



European Monitoring Centre  
for Drugs and Drug Addiction



*Scientific Institute of Public Health  
OD Public health and Surveillance*

**2009 NATIONAL REPORT (2008 data)  
TO THE EMCDDA  
by the Reitox National Focal Point**

**BELGIUM**

**New developments, trends and in-depth  
information on selected issues**

**REITOX**

Belgian national report on drugs 2009

OD Public Health and Surveillance, Scientific Institute of Public Health, October 2009, Brussels, Belgium

# Belgian national report on drugs 2009

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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.*

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# Belgian National Report on Drugs 2009

## SUMMARY

### ***National policies and context***

In 2008, there were no substantial changes towards the Belgian drug policy. The federal drug note of 2001 hasn't been changed or actualized since then. To date, it forms the structure of the Belgian drug policy. After all, the government policy statement of the former government Leterme I (18th of March 2008), declares that the government will continue the past policy towards drug dependency<sup>1</sup>. The government will also continue to reinforce the Belgian integrated drug policy.

### ***Drug Use in the general population and specific sub-groups***

Most of the surveys carried out in 2007 and 2008 show that cannabis is still the first illegal substance used.

It should be noted though, that the comparison between the different sources of information should be done cautiously since the data analysis and collection methods may vary considerably.

### ***Prevention***

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

In 2008, most of the prevention activities took place in the educational sector, targeting students and young people in general.

### ***Problem drug use***

For several reasons (lack of definition applicable on the field, lack of funding and lack of available database), no study aiming at assessing directly problem drug use incidence was recently carried out in Belgium.

Nevertheless, indications on problem drug use can be obtained through other data sources (needle exchange, snowball surveys...): they reveal, for example that heroin and cocaine seem to be the most commonly injected drugs.

### ***Drug-related treatment: treatment demand and treatment availability***

In Belgium, the treatment offer is very broad and differentiated (residential settings, low-threshold programmes, e.g.), but varies geographically.

The last analysis on treatment demands show that both in inpatient and outpatient settings, the demands were mainly related to opiates.

### ***Health correlates and consequences***

According to the AIDS/HIV Belgian database, the decrease in the proportion of IDUs in HIV cases is confirmed once again by the 2008 data. Moreover, regional data concerning hepatitis show HCV is still the most frequent type of hepatitis among drug users.

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<sup>1</sup> Vander Laenen, F., 'De Belgische drugwetgeving, onderdeel van het drugbeleid' (*The Belgian drug legislation: part of the drug policy*), *Antenne Themanummer Drugs*, 2008, 26, 4, p. 8-15.

In the frame of the Federal Police “Road safety action plan”, controls focusing on drivers under the influence of alcohol and drugs are performed. The 2008 results are comparable to the previous years’ ones: a majority of the analysed samples were positive and the most important substance detected was cannabis.

### ***Responses to health correlates and consequences***

Needle exchange programmes are implemented since several years in Belgium: these organizations usually get a pretty satisfactory syringes exchange rate (around 90%). Although prevention projects targeting specific groups exist (e.g. pregnant women...), it could be underlined that special emphasis is given to counselling and testing for hepatitis C and HIV. It seems that less prevention projects are dedicated to other drug use consequences or specific vulnerable groups.

### ***Social correlates and social reintegration***

Few quantitative studies focusing specifically on drug-related social consequences exist. Qualitative, ethnographic research is more common. However, partial data are available from active organizations on the field.

### ***Drug-related crime, prevention of drug-related crime and, prison***

In most of the drug-law offences registered by the Police, cannabis remains the most commonly involved substance. Moreover, in prison, around a third of the detainees declared having experienced drug-related problems during their current detention.

### ***Drug markets***

The two main produced drugs in Belgium are cannabis and synthetic drugs: that production is meant for national and foreign market. A large variety of drugs are also imported in the country. In 2008, the drug retail prices seemed to remain rather stable. When taking a closer look at the composition of the seized drugs, one remarkable change concerns the MDMA tablets concentration: between 2006 and 2008, the analyzed tablets’ concentration tripled.

### ***Cannabis markets and production***

Illegal cannabis cultivation in Belgium has been growing seriously in the past few years. From a seemingly minimal problem in 2003 it has, in a few years time, turned into one of the new priorities of the new National Security Plan (2008-2012).

