatment, methadone was prescribed in 21.5% of the cases.

8.4. SOCIAL COSTS

No study on social costs is available.

CHAPTER 9.
Responses to social correlates and consequences

The Federal Drug Policy Note mentioned that "*it is necessary to always take account of the fact that the consumption of drugs goes together with individual and social problems: to tackle a drug-dependence it cannot be efficient if the underlying problems are not highlighted. In that sense, the multidisciplinary aspect is very important.*" In this note the idea is to set-up platforms of dialogue and networks of social and medical facilities.

Since 1997, social assistance is offered in addition to medical care in the medical and social assistance centres (low-threshold centres-MSOC). Many in-patient treatment centres have their own after-care programme. Housing, education and employment issues in order to reintegrate (ex)-drug users exist but are linked to local initiatives. The offer varies a lot from one city to another.

Assistance to drug users is provided by the prison health services and the prison psychosocial services. In addition, a number of external specialized therapeutic services are invited to assist the prisoners. Substitution treatments are recently better accepted in the prisons than before.

9.1. SOCIAL REINTEGRATION

9.1.a Housing

Several Therapeutic communities and inpatient units for drug users offer a sort of aftercare in the sense of housing.

Specific initiatives that provide accommodation exclusively to drug users are rare.

9.1.b Education, training

In the Flemish Community, every year VAD organises a three days training on 'social reintegration'. This training pays attention to the integral, methodological and procedural character of the care offer. Different fields of social integration are studied: daily spending, housing, leisure time, employment, budgeting… While working on a case the participants get the chance to link the theory with practical experiences.

This type of service is well developed in the French Community and often takes place in reception facilities such as specialised centres with a "revalidation agreement" like day centres or therapeutic communities. However other types of facilities can offer also education or trainings to drug users.

The suggested trainings are numerous and varied: cooking, data-processing, horticulture, painting, building works, joinery...

Workshops more directed towards the education of the drug user also exist. Thus certain institutions propose workshops in the field of the culture and the leisure's, elimination of illiteracy or social information.

9.1.c Employment

During several years now the social workplace from 'De Sleutel' offers a job to (ex) users. The target group of ex (junkies) is not an easy employable group. The changeover from unemployment to work seems to be hard for those people. Working in the social workplace gives (ex) users the opportunity to join slowly the normal structures of life. Meanwhile the clients are guided in their personal problems like dependence, financial problems, relational problems, …

The 'Smid-project' (cooperation social reintegration drug addicts) in the province of Limburg is a cooperation between CAD Limburg and Katarsis. Both organisations have a great experience in the field of addiction and are convinced that employment is a very important form of daily activity which give people status and identity, development of personal abilities, … By bringing the employment sector and treatment centres closer to each other one realises a more fluent stream of patients between treatment and employment.

This type of service is also well developed in the French Community and proves to be central in certain institutions for the reintegration of the drug user. The search for employment is done according to active methods with the assistance of the specialized facilities and in collaboration with general structures specialized in the field of employment (ONEM/FOREM, CPAS).

In the Walloon Region, in 2003, the social Relays created on the initiative of the Minister for the Social Affairs and Health were regulated by the Decree related to the social integration (1 March 2004). This decree differentiates the social integration from professional insertion. It perpetuates the social Relays.

The target public of the social Relays concerns the populations in situation of acute social precariousness, namely: homeless persons or badly placed, inhabitants of the street, drugs users and sex workers.

If the general objectives are the improvement of the living conditions of the target public, the final aim of the social Relays is the social integration.

Parallel to the Relays, many institutions offer services of social rehabilitation and professional in the French Community. Training and employment remain the two principal interventions suggested in the field of the reintegration.

However, the concept of socio-cultural insertion gradually appears in the services offered.

The objective of all these initiatives of reintegration is to contribute to the quality of the situation of the user in the specific fields like: work, education, culture, housing, leisures, and health.

9.2. PREVENTION OF DRUG RELATED CRIME

9.2.a Assistance to drug users in prison

Prison authorities are aware that drug use and trafficking are a reality in the Belgian prisons, and that their existence has serious consequences for the prisoner and his environment. The prisons cooperate with external caregivers. Some specialised organisations offer informative and educational sessions for prisoners, others offer psychosocial help and treatment, either individually or in group. Introduction sessions introduce prisoners to the possibilities of treatment upon release.

In the Flemish community, a structured cooperation ("strategisch plan") between the prison service and the complete range of services offered by the Flemish government (culture, education, psychosocial treatment, job training and assistance in procuring a job) has been initiated in a pilot region. There is also an ongoing pilot project in some Flemish prisons ("central aanmeldingspunt") that aims to improve the through-care for prisoners. In this project, prison staff and specialised drug workers cooperate to liaison prisoners with treatment upon release.

Drug specific organisations also offer treatment to ex-prisoners on parole or on probation.

Since 2002, a drug policy coordinator is active in the prison service administration.

Assistance to drug users is provided by the prison health services and the prison psychosocial services. In addition, a number of external specialized therapeutic services are invited to assist the prisoners. Finally, prisoners can ask to see their own MD or therapist. In that case, they have to pay for this service themselves. If the prisoner is seen by an outside physician, this physician can propose a certain treatment (e.g. MMT) to the prison doctor, who stays in charge of the patient.

- Drug free departments

There are some pilot projects of drug free departments in Flemish prisons. A training program for guards and prison personnel and for prisoners is being realised. It focuses on drug use and HIV, Hepatitis, etc. A drug free, TC-like program exists in the prison of Ruislede since 1995.

- Treatment in prisons

- In cooperation with the prison authorities of St-Gilles in Brussels a specialised prevention team has set up a prison section 'section primaire'. The aims of this treatment programme were to prevent relapse offence behaviour among primary prisoners, drug addict or not, in fact people who are for the first time in prison for a period longer than six months. This programme works to promote a better rehabilitation in cooperation with outside specialised workers and the prison's personnel. Psychosocial counselling is provided by a specialised social worker.

- TIMC (Toxicomanies et Interventions en Milieu Carcéral, 1997) was an European collaborative network involving participants from Belgium, France, Luxemburg and The Netherlands. Its aim is to create exchanges about drug use in prison and particularly focusing on the role of penitentiary workers and other workers outside of the prisons. Training of penitentiary workers is one main operational achievement. A drug use surveillance system started in 1997 in participating prisons. Data are monthly transmitted by fax to a co-ordination centre (Verviers/Nancy). Until 2002, this project was mainly financed by the justice services.

- Substitution treatment

Substitution treatments are available in prisons. Although the possibilities (as described in the circular letter of the Ministry of Justice regarding the organisation of drug services in prison) are rather limited, there is more and more acceptance of substitution treatment (including maintenance treatment) in the field. In 2002, all prison physicians and psychiatrists received a new advice on the use of substitution treatment.

Maintenance is now recommended for all prisoners who enter the prison while already in treatment, and if they will (probably) not stay longer than one year. In case of longer penalties, it is recommended to try tapering. Caution is expected when the patients are

pregnant, HIV positive or suffering from hepatitis. Initiation of substitution treatment is possible.

- Harm reduction measures

Education, information material developed for outside prison can be distributed in prisons. In most prisons, when entering, the detainees receive a package including several information materials on HIV, hepatitis, tuberculosis and harm reduction linked to drug use. However, there is no strategy on informing prisoners of STDs and drug consumption. Activities of this type exist in certain institutions, sometimes under the supervision of an external NGO. The availability of information material depends on each individual prison and its medical service and/or on the possible presence of an NGO specialised in AIDS prevention.

