



*Scientific Institute of Public Health
Unit of Epidemiology*

**2005 NATIONAL REPORT TO
THE EMCDDA
by the Reitox National Focal
Point**

“BELGIUM”

**New Development, Trends and In-depth
information on Selected Issues**

FINAL

REITOX

IPH

Belgian national report on drugs 2005

Epidemiology Unit, Scientific Institute of Public Health, October 2005, Brussels (Belgium)

IPH/EPI REPORTS N° 2005 - 012

Deposit number: D/2005/2505/27

BELGIAN NATIONAL REPORT ON DRUGS 2005

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The report was achieved thanks to the contribution of many experts and professionals who participated in the data collection or in the review of the report. Their essential involvement is gratefully acknowledged.

Especially, we would like to thank for their very active collaboration:

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Call for contribution and comments

Everyone interested in contributing to the next Belgian Report on Drugs can contact the Belgian Focal Point. All comments are welcome.

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Belgian National Report on Drugs 2005

SUMMARY

National policies and context

Since the Federal Drug Policy Note of **2001**, new developments occurred in the Belgian Drug Policy. In **2003**, a new drug law distinguishing cannabis from the other illicit substances was released. Possession of a small quantity of cannabis, even for personal use, remains a criminal offence but the Public Prosecutor could not prosecute the cannabis possessor if there is no evidence of a problematic drug use or public nuisance. It is important to note that the criminal law and, as a consequence, the prosecution policy, does not apply to minors. End October **2004**, further to a decision of the Court of Arbitration, the new law was modified. Criticised by NGO's for the unclear concepts of public nuisance and problematic use, the concerned article (art 16) was suppressed. Early **2005**, a new common directive intended to fill in the gap opened by the deleted article, was released. It has to regulate the registration and the prosecution of cannabis possession offences. An adult in possession of cannabis for personal use (maximum 3 grams or one plant) is only subject to a registration if there are no evidence of aggravating circumstances or disturbance of public order.

In the French-speaking part of the country, an experts group was appointed in order to set up a "concerted action plan of prevention, help and care in drug addiction".

Drugs are perceived as easily available by the public opinion. Curiosity and peer pressure are reported to be the two most reasons to experiment drugs by youngsters (15-24 years).

Drug use in the population

All the most recent studies reported the popularity of cannabis among the general population and youngsters. During the school year 2003-2004, the last year prevalence of cannabis use among Flemish students (11-22 years), is about 15% compared to the last year prevalence of all other illicit drugs use that is 3%. From the school year 2000-2001 to 2003-2004, prevalence of cannabis and of other illicit drugs is stabilising among this school-aged population.

Prevention

Universal prevention programmes, which are under the responsibilities of the Communities and /or Regions, are mainly held in schools and more precisely in the secondary ones. General population is still interested by information, advices e.g. on cannabis, even if a decline is perceived). Indeed, in the Flemish and French Communities, around 40% of calls received by helplines in concerned questions on cannabis and approximately 15% were related to cocaine. Recently, drug helplines developed an email-counselling project in addition to the traditional phone service.

Few projects targeting ethnic groups were found.

In recreational settings, **selective** prevention is well developed in the country. Mainly, youngsters are targeted and projects are harm reduction oriented.

▀ Problem drug use

Comparable data on treatment demands at national level are not yet available. Therefore, a Belgian version of the Treatment Demand Indicator protocol was prepared but this still has to be implemented in order to meet the objective of having comparable information.

Data from non-treatment sources indicate in the French Community a decrease in the percentage of injecting use, with a current use of about 43% in 2004.

Data from needles exchange programmes still report polydrug use as a common practice.

▀ Drug-related treatment

In drug policy documents, importance is given to the multidisciplinary of addiction treatments and it is also mentioned that there is a need for a global and integrated offer. This could be realised by the creation of treatment circuits and networks. The treatments offer is very broad (residential settings, low-threshold programmes, e.g.) and varies geographically. Substitution treatments were prescribed for years although the first law recognising them was published in 2002 and followed by a Royal Decree in 2004. Texts for the implementation of this Decree are still waited for.

▀ Health correlates and consequences

Concerning data on drug-related deaths, only available for the period 1987-1997, a sudden rise was seen in 1993. This rise could be partly due to an improvement of the death certification quality. From 1993 onwards no significant change could be observed. Almost three out of four 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.

The decrease in the proportion of all IDUs among HIV cases is confirmed, amounted at around 10% in 1986, to approximately 3% in 2004.

In the French Community, the HBV self-reported prevalence in 2002 (9%) is lower than in 1997 (23%) and the self-reported HCV prevalence of 67% in 2002 is higher than during the last 5 years.

In the Flemish Community, the reported data on biological testing for HBV, indicate in 2003 a prevalence varying from 17% to 58%. Results of biological testing for HCV showed a prevalence ranging from 35% to 76% in 2003 according to source data.

In the framework of the "Road Safety Action Plan", blood samples were taken during police road controls when results of standardised physical and urine tests were positive. In 2004, out of 975 samples, 855 were found positive to illicit substance use and 120 were false positive. The most important substances detected were: cannabinoids in almost 60% of those samples, amphetamines alone in 15%, amphetamines with cannabinoids in 11% and cocaine in 5%.

▀ Responses to health correlates and consequences

An Early Warning System was developed and aimed at exchanging information on new and/or dangerous drugs. The National Focal Point, Sub-Focal Points, judicial authorities, police, forensic laboratories, emergency wards, helplines e.g. are part of the Early Warning network. Information on substances and related risks are broadly disseminated. Other instruments of drug-related prevention are the needles exchange programmes, available throughout the country (except in the German speaking Community), but safe injection rooms do not exist in Belgium.

In 2004, approximately 309 000 syringes were distributed and 306000 were given back to one of the needles exchange points of the Flemish Community. For the same year, in the

French Community, around 257 000 were given and approximately 265 000 were brought back. The access to other injection equipment is much lower.

Generally speaking, it could be underlined that special emphasis is given to counselling and testing for hepatitis C and to interventions related to psychiatric-co-morbidity.

▀ Social correlates and consequences

The number of people taken in for questioning continued to rise in 2004. However, a decrease of 16% in the number of drug-related offences is observed compared to 2000. Cannabis remains the drug the most commonly involved in drug reports, followed by cocaine. In prison too, cannabis use is the most regularly reported. It can be noticed that among prisoners there is a tendency towards polydrug use, with most detainees using three different substances or more.

▀ Responses to social correlates and consequences

The Federal Drug Policy Note insists on the importance of considering individual and social problems to tackle drug dependence. Social reintegration projects (housing, training, employment) vary according to geographical areas and local programmes. Regarding housing facilities for homeless drug users, recent reports indicate that there are too few of them. Some projects aimed at socio-professional reintegration of drug users exist in partnership with e.g. centres of social welfare, institutions specialised in employment,...

In prisons, health care is provided by the Ministry of Justice. Substitution treatments are available and managed by GPs or psychiatrists. Efforts to better diagnose hepatitis C in prisons started with a new protocol of detection, however not yet largely implemented.

▀ Drug markets

In 2004, results of the Eurobarometer showed that 50% of the Belgian respondents (between 15-24 year olds) have already been offered cannabis, 27% other substances than cannabis.

The National Security Plan (2004-2007) specifies four objectives as regards drugs issues. Priority is given to the fight against:

- illegal laboratories producing synthetic drugs,
- cocaine importation, exportation of synthetic drugs and re-exportation of heroin,
- criminal organisations especially active in synthetic drugs and heroin,
- drugs tourism and related nuisances.

Police services report that at national level ,trafficking is essentially polydrug trafficking It was observed that production processes of synthetic drugs and activities of traffickers are more geographically widespread than before.

From 2001 to 2003, prices of all illicit substances decreased a little, only LSD became a bit more expensive. In 2004, a gram of cannabis was approximately sold at EUR 5 and cocaine at around EUR 41.

No particular trend about the purity of seized drugs was observed.

▀ Gender differences

In Belgium few studies have been carried out on gender differences in drug use patterns and other drug-related subjects, however a few studies are currently ongoing.

Among the Belgian population older than 15 years old, the prevalence of experimental as well as recent cannabis use is significantly higher for men than for women. Furthermore, male injecting drug users seem to have higher rates of hepatitis B infection than women, while for hepatitis C no unequivocal statements can be made. Mortality figures demonstrate that women make up about one fifth of all drug-related deaths.

Overall, about 10% of all major drug-related offences are committed by women but this percentage is higher for offences related to cocaine (12%), heroin (14%), and amphetamine type stimulants (16%) and lower for offences related to cannabis (9%). The proportion of men in Belgian prisons is significantly higher than that of women, but a study results indicated about 40% of the female prisoners seem to be in prison for drug crimes while for men this percentage is much lower (13%). This can be explained by the fact that besides drug-related offences, men commit much more other crimes (e.g. violent crimes) than women. With regard to the responses to illicit drug use in Belgium, gender-specific initiatives in the sector of drug prevention and treatment, harm reduction and criminal justice are rather scarce.

▣ *European drug policies: extended beyond illicit drugs ?*

The Belgian Federal Drug Policy Note distinguishes licit and illicit drugs only when meaningful. Gambling is not addressed in this Note. The first Federal anti-smoking plan was launched in January 2004 in order to maximise the efforts of all actors in the fight against tobacco. As regards alcohol there is not yet a federal plan but it is foreseen. There is neither a global anti-doping policy because this issue is under the responsibility of the Communities. Then several anti-doping strategies coexist.

▣ *Developments in drug use within recreational settings*

Drug use is reported in all kind of nightlife activities. The musical programming of the event has an impact on the prevalence and patterns of drug use. No particular geographical location was identified where drug use in recreational settings was more prevalent (except may be along the country borders). In the French Community, the first harm reduction activities in recreational settings were carried out in 1996. The first Flemish global prevention concept for partygoers and nightlife professionals 'Partywise' was initiated more recently, in 2003. Safe settings in clubs, well-being charter, media campaign, flyers, brochures, trainings, participative projects, Early Warning System, are some of the instruments developed in order to response to the drug use in the nightlife scene. There is no legal text, nor a particular official policy guiding all these interventions in recreational settings.

PART A. New developments and trends



In 2003, there was an amendment to the drug law, distinguishing cannabis from the other illicit drugs. The new text was criticised by several associations from the French-speaking part of the country, who introduced an action of annulment before the Court of Arbitration. The concepts of “public nuisance” and “problematic use” were considered insufficiently defined. Later in October 2004, the Court cancelled the concerned article. On February 1st 2005 a new common directive about the registration and the prosecution of cannabis possession offences became effective.



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 1921¹). 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 society.

Overall, the note comprises three fields of action, being prevention, treatment and repression. For more details on the policy note, see one of the previous Belgian National Reports 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 longer seen as punishable *in se* (instead, drug use in presence of minors is emphasized). For more information on this subject, please refer to one of the previous Belgian National Report on Drugs (2003).

Annulment of article 16 of the Drug law of 3 May 2003

On 28 November 2003, five non-profit organisations demanded the Court of Arbitration to cancel article 16 of the drug law of 3 May 2003. This article stated that the possession of a certain amount of cannabis (a “consumer’s amount”) by an adult, without the presence of public nuisance or problematic use, would only lead to a registration by the police (i.e. it would no longer lead to prosecution).

Among others, the submitting organisations found the terms “public nuisance” and “problematic drug use” lacking a decent definition² and in violation of the principle of legality. Indeed, at that given moment, one could not be sure of the consequences of the possession of cannabis since police officers themselves had to judge whether the

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

² See 1.2.c on this issue.

situation was accompanied by “public nuisance” or “problematic use” lacking objective criteria, constituting a source of legal insecurity.

The Court of Arbitration ruled in favour of the five French-speaking submitting organisations and annulled article 16 of the drug law of 3 May 2003 on 20 October 2004.

A new directive

Since the decision of the Court of Arbitration mentioned above, the drug law fell short of regulating the judicial reaction on the drug phenomenon, especially concerning cannabis. As a result, a new joint directive of the Minister of Justice and the Prosecutors-general was published, dealing with cannabis-related infringements. This directive subjects the possession of an amount of cannabis for personal use by an adult to a simple registration only, if there are no aggravating circumstances or disturbance of the public order.

The **amount for personal use** is defined as a maximum of 3 grams of cannabis, or one plant (without any indication of the intention to sell or trade). The **aggravating circumstances** are those defined in the drug law of 1921, generally concerning the involvement of minors or inflicting permanent damage to another person. The circumstances causing a **disturbance of the public order** are defined in the directive as possession of cannabis in a penitentiary facility, a facility for youth protection, an educational institute or its direct vicinity (e.g. a bus stop near a school) and ostentatious possession in a public area or place accessible to the public (e.g. a hospital).

Note that when the possession of cannabis leads to a simple registration the cannabis itself is not seized and may remain in the possession of the person.

Local differences and circumstances can be taken into account by dispersing more detailed guidelines.

1.1.b Laws implementation

The Royal Decree of 17 January 2005 provides the possibility to create “drug plans”: local action plans aiming at the prevention of drug-related nuisance and local coordination of the actions taken concerning drug addiction. The cities / municipalities involved are granted funding through a contract signed with the State. Two Ministerial Decrees (20 and 24 January 2005) fixed the amounts for the years 2005 and 2004 respectively, ranging from EUR 27 568 29 to 73 748 32. The projects realised through these drug plans aim more at strengthening and consolidating existing structures and services than at creating new ones. Projects of local coordination of initiatives concerning drug addiction, outreach work, psychosocial help, ambulant help and the creation/strengthening of relief and crisis centres are given priority.

The Ministerial Decree of 7 February 2005 ensures the continuation of the security and prevention contracts between the State and 73 cities / municipalities for the year 2005, with funding ranging from almost EUR 20.000 to over EUR 2 700 000.

1.2.a Coordination arrangements

The German-speaking Community has promulgated and published a decree (21 March 2005) approving the cooperation agreement on a global and integrated drug policy of 2 September 2002 between the State and the different federate levels. So far, four federate bodies have approved the agreement: the Federal Government, the Flemish Community, the French-speaking Community and the German-speaking Community. The agreement has yet to be approved by the Walloon Region, the Brussels Capital Region, the Commission of the French-speaking Community and the Joint Community Commission.

1.2.b National plan and /or strategies

This section deals on one hand with the federal level and on the other hand with the federate levels (Flemish, French-speaking and German-speaking Communities, the Brussels Capital Region as well as the Walloon Region).

➤ Federal level

At federal level, the government continues the implementation of the Federal Drug Policy Note, started in 2001. In 2002, three pilot projects³ were initiated in collaboration with some federate entities. They concern dual diagnosis treatment offer, crisis intervention and case-management, and finally networks for integrated drug treatment programs (health coordinator). These pilot projects are under evaluation, results are still not published.

➤ Federate levels

◆ *Drug Policy in the Flemish Community*

In the policy paper of the Flemish government ('Flanders 2004-2009'), a paragraph deals with the prevention of addictive substances (tobacco, alcohol and drugs) and expresses the commitment of the Flemish government to strengthen a sustained and integrated prevention policy with extra financial means.

This commitment is repeated in the policy paper of the Flemish minister of health and the use of psycho-active medicines and gambling are added to the list of addictive behaviours. Family and environment are mentioned as important sectors for prevention. Early intervention and care for parents and family of addicted young people will be given special attention. Co-operation with the federal government is an important target.

The cooperation between the Flemish government and the co-ordinating agency VAD (Vereniging voor Alcohol- en andere Drugproblemen) continues 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.

³ More information on these projects on: <http://www.health.fgov.be>

At provincial level, the provincial networks are continued and the prevention workers pursue their work in the mental health centres.

The needle exchange programme continues on the basis of 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 "Health Promotion in School" (HPS) crews. The HPS decree (20 December 2001), has replaced the former concept of "School Medical Inspection" by "Health Promotion in School". The objective is to broaden the definition of the concept of health. 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. "Prevention 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 elaborate prevention plans 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 whether 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. Priorities of the government are given to prevention of tobacco and alcohol use.

- ◆ *Drug Policy in the Brussels-Capital Region*

The Brussels Drug Programme is continued (please refer to the previous Belgian National Report on Drugs). The health commission of the Brussels regional Parliament auditioned different experts (GPs, mental health services, medical houses, social services,...) in order to "evaluate the legal measures taken in the framework of the health policy as regards mental health and addiction". The important part taken by the problems related to the use of psychoactive substances in the problematic are reported by all experts. The health commission should prepare a report on these issues.

In the near future, the CTB/ ODB will launch initiatives to examine the difficulties faced by the external services working in prisons. In addition, it will work on how to improve interventions among the primary health care regarding the persons with "minor" drug related problems.

1.2.c Implementation of policies and strategies

A Royal Decree on the *Practitioners Prescribing Substitution Treatment* was adopted in 2004 (19 March 2004). This document indicates that practitioners regularly 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 track of several items in the medical file of the patient. The maximum number of patients by practitioner 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 decree mentions that data on the delivery of the substitution treatments should be gathered by the Tarification Office and anonymous information on the patient should be 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) was published (still has to be implemented) 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 gives advice on drug policy.

This decree is executed by the decision of the Walloon government of 3 June 2004. This text establishes 12 zones of treatment in the Walloon Region, each zone gathering several municipalities and constituting one network.

Each network of treatment, and each organisation inside it must ask its agreement to the Minister in charge of Health matters in the Walloon Region. The Minister bases his decision on the advice of a «Consultative commission in matters of drug-use».

In its agreement demand, each organisation and each network must provide a detailed five-year action plan (description of the treatment supply, definition of objectives, etc.).

Dialogue processes as well as clinical intervisions are held inside each network. The dialogue deals e.g. with the planning of actions, negotiations with other networks, information, the (mandatory) collect of statistical data necessary to evaluate the needs in the treatment of addictions...

The network is also in charge of the organization of intervisions between clinicians, and must also define the categories of professionals allowed to these intervisions. It is clearly stated that these persons are held to a strict professional secrecy.

The annual funding of a network amounts to EUR 25 000 for coordination charges, plus a contractual subsidy based on the number of inhabitants and is fixed each year by the government.

1.2.d Impact of policies and strategies

With the changes to 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, still is a criminal offence. However, in principle, the public prosecutor will no longer prosecute this type of criminal offence as long as the possession of an amount

for personal use is not accompanied by aggravating circumstances or disturbance of the public order.

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.

The study on “Problematic use of (illegal) drugs: operationalisation of the concept in a legal context” concludes that the concept of problematic use is not workable for the police and justice department and that it is not useful to elaborate an operational definition in the legislation (Decorte et al. 2005). The authors recommend to eliminate this concept from the legislation as it does not clarify the situation nor gives more legal security. Instead they suggest a new notion of “personal use” defined according to the quantity of drug found.