In Belgium, all possible cultivation methods are used, both indoor and outdoor. Moreover, the number (not the quantities) of seizures made by the police show that Belgium is more affected by herbal cannabis than by cannabis resin.



## **PART A. New developments and trends**

## CHAPTER 1.

### National policies and context

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In 2008, there were no substantial changes towards the Belgian drug policy. The federal drug note of 2001 hasn't been changed or actualized since then. To date, it forms the structure of the Belgian drug policy. After all, the government policy statement of the former government Leterme I (March 18 2008), declares that the government will continue the past policy towards drug dependency<sup>2</sup>. It will also continue to reinforce the Belgian integrated drug policy.

#### 1.1. Legal framework

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

###### ➤ Federal level

On February 6 2009, a circular concerning the drug law violations committed inside prisons was issued. This document aims at standardizing the prisons' managers, the police and the other judicial authorities' reactions when confronted to such violations.

On March 13 2009, the Ministers Council approved a law draft project tackling driving under drug influence, introducing saliva analysis controls instead of urine tests.

The Royal Decree concerning a Federal Addiction Fund has been changed on December 18 2008. It includes, inter alia, the possibility for representatives of Communities and Regions to take part in the advisory committee for attributing funding.

###### ➤ Federate levels

###### ◆ **French Community**

Sniffing legal products occurred several times between the end of 2007 and the first trimester of 2008 in the French Community. The products were N<sub>2</sub>O and butane gas, the first one being mentioned only on one occurrence. Sniffing butane gas led to accidents twice, causing explosions and serious burns. It was sniffed out of bottles intended for re-filling cigarette lighters.

On April 28 2008, a circular tackling this topic was issued. Along with a list of the various products, the circular describes the wanted effects (euphoric effects), as well as the unwanted ones ("hang over", etc.) and gives advices on how to handle the phenomenon are given.

###### ◆ **Flemish Community**

The Flemish government amended a prevention decree of 2003 and changed the institutional framework for co-ordinating partner organization of the government in the field of prevention (health promotion and disease prevention). By 2010, an open call for partner organizations will be launched and the government will work out a procedure to recognize a partner organization for the duration of 3 to 5 years. This includes the recognition of

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<sup>2</sup> Vander Laenen, F., 'De Belgische drugwetgeving, onderdeel van het drugbeleid' (*The Belgian drug legislation: part of the drug policy*), *Antenne Themanummer Drugs*, 2008, 26, 4, p. 8-15.

VAD, the current partner organization of the Flemish government in the field of alcohol and drug prevention.

### **1.1.b Laws implementation**

#### **➤ Federal level**

The Royal Decree of January 17 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 problems).

That decree was replaced by the *Royal decree concerning security and prevention plans (December 7<sup>th</sup> 2006)* fitting the security and prevention plans within a long-term perspective.

A third *Ministerial decree concerning the implementation of security and prevention plans* was issued on *January 15 2007*: with this 3<sup>rd</sup> document, the objectives for projects aiming to reduce drug-related nuisance have been narrowed (projects are in concrete more or less limited to outreach work with a strong emphasis on prevention of nuisance and crime).

Moreover, the Royal decree of 9 April 2007 determines the conditions for allocation, use and control of the grants received means of these plans.

On April 1 2009, the different social partners involved in the private sector, decided to adopt the collective convention number 100. This convention obliges all employers in the private sector to adopt an alcohol and drug policy for all their personnel. Employers are required to adapt their current policy or create a new policy compliant with the convention before April 1 2010.

#### **➤ Federate levels**

##### **◆ French Community**

The “Prevention and proximity plans” evaluation of the Ministry of internal affairs (formerly “security contracts” and “drug plans”), aiming inter alia at reducing the insecurity feeling among the population, revealed some lacks, among which the inaccuracy of the objectives and the lack of indicators of evaluation of the led policies.

Thus, on November 6 2008, following that evaluation, the Walloon Region issued a decree on the social cohesion plans in communes and towns of Wallonia, on the matters transferred from the French Community.