Specific information material on AIDS and hepatitis prevention for drug users in prison has been developed by NGOs in coordination with health services of the penitentiary administration of Ministry of Justice and has been widely distributed in prisons[26]. A second edition has been developed, in 2000 including a specific chapter for women. This version has been translated in Dutch.

Condoms are available in all prison canteens, as well as in the medical services, where they can be procured for free. Condoms are also available free of charge in the rooms for private visits. In practice, the canteens do not have their own stocks but have to procure them on demand at the local pharmacy. This expensive and hardly discreet mode of distribution actually limits accessibility. A specific packaging has therefore been developed. Each packaging is composed of one condom and one attached lubricant. Different ways of distributing have been studied according to each prison. These are available in medical services, in social services and in rooms for conjugal visits.

Bleach is available in some prisons only for cleaning the cells. In 2002, all medical services were advised to make disinfectants available whenever prisoners ask for it.

There is no needle exchange programme in prison.

A new protocol for the detection of viral infections and for the treatment of hepatitis C is being discussed and will take effect in 2004.

Prison nurses have been trained on HIV, and hepatitis prevention.

HIV and hepatitis risks are part of the basic training of every prison worker.

In few prisons, there are also specific follow-up in service training sessions organised for guards on harm reduction. However these activities are quite limited.

In 2001, an operation “Boule de Neige” in prison was innovated (more information is given in section 7.2.a). It includes prevention actions on hepatitis, aids and harm reduction. Drug user or former drug users prisoners are recruited, formed and paid for transmitting information and sensibilise other prisoners to harm reduction. In comparison with the methodology of the Snowball actions, these are adapted to the reality of penitentiary life. Without neglecting the problematic drug use, this operation focuses on more general topics of HIV, and Hepatitis prevention, like harm reduction related to tattoos and piercings,…

[26] “Vogue la Galère” Modus Vivendi Question santé 1998.
« Wat als je binnen zit ? » Free Clinic 2000.

- Community Links

Some external therapeutic settings arrange treatment help in prison for prisoners. They also organise introduction sessions to inform about treatment possibilities. Aftercare is offered too by some of them when it concerns psychotherapeutic help. Social help is provided by workers of the centres for juridical welfare.

Different handbooks, leaflets with useful information and addresses about specialised NGO are specifically addressed to detainees. The Flemish Community regularly publishes a prison specific journal, distributed in all the prisons of the pilot region.

9.2.b Alternatives to prison for drug users

Please refer to chapter 12.

9.2.c Other interventions for prevention of drug related crime

No new information available.

CHAPTER 10.
Drug Markets

Drugs are perceived as easy to obtain and especially cannabis. The phenomenon of multi-drugs trafficking especially towards the United Kingdom - became apparent in 1999. The quantities of seized illegal drugs may vary largely from one year to another but overall it seems that seizures have increased over the nineties.

More analyses on substances seized by the police and customs have been done in 2003 because of a new project of collaboration between the Justice and Health federal services.

Mean prices for illegal substances seem to decrease.

10.1. AVAILABILITY AND SUPPLY

10.1.a Availability of drugs

10.1.a.1 General population

A public opinion poll on drugs was managed from April 2002 to June 2002 among young European citizens aged from 15 to 24 years old. The access to drugs near the living place is seen as easy by 64% of the sample (European Opinion Research Group 2002).

10.1.a.2 Study among cannabis users

Results of the study among cannabis users indicate that almost half of the sample think that buying cannabis is less dangerous and easier (Decorte et al. 2004). Very often respondents buy drugs from friends and some in coffee shops in The Netherlands. Those who reported to buy the cannabis themselves said they could also buy other substances at the same place (except those who buy in the coffee shops).

10.1.b Production, sources of supply and trafficking patterns within the country as well as from and towards other countries

The following information is based on personal communication from the Federal Police-Service Central Drogues and on the Annual Report 2003 Part 3 UNDCP.

The phenomenon of multi-drugs trafficking (several drugs in one transport) - especially towards the United Kingdom - became apparent in 1999. Belgium is the last embarkation point for these lorries combining cannabis, amphetamines, cocaine and heroin for the British market.

- ***Heroin***

Heroin distribution seems to be controlled by Turkish organisations (it is difficult to reach and to eliminate these networks). It is known that Belgium is a transit country with the United Kingdom as destination (via Dover), but the country is also used as a storage and redistribution centre for the Balkan routes.

A few years ago it was thought that some Turkish criminal groups would shift their activities from the Netherlands to Belgium. So far, this information has not been confirmed.

- ***Cocaine***

The Central Drugs Department assumes that between 5 and 10 tons of cocaine are imported through the port of Antwerp on a yearly basis. In 2003, even if the number of seizures in Antwerp remained limited, it seems that Antwerp is a pivot in the international cocaine trafficking. Distribution and dispatching are also organised from there. Fruit containers are privileged transports means. Between 2000 and 2003, no more South American ships have arrived in the seaport of Zeebrugge. Dominican drug organisations (operating from the Netherlands) smuggle cocaine through the national airport by means of couriers and sometimes use the same couriers to export XTC to the United States. Since the direct flights from Paramaribo and Curaçao are suppressed, the traffic of cocaine through the national airport has decreased.

- ***Cannabis***

Large-scale Moroccan hashish importation in Belgium and the Netherlands is organised since almost 10 years by Moroccan criminal groups. Products are transported by a variety of transports means (car, minibus, camper, coach, lorry and containers).

In addition, it seems that cultivation of cannabis for personal use has increased, especially in the bordering zones of the Netherlands.

- ***XTC, amphetamines***

Since the end of the nineties, the number of illegal laboratories discovered in the country increased; however, these figures remain low if compared to other countries. In Belgium, a spread of manufacture sites was noticed, from the North-East to the West-South. It appears that border places are appreciated by the criminal groups for two main reasons: it makes them more difficult to trace and the proximity of a foreign market makes the distribution easier.

In 2003, due to intensified security checks at the airport, fewer couriers were arrested than the past years. It was also noticed that the criminal organisations may also organise intercontinental mega shipments at destination of the United States, Canada and Australia.

10.2. SEIZURES

10.2.a Quantities and number of drug seizures

Large yearly variations exist in the quantities seized in Belgium. There is not always a clear-cut explanation for these yearly variations. One large seizure can for example influence the figures, as can certain international law enforcement actions or stock piling of drugs...The statistics on the seized volumes of illegal drugs in Belgium are incomplete due to problems with the national database.

The quantities of seized **cannabis** have regularly increased from 9,504 kg in 1992 to 106,690 kg in 1996. They decreased considerably during the period 1997 to 2000 to reach the levels observed during the period 1990-1991 (less than 20,000 kg). In 2003, 14,345 kg of cannabis were seized (Standard table 13, 2004).

The quantities of seized **heroin** have greatly fluctuated from year to year without a clear pattern; the highest quantity of heroin being seized was in 1990 (291 kg). In 2003, 1,104 kg of heroin were seized (Standard table 13, 2004).

The quantities of seized **cocaine** exhibit an erratic increasing trend. First, there was an exponential increase from 1985 to 1993, followed by a sharp decline during the period 1994-96. A sudden rise occurred in 1997 when the highest seized quantities (3,321 kg) were observed. Finally, a significant decrease took place during the period 1998-2000.