An experts group was appointed (10/12/2004) by the Public Health authorities of the **French Community and Walloon region** in order to establish a “concerted plan of prevention, help and care in drug addiction”. A Brussels expert also participated in the group (Collège d’experts en assuétudes 2005).

The experts (from 1st January to 30th June 2005) had to:

- Draw up a **critical register** of the actions and projects carried out in the fields of prevention and care for drug users and their families and identify the shortcomings or duplicates, but this turned out to be too heavy to be realised.
- Establish an exhaustive and argued **inventory of the needs** requiring a joint action of both governments
- Propose **concrete priority actions**, intended to be funded in 2006 by the Walloon Region and the French Community.

➤ Among the 76 recommendations, 11 address more particularly political aspects and methodology:

1. *Status of the federal policy note:* The current status of the Federal Drug Policy Note about drugs of January 2001 should be re-defined, as well as the creation of the “General Coordination Unit”, recommended in the Federal Drug Policy Note but still not created.
2. *Definition of the basic principles:* The federate entities should find an agreement on the fundamental principles of a common drug policy.
3. *Inclusion of licit and illicit drugs:* Interventions in the drugs field should include all psychoactive drugs (legal and illegal), and *specify* them (as an indication: alcohol, tobacco, illicit drugs, psycho-active medication).
4. *Priority granted to health:* *Health*, before *security* or *nuisances*, should be recognised as the top issue related to drug (ab)use and its policy, even if the others must be taken into account. This should for example be reflected in the funding granted to these various issues
5. *Priority granted to prevention:* In order to promote health as the priority issue, prevention should be privileged (before cure or other issues). But the *object* of prevention must be defined by the governments as well (prevention of infringements, of social problems, of health problems...?). Finally, the governments must focus on the *evaluation* of prevention actions which are too rare.
6. *Appropriate terminology:* Too often are the terms of “drug use” or “drug addiction” used to cover a larger and more complex reality. The terminology should be enlarged to: *drug use/consumption; abuse; acute/chronic and addictions*.

7. *Use of the existing data:* The varied and numerous data coming from the field are not sufficiently used. This tendency should be changed.
8. *Priorities and objectives:* they should be defined more clearly by the governments.
9. *Appropriate communication:* Communication towards the public must be improved: underestimating alcohol and tobacco while causing the largest damage in terms of public health, should be avoided.
10. *Enlightened choice of strategies:* Under the light of field actors and administrations, the governments must define the choice and the chronology of the chosen strategies. This frame must then lead to very concrete decisions (legislation, agreement of services, funding...).
11. *Better use of the work of dialogue assemblies:* The governments should make a larger use of the available resources from dialogue assemblies.

➤ The priority actions:

Experts had to study 3 variables: *cure - harm reduction - prevention*, along 3 axes: *(delinquent) youth – housing – insertion*.

1. The improvement and diversification of help and treatment for drug addicts. Between 120 and 150 residential beds are available in the French Community, which is insufficient since they are partly dedicated to alcohol addicts. Besides, very few possibilities exist for women accompanied by their child(ren).
2. The definition of an optimal harm reduction policy :
The harm reduction approach should be flexible and innovative in order to keep up with the fast evolution of the substances and patterns of use.
3. The reinforcement of collaboration between harm reduction and medical actors. Actors involved in harm reduction seem to redirect drug users towards specialised structures when necessary. General practitioners e.g. should be encouraged to address harm reduction messages to their drug using patients.
4. The creation of new departments of guidance for parents of drug addicted persons.
5. The setting up of collaboration between specialised youth services and medical or therapeutic centres.
6. The creation of a global prevention strategy inside schools and other social environments of youngsters.
7. The participation of social-educational actors to the drug addiction network. Experts stress the creation of dialogue areas between the drug addiction network and other sectors.
8. The improvement of the intake of drug addicted delinquents, especially minors, including during a possible imprisonment. At the present time, the prison system *generates* a high risk of drug addiction. It is a place of initiation and of poor access to prevention means and reduction of risks. The measures should also be extended to the detention centres for minors (IPPJ).

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

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

The latest figures on drug-related public expenditures show that the Belgian trend is to increase the funds dedicated to the drug policy⁴ (De Ruyver et al 2004). This is especially observed in the research sector, which budget got the biggest increase (multiplied by 7 since 1993). Expenditures for the prevention sector were multiplied by 5 and for the assistance sector by 2. However, research and prevention remain very poorly funded. The “security” area receives 54% of the total budget, 38% goes to “assistance”; “prevention” 4%, “policy management” 3% and finally “research and epidemiology” is the least financed area with only 1% of the total budget.

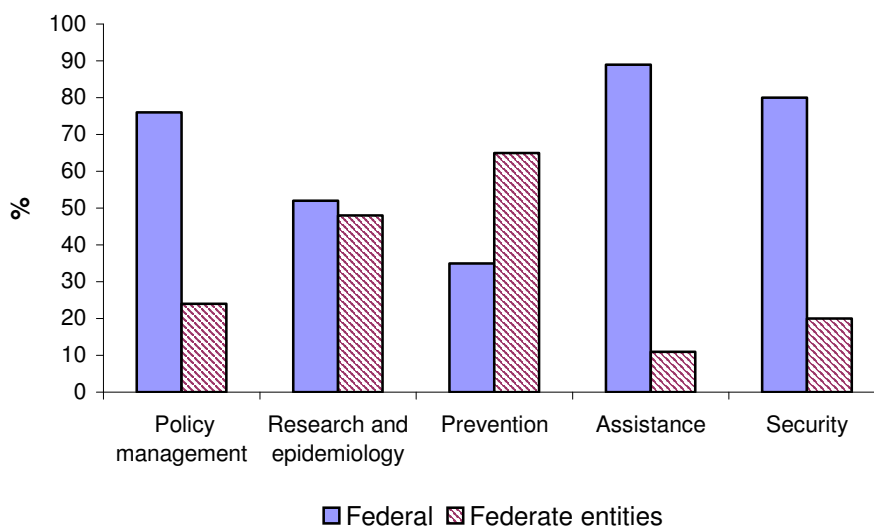
In 2002, the global public expenditures amounted to EUR 185 908 773,00 This corresponds to a contribution of EUR 18,03 per inhabitant.

A new follow-up study on public expenditures will start in October 2005, aimed at refining the methodology and measuring the public expenditures on drugs in 2004.

1.3.b Funding arrangements

As already explained in previous years, 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. 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).



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

⁴ It is important to notice that the reported data are based on estimation of budgets thus do not represent the exact budgets. Full information on the study were published in last year report.

With respect to the “prevention”, figure 1 reflects that the policy is under the responsibility of the federate entities. 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.

Concerning the “research and epidemiology”, the financing is almost at the same level for the Federal government as for the other entities. The Federal Government largely finances the three other sectors.

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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.

In 2004, the annual budget supported by each Community was the following:

Flemish Community: EUR 2 317 282,00

French Community: EUR 1 353 601,21

German Community: EUR 385 370,40

Walloon Region: EUR 1 390 242,00 (in 2003)

Mixed Community Commission of the Region of Brussels Capital: EUR 210 000,00

French-speaking Community Commission of Region of Brussels Capital:

EUR 3 429 000,00

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

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1.4.a Public opinions of drug issues

► Eurobarometer

In 2004, for the second time, a Eurobarometer study “Young people and drugs” was carried out in all EU Member States (EOS Gallup Europe 2004). The sample comprises 7659 youngsters between 15 and 24 years old.

In Belgium, 83% of the respondents think it is easy to get drugs at parties, compared to 79% in the EU (15 Member States). 60% of the Belgian respondents said it is easy to get drugs in or near school/college, compared to 57% in the EU.

When asked whether they know people who use cannabis, 74% answered positively. 53% of the respondents know people who use drugs other than cannabis. Half of the Belgian respondents were already offered cannabis, 27% were offered another drug than cannabis.

In 2004, the lifetime prevalence of cannabis use was 31% and 11% for last month cannabis use. The lifetime prevalence of other drug use was 8% and the last month prevalence 3%. More men than women have declared having tried cannabis or having consumed it in the last month.

Curiosity is the main reason to experiment with drugs, reported by 70% of the respondents; 45% answered peer pressure and 26% thrill seeking. In Belgium, 67% of the respondents think that drug dependence is a consequence of the use of drugs while infection with communicable diseases (HIV/Aids, hepatitis, ...) is less frequently perceived as a consequence (26%).

More women than men find cannabis very dangerous. In Belgium, 44% consider the occasional use of cannabis harmless.

Only 10% of the Belgian respondents tend to consider that occasional use of synthetic drugs such as XTC is harmless. In comparison, 65% of the respondents consider the occasional use of alcohol as harmless.

1.4.b Attitudes to drugs and drug users

In the 'leerlingenbevraging' school-aged children (N=1498) between 12 and 18 years old were asked why youngsters use drugs (Kinable 2004). The most reported answers were: 'just for the kick' (52.4%), 'to act tough' (52%), 'curiosity' (43.8%) and 'pressure from friends' (35.6%). The older the respondents are, the more the expected effects of drugs get important e.g. 'to feel great' or 'to relax'.

To the question 'why youngsters don't use drugs?', the most reported answers are: 'afraid to get addicted' (48%), 'because they don't need drugs' (34.5%), 'afraid for the reaction of their parents' (30.6%), 'because illegal drugs are dangerous' (27.8%).

When asked for the reaction of their best friend when he/she uses cannabis, 71% of the youngsters think their friend would reject his/her use. About 20% thinks it doesn't matter and almost 10% believes that the friend would approve his/her behaviour. Almost all students think his/her parents would reject the use of cannabis.

1.4.c Initiatives in parliament and civil society

► VAD conference

Every year the VAD organises a conference on new trends and topics in the alcohol and drug field. In 2004, the main issues were living in a risk society, craving, evaluating in the drug care, internet addiction, illegal drugs and public spending.

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

- One proposal is a direct consequence of the annulment of article 16 of the drug law of 3 May 2003, trying to define the terms "problematic use", "public nuisance" and defining the permitted quantity of cannabis aims at modifying the Narcotic Drug Act. However, considering that after this proposal the Minister of Justice and the Prosecutors-general issued a directive with other definitions than used in this proposal, it is unlikely that this proposal will be adopted. This proposal was introduced before the Chamber of Representatives (51K1600) as well as the Senate (3-1002).
- Another proposal wants to add the use of medicinal cannabis to the Narcotic Drug Act. For this purpose, an Office for medicinal cannabis would be created, answering for the cultivation, processing, storage and distribution of the cannabis. The patient would only be able to obtain the product from a limited number of pharmacies on doctor's orders. (51K1841) A similar proposal was introduced before the Senate (3-1181).
- A proposal concerning drugs and sport has been introduced before the Senate. This proposal foresees the possibility to reduce or let off the punishment for certain drug-related offences in sports if the person reveals offences committed by other sportsmen(-women) . This way, a kind of "tattle" system would be introduced to help find drug offences in sports. (3-762).

► Further to their joint action with four other institutions to cancel the art.16 of the 3 May 2003 drug law (see 1.1.a), Fedito (French-speaking Federation of centres for drug addicts) organised public debates on the cannabis issue. In January 2005, Fedito published a position on the cannabis status⁵ as a starting step for the future debates. They stress the importance to manage the issue of cannabis with new approaches (not the repressive ones, as they do not help to reduce cannabis use).

► Substitution conference

The CTB/ODB organised on 19 March 2005, a conference on substitution treatment with the presence of national and international experts. This initiative is in line with the recent availability of buprenorphine as substitution treatment on the Belgian market. Conference proceedings will be available by the end of 2005.

► Belspo conference

Findings of all the studies financed by the Federal Science Policy Office (Belspo) under the research programme in support of the federal drugs policy document were presented during a conference in 2005. Since the start of the programme, 22 research projects have been carried out.

1.4.d Media representations

The main topics related to drugs, discussed in the media :

- epidemiological data: general, cannabis, XTC, alcohol,
- young people and drugs: nightlife, young people and drug use, XTC, Viagra®, cocaine, speed; 'drug dogs' 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:

2004-2005: 26-45 years: with 'message in a bottle': website⁶, 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.

Press releases have reflected in a large way the debate around the use of cannabis since the suppression, by the Court of Arbitration, of article 16 of the decree of 3 May 2003, as mentioned previously.

⁵<http://www.fedito.be/>

⁶[http:// www.boodschapineenfiles.be](http://www.boodschapineenfiles.be)

In the meantime, as press releases report, the Minister of Justice was questioned by a deputy on the circular devoted to replace the ambiguous notions, and on a law that will be proposed “in the upcoming months”, to replace the circular, together by both the Ministers of Public Health and of Justice. The text was on study by the latter at the time of the press releases (mid February 2005), answered the Minister of Justice. It is stated in the articles that a circular is not equal to a law, which explains that a new law has to be made to re-define in a clear way the suppressed notions of article 16. And even if the circular is supposed to settle the way of establishing, registering and suing the infringements, the public prosecutors hold entire latitude of proceeding in case of “aggravating circumstances” or “trouble to the law and order”, recall the press.

Another specific subject, has been approached, reflecting in a way the evolution of public opinion on drug issues: the creation of an association called “Council of (il)legal drugs users”. The latter presents itself as an “observatory” made up of persons coming from the civil society (consumers, experts, lawyers...). It aims to inform and encourage mutual listening and dialogue between users of (il)legal drugs and official instances, considering that the opinion of drug users is rarely taken into account. For the council, the question of psychoactive drugs is, above all, a civil and a medical matter which should be taken out of the legal sphere. According to them, the distinction between “hard” and “soft” drugs is artificial, since a “standard” drug user does not exist. This group hopes to take part in the public debate on drugs and to the elaboration of future policies in public health, education, but also the repression of illicit traffic.

2.2.a National Health Interview Survey (NHIS)

In 2001, the first module on illicit substances was included in the National Health Interview Survey (NHIS 2001). The results presented in the 2003 annual report, will not be repeated in this edition. In 2004, data were collected for the second time but the questionnaire was modified. While in 2001, the questions concerned cannabis and XTC, the new 2004 module only includes questions on cannabis (lifetime, last year, last month prevalence), frequency of use and type of substance. The reason for this change is justified by the low level of XTC use in the general population survey and the high level of cannabis use. The results were not yet available when writing this report (Gisle et al.2001).

2.2.a ESPAD

From March 2003 to May 2003 the “European School Survey Project on Alcohol and other Drugs” (ESPAD) (Hibell et al 2004). was carried out nationwide for the first time (Lambrecht et al 2004). 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 is 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 prevalence 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 prevalence for some substances.

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	4.0	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	3.0	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

For every illicit substance questioned, most of the respondents among those admitting 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. Among the injectors, one or two times of intravenous drug use (n=20) is reported by 40% (n=8) while 25% (n=5) said to have injected 40 times or more.

About one out of three respondents who indicated to have used the substance during the last year, admitted to have used it 1 or 2 times. Still almost 16% of the respondents reported the use of marijuana or hashish 40 times or more. Among the respondents who indicated to have used the substance at least once during the last month, more than one third said to have used cannabis once or twice, while almost 8% said to have used cannabis 40 times or more.

For about all the substances, the age 14 and 15 years seems to be the age at which more respondents indicated to have used an illicit substance for the first time (among all respondents reporting the use of a substance at least once in their lifetime). More girls than boys seem to use sedatives or tranquillisers and they do so at a younger age; while it is the inverse for all the other substances.

2.2.b Flemish Community study

Since 1999 VAD has been conducting a large study in the secondary schools (12-18 years) in the Flemish Community. Three main goals of this study are to draw attention at the importance of drug policy in schools, to study lifestyles of students and to evaluate drug policies in schools. The study uses its own protocol, students are questioned anonymously, in their own classrooms by non familiar teachers. During the school year 2003-2004, 38.029 students were questioned (VAD 2005, Standard table 2, 2005). From these, a sample of 1.498 questionnaires, representative for grade (age), sex, type of education and type of institution was analysed.

The results of the study show a lifetime prevalence of illegal substance of 24.6%. In addition, the last year prevalence of illegal substances amounts to 14.2%.

Also, as shown in the following table, the frequency of use varies by sex: boys use more frequently illegal substances than girls (Table 2).

□□□□□□ Last year prevalence and frequency of use of illegal drugs (%), VAD, 2003-2004.

	Prevalence	
	boys	Girls
Not used last year	81.5	90.1
<1x/week	11.1	6.7
>=1x/week	7.3	3.2

Cannabis appears to be the most popular illicit drug used by the Flemish students. 14,9% of them used cannabis during the last year. Only 2.6% of the students have reported the use of illegal drugs other than cannabis during that period (Table3).

□□□□□□ Last year prevalence of cannabis and other illegal drugs (%), VAD, 2003-2004

	Not last year	Last year
Use of cannabis	85.1	14.9
Use of other illegal drugs (not cannabis)	97.4	2.6

The use of cannabis is higher among boys than girls. The percentage of users of all other drugs is in most cases also higher among boys than among girls, but the absolute numbers are too small to say something about the significance of this difference.

Since the school year 2000-2001 the use of cannabis did not change for the group of students as a whole. Nevertheless, there is a decline in last year prevalence for the students of general secondary schools (ASO).

During the last four school years, the use of amphetamines has decreased significantly, especially among boys (lifetime and last years prevalence) and among students aged 15-16 (lifetime prevalence). The (rather marginal) use of all other illegal drugs remained stable during this period (Table 4).