For 2003, 1,825 kg of cocaine were seized (Standard table 13, 2004).

The quantities of **XTC/amphetamines pills** seized appeared to increase in an exponential way from 1990: for instance, the quantities of amphetamines and XTC seized in 2000 (more than 800,000 pills) almost double in comparison to the quantities seized in 1999 (about 490,000 pills). 3702 tablets of XTC/ amphetamines were seized in 2003 (Standard table 13, 2004).

10.3. PRICE AND PURITY

10.3.a Price of drugs at street level

The following table contains information on the prices of illegal substances collected by the police services.

The given mean prices for 2003 are all of them lower than in 2001, except for LSD.

Table 33 : Mean price in Euros at street level of some illegal substances: Belgium, 1996-2003 (standard table 16, 2004)

DRUG	1996	1997	1998	1999	2000	2001	2002	2003
Cannabis resin (per gram)	8.1 (3.7-	3.1 (2.5-3.7)	7.4	8.1 (6.2-9.9)	5.6 (5.0-6.2)	7.3 (3.7-12.5)	n.a	5.5 (4-7)
Cannabis leaves (per gram)	5.0 (2.5-	3.7 (2.5-5.0)	6.5	5.6 (3.7-7.4)	4.2 (3.4-5.0)	7.9 (3.7-12.5)	n.a	5 (4-6)
Heroin brown (per gram)	37.2	22.3 (19.8-24.5)	21.1	39.7 (19.8-	26.8 (18.8-	30.7 (12.5-50)	n.a	27 (9-50)
Cocaine powder (per gram)	49.6 (37.2-	55.8 (49.6-61.2)	58.9	55.8 (37.2-	60.1 (45.9-	53.4 (42.2-	n.a	45 (10-75)
Amphetamines powder	-	-	-	7.9 (6.0-9.9)	5.0 (3.7-6.2)	11.9 (9.4-14.4)	n.a	7 (7-7)
'Ecstasy' (per tablet)	12.4	6.5	8.7	7.2 (4.5-9.9)	7.3 (5.7-8.9)	6.3 (3.7-13.1)	n.a	5.5 (4-7)
LSD (per dose)	6.2 (5.0-	6.8 (5.0-8.7)	6.9	-	3.1 (2.5-3.7)	8.7 (7.4-9.9)	n.a	10 (7-13)

* Minimum and maximum price are given in parenthesis.

The average price for one tablet of ecstasy was 1 euro cheaper in 2003, compared to the average street price in 2001. In general the consumer can purchase three tablets of ecstasy for 10 euros.

10.3.b Purity at street level and composition of drugs/tablets

The following table shows the results of analyses performed on substances seized by police services and customs. It concerns both seizures at user's level as well as seizures from large drug traffics. Some of these seizures are done at the national airport. At that level, the seized drugs present usually high levels of pure substance because they have not been cut yet. Finally, much more analyses have been done in 2003 because of a collaboration project between the Federal Public Services Justice and Health.

Table 34 : Mean purity at street level of some illegal substances, Belgium, 2002-2003 (standard table 14, 2004)

DRUG	2002 *		2003 *	
	Number of analyses	**Mean** (Minimum-maximum)	**Number of analyses**	**Mean** (Minimum-maximum)
Cannabis resin **	13	9.7 (1.6-18)	218	15.4 (0.7-47)
Cannabis herb	24	6 (0.2-22)	726	13.8 (0.2-28)
Heroin ***	33	26 (6-90)	98	19.4 (0.1-68)
Cocaine	88	64 (9-100)	225	71.4 (0.18-100)
Amphetamines	61	23.9 (0.3-97)	179	30.5 (0.5-100)

* the percentages are not weighted because the exact amount of sample on which the analysis was done is not known.

** % THC content.

*** brown and white heroin.

For the first time in 2003, results were obtained of tablets analysis containing more than 120mg MDMA per tablet.

PART B. Selected issues

CHAPTER 11.

Buprenorphine, treatment, misuse and prescription practices

Sandrine Sleiman

11.1. TREATMENT

11.1.a Is there a legal basis for providing substitution treatment with buprenorphine in your country?

On April 30, 2004 a Royal Decree (19 March 2004) on substitution treatments was published. In this legal text two substances are mentioned as possible substitution substances: buprenorphine and methadone.

11.1.b Is buprenorphine being prescribed for substitution treatment in your country?

11.1.c If so, which year was buprenorphine substitution treatment initiated in your country?

Buprenorphine is prescribed in Belgium since the mid-eighties (Reisinger 1999). The first experiences of substitution treatment with buprenorphine started around 1984 in Brussels.
Subutex® is newly being reimbursed, more precisely since august 2003.

11.1.d What are the criteria of admission to treatment with buprenorphine? Are there any guidelines or recommendations concerning the prescription of buprenorphine? E.g. differential diagnosis, age, pregnancy, length and intensity of opiate use.

Untill now, only a consensus concerning methadone was published originally in 1994 and was revised in 2000.
Some associations, like the Alto group (French Community) within the Scientific Society of General Medecine (SSMG), have published some guidelines (Van Woensel 2003).
Advices for the prescription of buprenorphine for detoxification are different than for substitution treatment. In a context of **substitution**: Buprenorphine should be chosen as a second choice after methadone.
Three reasons explain this choice:

- a preventive principle, in Belgium more experience is acquired on the use of methadone as substance for maintenance therapy;
- scientific studies have shown a greater efficacity of methadone than buprenorphine for maintenance therapy;
- Subutex® is highly cost effective.

For **detoxification**, Subutex® is suggested as a first choice, justified by some side effects which appear to be less important than with methadone.

Special cases are mentioned:

- Heroin injectors should not be prescribed Subutex®,
- Subutex® could be prescribed between the first contact and before the start of the methadone treatment,
- Subutex® could be used as final phase of the methadone substitution treatment,
- Subutex® should not be prescribed for pregnant women.

Guidelines for the prescription of Subutex® in prisons are also available[27].

11.1.e Does delivery of buprenorphine as substitution treatment take place through General Practitioners or specialised units or both? Is a specific accreditation needed in order to prescribe buprenorphine (e.g. training)?

Buprenorphine can be prescribed by GP's or by specialists. The Royal decree (19 March 2004) specifies that these doctors should have been trained specifically for substitution treatments or they should have an expertise in the field. The training could be organized by scientific association of GP's or specialists, day centres for drug addicts, network of institutions specialised in the care of addicts and finally by a specialised centre itself.
Expertise is approved by a day centre, network of institutions or by a specialised centre.

Every medical doctor should be able to prove that he/she reads articles in the related field, participates in activities of a day centre, in a network of institutions or specialised centre.

Finally, each doctor willing to prescribe buprenorphine should be registered in a day centre, network of institutions or in a specialised centre.

The Royal Decree is still not fully operational.

11.1.f How many clients are currently in buprenorphine substitution treatment? Characteristics of these clients? Differences to e.g. methadone clients?

These data are not yet available. In the future, information should be available as the Royal Decree indicates that anonymous data on the patients undergoing a substitution treatment have to be sent to a Pharmaco-Epidemiology Institute (IPHEB). This institute is in charge of the monitoring but has also the responsibility to check if a patient follows a substitution treatment simultaneously with several doctors. In that case, the doctors should be informed.

[27] Full text of the guidelines are available at the following path: http://users.skynet.be/toxicomanie/subutex.htm

11.1.g How has the number of subjects in buprenorphine substitution treatment developed in the course of the last years?

There are no data available see 11.1.f.

11.1.h Are training courses on buprenorphine prescription offered in your country? By whom (e.g. health authorities, pharmaceutical companies)

The French speaking association of GP's organizes some information session for its members.
The VAD (at the moment of writing the report) is planning training sessions for the prescription of buprenorphine.

11.1.i Please give information (and references) on any planned, ongoing, or concluded evaluation studies and/or research on buprenorphine in your country.

Reisinger, M., (1985). Essai de traitement des heroïnomanes par la buprenorphine. Pyschotropes, vol 2, 1.

Reisinger, M., (1985). Buprenorphine as new treatment for heroin dependence. Drug and Alcohol Dependence, Vol 16,3.

11.2. MISUSE

11.2.a To which extent does misuse of buprenorphine exist? (from general population studies, from treatment data, from specific studies)

There is no study concerning the misuse of buprenorphine as the substance is very rarely prescribed in the country.

11.2.b Which routes of administration other than sublingually are used? To what extent is buprenorphine injected. Are there any specific harm reduction measures related to buprenorphine, e.g. information, the provision of specific syringes?

No information available.

11.2.c Which other substances are reported to be used together with buprenorphine?

No information available.

11.2.d What is the level of diversion of buprenorphine into black markets? What is the cost of buprenorphine on the black market? In relation to other comparable substances?

No information available.

11.2.e Are the clients using buprenorphine in substitution treatment the same as those misusing buprenorphine? What are the characteristics of persons misusing buprenorphine?

No information available.

11.2.f What are the reported health consequences of buprenorphine misuse?

No information available.

11.2.g Were deaths reported related to buprenorphine misuse? In combination with other drugs, if so which?

Unfortunately it is impossible to get data on deaths related to buprenorphine misuse. Death by buprenorphine is reported on the death certificates as death by opiates.

11.2.h Evaluation results, statistics, research and training

No information available.

CHAPTER 12. Alternatives to prison targeting to drug using offenders

Sven Todts

12.1. POLITICAL, ORGANISATIONAL AND STRUCTURAL INFORMATION

12.1.a National Policy

National policy can be found in the Federal Note on Drug Policy. The note includes policies on alternatives to prison. In 2003, a ministerial circular letter guides the investigation and prosecution policy with regard to the (alternative) reaction towards drug users.
Drug policy is the competence of different (federal and regional) governments, as well as of different ministers within these governments. In 2003, an Interministerial Conference was created to synchronise all the efforts (Loi 3 Mai 2003). Day to day business will be taken up by a general coordination unit, that will meet monthly. This cell is not yet operational.

There are no relevant regional strategies.

Different laws are used to organise alternatives to prison. With few exceptions, none of these are specifically targeted to drug users. The Belgian drug law was thoroughly reworked in 2003 (Loi 4 Avril 2003)[28]. Emphasis is now on a primordial orientation toward rehabilitation, with prison remaining as an "ultimum remedium".

Pre-trial stage:
1. Police: Under certain conditions, the police do no longer have to book people in possession of small amounts of cannabis. Furthermore, in most cases where the police does press charges, there will only be a small fine to be paid[29].
Therapeutic advice: The police can immediately orientate a suspect to the treatment system, by referring a suspect to a so-called "therapeutic advisor". The suspect can refuse the possibility. The conditions, under which the referral is possible, are discussed beforehand with the local prosecutor. Since the recent changes in the drug law, therapeutic advice is a legal instrument that can be used by all the courts (Vander Laenen 2003).

1. The public prosecutor has different options to avoid going to trial:
1. Amicable settlement[30]: In this option, the suspect pays a fine. This is only possible for crimes with a possible maximum of five years. This option was not often used for drug users, but is now reintroduced specifically for cannabis users.
2. Conditional ("praetorian") probation: the prosecutor will drop the charges under certain conditions. If the suspect complies with the conditions (almost always put into a written contract), there will be no trial. This procedure was out of use for a long time, but was

[28] This is referred to as the drug law in this chapter.

[29] Koninklijk besluit van 16 mei 2003 tot wijziging van het Koninklijk besluit van 31 december 1930 omtrent de handel in slaap- en verdovende middelen alsmede van het Koninklijk besluit van 22 januari 1998 tot reglementering van sommige psychotrope stoffen, teneinde daarin bepalingen in te voegen met betrekking tot risicobeperking en therapeutisch advies, en tot wijziging van het Koninklijk besluit van 26 oktober 1993 houdende maatregelen om te voorkomen dat bepaalde stoffen worden misbruikt voor de illegale vervaardiging van verdovende middelen en psychotrope stoffen, B.S., 2 juni 2003.

[30] The legal base can be found in art 216bis Code of Criminal Procedure.

reintroduced (with limited success) by a ministerial circular letter in 1998[31]. The problem seems to be a lack of legal foundation for this alternative, as well as the fact that it is a time-consuming method for already overworked prosecutors.

3. Mediation in penal cases. This victim-oriented alternative was introduced by a law in 1994[32]. In this alternative the prosecutor will impose conditions that have to be met in a six-month period. Although the law explicitly states that drug offenders are candidates for mediation, the first experiments quickly showed that this is not a good alternative.
4. Conditional release from remand: The prosecutor can release a suspect under certain conditions (e.g. that he/she joins a rehabilitation program) while he or she awaits trial[33]. This alternative is problematic for the treatment system: either the therapist agrees immediately to accept a suspect as a client (often for a short or unknown period) or this person stays in prison. Furthermore, follow-up of this alternative by justice assistants is limited to three or six months. Since it often takes longer to go to trial, the unsupervised conditions are often not complied within some months.

Trial stage

1. Suspended sentence: The courts have the possibility to suspend the sentence, either or not under certain conditions (so-called "probation")[34]. There are two possibilities: either postponed probation, in which case there is no conviction, although the facts are considered to be proven, or deferred probation, in which case there is a conviction, but sentencing is suspended as long as the convict complies with his/her conditions (in both cases for a maximum period of five years). The drug law had already extended the possibilities for judges to use probation in case of drug use. The revision of the drug law in 2003 has extended these possibilities even further, by accepting a broader range of crimes that are eligible for suspension[35].

Post-trial stage

1. Conditional release (Parole): Parole is possible after one third (or in some cases two thirds) of the prison term. Drug offenders are eligible for parole. More often than not, some sort of therapy will be part of the conditions they have to meet to be eligible.

2. Electronic Surveillance: see 12.1.b.

12.1.b Public debates

Since the changes in the drug law in 2003, some debate has been going on about the relationship between the justice system (prosecutors, courts, etc) and the treatment system. A study was carried out in 2004 on this purpose and results will be published next year. The debate focuses on the need for professional secrecy versus the need of the courts to get reports about the suspects/convicts.
Other developments: Electronic surveillance was introduced in Belgium a couple of years ago, although not as an independent sentence: it can only be used at the end of a regular prison sentence. Originally a lot of drug offenders were excluded from electronic

[31] X, Gemeenschappelijke richtlijn over het vervolgingsbeleid inzake bezit en detailhandel van illegale verdovende middelen, 17 april 1998, niet gepubliceerd.

[32] Wet van 10 februari 1994 houdende de regeling van een procedure voor de bemiddeling in strafzaken, B.S., 24 april 1994.