□□□□□□ Lifetime (LFT) and last year prevalence (LYP) of illegal drugs (%), by school year, gender and age, VAD, 2005

		2000-2001		2001-2002		2002-2003		2003-2004		
	Age	Gender	LFT	LYP	LFT	LYP	LFT	LYP	LFT	LYP
Cannabis	15-16	boys	33.2	23.0	37.6	27.7	30.6	16.5	37.0	24.7
		girls	26.2	14.8	23.3	12.9	19.7	11.8	24.5	15.5
		total	29.7	18.9	30.5	20.3	25.2	14.2	30.5	19.9
	17-18	boys	51.6	34.0	53.4	36.8	51.1	35.8	55.4	35.3
		girls	40.7	30.3	39.2	19.0	38.5	16.8	37.7	19.5
		total	46.4	32.2	45.7	27.1	45.1	26.7	47.3	28.1
XTC	15-16	boys	4.1	1.2	7.8	3.3	2.9	1.2	5.4	1.8
		girls	4.9	2.5	2.1	0.8	3.4	2.1	5.5	2.1
		total	4.5	1.8	4.9	2.1	3.1	1.7	5.5	2.0
	17-18	boys	10.8	3.8	18.2	7.6	12.4	8.5	7.1	5.5
		girls	7.6	4.1	9.5	1.3	8.7	2.5	4.5	2.6
		total	9.3	4.0	13.4	4.1	10.7	5.6	5.9	4.2
Amphetamines	15-16	boys	6.9	2.4	7.0	3.7	2.9	0.4	4.1	2.7
		girls	7.0	2.5	2.5	0.4	2.1	0.4	4.3	1.3
		total	7.0	2.5	4.7	2.1	2.5	0.4	4.2	2.0
	17-18	boys	12.6	6.3	14.9	6.7	9.6	5.1	8.7	3.3
		girls	6.8	3.4	6.4	2.5	5.6	1.9	6.5	2.6
		total	9.8	4.9	10.3	4.5	7.7	3.6	7.7	3.0
Solvents	15-16	boys	9.0	4.1	12.7	5.3	6.6	1.2	5.8	1.8
		girls	8.2	2.9	3.3	2.5	3.3	1.3	4.7	0.4
		total	8.6	3.5	8.0	3.9	5.0	1.2	5.2	1.1
	17-18	boys	11.3	3.8	10.6	3.8	10.8	2.8	9.2	0.5
		girls	14.4	0.7	9.5	2.5	5.6	1.2	3.2	1.3
		total	12.8	2.3	10.0	3.1	8.3	2.1	6.5	0.9

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2.3.a Study on Cocaine users

In 1996-1997 a survey was carried out among experienced cocaine- and crack-users (Decorte 2000). Participants were recruited by a snowball sampling method and by a participating observation in the Antwerp nightlife. 111 experienced cocaine- and crack- users were recruited and interviewed.

The aim of the follow-up study was to get an idea about the evolution of their use. How did their substance use evolved between 1997 and 2003? Which person- and environmental- related factors were important? Can we speak of 'controlled' use? (Decorte & Sloock 2005)

Of the 111 users from the original sample survey, 77 people (69.4%) were tracked down and prepared for a new interview. Statistic analysis show that the follow-up group does not differ much from the drop-out group, and the researchers concluded

that the results derived from the follow-up respondents can with a certain confidence be generalised to the whole sample survey.

Fifteen respondents (19.5%) have completely stopped using cocaine since 1997. 32.5 % (N=25) of the follow-up group did not use any cocaine during the last year. More than a third (N=28; 36.4%) used cocaine during the last year at a low level (this means less than half a gram per week); 11.7% (N=9) used more than half a gram per week.

These users experienced the different methods of intake and especially the high prevalence of 'freebasing' (smoking cocaine) stands out: 72.4% of those who kept on using since 1997 already freebased. Freebase coke is made by the user him/her self (by cooking cocaine with ammoniac or sodium bicarbonate). Prepared freebase is not sold in Flanders.

Already in 1997 it seemed that most cocaine-users were polydrug users. They experienced a lot of different legal and illegal stimulants. In 2003, they were still regularly using alcohol, tobacco and cannabis. Most users have not really experimented other substances since 1997.

Users indicated that since 1997 they have had more and more disadvantages from their cocaine use, and thus reduced or even completely stopped their use. Many of them could not combine their substance abuse with the responsibilities and new roles in their lives: they got married, got kids, a job ... But these users still experienced certain positive effects of their use, and most of them are not really intent on quitting completely. They still enjoy it and do not refuse when offered by other users. Sometimes they experience 'craving' but they are nevertheless capable to limit their use to certain locations, situations, circumstances and company. To put it briefly, the spontaneous processes of self-regulation are still active, and are constantly developed and refined. Their own experiences with the drug, their and others' knowledge, the informal social control amongst users themselves and between users and their non-using environment... result in a complex unity of ideas that makes it possible for them to use the drug in a 'controlled' manner.

2.3.b Drug use among sex workers

For the first time, data on drug use among sex workers were collected during a vaccination campaign against hepatitis B in the **French Community**. From 1998 to 2002, three large cities were concerned: Liège, Namur, Charleroi.

When circumstances allowed it, vaccinated prostitutes were questioned during face-to-face interviews by social workers of a NGO (Espace P 2004). For methodological reasons, these data must be considered as purely indicative. Concerning drug use, the study only focused on the proportion of injecting drug users (IDU), as this route of administration could lead to HBV contamination.

In total, 934 questionnaires were collected. Respondents were predominantly females (96.6%), the mean age was 31.8 years. Among the respondents, 7.4% (49/664) claimed to be or to have been an IDU but the percentage of missing answers is 29% (N=270/664). This could probably be explained by a reluctance of the social workers to ask about drug use during the first contact and should not be considered as refusals from respondents.

Nationality slightly influences the use of injecting drugs. Among the Belgian respondents 8% reported to be IDU and 5% among foreigners.

IDU percentages varied according to the work location:

- 7% of the IDUs respondents worked in bars,

- 4% in private places,
- and 32% in the streets.

As stressed by the study, it is a risk factor to be “foreigner”; it is also a risk factor to work in “bars” or “street”. “Foreigner” sex workers operate more often than Belgians in “bars” or “street”, increasing risk factors.

Data show a rise of the injecting drug use among the sex workers. The rise is significant according to the study (tendency test: $p = .004$).

Screening for HBV, HCV, HIV and syphilis were performed. Regarding HCV, injecting drug use was identified as a risk factor and not the prostitution itself. Indeed, though a sero-prevalence of 3,4% was observed among the sex workers, 23% of the sex workers (ex)IDUs were HCV positive, for only 2% among the sex workers non-(ex)IDUs.

In the **Flemish Community**, there are no specific data on drug use among sex workers only a few organisations (Pasop and Gh@pro) care about sex workers and offer them preventive medical assistance and treatment.

In 2001 EUROPAP⁸ financed a study on health and infection risks among sex workers in **Belgium**. In total 83 female sex workers were questioned. 76% had the Belgian nationality, 12% was French and 12% of other nationality. 50% of the women were under 30. The reasons or circumstances in which women indicated having started working in prostitution were varied. Two main elements emerge: financial and relational problems ($n=43$ or 51.8%), often in combination. A few woman mentioned ‘drug dependence’ as a reason.

One item on the CAGE questions (problematic alcohol use) was positive for 18 women, and 4 scored 2 or 3 positive questions. Around 15 women smoked marihuana. Five women said to use cocaine, 4 women mentioned current use of speed. In total 31 women (39.4%) said never to have used drugs, of which 4 used heroin⁹.

2.3.c “Street” cannabis users: a snowball operational-research in Brussels

Through a pilot peers prevention of problematic use of cannabis project, based on snowball methodology, 84 cannabis users were met in July 2004 in Forest a commune of Brussels (Marchal 2005)¹⁰ (see 3.2.b for methodology details)

The ages ranged from 13 to 26 years and the mean was 19 years. Women represented 25% of the group; 49% of the population was Belgian, 15% came from other EU countries, 29% from Morocco.

Most of the people lived with one (18%) or two (46%) parents, 31% lived alone.

7% had no diploma; 47% were in secondary school. 5% had a higher education diploma. About a fifth (19%) worked and 16% was looking for job.

⁸Europap Final Report. <http://users.ugent.be/~rmak/europap/rapbel.html>.

⁹ Sexwork in Belgium: report questionnaire 2001 (2002).
<http://www.pasop.info/pdf/reportquestionnaire2001.pdf>

¹⁰ Marchal C. Recherche-action sur la pertinence de la mise en œuvre d’un projet de réduction des risques visant la prévention d’un usage abusif de cannabis auprès des jeunes. Mémoire en vue de l’obtention du titre de licenciée en Sciences de la santé publique. Faculté de médecine. UCL. Bruxelles 2005.

The mean age at first use of cannabis was 18 (11 to 24 years) for women and 16 for men (8 to 22 years).

81% of the men and 48% of the women used cannabis every day. 42% of them smoked the first time of the day on their way to school or to work. 7% started at noon and 24% in the afternoon. Most of the people used cannabis in group and a fifth mainly alone. Almost half of them (46%) used cannabis in the street, and 5% at school. 44% declare they smoke cannabis for pleasure, 42% to forget their problems, 13% to do like the others.

Most of them get their cannabis from friends (49%), 33% take it from Dutch “coffee shops”, and 20% grow their own cannabis.

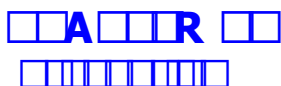
They spent from EUR 10 up to EUR 350 per week to get their cannabis: between EUR 20-30 for 35%, less than EUR 20 for 20% and more than EUR 40 per week for 14%.

In terms of problems, 83% report the need to smoke cannabis to be able to have fun, 67% the need to increase their use, 60% report difficulties in concentrating, 56% having been unable to get up in the morning, 49% are looking for the company of other cannabis users, 46% report experiences of “bad trip”, 44% respiratory problems, 43% report lack of energy, 34% difficulties in their social relations, 32% driving accidents.

Regarding social consequences, 37% had problems at school, 11% in their work, 27% with their family, 25% with Justice and 21% with their friends.

44% felt concerned about these problems, 31% felt once they should seek for help from professional and 22% met a GP, a psychologist or a street worker. GPs are the first professionals (54%) they would contact if they needed, followed by friends (37%), family (17%) and 13% said they would not know where to go to get assistance.

The results of a short quiz (5 items) on the effects of cannabis were perfect for 37%, and 75% gave at least 3 good answers out of 5. However, 66% of them estimated they are sufficiently informed on the cannabis and its effects.



The Federal Government is not responsible for the prevention policy, which is managed by the Communities governments.

In the **French Community** prevention is under the responsibility of the Ministry of Health. Prevention policy of drug dependence is based on the concept of “health promotion” (Ministère de la Communauté Française 2004). In its programme, the French Community stressed the idea that the school authorities have to enforce health promotion and prevention policy and to avoid the intervention of the police force in all prevention drug programmes.

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 most prevention activities.

Prevention targeting **families** is not restricted to parents of drug using children. Activities targeting ethnic communities are initiated like a new project in Brussels.

In **recreational settings**, mainly young people are targeted. Activities are available in the whole country and principally harm reduction oriented within the French Community. 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.



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 also recommends to organise a coordination of prevention activities as actors are at different levels and are numerous.

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

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

The new decree of the **French Community** related to Health Promotion (20 December 2001) reorganised the mission of the service of Promotion of Health at school (PSE). The use of these services and centres is free. Their mission focused also now to ensure the wellbeing of the children in their environment.

PSE has to take into account the health of the children globally: has to ensure and develop the quality of life and wellbeing in the school; has to set up projects aiming

pleasant school environment, place of exchange and communication in which the students, the teachers and the parents can open out.

In 2004, it can be noted that prevention programmes in schools funded by the Ministry of Health are the initiative of a large number of NGO's. Following the decree, the projects are based on health promotion, training of adults (teachers, educators, psycho-social workers) and must be evaluated. These services assist school authorities in solving problems related to drug use, in developing policy regarding the use of drugs and provide methodological support to develop tailor made school projects for prevention, including all the actors, students, directors, teachers and parents. Besides these projects, exist a wide range of local initiatives, implemented by local authorities.

As an example there is a project of the city of Mons. In collaboration with the university of Mons-Hainaut the project focused on training teachers of secondary and primary school and/or all related educators with a particular teaching method related to the "optimisation of the development of the person". Through a two-day training, the teachers learn the four vital needs and twelve others associated. The process of prevention consists through various role-plays with the students to develop those vital needs. Pedagogical tools like a book with practical games designed by the university of Mons-Hainaut helps the teachers in their mission of prevention.

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 school education is based on the same framework, but is also characterised 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, other school personnel, parents (associations), school health service, etc and provides tools to evaluate the drug policy.

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,...).

Evaluation of the prevention projects on a regular basis is also considered as important.

School advisory services give free and multidisciplinary support to students, parents, teachers and schools. These services are active in four fields: preventive healthcare (health promotion of which drug prevention is one aspect), learning and studying,

study career and psychological and social functioning. Advisory services negotiate policy agreements with schools to determine the responsibilities of both schools and advisory services in these four fields.

Specialised health organisations offer a broad range of interventions from training, education and 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 Community**, priority is still given to prevention projects on alcohol but more recently also to tobacco. A pilot project on tobacco abstinence and prevention of use will be carried out in two schools.

Preventive activities are carried out on a voluntary basis in schools with the collaboration of the local police or of the ASL.

➤ Evaluation

French Community

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

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

Despite the numerous recommendations, prevention activities (MEGA) carried out by police services in French-speaking schools are still common. However, many schools directors have difficulties to adopt a prevention policy and then they are seduced by prevention projects carried out by police services, accessible, visible and free of costs. Recently many police interventions (drugs controls) occurred in schools.

In 2005, a group of experts representative of the French-speaking actors in the drug-related field underlines the importance to target the behaviour instead of the product (see chapter 1 for more information) (Collège d'experts en assuétudes 2005).

Actions implemented by the police are criticised by experts of the field. Experts think that prevention and repression should not be mixed, and must be carried out by professionals from health sector, trained on health promotion and prevention. They also recommended to inform parents federations (UFAPEC, FAPEO) of French Community about the place of health promotion in schools and about available specialised services.

Flemish Community

In 2004 the drug prevention project "drug policy at schools" was evaluated. To know to what extent the student consultation gained its objectives, VAD organised an evaluation research in association with the profession group orthopedagogics of the university of Ghent. Executive board members, teachers, students and in some cases parents from seven secondary schools in East-Flanders were interviewed to get a view on the drug policy of the school. For the analysis of the contents from the drug policy on school drugs the

School framework (DOS) was used. This research made clear that three quarters of the schools passed on the results of the consultation to the teachers, but that the flow happened to the students themselves and the parents only to a limited extent.

In 2004, monitoring data from the Ginger programme showed that about a third of registered prevention activities took place in the educational sector (Rosiers 2005a). It is by far the most reached sector. Two third of the activities in the educational sector are organised in **secondary schools**. The general curriculum (ASO) as well as technical (TSO) and professional (BSO) study branches are the most reached. Prevention activities in schools mostly consist in training students and teachers, and consultation with teachers and the school board.

Noteworthy is the fact that about a fifth of all prevention activities in Flanders take place in a context of **intersectoral collaboration** (different sectors participate in one activity). The sectors 'health', 'welfare' and 'government' are the most active contributors in intersectoral collaboration.

Analysis of the monitoring results over the last five years shows that the educational sector is the dominant field of action of prevention workers over the years (Rosiers 2005b).

An evaluation, held in the summer of 2004, shows that the participants in the yearly Ginger registration indicate that Ginger is a good and reliable method to monitor the prevention activities in Flanders.

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

In 2004, modules of training on "Dependence and parenthood" continued to be organised targeting the professionals of the pre and postnatal clinics of the ONE (medico-social workers: nurses, welfare officers).

Parents could be also informed through pedagogical school prevention activities.

In 2003, a new centre "Alizés" opened in Brussels. This centre aimed at counselling drug using parents and non-drug using parents by the mean of various activities. A playroom is freely available, information sessions, psycho-motricity activities e.g..

The helpline, Infor-Drogues has on its website numerous "FAQ" targeting specifically parents answering questions such as "*How to talk about drugs to my children*" or "*I suspect my son to smoke cannabis, what can I do?*" e.g.

Flemish Community

DrugLijn has put large amounts of information on its website. Besides the general information about the products, the law, the risks, and other random information, parents can also find some specific information. For example: how they can discuss the topic with their children, a list of interesting books and brochures.... The DrugLijn can also be contacted by e-mail and several parents frequently use this tool for more information. 30% of all people contacting DrugLijn are parents.

'*Hole in the fence*¹¹' 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.

De Sleutel, the organisers of the Hole in the fence programme, give also training sessions for teachers and parents 'how to work with the program' and especially how to work on social skills with children.

"*Lindestraat 14*" is a manual for training sessions about alcohol and illegal drugs. The concept is set up for parents with children experimenting with drugs. In different parts of the Flemish Community prevention workers use this manual to train parents about drug prevention in the family. In some region prevention workers organise 'train-the-trainer –session' to teach other fieldworkers to use this manual for training sessions for parents in schools or the local community.

"*Leefsleutels/Clefs pour la jeunesse*" is a life skills programme aiming at preventing drug addiction and deviant behaviour.

"*Drugs etc*" is a concept on substance information that was developed in 2003. It is a set consisting of a brochure, cd-roms, fact sheets, folders and didactic cards. It is an instrument to inform parents, teachers, youth workers,... about the different types of substances. One of the didactic cards focuses on 'parents and family'. This card describes how the prevention worker or other health or social worker can organise a training session for parents: what are parents interested in? Which questions are frequently asked by parents (FAQ's)? Which topics do you put in the picture? In 2004, two 'train-the-trainer-sessions' took place to train prevention workers to use this concept with parents as target group.

In 2004 a workmap '*Groepswerking ter Ondersteuning van Ouders met Druggebruikende kinderen. Leidraad voor begeleiders*' (Supportgroup for Parents with drug using children. A manual for facilitators) was finalised and implemented. The manual consists of different topics: role and tasks of the facilitator, starting with a group, dealing with conflict in the group, evaluation of the group. The manual also focuses on the different subjects (and working materials) the facilitator can introduce in the group for example influence and communication, substance use and the family, motivation to behavioural change, adolescent development and responsibility, self-care and resources.

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

In 2004, the VAD worked out a shooting script on psycho-education for family members. This script offers didactical support to care workers who want to inform family members (parents, children, brothers, sisters, ...) about the specific

¹¹ Het gat in de haag', De Sleutel.

perception, consequences and coping possibilities of cohabitation with an alcohol or drug mis-user. In springtime 2004 the pilot phase started.

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 single parent families 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

➤ Helplines

Infor-Drogues and the DrugLijn are respectively the drug helplines for the French and Flemish Communities (Infor-Drogues 2004, DrugLijn 2004).

Results indicate that females constitute the larger part of callers.

Cannabis is the product in both communities for which questions are the most frequently asked (Table 5). In 2004, the DrugLijn gradually noticed a decrease in the number of calls. A drop in the political debate and media attention on cannabis legislation could be one of the reasons for this decline. The most important trend in the calls of the DrugLijn in 2004 remains the increase in calls on cocaine (an increase from 10% in 2000 to 15.5% in 2004). Calls on alcohol and psychoactive medication are rising as well. The number of question about cannabis, heroin, XTC and amphetamines (speed) remain more or less status quo.

The decline in number of telephone calls at the DrugLijn, which already started in 2003 (with the political debate and media attention on the topic of cannabis legislation dropping) persisted in 2004. On the other hand, the DrugLijn broadened its service to the general public by launching a pilot project on e-mail-counselling. This resulted in a total of 559 inquiries by e-mail, a number which exactly compensates the decline in phone calls, leaving the sum of answered enquiries (via telephone + e-mail) at 5 749 (compared to 5 779 in 2003)

Infor-Drogues registered 5 739 contacts (91% are phone calls). For more than 60 % contacts come from females except between the 26 to 35 year olds.