[33] Art. 35-38 van de Wet van 20 juli op de voorlopige hechtenis, B.S., 14 augustus, 1990.

[34] Wet van 29 juni 1964 betreffende de opschorting, het uitstel en de probatie, B.S., 17 en 24 juli 1964.

[35] Article 9 of the drug law.

supervision. As more slots are becoming available, circular letters have extended the possibilities for all kinds of drug offenders to participate. It is also possible to follow a residential program while under electronic surveillance.

12.1.c Implementation structure

1. Houses of Justice: The Houses of Justice, depending on the different Courts of Justice, are the structures that organise the work of the Justice assistants. Justice assistants exercise control over suspects and convicts in different alternative regimes, such as probation, conditional release, mediation, etc. They report to the Court of Justice.
2. Justice Case managers and therapeutic advice. The revision of the drug law of 2003 creates a new function: the Justice Case Manager. This case manager will assist the Public Prosecutor in deciding about drug cases (mostly under the form of therapeutic advice). The position will be comparable with the position of justice assistants. One of the main tasks of the case managers will be to orientate suspects to therapeutic advisors. Therapeutic advisors are independent experts (comparable to other legal experts) who will advise the prosecutor on the need and (eventual) nature of therapy. Therapeutic advice already existed in a more informal way in the past, and now got accepted as a legal instrument. The inscription of therapeutic advice allows for the use of this instrument. Up to now the Justice Case Manager are still not appointed (Vander Laenen 2003).
3. Commissions of Conditional Release. The law on conditional release authorises the different Commissions on Conditional Release with the selection and follow-up of individuals eligible for parole. A specific law sees to it that drug users can leave prison as early as possible in order to join a treatment program.

12.2. INTERVENTIONS

12.2.a Types of intervention

There are no restrictions on the types of intervention. Although it is certainly true that a number of judges will only consider an alternative to prison if it involves residential treatment (which is then often considered as a surrogate imprisonment), there are numerous examples of people being released into ambulatory programs, often even of a low-threshold, harm reduction nature.

12.2.b Implementation

See 12.2.a.

12.2.c Funding and provision

No information.

12.2.d Monitoring

There is no structured monitoring of the interventions in the group of drug offenders, although some registration systems in the treatment sector register which clients were referred by the courts.

12.3. QUALITY ASSURANCE

12.3.a Guidelines

Laws and Royal decrees are often accompanied by circular letters (e.g. by the Minister of Justice, the College of Prosecutors-General) specifying how to interpret the law, etc.

12.3.b Evaluation and research

There is no evaluation going on that looks specifically at the effects of the alternatives described above on drug offenders.

12.3.c Training

No information.

CHAPTER 13. Public nuisance : definitions, trends in policies, legal issues and intervention strategies

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13.1. DEFINITION

Nuisance: it is what is called a concept in development – notwithstanding it is used ever more frequently, it lacks a proper univocal definition (Decorte et al., 2004:) - although this can be said equally of numerous other concepts in human science in general, and especially criminology ("deviance" probably being the best known, if not the most notorious).

Nevertheless, nuisance can in its own subjective experience pose a real problem, affecting the quality of life and being taken to increase the – likewise notorious – feelings of insecurity. And because of that reason, nuisance became one of the priorities in the "Federal Security and Detention Plan" and a point of action in the Federal Drug Policy Note as well.

13.2. GENESIS IN THE BELGIAN POLICY

It appears that neither national nor international literature can provide a specific definition of the term "nuisance", even though it is often used.

Since the term nuisance is not univocally defined, the registration of data on the level of police, prosecution and courts poses a series of problems, leading to – as a consequence – a poor availability of data. In fact, the availability of these data depends on the priority in the policy of the different categories of drug-related crime. Whereas data concerning infractions against drug laws are generally available, data concerning public nuisance are a lot rarer.

Consequently, police registration of drug-related offences is fragmentary and incomplete. The categories of infractions used in the databases do not include or cover the term nuisance. In other words, facts of drug-related nuisance are registered as specific (other) phenomena and not as nuisance "as is".

The concept of nuisance appeared in the Federal Drug Policy Note (Federal Government 2001) already (cfr. infra). At that moment, federal priorities were already defined in the Federal Security and Detention Plan (2000) through the context of the police reformation. In this plan, the fight against nuisance was also seen as important. Finally, in springtime 2004 the problem of nuisance was given a special place in the Integral Security Framework Note, while in the meantime the new drug law was enacted in 2003, also containing provisions on nuisance. Concerning research, this year the first scientific study on "drugs and nuisance" within the Belgian context has been conducted.

On the following pages, these four important Belgian federal sources will be described. After that, the results of the scientific study on drugs and nuisance will be presented.

Since the Executive Note is the most recent, it will be discussed first, also because the other notes have been more or less dealt with in previous National Reports.

13.2.a The Integral Security Framework Note

The Belgian Federal Government has indicated the fight against nuisance (and neighbourhood crime) as one of its priorities in the Integral Security Framework Note [36].

In this Executive Note, nuisance phenomena, described as "small facts with a strong disturbing character", are divided among three categories[37]:

- public nuisance that is explicitly penalized;
- non-criminal nuisance;
- facts like those described in the Municipalities Law, wether or not they're subject to criminal or administrative settlement.

The Executive Note states that a specific approach within an integral and integrated security policy is recommended for the fight against nuisance. Nuisance phenomena therefore have an important place within a local security policy. Gearing police activities and others involved to each other is essential. Only "an integral and integrated security policy is susceptible to lead to results in the fight against nuisance"[38]. To ensure this tuning process, the Executive Note suggests that the nuisance policy should be incorporated into the "Zonal Security Plans" to ensure the contribution of the police to the entire nuisance policy. Here, central objectives are combatting impunity and the dissatisfaction of the population on the one hand, and improving the quality of life in society on the other hand (o.c., p. 83).

However, the categorisation in this note is, as mentioned, not specifically linked to drugs. In studying the link between drugs and public nuisance, there also appear to be local differences. These local differences are based on different local interpretations of the issue by both the police and the public prosecutors.

13.2.b The Federal Security and Detention Plan & the National and the Local Security Plans

Since the police reformation, this sector is more and more characterized by planning, organizing and management (Devroe and Keppens 2004). The idea behind this approach

[36] Executive Integral Security Note, 30 March 2004 (approved by the Council of Ministers of 30-31 March 2004), p. 81 and further.

[37] This categorization is based upon a bill aiming to change the New Municipality Law, *Gedr.St.*, Kamer van Volksvertegenwoordigers, zittingsperiode 2003-2004 (51), 837.

[38] Note-Cadre « Sécurité Intégrale » des ministres de la justice et de l'intérieur, du 30 et 31 mars 2004, p. 82.

originated from the Federal Security and Detention Plan[39]. This plan sums up the priorities for the federal police, which include drug-related nuisance and drug-related crime[40]. Based upon the Law on the Integrated Police[41] and the circular letter PLP 26[42], the first Zonal Security Plans[43] were drawn up in 2003. These plans, on the one hand, should be based upon federal directives (Federal Security and Detention Plan as well as the National Security Plan[44]), but on the other hand leave sufficient space for specific local outlining. To this extent, the local operationalisation is adjusted by the priorities put forward. Therefore, every plan has to be approved at zonal level by the public prosecutor and the mayor(s) first, and subsequently submitted to the federal ministers of Internal Affairs and Justice for final approval.

Although these plans contain crucial information for the functioning of the police services today, there are no universal definitions of public nuisance contained therein. They do refer, however, to the whole of the drug issue and more specifically to drug-related crime.

The local operationalization of the federal priorities give an impression of how nuisance is regarded locally. There does not seem to be a universal interpretation of the concept; it ís characterizing however that “nuisance” often gets linked to the drug issue, particularly when listing local points of action; for instance:

- dealing (in schools and sports environments)
- drug-related nuisance (dealing and use, especially in discotheques and their vicinity)
- drug-related crimes by youths
- public nuisance and international drug tourism

In other words, there is indeed a lot of attention to “nuisance” in local police security plans; however, the concept is interpreted in a very diverse way[45].

13.2.c The Federal Drug Policy Note

With the approval of the Federal Drug Policy Note (2001), a comprehensive set of measure was introduced, thought of by the Belgian government as necessary to stand up to the drug problem.

[39] Het Federaal Veiligheids- en Detentieplan, Belgische Senaat en Kamer van Volksvertegenwoordigers, Zitting 1999-2000, 13 juni 2000, 2-461/1 (Senaat), DOC 50 0716/001 (Kamer), 144 p.

[40] In total, 22 priorities were described: 9 in the « Federal Security and Detention Plan » and 13 in the « National Security Plan », cf. Devroe & Keppens, o.c.

[41] Wet tot organisatie van een geïntegreerde politiedienst gestructureerd op twee niveaus, 7 december 1988, *B.S.*, 5 januari 2002.

[42] Omzendbrief PLP 26 betreffende de onderrichtingen voor de procedure tot indiening en goedkeuring van de zonale veiligheidsplannen 2003, 5 juni 2002, *B.S.*, 15 juni 2002.

[43] There are 196 police zones in Belgium. The Service for Criminal Policy (FPS Justice) is responsible for the evaluation of the judicial part of the Zonal Security Plans; the other parts are evaluated by the General Direction Safety and Prevention Policy (FPS Internal Affairs).

[44] The Federal Security and Detention Plan gave a clear definition of the nine priorities for the federal police; among those, « drug-related nuisance and crime » ; all this, while the six local priorities of the National Security Plan lacked a clear way of interpretation. (Devroe & Keppens 2004)

[45] Devroe and Keppens’ study (2004.) offers a detailed analysis and synthesis of the relative share of the problem « nuisance » within the different Zonal Security Plans for the year 2003. A similar analysis is foreseen for the Zonal Security Plans of 2004.

Reducing public nuisance was not described as a separate action point but was mentioned implicitly in the Federal Drug Policy Note as an important objective for the drug policy:

"The policy of the federal government will act upon the offer as well as on the demand. The most important objectives are:

- a decline in the number of dependent citizens
- a reduction of the physical and psychosocial harm that drug abuse can cause
- a reduction of the negative consequences of the drug issue on society (including public nuisance)" (Federal Government 2001).

In other words, the Drug Policy note only gives a general description of "nuisance", being a negative consequence of the drug phenomenon on society. The concept is used further throughout the whole note, yet without a proper definition.

The federal government yearly makes available almost 12,5 million euro worth of extra resources for the execution of the Federal Drug Policy Note. With this budget, scientific research is stimulated as well (cfr. infra).

Under the heading repression, concerning the judicial policy regarding drug users, drug-related crime and drug traffic, the note claims:
"The prosecution policy is based on two pillars: the nature of the product and the severity of use. The directive uses, as to the severity of use, an ample frame of notions: "limited possession for personal use", "once-only use", "problematic use" and "public nuisance". These different concepts aim at a differentiated, adapted approach to the diverse types of drug use" (Federal Government 2001).

13.2.d Nuisance in the new drug law

The concept of "nuisance" is given, together with other concepts, a central place in the new modified drug law of 4 April 2003 and 3 May 2003.

The new drug law distinguishes three categories of behaviours. One of these categories concerns actions implying personal use of cannabis only, namely the supply, the possession, the import, the purchase and culture of cannabis. These actions lead to the most mild judicial reactions, essentially police penalties (art. 2ter, 1°, 2° and 3°). However, when it is a matter of public nuisance, they are penalized with the punishments fixed by article 2ter 4° of the drug law (correctional punishments). Also, nuisance influences the reactions of the public prosecutors on *all* drug-related infractions – also others than cannabis-related ones – and always aggravate the punishments.

While it lacks a proper definition, nuisance has important implications, although reference is made to article 135 §2 7° of the New Municipalities Law (De Nauw, 2004; Van Gaever, 2003; Vander Laenen & Dhont, 2003). Van Gaever nevertheless clarifies, referring to jurisprudence of the Supreme Administrative Court, that the concept is all about:

- less severe types of disruption of the public peace, safety, health and cleanliness,
- situations where drug-related behaviour is annoying for the environment,

- individual, material behaviours that can disrupt the harmonic ways of human activities and can restrict the quality of life of the inhabitants of a commune, neighbourhood or street in a way that exceeds normal pressures of social life – for instance: urinating in public, pollution, noise, verbal aggression, hindrance, being drunk in public, bothering other people,… The latter phrasing is taken from the Ministerial Circular Letter OOP dating from 2 May 2001, trying to make up for the lack of a proper definition in the New Municipalities Law (Decorte et al., 2004).

There are however also more objective circumstances: possession of cannabis in a penitentiary, in an educational institution, in a public institution building or its direct vicinity, or at places where minors gather for education, sports and other collective activities (Van Gaever, 2003: 284, k1; Vander Laenen & Dhont, 2003: 231, k2). Thus, music festivals and soccer stadiums are also included here in, although on this point there seems to be no consent between the minister of Justice and the minister of Public Health (De Nauw, 2004: 10).

And so, the concept is being associated with the broader issue of public peace and security and has as such nothing in specific to do with drugs.

13.3. RESULTS AND EVALUATION

Belgium contends with a lack of scientific research on drug-related crime and drug-related nuisance. Official statistics provide only a partial view of the issue. Therefore it is impossible to assess roughly how big the problem is (Federal Government 2001).

The Federal Drug Policy Note, as described above, foresaw a section “Epidemiology / Evaluation / Research”. Using the supplementary financial resources made available by the government, drug-related research can now be conducted at federal level. The research in the scope of the Federal Science Policy is something new for Belgium and thereby also means a sort of “zero-measurement”.

So, proceeding from the research programme supporting the Federal Drug Policy Note, research has been recently conducted on “Drugs and nuisance” (Decorte et al. 2004). This research recorded the phenomenon “drug-related nuisance”, studied its effects and gave an impression of the reaction to it. The study was conducted using three different approaches (experts, general population and drug users). The following research questions were dealt with:

- what is the relation between nuisance and drug-related nuisance
- consequences of the concept (drug-related) nuisance and the perception of it
- nature and scope of the (drug-related) nuisance phenomenon
- attitudes and opinions regarding (drug-related) nuisance.

The research indicated a clear distinction between different types of nuisance, with the already mentioned distinction between objective and subjective nuisance as a key element.