Since 2000 till now, contacts from people younger than 18 have decreased, this contrasts with the extension of consumption of drug in this age bracket.

In 2004, more relatives and friends of drug users contacted the service (46% of all the contacts), sometimes people have no evidence of a drug use but would like to prevent a future use, 51% of those people are mothers.

As mentioned above, cannabis is related to almost 40 % of the calls, cocaine is in second place.

When crack and cocaine are combined, they constitute 16.7% of the calls. A rise of calls about methadone is noticed.

□□□□□ Frequency of substances in related calls (%), Infor-Drogues, Druglijn 2003-2004

	Infor-Drogues		Druglijn	
	2003	2004	2003	2004*
Number of calls	5579	5739	5779	5749
Males	35.6	37	39	38.2
Females	64.4	63	61	61.8
Involved substances in calls				
Cannabis	40.4	38.5	40.9	40.8
Cocaine	15.7	14	14.2	15.5
XTC (mdma)	5.6	6.3	8.0	8.5
Heroin	8.3	8.5	6.1	5.7
Alcohol	10.0	9.4	18.6	20.5
Psychoactive medicines	7.3	6.7	7.2	8.8
Crack**	n.a	2.7	n.a	n.a
Methadone	3.9	4.6	1.7	2.0
LSD	1.1	1.6	1.1	0.7
Amphetamine	2.4	2.6	11.0	11.2

*Figures for the DrugLijn include telephone calls as well as enquiries by e-mail.

**Since 2004, crack is distinguished from cocaine.

The DrugLijn received 8 889 calls in total. Among them, 2 710 were outside the opening hours (Mon-Fri 15-21h and Sat 15-21h); 430 were hoax calls, leaving 5 779 effective calls (compared to 6 527 in 2001; being –11%). On top of that the helpline answered 559 inquiries by e-mail.

About one in four callers (27%) are users and ex-users; 30% are parents; 20% family members, partners and friends; 20% intermediates; 3% are simply “interested” persons.

Six calls out of ten concern 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 The DrugLijn are towards outpatients settings.

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

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

□□□□□ Frequency by age of callers (%), Infor-Drogues, Druglijn 2004

Class age	Infor-Drogues	Druglijn*
Under 18	1.95	6.6
18-25	11.55	20.6
26-35	15.6	20.4
36-50	42.8	36.8
50 and older	28.9	15.7

*Only 1 in 3 callers is asked about their age; the results are only indicative.

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

➤ **Ethnic groups**

French Community

The NGO « *Projet Matongé* » has launched a prevention project targeting a sub-Saharan African community living in a particular neighbourhood of Brussels called Matongé. It makes use of the own resources of that community, depending on a common cultural fellowship.

Indeed, the initial situation revealed a certain taboo inside that African community (mainly from Congo) as to the bare recognition of consumption itself. The project aims to sensitise adult-relays (social workers, families) of that community to the acknowledgement of the existence of drug problems among the youngsters of Matongé. The situation can be discussed with the youngster and a chosen person of his/her family (mainly the mother).

If necessary, young consumers are re-directed towards specialised institutions.

The Matongé project also gives proper information (oral information, brochures...) on harm reduction related to the use of drugs.

Flemish Community

“Tuppercare” (derivate from Tupperware) is a low threshold project addressed to Moroccan and Turkish women. Women not usually reached by other channels (associations) are specifically targeted. Within the social networks of these women one searches a key figure who wants to invite friends, family and other relatives to join together at her place (max. 8 persons). This method makes it possible to inform these women about drug-related topics. The key figure (host) gets a reward for her hospitality. Sessions are organised in the women’s language and pay attention to specific values and norms of the different cultures. This project is an initiative from the centres for alcohol and other drug problems.

➤ **Other projects**

French Community

For the first time in 2003, a specialised centre (Zephyr), Bypass 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 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 parade 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 recognised 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. Every year, publications are updated or new publications are produced. In 2004, the series 'A local alcohol and drug policy: Join in!' the sector brochure 'school' was updated.

S A R

3.2.a Recreational settings

3.2.a.1 Parties, festival,...

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.

Information by peers in recreational settings: project "Drogues risquer moins".

Information stands, with brochures on products, on STDs and condoms are held by trained peers with or without professionals according to the specificity of the project in different types of recreational settings. In 2004, about 30 different organisations partners of the project have covered 119 events. Events could be intervention in nightclubs, in raves, in small music festivals, in parties etc.

Flemish Community

About one out of ten prevention activities takes 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 consultancy 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.

In 2003 VAD-The DrugLijn developed a 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's 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 so on. In cooperation with media partners, advertising in youth and music magazines, 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.

In 2004 VAD-de DrugLijn continued spreading information on safer clubbing and maintained the "Partywise concept". More specific in the summer of 2004 the topic 'party tourism' was the central theme of the campaign. 'Streetwise', a booklet with straightforward information on safe and healthy party conditions, lifestyle and various topics related to the party and youth culture was launched. A second edition of the 'streetwise' booklet appeared in the end of 2004. The central theme in streetwise N° 2 was healthy food and drinks.

Partywise took part in the 'Cityparade 2004' (Ghent). This is a huge street parade that yearly attracts 200.000 people. Partywise participated in this parade with a colourful truck in Partywise style. The aim of this participation was to sensitise youngsters on safe clubbing and going out wisely and to promote the website.

Another initiative was 'First Aid in case of Drug Incidents' (FADI). Two sessions FADI were organised for health professionals and prevention workers in the field.

Since the start of the Partywise project, initiatives were taken 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.

In addition to those activities aimed at partygoers, VAD developed a website in cooperation with six youth work organisations (in 2003). The website is called www.drugsinbeweging.be (drugs in movement) because of the connection with youth in movement. Target groups for this website are the leaders of youth organisations. It contains:

- Some theory about drug prevention,
- Practical suggestions for the making of a drug policy in the organisation,
- Information and addresses.

This cooperation is still ongoing in 2004: updates are made on the website, new initiatives developed, new information is spread by a newsletter. This network is also used to send other publications or advice from VAD.

In 2004, there was also a training for prevention workers and youth workers to support local youth organisations or youth clubs to develop a drug policy.

3.2.a.2 Sports

French Community

In 2003, the French Community started a new action program, inside sports clubs, based on the Decree of March 8, 2001 on Health Promotion in sport and prevention of doping. The decree authorises controls during training sessions (e.g. not only during official manifestations) among professional clubs, but also in amateur federations.

In spring 2004, with the appointment of new ministers at regional and community levels, changes occurred. Firstly, doping prevention and controls are now within the

competence of the Minister of sports (instead of the Minister of Health). Secondly, 85% of the anti-doping controls will target professionals, while 15% will target amateurs, at the exact opposite of the previous ratio. This change is justified as an answer to the increase of doping cases among professionals at the end of 2004, as stated at the time in the media.

Despite the relative increase among professionals, the record of the anti-doping cell of the French Community at the end of 2004 revealed positive controls in 8% (n=1099) of the amateurs and only 4.3% (n=74) among the professionals.

Only 88 on the 1027 controls in 2004 were done without warning the targeted sportsman.

Flemish Community

In 2004, VAD continued two parallel projects for the sports sector in cooperation with the Belgian Football Association and the Flemish Sports Federation. In 2003, 10 information sessions (KBVB and SPORTAC) were carried out. The target group are coaches and policymakers. The aims are to explain the role of sports and sport clubs in prevention and thinking on the issue of implementing a drug prevention policy in the sport club. VAD and the Belgian Football association decided to continue their collaboration in 2004. A first concrete prevention initiative is a training session for security officers of clubs who are playing in the first and second soccer league. The implementation is planned for the beginning of 2005. The project in cooperation with the Flemish Sports Federation continued in 2004.

In the framework of a decree concerning medically responsible practice of sports, the Flemish government decided in 2004 to make the names, the suspending periods and the discipline of suspended sportsmen public via the internet¹². 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.

Also in 2004 VAD launched a prevention campaign '*Message in a bottle*' which is part of a bigger campaign '*alcohol, give it a sober look*'. This campaign gives a special attention to the target group of 26-45-year old drinkers. One of the topics in this campaign is the relationship between sports and drinking. The target group is more specifically informed on the negative consequences of drinking in sports and sensitised on the effects and risk of this combination.

German Community

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.

¹² <http://www.vwc.vlaanderen.be/dopinglijjn/paginas/inhoudframe.htm>

3.2.b At-risk groups

Flemish Community

In Flanders figures concerning the use and the misuse of alcohol and illicit drugs in what is called the 'social 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 are highly recommended. VAD and its partners in the field support these initiatives.

A comprehensive alcohol and drug policy is an important step forward in the prevention and effective treatment of functioning problems as the result of alcohol and drugs. Increasing awareness of employees and training and coaching management is important to allow everyone to play his/her role in this policy.

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 through prevention work: e.g. foreigners, newcomers and asylum seekers, underprivileged, less verbal youngsters. In 2004, a needs assessment took place.

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 Ghent there is an organisation 'De Eenmaking' that focuses on migrants and drug use.

They do drug prevention in prisons, counselling, trainings and they ask help to develop a diversity policy in institutions.

French Community

A pilot project was set up in 2004 to use the snowball methodology for a peer prevention project targeting **cannabis users**. The objective was to inform drug users about possible problems related to the use of cannabis and to give the users solutions to avoid them.

The project was implemented in a commune of Brussels, Forest. Nine cannabis users have been recruited by different organisations. After a four-session training on the objective and methodology, the health consequences of cannabis abuses, on the legal status of cannabis, and on communications, the "jobists" (trained drug users) were sent in their environment to meet their peers and inform them. They used a questionnaire and harm reduction brochures on cannabis. In total these "jobists" met 87 peers. The evaluation allowed the identification of several problems in terms of recruitment, duration of the training, and other weaknesses. The analysis of the data collected through the questionnaire (see Chapter 2.3.c) shows that the public met had already experienced several problems related to the use of cannabis. However, professionals decided to renew the experience in 2005 with a new evaluation.

3.2.c At-risk families

Flemish Community

There are only a few initiatives for children of alcoholics in Belgium. 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 pay attention to this group.

In 2001, “Broeders Alexianen in Tienen“, 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 parent and the consequences in the family. This program consists of 4 important issues:

- psycho-education
- cognitive and social skill training
- coping with stress and mixed feelings
- look after yourself.

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

Outpatient and inpatient treatment centres in Flanders try to have more attention to the issue of children of alcoholics.

In 2004, Broeders Alexianen (Tienen) launched a website www.koap.be for children and partners of alcoholics and participated with the VAD in an active way on the 1st symposium about children in families with Alcohol Problems. The focus of this European conference was on Coping with Parental Drinking.

Bubbels & Babbels is a prevention project funded by the Flemish government (*Stedenfonds*) in Antwerp focusing on the problems of children of (ex) drug dependent parents. Participation of the target group is on a voluntary base. The project offers comprehensive coordinated services to decrease the harmful effects of drug addiction on children, families and the community.

Bubbels & Babbels provides case management to clients, based upon the assumption that the families face multiple services need, that they are unable to address on their own. The family is engaged both in identifying and meeting its own goals, so that the traditional case management approach of simple arranging services is expanded significantly. The case manager assists families in developing their goals, identifying their needs, and obtaining these services.

In 2004, Bubbels & Babbels supported 22 families affected by drug abuse. In addition to the client work, Bubbels & Babbels organised training sessions about drug abuse and pregnancy-parenthood and answered more than 50 questions of social workers about this topic. Bubbels & Babbels also publishes newsletters for professionals.

French Community

Several treatment services 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.

Example, the Kangourou project which is an initiative of the Trampoline organisation has an increasing success. Since 2003, they welcome more women and they have noted an increase of the fathers presence in the education of the children.

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.

Regarding the profile of clients in treatment, a Belgian TDI protocol was prepared these two last years and, still has to be implemented.

Drug users frequenting needles exchange programmes are predominantly males, polydrug users. Cocaine use seems to be more prevalent.

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In 2004 no new Belgian studies on prevalence or incidence estimates were published.

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

As for the previous 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.

Meanwhile the discussions have resulted in the development of a Belgian version of the European TDI protocol. This protocol was finalised and approved by the Health Policy Drug Unit. A result of this approval was the foundation of the TDI working group of the Health Policy Drug Unit. The aim of this working group consisted of (i) investigating which adjustments of the existing registration systems were necessary to comply with the Belgian TDI protocol, and (ii) to estimate the financial implications of these adjustments. The final aim was to write a report for the Inter-Ministerial Commission of Health.

During the meetings of the working group, the need to make some concepts of the Belgian TDI protocol more concrete arose. The way some concepts were formulated was too vague. Those concepts needed to be formulated more specific to have one common national perception of what a “TDI case” is in Belgium.

To achieve this, an agreement was reached by mutual consideration about the national strategy regarding the TDI registration. This was made concrete by the development of a Technical Annex, in addition to the Belgian TDI protocol, describing in detail how to see/interpret every concept of the protocol.

The Health Policy Drug Unit adopted the protocol and its technical annex.

4.2.a Study in the province of Antwerp

From March 2004 until February 2005 a study was done regarding the intake and the (out) flow in the alcohol and drug assistance in the Province of Antwerp (Colpaert et al. 2005).

The mean age of the patients using frequently illegal drugs was 28.9 years, almost 80% of them were male. 94% of the registered patients lived in the Province of Antwerp and the majority was born in Belgium (81.7%). Women live significantly more together with a partner or alone with their children and men live significantly more alone or with their parents.

One fifth of the registered patients had a regular job in the past three months.

The highest percentages for **regular use** of substances were found for **cannabis**, **cocaine** and **alcohol**. The majority of the registered patients were polydrug users (78.8%). For patients using at least one illegal drug, cannabis is in more than one fourth of the cases the most important drug. 33% of the patients had ever injected drugs.

30% of the patients had never been treated before for drug problems. The mean age of patients in outpatient treatment centres was significantly lower than the mean age of patients in inpatient treatment settings. In 63.3% of the cases, treatment started immediately after the intake, and 41.9% of these patients dropped out prematurely. 8.3% of the patients were put on a waiting list after their intake.

4.2.b Study on methadone delivery by pharmacists- second phase

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 mean age of these patients in substitution treatment was 31.5 years and were mostly male representatives (74.3%). **Cannabis** was reported to be currently used by 60.8% (currently : defined by during the last three months) then **Heroin** by 44.5% of the respondents. **Cocaine** was reported to be currently used by 29% and **XTC** by 7.2% of the respondents.

The second phase of this research added new information regarding the profile of the patients (Ledoux 2005).

Almost half of the patients lived together with a partner and 64% of the patients were unemployed.

The concern regarding medical shopping was not confirmed. 73% of the patients did not have more than 2 GP's. Only 4.5% visited more than 6 GP's.

The first use of methadone was situated at the age 24 in Flanders and at age 26 years in the French Community. The first use of heroin was situated at the age of 20.4 in both Communities. Surprisingly no connection was found between the dose of methadone and the use or non-use of heroin.

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

4.2.c Study of methadone treatment and client profiles in De Sleutel

In 2004 a special study was also conducted only on patients getting methadone in De Sleutel (Raes 2005). The profiles of these patients do not correspond to the ones presented in 4.2.b. The selection of patients is different: on one hand, patients from a group of specialized treatment centres in Flanders and on the other, a study among pharmacist in Belgium.

Within the treatment centres, mean age of outpatients getting methadone was 31 (n=103). In the treatment centres 25% of these patients lives alone, another 15% in unstable conditions. Only 11% lives within a family (parents or own family). Educational level of basic school or even lower was true for > 50% of the treatment centre group. 69% was economically inactive, getting his income from either unemployment, Public Social Service or Health Insurance.

4.3.a Substance used

➤ Snowball survey (French Community)

Through a HIV/Hepatitis peers prevention project, snowball surveys are carried out yearly to investigate drug use, its pattern, knowledge and attitudes (Hariga, personal communication). The users are interviewed in different regions (Brussels, Charleroi, Liège, Namur, Mons, Verviers and Wavre) but these regions may vary each year.

Table 7 shows that between 2001 and 2004, both cocaine and heroin use are quite stable. Amphetamine use is decreasing while illegal methadone is increasing. In 2004, about one third of the drug users met through the snowball project reported the use of black market methadone. Buprenorphine use is less reported than the use of methadone.

Percentage of current drug use, French Community, 1999-2004, Snowball surveys.

Drug	1999	2000	2001	2002	2003	2004
N	928	574	1052	881	690	1140
Heroin	81	69	69	68	74	67
Cocaine	69	64	62	58	62	59
Amphetamines	23	30	28	23	14	16
Methadone	28	36	27	28	24	32
Buprenorphine	-	-	10	10	6	11

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

In addition the use of LSD and Ecstasy is quite common among this group. In 2004, about a quarter (25%) reported a use of ecstasy and a fifth (18%) the use of LSD during the last month.

The use of several different drugs is the norm among this group, with an average of 3 different illicit drugs currently used per person. About two third report the use of 3 up to 6 illicit drugs, not taking into account medicines illegally used.

Percentages of polydrug use among drug users Snowball surveys, French Community 2001-2004.

	2001	2002	2003	2004
N=	1052	881	690	1140
1 drug	13	14	19	18
2 drugs	20	25	21	23
3 or more	68	60	61	60

In 2004, all the respondents reported the illegal use of medicines. In frequency order, benzodiazepines are the most commonly used (40%), followed by methadone (32 %) then by barbiturates (12%) and buprenorphine (11%).

Taking into account these medicines, the average number of products illegally used is 5.

About half of the current heroin users were under substitution treatment at the time of the project, most of them with methadone, some with both methadone and buprenorphine. Only one fifth had never been under treatment.

Percentages of current heroin users in treatment, Snowball surveys, French Community 2001-2004.

	2001	2002	2003	2004
N=	736	597	443	765
R/Buprenorphine	1	1	2	2
R/Methadone	39	41	50	44
R/Buprenorphine and methadone	6	5	3	4
Not currently under treatment	26	33	29	30
Never treated	28	21	17	20

4.3.b Injecting use

➤ Snowball survey (French Community)

Despite the selection bias related to the objective of this HIV peers prevention project, the proportion of IDUs met is going down (Table 10). In 2004, 62% of the sample had at least once injected a drug and 43% are current injectors, this corresponds with a decrease of more than 10% in 10 years.

A declining trend in the proportion of IDUs sharing syringes is observed but the percentage remains high, above 40%. Sharing other injection materials, such as spoon, cotton, water, happens even more frequently (49%) in 2004.

Percentage of lifetime and current IDUs and sharing of injecting materials among current IDUs, Snowball surveys, French Community, 1996-2004.