Objective point of view

- Criminal nuisance: the type of nuisance that can most easily objectified. It encompasses 3 types of infractions:
    - Acquisition crimes: infractions committed in the scope of being able to satisfy one's need for drugs (burglary, theft, assault,…)
    - Consensual crimes: often infractions without a direct victim, but increase the feeling of personal unsafety (dealing, trafficking,…)
    - Expressive crimes: infractions committed under influence of either legal products (alcohol,…) or illegal products (other drugs).
- Public nuisance: nuisance can be objectified a little less, but can nonetheless be defined in the judicial field. It concerns taking over public space, commotion,… At this level it becomes more difficult to differ between drug-related nuisance and more general forms of nuisance.
- Audiovisual nuisance: the most subjective form. It comprises the perception of behaviours, beyond the established norms and standards, that can provoke feelings of unsafety (homeless users, pollution of the environment, socially unadapted behaviour,…)

Subjective point of view

- Objective nuisance is verifiable and applies to everyone. The police registrations can be used for measuring this type of nuisance.
- Subjective nuisance, however, exists through a bias in experiences and feelings of unsafety towards different aspects related to the use and trade of drugs.

The researchers studied the impact of the following phenomena on nuisance during 12 months in different situations:

- traffic noise
- droppings of animals on the streets
- theft out of / vandalism of transportation vehicles
- garbage on the street / illegal dumping
- aggressive conduct in traffic / traffic accidents
- theft of transportation vehicles
- burglury in residences / other buildings
- odour coming from street traffic
- vandalism / graffiti on public property
- noise at night caused by people on the streets
- odour from street litter, containers, droppings
- vandalism / graffiti on private residences
- urinating in public
- noise caused by pets or garden animals
- noise caused by children playing outside
- robbery / aggressive theft
- noise caused by television / music from the neighbours
- brawls on street
- snatchers / pickpockets
- dilapidation of buildings
- noise caused by neighbours' quarrel
- noise caused by bars / discotheques

- steaming
- street prostitution.

This research showed that nuisance caused by drug users is rarely experienced as a problem. 84% of the people questionned indicated they had never felt threatened by drug users. The Security Monitor shows that 5,6% of the respondents consider nuisance caused by drug users as a problem. Nuisance caused by youths and by users of legal products (like alcohol) and the degeneration of the neighbourhood are considered worse. Drug-related nuisance does not appear to be a separate phenomenon, but exists in a context of general nuisance.

The research team concludes that a global nuisance policy has to act on the controllability and on the restoration of the livability. Besides the police, especially community workers and social (drug) workers should deal with nuisance. This policy should be the result of a balance between concentration and the spread. Hereto, attention has to be paid on (supra)local level to(Decorte et al 2004):

- keeping public spaces accessible by environmental planning and urban renewal
- counteracting concentrations of illegality and marginalization
- environmental preservation
- housing policy (among others against rack-renters)
- finally, all this needs to be supported by the necessary government instruments and a suitable (judicial) government reaction.

A local approach evidently has to be set within supra-local conditions (legislation, financing,…). Hereto, coherrence of measures and cooperation between communes, drug treatment, police and justice are essential.

At the moment, by order of the Federal Science Policy, a meta-analysis is carried out on the impact of local projects on drug-related nuisance. The results of this study will be available in autumn 2004[46].

13.4. CONCLUSION

Nuisance has become a point of interest with priority in the present policy notes. Depending on the specific point of view from which nuisance issues are looked at, different interpretations are given to the concept. In the above analysis, the emphasis lay with the judicial interpretation of the concept nuisance and so an overview of important relevant Belgian policy notes was given.

Recent policy notes regard the reduction of nuisance justly as a priority, and as a part of it see an important role for keeping specific forms of nuisance, caused by the drug phenomenon, controllable. The Executive Integral Security Note puts as essential objectives concerning nuisance (and neighbourhood crime) the amelioration of the quality of life of society and the reduction of impunity and the dissatisfaction among the population. To achieve this, coordinated policy actions are needed in preventive, repressive and curative areas. These actions should preferably coordinated at a central level and given shape and executed locally.

[46] More information on the federal research projects on drugs can be found at the following url: www.belspo.be

Recent Belgian research shows that drug nuisance does not exist as is, but must be regarded in a context of general nuisance like degeneration, rack-renting and vandalism.

A global nuisance policy therefore needs to be integrated and differentiated to be able to control the nuisance phenomenon and thereby restore the quality of life within a neighbourhood. The effectiveness of such a policy presumes the necessary (judicial and administrative) instruments allowing for a suitable reaction from the governments.

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Decreet 17 juli 2003 houdende instemming met het samenwerkingsakkoord van 2 september 2002 tussen de Staat, de Gemeenschappen, de Gemeenschappelijke Gemeenschapscommissie, de Franse Gemeenschapscommissie en de Gewesten voor een globaal en geïntegreerd drugsbeleid, Moniteur Belge/Belgisch Staatsblad, 10 September 2003, 45522-45523.

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Besluit 3 oktober 2003 van de Vlaamse regering houdende reglementering van de handel in en de keuring van zaaizaad van oliehoudende planten en vezelgewassen, Moniteur Belge/Belgisch Staatsblad, 7 November 2003, 54311-54340.

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Besluit van de Regering van de Franse Gemeenschap 10 december 2003 tot wijziging van het besluit van 10 oktober 2002 betreffende de controleprocedure voor de dopingpraktijk en tot vaststelling van de inwerkingtreding van sommige bepalingen van het decreet van 8 maart 2001 betreffende de promotie van de gezondheid bij de sportbeoefening, het dopingverbod en de preventie van doping in de Franse Gemeenschap, Moniteur Belge/Belgisch Staatsblad, 22 January 2004, 3913-3918.

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Besluit 4 maart 2004 van de Waalse Regering betreffende het in de handel brengen van zaaizaad van oliehoudende planten en vezelgewassen, Moniteur Belge/Belgisch Staatsblad, 21 April 2004, 23346-23388.

- Décret **19 mars 2004** portant approbation de l'Accord de coopération du 2 septembre 2002 entre l'Etat, les Communautés, la Commission communautaire commune, la Commission communautaire française et les Régions au sujet d'une politique des drogues globale et intégrée.

Decreet 19 maart 2004 tot goedkeuring van het Samenwerkingsakkoord van 2 september 2002 tussen de Staat, de Gemeenschappen, de Gemeenschappelijke Gemeenschapscommissie, de Franse Gemeenschapscommissie en de Gewesten voor een globaal en geïntegreerd drugsbeleid, Moniteur Belge/Belgisch Staatsblad, 3 May 2004, 36422.

- Arrêté royal **19 mars 2004** réglementant le traitement de substitution.

Koninklijk besluit, 19 maart 2004 tot reglementering van de behandeling met vervangingsmiddelen, Moniteur Belge/Belgisch Staatsblad, 30 April 2004, 35927-35930.

- Arrêté du Gouvernement wallon du **22 janvier 2004** modifiant l'arrêté du Gouvernement wallon du 07 novembre 2006 portant exécution du décret du 04 avril 1996 organisant l'agrément et le subventionnement des services de santé mentale.

Besluit van de Waalse Regering tot wijziging van het besluit van de Waalse regering van 7 november 1996 tot uitvoering van het decreet van 4 april 1996 betreffende de erkenning en de subsidiëring van de diensten voor geestelijke gezondheidszorg Moniteur Belge/Belgisch Staatsblad, 07 April 2004.