	1996	1997	1998	1999	2000	2001	2002	2003	2004
Number of users	1294	1395	1243	898	550	981	798	616	1033
Mean age	27	28	28	28	29	30	30	31	32
males	66	69	67	70	70	65	67	66	64
Lifetime IDUs/drug users	68	74	65	68	60	65	65	64	62
Current* IDUs/drug users	53	56	43	52	40	46	46	46	43
Sharing needles /IDUs (%)	60	59	53	52	43	44	44	47	43
Sharing injecting materials /IDUs	-	-	-	61	57	48	52	54	49

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

Recent (2 years or less) IDUs are not much represented in this sample. They constituted between 8 to 10% of the total number of IDUs. In 2004, 43% were women and the mean age of the respondents was 25 years old.

The mean age at onset of intravenous use is quite stable, around 20 years old, with a minimum age of 10 years old. No difference according sex was noticed.

The next table indicates that over the last five years, the trends for injecting heroin and cocaine are stable. The trends for methadone seem to increase. The injection of buprenorphine is less common but stable.

Percentage of current* IDUs by drug, Snowball surveys, French Community, 1999-2004.

Drug		1999	2000	2001	2002	2003	2004
Heroin	N	755	397	416	535	443	764
	%	54	50	56	53	53	48
Cocaine	N	644	367	362	448	376	674
	%	58	46	55	54	52	50
Amphetamines	N	211	171	62	181	85	187
	%	19	19	21	21	27	18
Methadone	N	208	208	65	212	146	362
	%	12	16	25	20	27	22
Buprenorphine	N	140	60	101	86	57	122
	%	12	18	9	20	12	12

*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)

The next table shows the results of the data gathered in one particular festival covered since 1996. In 2004, current drug users represent 73% of the sample and

1% are IDUs. Current was defined as last month prevalence except for 2000, it was defined as the last 6 months.

Percentage of IDUs, Rock festival, French Community, 1996-2004

	1996	1997	1998	1999	2000	2001	2002	2003	2004
Number of interviews	123	167	157	686	479	454	172	160	222
Current drug use	87	96	88	88	83	87	78.5	55	73
IDUs / users	25	13	13	4	4	5	3	3	1

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 the camping.

The next table indicates that in 2004, 29% of the respondents have used one drug at least once in their life, while 40% reported a use of 3 drugs or more.

Lifetime of polydrug use in percentages, Rock festival, French Community, 1996-2004

	1996	1997	1998	1999	2000	2001	2002	2003	2004
N	123	167	157	686	479	454	172	160	222
Only 1 drug	47	40	25	33	30	22	23	26	29
3 drugs or more	32	45	36	36	40	35.5	51	52	40
At least 1 illicit drug	87	93	88	88	83	93	92	89	88

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.

Data have also been collected regarding the use of a drug during the event (Table 14). These data underestimate the real consumption during the event as they are collected at the time the person is met and not after the event. It could be noticed that the most frequently used substance is alcohol, followed by cannabis and ecstasy. The reported use of cannabis is close to the reported use of tobacco.

Drug Use in recreational settings: drug use during the event; French Community ; 2002-2004.

	2002	2003	2004
N (locations or events)	10	10	38
N (respondents)	1118	861	1198
Amphetamines	6	10	9
Cannabis	37	36	35
Cocaine	3	6	4
Crack	1	2	1
XTC	11	19	11
GHB	1	2	0,3
Mushrooms	5	5	3
Heroin	1	2	1
Ketamine	1	2	0,3
LSD	1	4	1
Tobacco	39	38	40
Any illegal drug	34	41	42
Any illegal other than cannabis	14	26	20

The use of several drugs during the same event is quite common. In 2004, 37% of the respondents reported, when they were met, the use of 2 or more different drugs including alcohol. The maximum number of different products reported was 8.

➤ Needles exchange programmes

Flemish Community

In the Flemish Community, 191 IDUs frequenting the needles exchange facilities were interviewed (Windelinckx 2005). The most important results are presented below.

1. Socio-demographically:
 - 70.9% are male;
 - 70.1% are over 25; amongst those 32.43% are older than 35;
 - 10.60% are under 21;
 - 39% live alone, 31.8% live with partner or partner and children, 7% are homeless, 4.2% 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 70.2% of the cases, followed by cocaine (58.9%) and amphetamines (38.2%);
 - The combined use of heroin and cocaine is clearly prevalent in the Flemish cities, 28.6% are injecting these speedballs (snowballs);
 - The exchange programme currently reaches more speed and/or cocaine users than previous years.

3. Risk behaviour

- The majority (58.6%) of the IDUs interviewed did not share injection materials in the last month;
- Sharing occurs more easily with sex partners than with strangers or friends;
- Back loading (using one syringe to squirt drug into back of other syringes) are not common;
- 47% of the IDUs share the spoon; 60% do not always clean their spoon with alcohol swabs;
- 69.6% never share their filter;
- 30.4% share water;
- 17.3% use syringes that they get from a container, that other IDUs used 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;
- 42.1% also get syringes for friends, 31% 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 always throws them on the street;
- most of the interviewed IDUs got their information about the exchange from drug services (63%), 5% from media. In comparison to the last year less IDUs got the information from street corner work (outreach) or user association;
- 92% had no problem to buy syringes from pharmacists;
- 52% prefer day time opening hours;
- Monday, Tuesday, Wednesday and Friday are the preferred opening days.

5. Health

- 71.6% had been tested for HIV in the previous year, 2.6% tested positive;
- 72.1% had been tested for HBV in the previous year; 5.7% reported to be positive;
- 77.7% had been tested for HCV in the previous year, 34.9% reported to be positive;
- 67.7% had been tested for TBC in the previous year, 5.5% tested positive;
- 24.3% of the IDUs interviewed did use syringes in prison;
- most of the interviewed IDUs already had drug treatment in the past, mostly in residential institution;
- 69% are still in a drug treatment while contacting the syringe exchange, 69.7% followed a methadone programme;

6. Free-base cocaine

- 98 (51.3%) are using freebase-cocaine;
- most of the users clean their cocaine with ammoniac (74.5%);
- Most of the interviewed IDUs are both injecting cocaine and using freebase cocaine.
- 12% of 85 IDUs smoke freebase cocaine on a daily base, 38.8 smoke weekly, 48.2% smoke on a monthly base.
- 19.8% of 86 IDUs inject cocaine on daily base, 36% on inject weekly and 44.2% inject cocaine monthly.

Brussels

In Brussels (French-speaking Community), 32 IDUs using a needles exchange facility were interviewed (Hariga 2005). The most important results are presented below.

Socio-demographically:

- 84% are male;
- mean age: 32; range: 24 to 44 years;
- 52% live alone, 10% are homeless, 6% live in a squat, 13% live together with friends, 16% with family and 3% in institution;
- 16% have a job;
- 63% have been between 1 and 6 times in prison.

Drug use

- Polydrug use is common;
- Cocaine is the most injected drug (84%) followed by heroin (72%) and amphetamines (31%), methadone (31%);
- Mean age IDU is 22 years;
- Daily number of injections is 4 and varies from 1 to 10 per day.

Risk behaviour

- The majority (80%) of the IDUs interviewed did not share needles in the last month, when shared it occurs often with sex partners;
- 59% never share the filter;
- 53% never shares the water;
- 62% re-use their own filters;
- 33% used the same syringe only once;
- 78% made their last injection at home, 3% in a car, 13% in a squat and 6% by friends;

Evaluation syringe exchanges

- Syringe exchanges and pharmacists are most commonly used to get syringes;
- After the last injection, the used syringe was brought back to the needle exchange programme (60%), or kept for later (16%), or thrown

away without care (6%), with care (9%) or put in a safe needles container (9%);

- Almost half (45%) of the IDUs go to the service once a week, 33% twice a week and 22% less than once a week;
- 50% prefer day-time opening hours.

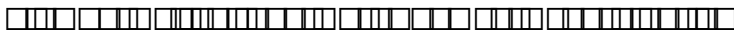
Health

- 91% had been tested for HIV in the past, 3% tested positive and 7% do not answer;
- 84% had been tested for HBV in the past; 19% tested positive and 4% did not answer;
- 72% had been tested for HCV in the past; 56% tested positive and 11% did not answer;
- 40% of the IDUs interviewed did inject while in prison;
- 81% of the IDUs had a methadone treatment during the last 6 months, 66% made a withdrawal attempt during the last 6 months and 6% went to a residential treatment service; 3% had not followed any treatment in the past 6 months.

problems are treated. However, some psychiatric hospitals or psychiatric units in general hospitals have created a specialized substance abuse unit. All of these treatment centres follow the same general regulations as other hospitals and are therefore mostly subject to federal legislation. Communities have however certain competencies on the matter (e.g. quality assurance).

A **third group** consists of *Centres for Mental Health Care (CMHC)*. As well as the psychiatric hospitals and in the psychiatric units of general hospitals, a large number of psychological or psychiatric problems are treated in these centres. Some of those CMHC have however developed a certain specialisation in the treatment of drug problems. The Communities of Belgium are responsible for the CMHC but due to historical and pragmatic reasons, in the French-speaking part of Belgium the responsibility has been transferred from the French Community to the Walloon Region (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. Other treatment facilities should not be ignored or underestimated i.e. 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.



Following the Federal Drug Policy Note, **9 provinces** participate in a pilot project about "Implementation of care coordinators in dialogue mental health platforms as regards treatments for substance abusers" (Cellule drogues 2004). Mission of the coordinators are to improve the dialogue between the different services involved in the treatments and to enhance a maximum participation of different actors. Moreover, they have to set up collaboration agreements. Personalised care and continuity in the treatment are the main issues of this project.

In **Flanders**, 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 guarantee the continuity in care and care adapted to the specific needs of the client (Nassen et al. 1999).

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

In the **French Community**, the concept of network has been introduced by a decree of the Walloon Region (details are given in 1.2.c).

5.2.a Evaluation results, statistics, research, training and quality insurance

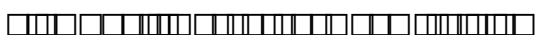
A new study about the implementation of **case management** among drug abusers in the treatment and the **criminal justice system** was published in 2005 (Geenens et al. 2005).

The aim of this study was 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 research focused on case management for persons older than 18 years, addicted to illicit drugs.

Case management is applied in the care circuit but not yet in the judicial one, even if it is mentioned in the Federal Drug Policy Note. It is more developed in the Flemish part of the country than in the French-speaking one. In total, 17 case management projects were found in Belgium. Due to the lack of a sufficient number of randomised and controlled studies, case management can, at this moment, not be considered as an evidence-based practice. Case managers need to be trained in order to get a clear idea of their tasks.

Some difficulties faced by the case-managers and mentioned by the authors are:

- When case-managers work in crisis units, they only have a short period (5 days) to do their job, which is not enough.
- GP's should become a key person in the network of the patient, but it seems difficult to involve them, as they have to participate on a voluntary basis in the network.
- Case management is not generalised, existing case management projects have a limited capacity: all patients cannot benefit of it.
- If the case-management is not integrated in the network of services, this intervention risks being just one fragmented piece of the system of services.
- Financing of case management is mostly done on annual basis, it hinders long term planning.
- It seems that there is a lack of clarity on the necessary duration of the case-manager's intervention.



Since 1st April 2004, Trempline (a Therapeutic Community) has introduced the Europ-Asi questionnaire for each client of the institution. This tool aims to measure the severity of addiction of new clients, to follow the evolution of the clients and to assess the outcome of the treatment. This instrument also offers the possibility to compare results with other Therapeutic Communities in Belgium and in the EU. Trempline hopes that the Europ-Asi will help to determine "Therapeutic Goals to Reach".

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 the Walloon Region.

In the Walloon Region, 7 out of 56 mental Health services, financed by the Region, are identified as specialized in drug dependence. In 2004, a 8th mental health service was recognized by the Walloon Region as specialised service in the Province of Walloon Brabant. However, almost all the mental health services deal with drug dependent patients without being subsidised specifically for this mission.

In the Flemish community, VAD organises specific training and education programs for the different aspects of treatment. Every year there are a few standard trainings e.g. motivational conversations, a two-year programme for health workers, working in treatment centres etc. In 2004, VAD organised 7 trainings e.g. consult for parents with drug using children, working with problematic substance abuse, Europ-Asi training, In addition, several one-day seminars took place in 2004. E.g. Pharmaco therapeutic interventions in alcohol and drug problems, crisis intervention and first aid for drug users, psycho-education and social skills, ...

In some institutions “evaluation” is conceived as a philosophy of work directed towards the patient, they permanently seek to improve the processes of work by implementing evaluation and assessment tools. Some of them work with external evaluators.

A “research platform substance abuse” was created by the VAD, which aims at bringing research and practice in the Flemish alcohol and drug field closer to each other.

In 2004, VAD included a workshop on ‘evaluating in the drug care’ in their yearly conference.

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5.4.a Inpatient treatments

There are therapeutic Communities, specialised crisis centres, psychiatric units in general hospitals and units for substance abuse problems in psychiatric hospitals (see 5.1.).

5.4.b Outpatient treatments

Part of outpatient treatment consists of drug free treatment centres, such as the Centres for Mental Health Care (CMHC). The medical-social care centres on the other hand, who also have a RIZIV/INAMI convention, mostly do not provide drug free but rather substitution treatment. Finally, the specialised substance abuse day care centres with a RIZIV/INAMI convention offer both.

However, the type of treatment that is provided will always be tailored to the individual needs of the patient and treatment centres often provide drug free as well as substitution treatment.

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5.5.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, specialised crisis 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.

5.5.b Substitution treatment

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).

After the first law on substitution treatments enacted in 2002, a Royal decree was adopted in 2004 (see 1.2.c), still the decree has to be implemented. 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). For buprenorphine similar national consensus does not exist yet. Buprenorphine is newly (2003) reimbursed by the social Security and data on its prescription are not yet available.

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, outpatient 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.

The overall number of methadone prescribing GPs is unknown.

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.

Two projects, related to the evaluation of substitution treatments were financed under the research programme "*Supporting actions to the federal policy note on drugs*"¹⁵ of the Belgian Science Policy.

- Action research on methadone provision through community pharmacists in Belgium (See Chapter 4.2.b).

This study, carried out by the Belgian Pharmaceutical Association, was patient-oriented, and involved community pharmacists to evaluate patients buying methadone in their pharmacy (Ledoux 2005).

In November 2003 a second phase of this study started, in order to continue the evaluation of the patients registered in the first phase of this study. This second phase focused on the self-evaluation of patients in substitution treatment. The study confirms that the therapeutic alliance (the quality of the relationship between the patient and the GP, the patient and the pharmacist) plays an important role in the well-being of the patient and the success of the treatment.

- Cure through substitute treatments in Belgium: development of a model for assessment of types of care and patients (Pelc et al. 2005).

¹⁵Some of the final reports are available on the following website:
<http://www.belspo.be/belspo/fedra/prog.asp?l=fr&COD=DR#docum>

The study started in 2002 and a follow-up of the project was organised from October 2003 to October 2004.

The study concludes that the balance sheet of the practices of the substitution treatments in Belgium is positive. The variety of treatments in this field is relatively high, with possibilities of a complete treatment of the problem by either the GP's, either a wider range of institutional channels. It seems essential that these two large modalities of treatment remain and continue to develop.

Nevertheless, the objectives of the substitution treatments through the diversity of practices are an important difficulty. If abstinence is not considered as an inevitable preliminary stage of the treatment, this objective is not been replaced by another positive objective of the treatment, and maintenance is perceived as an objective by default.

The researchers finally suggest including basis training for GP's in the field of drug addiction in the course of their academic study. Such training should not only concern drug addiction problems, methods of medical treatment, symptomatology and/or pharmacology of substitution treatments, but also the psychological and social dimensions of drug addiction.

5.5.c Other medically assisted treatment

A new project, financed by the Belgian Science Policy, concerns the « Controlled heroin provision: feasibility study and follow-up (DHCo) »¹⁶ (Ansseau et al. 2005). 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).

¹⁶ Full report is available at <http://www.belspo.be/belspo/fedra/proj.asp?l=nl&COD=DR/10>

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

Figures available through the Belgian database of HIV and AIDS cases indicate a declining trend of the number of IDUs among the HIV cases. The prevalence of HIV among IDUs vary from 1.2% to 7% according the source.

If compared, data on prevalence of HCV are by far higher than that those of HBV.

In 2002, the prevalence rates for HBV vary from 9% (self-reported) to 66% (biological tests). In 2003, results of biological tests for HBV indicated a prevalence ranging from 17% to 62%.

In 2002, reported results on HCV (self-reported and biological tests) varied from 43% to 79%. In 2003, results of biological tests for HCV ranged from 35% to 79%.

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. In 2004, out of 975 samples, 855 were positive and 120 were false positive. The most important substances detected were: cannabinoids in almost 60% of those samples, then amphetamines in 15%, amphetamines with cannabinoids in 11%, cocaine in 5%.

This year some data on road traffic accidents are also presented.

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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 its 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 is 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.

□□□□□□□□ 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 increased suddenly in 1993 with nearly twice as much cases as the year before. From 1993 onwards no remarkable changes could be observed.

More men than women died of drug-related causes, with 651 men (73.1%) as opposed to 239 women (26.9%, from 1987 to 1997, all added together).

Information on the number of drug-related deaths in prisons is available in the next table.

□□□□□□□□ Number of drug-related deaths in Belgian prisons, 2000-2004¹⁷.

Year	Number of deaths
2000	6
2001	4
2002	5
2003	5
2004	2

¹⁷ Vr. en Antw. Kamer 2004-05, 27 juni 2005, 14445-14446 (Vr. nr. 575 Marinower).
Q. et Rép. Chambre 2004-05, 27 juin 2005, 14445-14446 (Q. n° 575 Marinower).