- Loi **12 avril 2004** insérant dans la loi du 24 février 1921 concernant le trafic des substances vénéneuses, sopoforiques, stupéfiantes, psychotropes, désinfectantes ou antiseptiques et des substances pouvant servir à la fabrication illicite de substances stupéfiantes et psychotropes une disposition réautorisant les officiers de police judiciaire à pénétrer et à fouiller dans tout lieu pendant la nuit sans autorisation préalable du tribunal de police.

Wet 12 april 2004 tot herinvoering in de wet van 24 februari 1921 betreffende het verhandelen van giftstoffen, slaapmiddelen, psychotrope stoffen, ontsmettingsstoffen en antiseptica en van de stoffen die kunnen gebruikt worden voor de illegale vervaardiging van verdovende middelen en psychotrope stoffen van de bevoegdheid van officieren van gerechtelijke politie om 's nachts alle plaatsen te betreden en te doorzoeken zonder voorafgaande toelating van de politierechtbank, Moniteur Belge/Belgisch Staatsblad, 13 May 2004, 38380-38381.

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Moniteur Belge, Belgisch Staatsblad.
http://www.just.fgov.be/index_fr.htm

National Institute of statistics
http://www.statbel.fgov.be

FEDRA Federal Research Actions
http://www.belspo.be/belspo/fedra/pres_fr.stm

COFRAREF Publications of the Belgian French Community
http://www.cfwb.be/cofraref/

Web Sites

Arbeitsgemeinschaft für Suchtvorbeugung und Lebensbewältigung (ASL)
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http://www.ulb.ac.be

ULB Unité de Promotion Education Santé
http://www.ulb.ac.be/esp/promes/sommaire.html

Université de Liège
http://www.ulg.ac.be

University of Antwerpen
http://www.ufsia.ac.be/

University of Leuven
http://www.kuleuven.ac.be

Vereniging voor Alcohol- en andere Drugproblemen
http://www.vad.be

ANNEXES

ANNEX 1 LIST OF STANDARD TABLES AND STRUCTURED QUESTIONNAIRES

Standard tables used:

02 (2004), 06 (2003), 10 (2004), 09 (2004),11 (2004), 12 (2004), 13 (2004), 14 (2004), 16 (2004), 19 (2003).

Structured questionnaires used:

22 (2004) and 23 (2004).

ANNEX 2 LIST OF TABLES

ANNEX 3 LIST OF FIGURES

ANNEX 4 LIST OF ABBREVIATIONS

APSD/SGAP	Algemene Politiesteundienst / Service Général d'Appui Policier
ALTO	Alternatives aux Toxicomanies
ASBL	Association Sans But Lucratif (non-profit organisation)
ASL	Arbeitsgemeinschaft für Suchtvorbeugung und Lebensbewältigung
BCR/CBO	Bureau Central de Recherche - Programme Drogue / Centraal Bureau voor Opsporing – Programma Drugs / Central investigation office – Drug programme
BELSPO	Belgian Science Policy
CAD	Centrum voor Alcohol- en andere Drugproblemen (Hasselt)
CAPA	Centre d'Actions de Prévention des Assuétudes
CAT	Centrum voor studie, behandeling en preventie van Alcoholisme en andere Toxicomanieën (Ghent)
CBO/ BCR	Centraal Bureau voor Opsporing – Programma Drugs / Bureau Central de Recherche - Programme Drogue / Central investigation office – Drug programme
CCAD	Comité de Concertation sur l'Alcool et les autres Drogues
CGG	Centrum voor Geestelijke Gezondheidszorg
CIC	Crisis Interventie Centrum
COCOF	Commission Communautaire Française *(Communauté française à Bruxelles)*
CPAS/OCMW	Centre Public d'Aide Sociale / Openbaar Centrum voor Maatschappelijk Welzijn
CTB/ODB	Concertation Toxicomanies Bruxelles / Overleg Druggebruik Brussel
CFWB	Communauté française Wallonie Bruxelles
DWTC/SSTC	Federale Diensten voor Wetenschappelijke, Technische en Culturele aangelegenheden / Services fédéraux des affaires Scientifiques, Techniques et Culturelles
EDDRA	Exchange On Drug Demand Reduction Action
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
FNRS	Fonds National de Recherche Scientifique
GEMT	Groupe d'Etude des Maladies liées à la Toxicomanie
HBSC	Health Behaviour in School-aged Children
INAMI/RIZIV	Institut National d'Assurance Maladie-Invalidité/RijksInstituut voor Ziekte- en Invaliditeitsverzekering
IPH/ISP/WIV	Scientific Institute of Public Health/ Institut Scientifique de la Santé Publique/ Wetenshappelijk Institut Volksgezondheid
IVDU(s)	Intra-Venous Drug Use(rs)
KUL	Katholieke Universiteit Leuven
LOGO	Loco-regionaal-Gezondheidsoverlegen Organisatie (Flemish Community)
MASS/MSOC	Maison d'Accueil Socio-Sanitaire / Medisch-Sociale Opvang Centra
MKG/RCM	Minimale Klinish Gegevens / Résumé Clinique Minimal
MPD/MPG/RPM	Minimum Psychiatric Data /Minimale Psychiatrische Gegevens / Résumé psychiatrique Minimal /
MSOC/MASS	Medisch-Sociale Opvang Centra / Maisons d'Accueil Socio-Sanitaire
OCMW/CPAS	Openbaar Centrum voor Maatschappelijk Welzijn / Centre Public d'Aide Sociale
OCRTIS	Central Office for the Repression of Illicit Narcotics Trafficking
PZ	Psychiatrisch Ziekenhuis
PPP	Provinciale Preventieplatforms (*Flemish Community*)
PAAZ	Psychiatrische Afdeling van een Algemeen Ziekenhuis
RCM/MKG	Résumé Clinique Minimum / Minimale Klinish Gegevens
REITOX	Réseau Européen d'Information sur les drogues et Toxicomanies / European information network on drugs and drug addictions
RIZIV/INAMI	RijksInstituut voor Ziekte- en Invaliditeitsverzekering/Institut National d'Assurance

	Maladie-Invalidité
RPM/MPG	Résumé Psychiatrique Minimum / Minimale Psychiatrische Gegevens
SGAP/APSD	Service Général d'Appui Policier / Algemene Politiesteundienst
SODA	Stedelijk Overleg Drugs – Antwerpen
SPZ	Sozial Psychologisches Zentrum
SSTC/DWTC	Services fédéraux des affaires scientifiques, techniques et culturelles / Federale diensten voor wetenschappelijke, technische en culturele aangelegenheden
TG	Therapeutische Gemeenschap
TIMC	Toxicomanies et Interventions en Milieu Carcéral
ULB	Université Libre de Bruxelles
UNDCP	United Nations International Drug Control Programme
UG	Universiteit Gent
ULG	Université de Liège
VIG	Vlaamse Instituut voor Gezondheidspromotie
VLOR	Vlaamse Onderwijs Raad (Flemish Community)
VRM	Vlaamse Registratie Middelengebruik
VSPP	Vast Secretariaat voor het Preventiebeleid / Secrétariat Permanent à la Politique de Prévention
VAD	Vereniging voor Alcohol en andere Drug problemen
VDAB	Vlaamse Dienst voor Beroepsopleiding en arbeidsbemiddeling / Flemish Service for Employment Mediation
VVBV	Vlaamse Vereniging voor Behandelingscentra in de Verslaafdenzorg
VZW	Vereniging Zonder Winstoogmerk (non-profit organisation)

ANNEX 5 INDEX