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3.3.a6.2.a HIV/AIDS

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

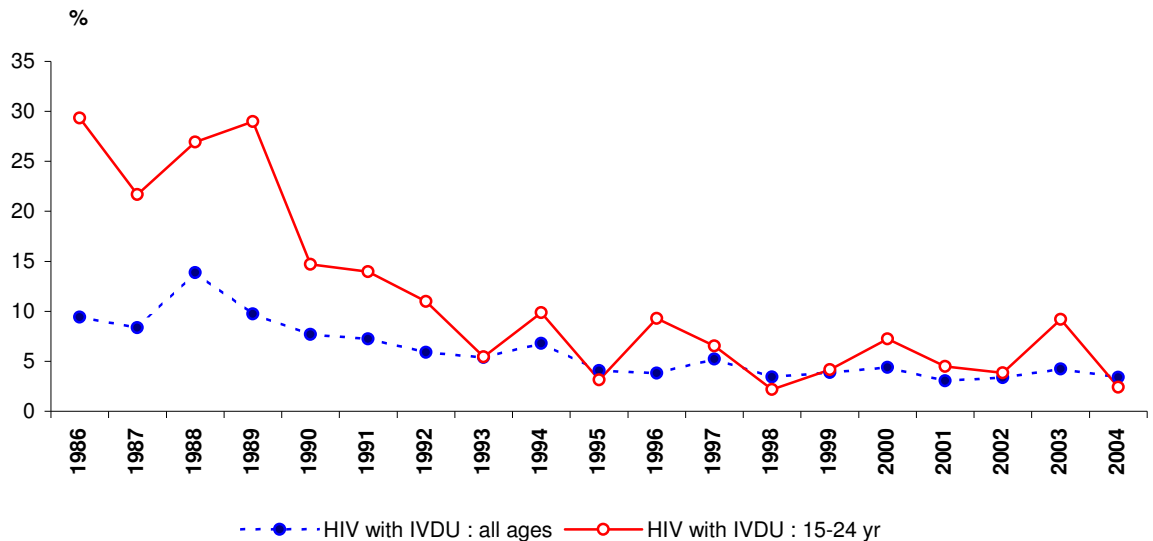
In Belgium, diagnosed seropositive HIV people and AIDS cases are registered in two integrated databases at the Scientific Institute of Public Health in Brussels¹⁸.

From the beginning of the epidemic to December 2004, 16 966 HIV infected patients were registered. Among these, 3 226 have reached the clinical stage of AIDS.

Between 1997 and 2003, information on the risk factor status is globally available for 88.5 % of the cases.

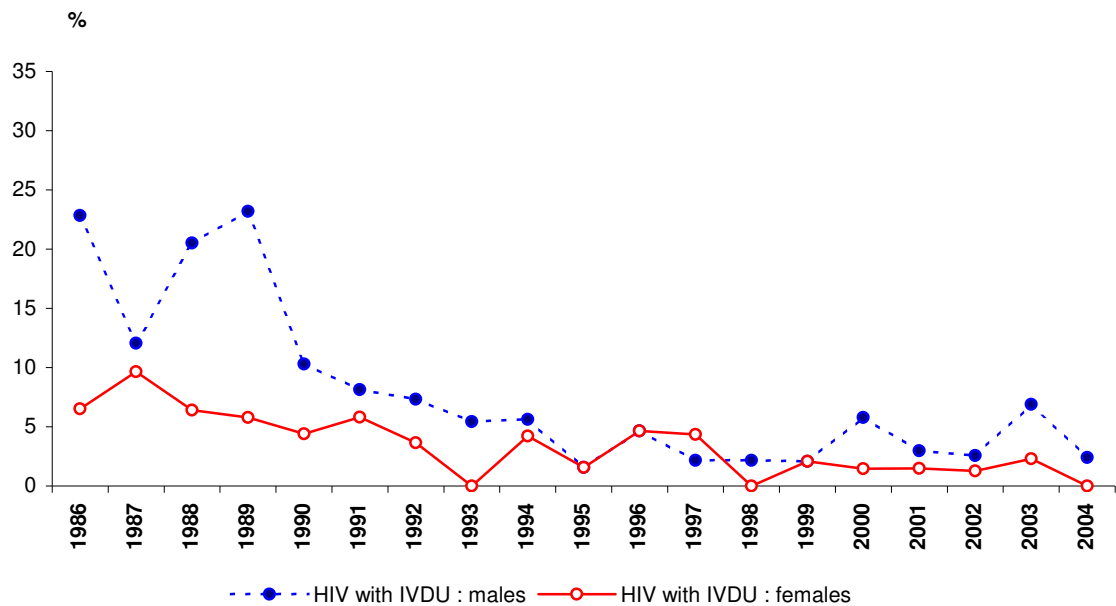
There is a decrease in the proportion of all IDUs among HIV cases (cases of HIV with intravenous drug use as risk factor) from around 10% in 1986 and approximately 3% in 2004 (figure 2).


Infection via intravenous drug use was higher among young people, but the last years it has become comparable to the observations among older people. Among infected people aged between 15 and 24 years, the number of new cases stating IDU was 8 cases in 2003 and 2 in 2004.



Percentage of IDUs among new HIV-cases from 1986 to 2004 in Belgium (Sasse Personal communication 2005).

¹⁸A unique 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. Detailed information on these systems is available in Sasse and Defraye 2004.



 Percentage of IDUs among new cases aged between 15-24 years from 1986 to 2004 in Belgium, according to sex (Sasse Personal communication 2005).

Trends of IDUs among HIV new cases according to gender are quite similar since 1995 the trend of IDU among HIV. In 2004, no female case was registered.

3.3.a.26.2.a.2 HIV seropositivity among drug users

Results of the snowball survey (already described in 4.3.a) indicate that in 2004, 79% of the respondents (n=661) reported having been screened at least once in lifetime and 44% during the last year. In comparison, only 64% of the respondents had already been screened for hepatitis. Trends regarding the percentages of respondents already screened for HIV or hepatitis seem to be quite stable over the last four years (Hariga, Modus Vivendi, personal communication).

In 2004, 7% of the participating IDUs reported to be HIV positive (n=497). Among the women who reported to have been tested, 8% declared to be HIV positive; among the men, 6% reported to be HIV positive.

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 IDUs and the same trend is observed since 1998 in the blood screening data of De Sleutel (table 17).

Percentage of self-reported HIV-seropositivity among IDUs asking for treatment in centres of the French Community and De Sleutel, 1994-2003, Standard table 9, 2004

Year	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
French Community										
Number of treatment demands from IDUs	607	550	666	620	505	697	412	579	761	n.a.
Number of IDUs self-reported	270	255	314	294	255	217	128	267	180	n.a.
% HIV + (self-reported)	7.4	3.1	1.3	2.7	2.7	2.3	3.1	3.4	-	n.a.
De Sleutel (Flemish institution)										
Number of treatment demands from IDUs				236	75	352	303	241	306	269
Number of IDUs tested				120	56	186	161	118	62	82
% HIV+ (tested)				0.8	5.4	0.5	1.2	1.7	1.6	1.2

In the outpatient centre "Free Clinic" (medico-social centre) all attending patients are offered a blood screening on a regularly basis.

In 2004, 18 patients were tested positive for HIV (table 18).

Percentage of sero-prevalence of HIV in an outpatient centre, Antwerp, Standard table 9, 2005

IDU	2001	2002	2003	2004
Number of IDUs	333	340	408	416
Number of IDUs tested	254	259	287	295
% HIV+ (tested)	5.9	6.2	5.6	6.1

3.3.b6.2.b Hepatitis B and C

The prevalence of HCV is higher among the IDUs and the non-IDUs than among the general population (Matheï et al. 2005a). In Belgium, current hepatitis C prevalence in the general population is estimated to be around 1% (Beutels et al. 1997).

Sharing contaminated needles and syringes and other injecting materials are risk factors of infection. The transmission of HCV among non-IDUs could be due to sharing of snorting materials, high risk sexual behaviour or via household contact with IDUs (Matheï et al. 2005 a). It seems that the significance of sexual transmission among IDUs is very limited since HCV is far more effectively transmitted by parenteral route. However, among the non-IDUs the sexual transmission might contribute to the higher prevalence rates of HCV than in the general population (non-IDUs having most often IDUs sexual partners most often infected with HCV). Moreover, a low level of education, unemployment, marginalisation and loose of social network were found associated with HCV infection (Matheï et al. 2005 a).

Monitoring of infection is important in order to provide a feedback on the effectiveness of interventions. However, it is difficult to monitor trends in HCV because most people chronically infected with hepatitis C show only mild or no symptoms at all for 20 years or more. In Belgium, HCV is highly prevalent among IDUs. The available limited data suggest for a high chronicity rate, which could be a result of continuous exposure and re-infection. The presence of HCV-RNA is considered to be an indicator of chronic infection and infectivity. In one sample, HCV-RNA was present in 135/142 tested samples (95%), from anti-HCV positive IDUS while in Western Europe, HCV-RNA prevalence rates among IDUs varied from 26% to 86%. These variations could be partly due to different methods of diagnoses (Matheï et al. 2005b).

3.3.b.16.2.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 66 % 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 3.9 % in 2003 (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.

Percentage of hepatitis B infected among IDUs asking for treatment, in centres of the French Community and De Sleutel, 1997-2003

	1998	1999	2000	2001	2002	2003	
French Community							
Number of treatment demands from IDUs	620	505	697	412	579	761	n.a.
Number of IDUs (self-reported)	115	240	195	127	275	184	n.a.
Number of hepatitis B + (self-reported)	27	57	39	20	38	17	n.a.
Prevalence rate (%)							
All IDUs	23	24	20	16	14	9	n.a.
Males	21	22	27	16	15	10	n.a.
Females	28	29	19	15	7	7	n.a.
<25 years	14	18	10	7	5	-	n.a.
25-34 years	25	22	21	16	14	12	n.a.
>34 years	33	35	26	22	18	7	n.a.
IDUs using opiates	23	24	21	16	11	11	n.a.
IDUs not using opiates	25	18	17	15	21	6	n.a.
De Sleutel (Flemish institution)							
Number of treatment demands from IDUs	236	75	352	303	241	306	269
Number of IDUs tested	73	54	155	123	89	47	58
Number of hepatitis B +(anti-HBc+)	15	13	37	27	14	10	10
Prevalence rate (%)							
All IDUs	21	24	24	22	16	21	17
Males	23	23	28	22	14	22	21
Females	8	33	7	20	25	14	0
<25 years	11	7	12	8	0	10	7
25-34 years	27	21	26	26	21	50	100
>34 years	57	50	44	42	32	44	33
IDUs using opiates	24	29	34	-	18	21	18
IDUs not using opiates	13	8.3	-	-	0	27	13

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, increased from 47% to 67%. In 2003, 35% of tested lifetime IDU patients of "De Sleutel" have antibodies against hepatitis C (table 20).

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 20).

Percentage of hepatitis C infected among IDUs asking for treatment, in centres of the French Community and De Sleutel, 1997-2003, Standard table 9, 2004

HCV	1997	1998	1999	2000	2001	2002	2003
French Community							
Number of treatment demands from IDUs	620	505	697	412	579	761	n.a.
Number of IDUs (self-reported)	115	240	195	127	275	184	n.a.
Number of hepatitis C + (self-reported)	54	124	100	66	182	124	n.a.
Prevalence rate (%)							
All IDUs	47	52	51	52	66	67	n.a.
Males	46	49	49	52	66	68	n.a.
Females	48	60	57	52	67	64	n.a.
<25 years	41	47	32	27	55	29	n.a.
25-34 years	46	49	57	54	65	68	n.a.
>34 years	67	58	54	57	74	73	n.a.
IDUs using opiates	44	53	56	48	66	59	n.a.
IDUs not using opiates	62	39	59	63	67	82	n.a.
De Sleutel (Flemish institution)							
Number of treatment demands from IDUs	236	75	352	303	241	306	269
Number of IDUs tested	114	56	195	164	120	65	80
Number of hepatitis C + (biological testing)	45	26	74	59	43	28	28
Prevalence rate (%)							
All IDUs	40	46	38	36	36	43	35
Males	40	40	39	34	33	42	35
Females	39	100	30	47	53	50	33
<25 years	25	21	14	16	16	19	28
25-34 years	53	52	51	45	42	50	0
>34 years	77	62	63	60	56	85	50
IDUs using opiates	47	50	50	-	34	48	41
IDUs not using opiates	21	33	-	-	50	33	24

The following data are the results of the blood testing diagnosis (the context is already described in 6.2.a.3). In 2004, 76% of the patients tested at Free Clinic were tested positive for hepatitis C and almost 58% of the tested patients were positive for HBV(anti-HBc+) (table 21).

Percentage of hepatitis B and C infected among IDUs asking for treatment, in Free Clinic, 2001-2004, standard table 9 2005.

Free Clinic Antwerp	2001	2002	2003	2004
HBV				
Number of treatment demands from IDUs	332	340	408	416
Number of IDUs tested	249	255	281	252
Number of hepatitis B + (biological testing) (anti-HBc+)	107	168	174	147
Prevalence rate (%)				
All IDUs	43	65.9	61.9	58.3
Males	42.4	67.9	64.6	59.7
Females	46.3	63.2	56.5	55.3
<25 years	66.7	33.3	33.3	57.1
25-34 years	39.3	58.2	54.9	51.4
>34 years	45.5	72.2	67.4	61.4
HCV				
Number of treatment demands from IDUs	333	340	408	416
Number of IDUs tested	252	259	287	258
Number of hepatitis C + (biological testing)	201	206	227	196
Prevalence rate (%)				
All IDUs	79.8	79.5	79.1	76.0
Males	80	80.1	81.5	78.0
Females	79.3	78.4	73.9	71.1
<25 years	66.7	33.3	50	64.3
25-34 years	77	77.6	76.9	82.7
>34 years	82.4	82.5	82.4	74.0

6.3% of the tested patients were positive HBV surface antigen (HBs-Ag) in 2001 and this percentage decreased to 3.5% in 2004 (Standard table 9, 2005).

A study compared the prevalence of HCV and related risk factors in drug users in two regions¹⁹ of the Flemish part of Belgium. Prevalence rates of hepatitis B and C were higher in the city (respectively 62% and 71%) than in the mixed area (21% and 46%). It appears that the difference in HCV prevalence is entirely explained by differences in behaviour and characteristics. The findings also suggest that variations in sexual risk behaviour and socio-economic status in addition to drug-related risk factors have to be taken into account when trying to understand geographic differences of HCV prevalence in drug users (Matheï et al. 2005a).

6.2.b.2 Hepatitis among drug users- Snowball survey (French Community)

The **snowball survey**, for which details are given in section 4.3.a, (Hariga, Personal Communication), give additional information on hepatitis for the French Community. The following table shows that HCV is by far the most frequently reported infection.

¹⁹ City of Antwerp and mixed rural and urban area of Limburg.

Percentages of self-reported positive results among tested IDUs for hepatitis, Snowball surveys, French Community, 2003-2004.

	2003	2004
N	296	489
HAV +	9	11
HBV+	28	32
HCV +	51	61
HDV +	1	1

3.3.c6.2.c Tuberculosis

In 2004, 1226 tuberculosis cases were registered (incidence rate: 11.8/100.000 inhabitants) (Fares/VRGT in press). Among them, 15 cases stated intravenous drug use: 2 cases in Brussels, 8 in Flanders and 5 in the Walloon Region.

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There is no national estimation in Belgium of the number of double diagnosed patients. Different studies were carried out such as a clinic study on double diagnosis²⁰.

Evaluation of treatments effectiveness of inpatient treatment programmes for dually diagnosed patients is an ongoing project (see chapter 7).

In 2004, De Sleutel made an estimation based on all patients documented with EuropASI between 1998 and 4/2004²¹. Percentages are calculated for those patients having a severity index of 4-5 and/or 6-9 for drug problems as well as for psycho-emotional problems (i.e. depression, anxiety, tension, ...). 42% (n=2800) could be assigned to moderate (32%) or severe (10%) double diagnosed.

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

From October to December 2003, in the 20 hospitals of Brussels, 2.05% of all the visits to an emergency service were related to a drug-related problem. Data come from the RCM database, selection on the basis of ICD9 codes. The use of ICD9 is not mandatory for ambulatory patients, then this percentage is probably an underestimation (Broekaert, Personal Communication).

²⁰ Etude clinique sur le double diagnostic. La fonction de la drogue dans la clinique des psychoses. Mémoire de fin d'Etude de Caroline Schiltz, Faculté des Sciences Psychologiques et de l'Education, 2003-2004.

²¹ De Sleutel-Dept. Of Research, Dubbel diagnose: analyse van de omvang en de hulpvraag (*Double Diagnosis: analysis of number and treatment demand*), April 2004, 5p., unpublished document.

6.4.b Driving and other accidents

6.4.b.1 Data from police services

In October 2002, the Federal Police 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 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 for 2003-2004.

□□□□□□□□ Results of the controls in the framework of the "Road safety action plan", Deblaere, Personal Communication 2005.

		2003	2004
Controls		275	525
Urine tests	Positive	108	198
	Negative	31	64
	Total	139	262
Blood tests		108	198
Refusal		7	4
PV's		115	202
Driving license revocation		18	27

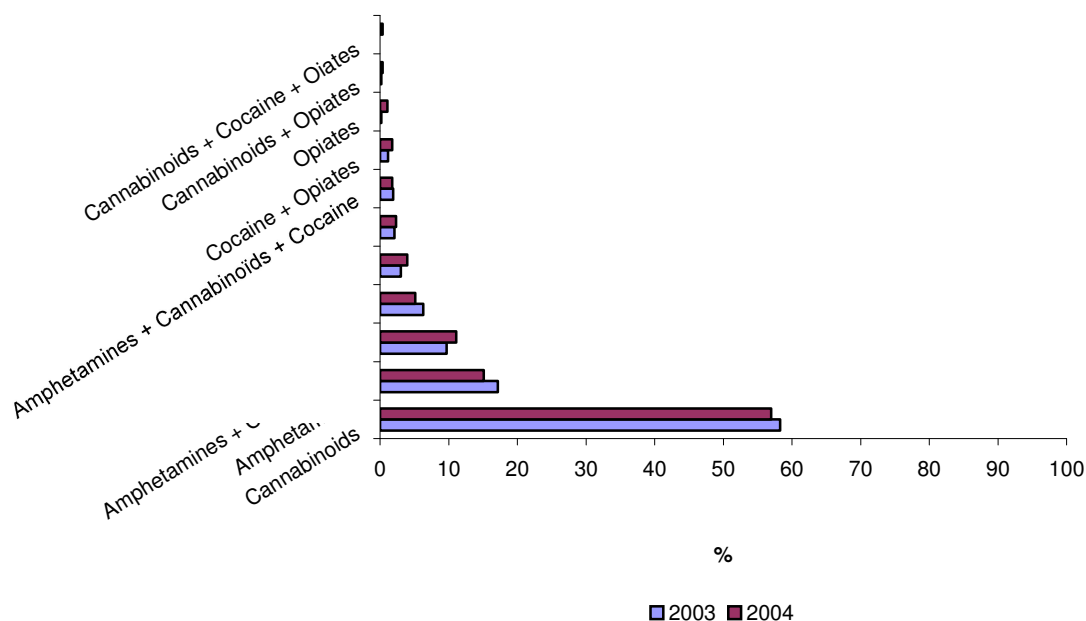
The law of 16 March 1999 and the different subsequent legal acts, have mentioned 5 groups of substances to be controlled within the framework of road safety. These substances are the following: cannabis, amphetamines, methamphetamines, morphine, and cocaine (Deblaere 2003).

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 were positive, a urine test is done. If this result is positive, then a blood test is requested. Policemen should have followed a theory training of 2 days and 8 hours of practical tests before carrying out such tests.

The next figure presents the results of the blood analysis performed in 2003 and 2004 (Deboeck Personal Communication). Blood samples were taken during police road controls (both local and federal police services). In 2004, out of 975 tests 855 were positive and 120 were false positive.

More than a half of the samples contained only cannabinoids, followed by amphetamines and then cannabinoids associated with amphetamines.



Results of positive blood tests in the framework of road controls done by local and federal police services, N= 616, N= 975, NICC 2003-2004.

6.4.b.2 Data from harm reduction project

In the framework of activities within the recreational settings, questions were asked on driving risks (Hariga Personal Communication 2005). In 2004, 35% of the people (n=499) who had already used an illegal drug during the event reported a safe mean of transportation back home, 23% a doubtful mean (passenger in the car of a friend at the same event) 15% declared they will drive themselves, and 27% did not answer.

6.4.b.3 Road traffic accidents

The next table presents national data from police reports on the driver's status registered by police in case of road traffic accidents. From 1993 to 2002, there is no particular trend to note when considering the number of fatal and non-fatal road traffic accidents with drivers under influence of medicinal or illicit drugs. Unfortunately, no information on the type of involved drugs is available.

State of drivers victims in a road traffic accident, NIS 2005.

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Under influence of medicinal or illicit drugs	96	112	120	104	117	114	112	102	109	110
Under alcohol influence	2177	2048	2171	2189	2226	2360	2190	2233	1992	2114
Total number of drivers victims (all status reported)	57189	55464	53362	51223	53024	54146	54869	52564	50684	50773

A two-year study on the issue of “Driving under influence of psychoactive substances²²” (ROPS) started end 2002. It aims at presenting political recommendations on the basis of a literature study and experts conclusions.

6.4.c Pregnancies

Until now there is no systematic data collection on pregnant women drug users or mothers drug users (even in treatment) and their (young) children in Belgium.

²² More information on this project please refer to <http://www.belspo.be>

Two flyers have been developed especially for a public in recreational settings (Modus Vivendi) to sensitise to the related-risks to XTC use. One talks about the uncertainty of the contents of pills sold for ecstasy (Flyer “gloups”) and the other one about the needs to drink enough water (Flyer “h2o”).

In the **Flemish Community**, a local training in overdose prevention for drug workers is set up through the provincial co-ordinators of the needle exchange programmes (it was also formerly addressed to drug users, but not anymore). Some peer projects (Ostend & Ghent) organise group sessions on overdose prevention for drug users.

An information brochure on overdose prevention is also available and distributed through drug services, street corner workers and needle exchange programmes (Windelinckx, 2005).

7.2.a Prevention

Needles exchange programmes

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.

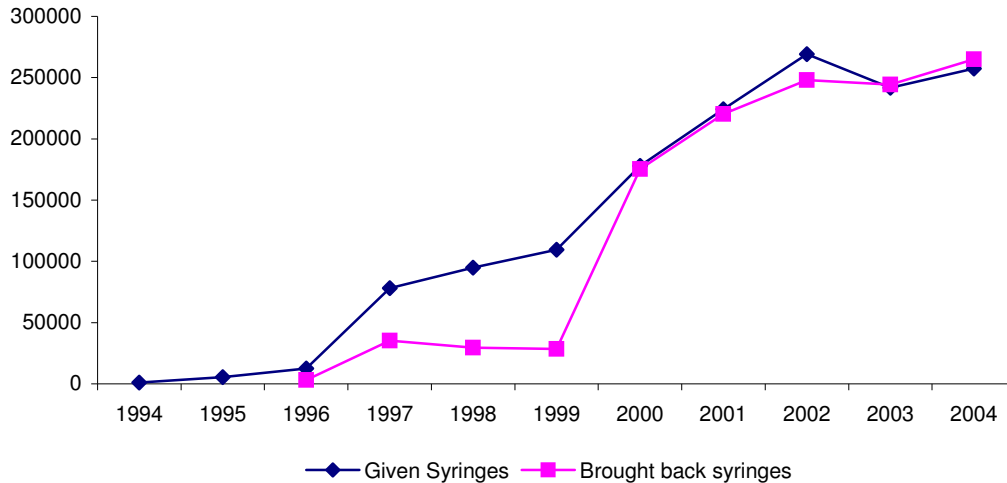
In every province of the **Flemish Community** a coordinator for syringe exchange was appointed and several exchange places exist (low threshold organisations, pharmacies, outreach workers, ...). Via the projects, syringe exchange injection kits are spread among users, including: syringe, sterilised water and alcohol swaps (to clean the spoon). Collaborators of the project also distribute baking soda (for cooking base-cocaine) and make users sensitive to base-cocaine. A handbook for syringe exchange programmes was developed about e.g.: the legal framework, good practice, infectious diseases, health problems related to injecting and alternative ways of using (Windelinckx, 2005).

Over the whole Flemish community, 237 023 syringes were distributed and 239 452 were given back in 2003. In 2004, 309 666 were given and 306 594 were brought back (Windelinckx, 2005).

In the **French Community**, needles exchange programmes are available in 5 cities (Brussels, Charleroi, Liège, Dinant, Arlon).

More than 250 000 syringes have been distributed in 2004 through needles exchange programmes within the French Community (Fabienne Hariga, Personal Communication). According to cities, one can observe completely opposite trends. In Liège, since 2001, the number of needles distributed has decreased while in the other cities it has increased. Currently there is no clear explanation about the decrease in Liège. In 2004, needle exchange projects, both on the street and in services allowed for more than 25 000 contacts with IDUs.

The rate of exchange in 2004 is 103%. In other words more needles were brought back than distributed. Rules of exchanges vary in relation to a city or a service :e.g. in some places strict exchange might be applied (same number of syringes is distributed as the number of brought ones), in other places this rule does not exist.



□□□□□□□ Volume of the exchanged syringes, French Community, 1994-2004.

The access to other injection equipment is much lower. For example the number of Stéricups© distributed in 2004 in the French Community is about a third of the number of syringes due to the lack of funding. This illustrates the weakness in terms of hepatitis B and C prevention.

Injection kits: Stérifix

Stérifix is a kit containing 2 syringes/needles, water for injection, disinfectant swabs, information on the risk of transmission by syringe sharing and addresses of HIV screening centres and needle exchange programmes. The package is sold at EUR 0.5 in pharmacies in the French Community. The participation rate in “high risk” areas of Brussels is 30%, but lower in other areas. Promotion of kits is done by drug users within the framework of a participative project.

□□□□□□□ Number of Sterifix sold by pharmacists in the French Community, 2000-2004.

	2000	2001	2002	2003	2004
N injection kits	14493	12083	14000	15925	23425

Prevention of HIV/hepatitis in prison

There is no access to safe injection equipment, nor to disinfectant, limited access to condoms and no access to lubricants. Sentenced prisoners can ask for hepatitis B vaccination.

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

Prevention of hepatitis C transmission through “sniffing” drugs

Sniffing kits are available in limited number in some harm reduction projects in recreational settings. These kits contain an information flyers and a straw.

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 only target children.

The results of the snowball peers project indicate that the immunisation rate against hepatitis B among IDUs is very low and varies from 14% for recent IDUs (less than 2 years) up to 18% among all IDUs (Hariga 2005 Personal Communication).

Information brochures

In the French Community, the NGO Modus Vivendi is responsible for the HIV/Aids prevention activities specifically targeting drug users and then develop and disseminate information material:

- about Aids;
- 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.

These brochures are distributed through peers prevention projects (snowball), specialised ambulatory treatment centres and needles exchange programmes, in some prisons and finally by a limited number of pharmacists. In addition, a Flyer "sniff" (see kit sniff), is distributed in recreational settings.

Other HIV and hepatitis C prevention activities

A small brochure ("Vous êtes en contact avec des seringues usagées") targeting staff of public parks, police or any professional who might be in contact with used syringes in public areas was published. The objective is to inform them objectively on the risks of contamination, on how to prevent accidental punctures and how to react in case of accidents.

Peers prevention project

The '*Operation Boule de neige*', is a peers prevention project, concerns HIV, hepatitis and other drug-related risks and aims at reaching, through a snowball methodology, specific groups not easily accessible. (Ex)-drug users in short-term contracts ('jobist'), training them on HIV, hepatitis or overdoses prevention. After their 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 and attitudes. Evaluation of each intervention is made with the "jobists" and is both collective and individual. About 1500 drug users, mainly IDUs are reached every year in the French Community.

In 2002, with the support of EC-DGV, the project "Euro Boule de neige" was transferred to Finland, Greece, Italy, Portugal, Spain, and Slovenia.

Due to the lack of funding, and despite its positive evaluation, the pilot snowball project in prison implemented in 2002 and 2003 was not extended in 2004.

3.3.b7.2.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).

The objectives of the network are to improve the prevention of hepatitis C among drug users and ameliorate the access to screening and to hepatitis C treatment. The network organises seminars on hepatitis C treatment but also monthly meetings to discuss the treatment of patients who are in drug treatment services or GP patients and treated or followed by hepatologists for their hepatitis C infection. In 2004, a seminar was organised and 150 patients were included in a clinical protocol for hepatitis C treatment (CARE).

The needles exchange programme, ("Le comptoir"), in partnership with the NGO "Sida MST" (HIV reference centre) in Charleroi offers IDUs the opportunity to be tested for HIV and hepatitis during the opening hours of the needle exchange programme. The number of participants is relatively low (30 people in 2004) and not all of them reported to be IDUs. However, in 2004, 60% of the total number of tested persons, were HCV positive and none were HIV positive. This population showed a high prevalence of cumulating both sexual and injection risks²³.

The Belgian Association for the Study of the Liver (BASL²⁴) published new guidelines for the management of chronic HCV among drug users (Robayes et al. 2005). The implementation of these guidelines should avoid the evolution of chronic HCV to end-stage liver disease, prevent liver transplantation in those patients and reduce the spread of viral infection.

In Flanders, drug users have many places to be tested for infectious diseases. The screenings (HIV, HCV, HBV) are mostly offered in outpatient and inpatient treatment centres. For TBC-screening there is cooperation between the MSOC's and the VRGT (Flemish association for respiratory health and prevention of tuberculosis) (Windelinckx, 2005).

One month treatment of hepatitis C infection costs the patient who has no medical insurance about 1 700 Euro per month. If the patient has a social insurance it costs him EUR 25.

The criteria for reimbursement of the hepatitis C treatment by the social security were revised in 2004. In addition to a PCR positive and to an elevation of the ALT, according to the type of genotype to get reimbursement the diagnosis must be confirmed by a biopsy for genotypes 1, 4, 5 and 6. There is no need for a biopsy for genotype 2 and 3.

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Overall there is more attention for psychiatric co-morbidity in the treatment provided to drug users (e.g. therapeutic community De Sleutel for double diagnosed patients, ...)

There is an ongoing project on the "Effectiveness of inpatient treatment programs for dually diagnosed patients"²⁵. The aim is to answer two questions: are dually diagnosed patients effectively treated when they follow a residential integrated treatment programme? And is there a difference in efficiency between the residential integrated

²³ Le comptoir ASBL. Rapport d'activité dépistage 2 ième année ; Charleroi 2004.

²⁴ <http://www.basl.be>

²⁵ Results of the first phase of this research are available at <http://www.belspo.be>

Sabbe, B., De Wilde, B. (2004). Effectiveness of inpatient treatment programs for dually diagnosed patients.

treatment programme and the residential non-integrated treatment programme? The residential integrated treatment program is defined as a combination of special assessment, outreach, motivational interviewing, individual and group counselling, a pharmacological treatment, psycho-education, a long-term perspective, different treatment phases and social network factors.

40 dually diagnosed patients who followed an integrated treatment program were compared with 40 dually diagnosed patients who followed a non-integrated treatment program.

The second part of the project focuses on the people who work with double diagnosed patients. The researchers investigated whether the job satisfaction is higher and the work stress is lower among staff working in hospitals with integrated treatment programs.

By the end of 2002 two hospitals (in Sleidingen and Liège) started a pilot project 'intensive care for patients with a double diagnosis'. The main objective of this programme is to try out and rephrase a care policy for the specific target group (De Cuyper 2003). Secondly, an integrated care plan was developed that guarantees collaboration and continuity of acute treatment, prevention and aftercare. Therefore this section got extra paramedical assistance. The inpatient unit has a capacity of 10 patients 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 mandatory (judicial decision). Each year, 25 to 30 patients enter in the project. Most of them stay for 6 months. The federal authorities fund the project.

7.4.a Somatic co-morbidity

In the MSOC in Gent every new client is screened for HIV and hepatitis B & C (Dr. 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, problematic substance users can both be treated in the general services, in the emergency department as well as in the psychiatric ward for serious somatic or psychiatric problems. 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. 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 alcohol and drug addicts in crisis for maximum stay of five days. Every crisis unit is linked to a case manager who guides the patients and does outreach work.

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

Up to now, the Belgian Road Safety Institute (IBSR/BIVV) organised two campaigns specifically dedicated to drivers under drugs influence: the first one in 2001 “Je roule clean” and “Rouler drogué, c’est parti pour un mauvais trip” in 2002. These campaigns target the regular and occasional drug users with a harm reduction message. Leaflets and posters are distributed through specialised NGO’s, police, ...and not through mass media such as for the prevention campaign “BOB” (only focusing on driving under influence of alcohol). The Belgian Road Safety Institute insists on the necessity to organise such campaigns but also claims for evaluation of those (Delcourt 2004).

In 2004, Modus Vivendi NGO developed a flyer tailor made for drug users in recreational settings named “road trip”.

The latter is a warning against the danger of driving a car under influence of psychotropic products (LSD, ecstasy, amphetamines...). It explicitly refers to the Belgian Road Safety Institute’s campaign BOB, advising the readers, in case of consumption, to elect a “Bob” (who will not consume). The flyer concludes by advising, if the reader nevertheless decides to consume and no “Bob” has been chosen, to quit using several hours before taking the car, and to have a rest.

On the back of the flyer, the general principles of the harm reduction are recalled, as well as the helpline’s number of Infor-Drogues.

For Modus Vivendi, the principle of the flyers (versus brochures) is to actively go towards the consumers. Indeed, Modus Vivendi’s “Local point of reception for party drug users” usually provides brochures and oral information on the reduction of risks related to the consumption. On the contrary, flyers made of a single back-and-front page are easily spread from hand to hand by the workers on site, and even put on car’s windshields in the case of the “road trip” flyer.

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.

The syringe exchange project in **Flanders** sensitises drug users to test for TBC and offers them the opportunity to be tested for TBC in cooperation with the MSOC’s and the VRGT (Windelinckx 2005).

In 2004, a research regarding the desirability and the feasibility of a drug consumption room in **Antwerp** was carried out (Barendregt & Rodenburg 2004).

Drug users and social workers felt the need for a drug consumption room, especially for a group of 20 to 40 drug users seriously marginalized. They reported that a drug consumption room is more hygienic and can contribute to a decrease of nuisance on specific hiding places. The inhabitants of Antwerp were against a drug consumption room. Furthermore, before a drug consumption room could be implemented, an adjustment of the federal legislation would be necessary, since providing a room for drug use is punishable at present.

There is a mobile harm reduction team in the **French Community**. During major events (major in size or because of an expected high prevalence of drug use during the event), a

mobile team with both professionals and trained peers are present and offer various services such as: information on drugs and STDs distribution of brochures, needle exchange, water distribution, safe sniff kits, and on site “bad trips” management.

Modus Fiesta, Information, harm reduction, and orientation for “party drugs” users

This service opened in Brussels end of 2002 with the objectives of offering a “friendly” place where party drug users can come to get information, harm reduction equipment, express their problems and possible medical, social and psychological needs. The premises are convivial, and decorated in line with party drugs users culture. Cultural events are sometimes organised. Service opens on Monday, Wednesday afternoon and on Friday evening. During opening hours, drug users can come and meet with trained peers, and with harm reduction professionals. Since 2004, in order to answer to the “problems” met by the public in link with their drug use, psychologists from partners from specialised treatment services (Enaden, Infor Drogues and Projet Lama) are also on duty in order to answer to some of the problems and to create a first contact with drug users who would like to start a treatment. If there is a clear demand for a treatment the person will be referred to a specialised treatment centre.

In 2003, the service achieved 200 contacts. In 2004, 493 contacts were made, 80% with “party drugs” users, 5% with professionals, and 15% with students or artists. Among the drug users one can count 62% of first contacts. 58% of the drug users came at least twice during the year. The mean age is 25 years old and 67% are younger than 25 years old. Finally 6% of the demands have been relayed. The unexpected result of this project is the meeting with a population of party drug users with a relative high demand for assistance.

It is expected that in 2005 the service will be one of the sites where pill testing will be organised in the framework of an experimental project.

7.4.e Interventions concerning pregnancies and children born to drug users

In the Flemish Community, De Sleutel took part between April 2000 and April 2002 in an European project Vulnerable People; addicted mothers and their young children.

At that time the possibilities for identifying and assisting this target group were minimal in the various European countries. Now, the issue has become widely known and many agencies have gained greater awareness about the existence of these vulnerable people (Vulnerable people, 2002) (See Belgian national Report on drugs 2003, chapter 9.3.c).

De Sleutel has concentrated on prevention by conducting needs assessments for the target group, designing questionnaires and training intermediaries.

A second organisation that pays specific attention to this target group is “De Kiem” (therapeutic community). In 1996 they started a project called ‘Tipi’. This project provides housing and care for 4 woman and their children. The mean duration of a stay in the Tipi is approximately one year.

The specific guidance at “De Tipi” consists of a weekly gathering of the group. During this gathering there is extensively spoken about topics concerning the evolution of the children, the planning and organisation of the household and the cohabitation of different families. Besides that there are, on a regular base, separate trainings concerning specific topics. The Tipi-mentors are regularly present (participating or not) to observe, support and provide individual coaching. The mother makes up a plan regarding the education of her child(ren), this plan is regularly evaluated and adjusted.

Next to the specific guidance at “De Tipi”, the mothers work on their addiction and addiction related problems in therapeutic community.

The number of specific requests for ‘De Tipi’ during the years, is on average 8.94 % of the total amount of registrations. The table below shows us a survey of the amount of specific registrations in function of ‘De Tipi’ since its start.

Number and percentages of admissions in therapeutic community and in Tipi, 1996-2004

	1996	1997	1998	1999	2000	2001	2002	2003	2004
General	182	207	208	195	208	200	241	216	174
Tipi	11	20	15	22	17	19	26	19	16
%	6.04	9.66	7.21	11.28	8.17	9.50	10.79	8.79	9.19

It is noticed that a lot of women drop out before or after the start of the introduction conversations. This confirms that a lot of women struggle with the idea to let themselves be taken in together with their child. They are afraid of what is going to come, and they hope, often against better knowing, that they can manage without intake to get their addiction under control. This is also seen in data concerning referrals (Derluyn, et al. 2002). De Sleutel and De Kiem have also started a cooperation.

Another organisation that is specialised in prevention and care for drug using mothers and their children is Bubbels & Babbels. For more information on this project see 3.2.c.

Besides the treatment modalities in the specific programmes mentioned above, case managers can coach drug using mothers and their children. On the other hand there are 5 MSOC’s (Medical and social care centres) spread over Flanders who also care for drug using mothers and their children.

The MSOC’s set themselves the tasks to:

- get the parents aware of the consequences of their addiction for their children
- cooperate with other services to develop a specific help service for drug addicted parents and lead the parents to these initiatives.
- inform the clients about the existence of the different available services and encourage them to make use of these services.
- improve the skills of other organisations working with drug addicted parents
- integrate educational assistance in the existing framework (de Bruyn, Smits 2002).

In the **French Community** (Liège), the NGO ALFA (Center for Mental Health) proposes a project on parentality. It offers a psycho-medico-social follow up for pregnant women or women with a newborn baby, in order to prevent future drugs problems for the children.

1/3 of the patients come voluntarily, 2/3 under mandate of an institution such as the specialised youth help (SAJ) or the Service of Judicial Protection (of youngsters) (SPJ). Even day nurseries occasionally send drug-using parents to ALFA, in order not to have to warn the SAJ or SPJ. Nonetheless, whatever the motive (mandatory or voluntary), the last decision to integrate the parental program of ALFA is left to the parent himself.

According to the CAW these data are an underestimation of the real figures because of difficulties in the registration system. In the future this problem will be remediated (Mendonck and Van Menxel 2005).

The study in the province of Antwerp (see 4.2.a) indicated that among all clients demanding treatment in one of the treatment centres, almost 10% was homeless or lived in unstable living conditions (Colpaert et al. 2005). Compared to not homeless clients, they appear to be more often polydrug users, using to a larger extent opiates, cocaine, alcohol and hypno-sedatives, and having a longer treatment history. They are not significantly older or younger. Among homeless drug users, the percentage of women is lower (16.4%) than among drug users living in a more stable environment. Homeless drug users hang around in the city centre of Antwerp and less in the surrounding cities and towns. Some contacted homeless shelters reported that between one fifth (21.8%) and one third (35.4%) of all homeless asking them for help regularly used illegal drugs and/or alcohol (the latter in an excessive way). Finally the study also indicated, although over a limited period of time (i.e. 6 months), an important overlap between treatment centres and homeless shelters: about 25% of all clients with substance abuse problems registered in homeless shelters were also registered in one or more treatment centres. Authors stress the need for a good collaboration between these two sectors.

8.1.b Unemployment

No new information.

8.1.c School drop out

In Chapter 2, a paragraph deals with youngsters and school.

8.1.d Financial problems

No recent survey was carried out on this issue.

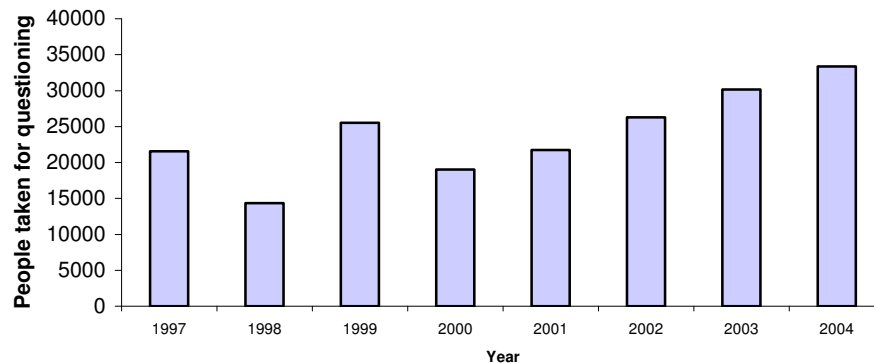
8.1.e Social networks

As mentioned by Eurotox (2004), the study on drugs and nuisance (Decorte et al. 2004) brings to light some information about social networks. The study was partly based on an ethnographic research targeting drug users living in two particular neighbourhoods, but also city dwellers passing there ("De Coninckplein" (Antwerp) and the "Ville Basse" (Charleroi)). In terms of social networks, one will notice that drug users declare to join these places because these are the ones where they still can gather. These places are the unique environment where they feel somehow understood. On the other hand, paradoxically and despite the "social network factor", "survival of the fittest" is a still reality.

RU R A R M

8.2.a Drug offences

In 2004, 33348 reports of drug use, possession and or traffic were registered by police services (standard table 11, 2005). The trend seems to sharpen, but it has to be noticed 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, this could partly explain the rise.



Number of people taken in for questioning, Belgium, 1997-2004, standard table 11, 2005.

Persons who were intercepted were not necessarily arrested, i.e. held in custody.

Cannabis is the most commonly involved drug of all drug related reports in 2004 (23377 'arrests' for drug use, possession and or traffic). The second substance involved is cocaine (3774 cases) and thirdly heroin (3363 cases) (standard table 11, 2005).

A specific analysis of the drug-related reports between 2002-2004 in Brussels reveals an increase of 29.6% (Buy 2005). Of 8889 reports, 75% concerned possession/use, 15% drug dealing and 10% trafficking/drug tourism. As regards possession/use of drugs, the rise in the number of reports is about 25%, reports about deals of drugs increased by 50% and finally reports for drug trafficking by 35%.

More reports were registered during the summer (may be because of the frequent festivals, open air event,...).

Looking at the authors of the offences (n=6847), 80% were identified as drugs users, 10% as dealers and 10% as traffickers/drug tourists.

Among those identified as **drug users** (all drugs confounded) 91% are males but it has to be noticed that cocaine use is relatively more frequent among women. Furthermore, 53% are aged between 15 and 23 year olds, 81% are Belgians, Moroccans or French.

Those identified as **dealers** are also predominantly males (94%). Until 20 years old they mainly sell cannabis, from 21 years onwards they sell cocaine more frequently and then opiates when older. 71% of those dealers are Belgians or Moroccans.

92% of those recognised as **traffickers/drug tourists** are males. Cannabis and cocaine are the substances most frequently mentioned in the reports, 70% of the registered are Belgians, French or Moroccans.

Figures from 2000 and onwards could not be compared to previous years, due to changes in the methodology of data collection and counting methods. If several infringements are noted in one police report, they are counted separately in the database.

Compared to 2000, in 2004 there is a decrease of 16.1% in the number of offences related to drugs. Still, a rise of 2.1% is observed in 2004 compared to 2003 (Table 27).

Number of offences related to illegal drugs ,
Belgium, 2000-2004 (NIS²⁶)

Year	Total	Possession	Use	Trafficking
2000	51382	20603	17004	12243
2001	43321	17476	13319	11157
2002	45947	19164	14415	11389
2003	42039	18148	12337	10807
2004	43096	19347	11589	11451

If the evolution of the number of police reports related to illicit drugs is an indicator of the activity of the illicit drug market, it is also one for the activity of police services and their efforts to control the situation. In addition, there is of course a dark number but it is not known how this number could affect the interpretation of the available data.

In Belgium, data regarding **prosecutions** of drug related crime are not systematically gathered. There is, however, a research started in 1990, gathering information about drug users based on Public Prosecution statistics. Results²⁷ show that the age categories 18-20 year olds and 21-24 year olds are the most represented. In fact, at least half of the offenders with a police report for drug use, seem to be between 18 and 24 years.

The substance mentioned most frequently in the Public Prosecutor's Offices' data 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.

The Ministry of Justice publishes on an annual basis a report gathering a summary of the main criminal data. This document, "Justice in numbers 2005" contains among other things information about the convictions (Table 28).

Evolution of persons convicted for drug-related offences*, Belgium, 1994-2003 (FPS Justice 2005).

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
N° convictions	5343	4922	5426	5363	4491	3981	4039	3962	3933	3934

* Number of individuals, no double counts could occur.

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

²⁶ <http://www.statbel.fgov.be>

²⁷ Detailed results were given in the last year Belgian National Report, updated data were not available this year.

3.3.b8.2.b Other drug related crime

Last year, chapter 13 of the national report was dedicated to “public nuisance” and chapter 1.4 provided results of the study “drugs and nuisances”²⁸. This information will not be repeated this year.

A Monitor Integral Local Policy concerning drugs is recommended to provide an overview of the local situation (Ponsaers et al. 2005). Two axes are foreseen: use of drugs and social consequences; drug-related nuisances and overall nuisances. The data collection for the monitoring system should first be based on interviews of key persons, quantitative data would be collected in a second time, and finally a new qualitative phase should study structural indicators.

RU US RIS

In last year report, the results of a study carried out in 2003 by two NGO’s (Modus Vivendi and Street Wise).

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 prevalence of any illicit drug use in prison is 33%. Cannabis comes at the head of use in prison with 28.9% and heroin follows with 13.3%. 2.5% of the prisoners reported to have injected drugs.

11.4% stated that they used cannabis for the first time in prison and 7% report a first use of heroin in prison. In addition, almost 1% reported their first drug use by injection in prison. Moreover, there is a tendency towards polydrug use: while 37% uses 1 substance; 13% uses 2 substances and 50% uses 3 substances and more.

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

3.5% of the prisoners reported sharing injecting materials in prison, compared to 4.2% before imprisonment. It seems thus, that certain detainees gave up this practice once in prison.

8.9% of drug users reported to have followed a methadone treatment 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 of GP’s, 51.7% of the drug users did not have any throughout their imprisonment. However, for those in treatment, methadone was prescribed in 21.5% of the cases.

S A S S

No study on social costs is available in Belgium.

²⁸ An extended summary of the research is given on the web site: <http://www.belspo.be>

In the **Flemish Community**, several Therapeutic communities and inpatient units for drug users offer a sort of aftercare in the sense of housing. A few centres (CAW - centres for general social work) are specialised in the reception of homeless drug users.

There are several possibilities for drug users to find shelter in centres not specifically dedicated for drug users. (a) Reception centres. These homes are open for different target groups like women, refugees, addicts, The length of stay and the intensity of coaching is related to the population. (b) Night-shelters. Night-shelters accept clients for a short period. They mostly offer a bed, a meal, a shower and some basic needs like rest, safety and anonymity. During the short stay in these houses the client is reoriented to find a solution for his problems. (c). Accompanied living. This form of housing is created for people who want to progress to a independent living but still need a minimum of guidance. Outpatient guidance is provided in these houses (www.caw.be).

Although there are several centres where homeless drug users can find shelter, recent studies show that there is still a shortage in the reception of homeless drug users in Flanders (Colpaert et al. 2005; Follon 2003).

In the field of housing, the « **Walloon Code of Housing** » specifies various possibilities:

Temporary housing for households in a precarious state or deprived of housing (timeframe : max. 6 months, once renewable); reintegration housing for households in a precarious state (timeframe : min. 3 years); social housing for households in a precarious state or having a modest income.

Emergency accommodation/shelter is not governed by the Walloon Code. It falls within competences of the Minister of Social Action and includes the reception houses and night shelters for homeless.

There are two types of assisted housing facilities who integrate every-day life:

- the "Initiatives of Protected Accommodation" ("Initiatives d'habitations protégées" /IHP) for people encountering psychosocial or psychiatric difficulties and
- the "Houses of Psychiatric Care" ("Maisons de soins psychiatriques"/ MSP) for people with chronic psychiatric disorders that are stable but do not require hospital treatment.

The Experts Group Report underlines both accessibility and availability problems for drug users in the accommodation field. It concludes that the specialised institutions do not have sufficient means nor technical competences to face the problem of drug users housing and that the accommodation/shelter area is generally absent in specialised drug field networks. Some recommendations of the Group try to fill this lack (Collège d'experts en assuétudes 2005).

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.

In 2004, VAD organised 5 trainings in collaboration with the VDAB on how to work with drug users. The training contains a short introduction on the problems, information on substances, relation between the labour market and employment, the organisation of

assistance and the role of the VDAB. Also in 2004, 4 follow-up modules were organized recognising addiction and opening discussion on this issue.

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 education or trainings to drug users also.

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

Workshops more focused on the education of drug users also exist. Thus certain institutions propose workshops in the field of culture and leisure’s, elimination of illiteracy or social information.

There are two types of structures that deal with the professional reintegration: the Organizations of socio-professional reintegration (“Organismes d’Insertion Socio-Professionnelle »/ OISP) and the Enterprises of training by work (“Entreprises de Formation par le Travail”/ EFT). The OISP concern people without higher secondary degree at school, the EFT concern people without lower secondary degree at school. Several specialised institutions in the drug field work with or hold the title of EFT or OISP.

The Experts Group Report underlines the same conclusions as for housing: accessibility and availability problems. The Group recommends more particularly to create a specific supply of EFT for the drug users (Collège d’experts en assuétudes 2005).

9.1.c Employment

In the **Flemish Community**, since 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 these people. Working in the social workplace gives (ex) users the opportunity to reintegrate 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 gives people status, identity and development of personal abilities,... By bringing the employment sector and treatment centres closer to each other a more fluent stream of patients between treatment and employment is realised.

In October 2004, the centre for mental health care in Turnhout started a new project for job course accompaniment. This project focuses on (ex)users who notice problems in finding or keeping a job. If the (ex)user is not ready to work, training or education is part of the pre-course. The project is funded by EFRO (European funding for regional development). The project works in close cooperation with the VDAB (Flemish service for job mediation).

This type of service is also well developed in the **French Community** and tends to be central in some institutions working at the reintegration of drug users. The search for a job is done according to active methods with assistance of specialised facilities and in collaboration with general structures specialised in employment (ONEM/FOREM, CPAS).

The association « Autrement » aims at social and socio-professional accompaniment of persons with a drug-addiction problem (Autrement 2005). These persons are sent to « Autrement » by CPAS (public centers for welfare), prisons or other actors of social help. They offer individual psychotherapeutic follow-up as well as group therapy. Psychosocial follow-up includes social and administrative help but also support to the families. Internal training are organized (renovation of buildings and initiation to software programs).

A pilot project of socio-professional insertion is led since June 2002 by the NGO Phenix (Namur), in partnership with the CPAS of Namur and under the aegis of the Ministry of Social Integration. Drug-addicted persons, who “benefit” the minimum welfare from the CPAS, are addressed to the NGO Phenix, which manages different projects in the field of drug addictions (Phenix 2005).

The drug users are considered for the occasion as “trainees”. It means they are remunerated (EUR 1/hour) to achieve a weekly program, in the framework of various workshops (cooking; renewing of the association’s buildings – as in the NGO “Autrement”; joinery; communication, computer initiation ; etc.)

These workshops are meant as educative tools of socialization: they allow the emergence of skills, of interest in leading a task, of social attitudes, as well as the learning of a framework and of the basic rules that are necessary to the working of the workshops.

The objective of the Regional Missions for Employment (“MIRE”) is to carry out reintegration and assistance actions for the least professionally integrated aiming at leading them to a long-lasting job. There are 11 MIRE in the Walloon Region. As regards their policy towards drug users, only “non-active” drug users can have access to measures and devices developed in socio-professional matters. This implies that drug users have first followed a previous program of social reintegration.

9.1.d Basic social assistance

Not exclusively addressed to drug users but to all individuals in precarious situation, the **Walloon Region** (Ministry of Social Action, Health and Equality) created “Urban Social Relays”. They aim at coordinating, networking public and private actors involved in helping excluded persons (Decree of the Walloon Government 29/01/2004²⁹). There are five social relays in the Walloon Region (Charleroi, Namur, Mons, Liège, Verviers). Two of those Relays (Liège and Charleroi) have clearly integrated drug users as target groups. If the general objectives are the improvement of the living conditions, the final aim of the social Relays is social integration. In the field of health, social relays organise harm reduction activities (condoms distribution and needles exchange). More information on harm reduction activities is available in chapter 7.

In the French Community, parallel to the Relays, many institutions offer social rehabilitation and professional activities. Training and employment remain the two principal interventions organised for reintegration. However, the concept of socio-cultural insertion gradually appears in the services offered. The objective of all these initiatives is to improve the quality of life of the user.

²⁹ 29/01/2004 Arrêté du Gouvernement wallon relatif à la reconnaissance et aux subventions des relais sociaux.

Since 1982, the Interdepartmental Direction of Social Integration (“Direction Interdépartementale d’Intégration Sociale”/ DIIS) is a coordination tool aiming to follow, assess and initiate projects against exclusions. The DIIS facilitates social integration through other local initiatives such as street sport, youth training, travellers reception, etc.

In 2003, in the Decree concerning the Proximity Prevention Plans (“Plans de Prévention de Proximité”/PPP), the Walloon Government clearly established links between the fight against poverty and social exclusion on one hand and addiction on the other hand. The Proximity Prevention Plans develop the following actions:

- answering local needs in matters of prevention of precariousness, poverty and exclusion
- answering local needs in matters of drug harm reduction.

The Decree relating to the « PPP » includes Integrated Social Plans (« Plans Sociaux Intégrés »/PSI) and Prevention and Security Contracts. Among the PSI priorities there are :

- professional reintegration,
- social and cultural reintegration of young people,
- drug prevention and addiction treatment.

For Fly Tox (a specialised institution), social reintegration is considered as a mean for progression of drug users and a goal of the treatment. Fly Tox developed a partnership with the CPAS of Liege for juridical services. A jurist is on duty to help drug users with debt counselling, problems with owner about rent, e.g.

In the **Flemish Community**, in the framework of the “Big City Government” (an annual contract between the Federal government and the biggest Belgian cities) some projects were created under the umbrella idea ‘liveable districts’. The “Activating-project” is one of the three drug-related projects in the Athenaeum-district. The aim of this project is to ameliorate the integration between all groups present in the district. This means: being able to spend time together in group, to talk about life experiences in a different and useful manner, to improve the consent and sense of responsibility.

In the first phase this is limited to ‘inviting the members for the different activities’ and ‘the individual approach on ‘het Conicksplein’. To just be there for them, and to be as much as possible part of their group: gain trust, jabber away, do nice things, bring activities they wouldn’t have thought possible close to them.

Some examples of activities in 2004:

- sports activities (volley, football, badminton, pool,...),
- cultural activities: Flandria-tour, music-quiz,
- culinary activities: eating in social restaurants (Donckers et al. 2004).

Furthermore, there are two other centres offering basic social support, but not exclusive for drug users. The public centre for social well-being (OCMW) is an autonomous institution where all citizens can go with their social problems. The main aim is to insure the right of everyone to have a decent existence. The centre for general well-being (CAW) is open for people with questions and problems and is low threshold as much as possible.