The main objectives of the decree are the social development of the neighbourhoods and the struggle against all forms of precariousness and insecurity. The will of reducing the insecurity feeling, already shown in the “security contracts” and “drug plans” remains. But the social development of the neighbourhoods, as an equally important objective, is newer.

In order to reach these goals, actions must be led by the communes according to the three following axes:

- Social and professional insertion;
- Access to health and treatment of drug-addictions;
- Restoring of social, inter-generations and intercultural links.

After a call to tender and according to several criteria, the government of the Walloon Region evaluates the applications of the communes. Two tools are then used to evaluate the situation of the applying communes, in terms of social cohesion: a synthetic indicator of access to fundamental rights and a diagnosis of social cohesion.

The budget of the plans is made of a basic funding depending on the size of the commune, completed by a funding in proportions of the social cohesion synthetic indicator.

Once the plan is granted, the commune chooses a project manager and builds an accompaniment commission of the plan.

The plans are granted for a renewable period of six years. During the last year of the communal term, the commission evaluates the plan. That evaluation, along with the implementation of the plan, must be accompanied by a service chosen by the government. Another service is chosen by the government to ensure the financial follow-up of the plan.

## **1.2. Institutional framework, strategies and policies**

### **1.2.a National action plan, strategy, evaluation and coordination**

This section deals on the 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 of 2001. Since then, several pilot projects were initiated by the federal Minister of Public Health.

A research study on treatment of patients in crisis, including in the fore mentioned units, has started in 2008. The results will be available in 2009.

In 2004, Belgium engaged in the International Cannabis Need of Treatment project (INCANT)<sup>3</sup>. This project, to which the Netherlands, Luxemburg, France and Switzerland also take part, aims at comparing the efficiency of Multi Dimensional Family Therapy for young cannabis users with classic therapeutic models. A preparatory study started in 2004 and ended in 2006. The main study, started in 2006, will end in April 2010.

In 2006, a Federal Addiction Fund was created. An annual amount of 3.000.000 € is available for financing innovating health projects related to illicit drugs, alcohol and psychoactive medication.

In 2008, 23 projects were continued and 15 new projects were started for a total amount of 3,286,000 €. The topics of these projects are diverse, covering the exploration of new low threshold services, information on health risks, parents and substance abuse, etc...

A new pilot project has started in 2008 focusing on the feasibility of using Community Reinforcement Approach and Contingency Management for treatment of cocaine users. The results of this study are expected in September 2010.

Moreover, the national 2008-2011 security plan of the Federal Police was issued. It focuses on the fight against the following issues: synthetic drugs production, illegal cannabis plantation, cocaine and heroin import, street business including drug tourism.

#### **➤ Federate levels**

##### **◆ Drug Policy in the Flemish Community**

In 2008, the third Flemish minister of health since the regional elections of 2004 took office. Since then, there were new regional elections in June 2009 and this new minister chose to continue the existing policy and did not take any new initiative in the field of drugs.

The minister extended some of the projects which started mid 2008.

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<sup>3</sup> For more information : <http://www.incant.eu/>

Within the context of a general prevention decree (see 1.1.a), the minister also introduced an institutional framework for the recognition and organisation of partner organizations (co-ordinating bodies) for prevention. This also involves the coordinating organisation for alcohol and drugs (VAD). In the future, the government will launch an open appeal for partner organizations, introducing a 'market driven' concept for the recognition of partner organizations in the prevention field.

Moreover, a cooperation agreement was signed in 2008 between the VAD, the Centres for Mental health with prevention workers and the Minister of Health, in which the co-ordination and implementation of the Flemish policy are agreed upon. This agreement lasts until 2010.

In the follow up of the health conference 2006 on tobacco, alcohol and drugs (TAD), a Flemish working group prepared different working papers that resulted in a Flemish Action Plan on TAD 2009-2015, which was accepted by the Flemish Government in 2009.

The plan consists of three structural and four strategic axes:

Structural axes:

- Working framework for the different actors in prevention
- To increase the capacity of field workers
- Investment in registration, monitoring and evaluation

Strategic axes:

- to improve the impact of existing prevention interventions
- to integrate methods for prevention of tobacco, alcohol and drugs (integral approach)
- to implement programs to quit smoking and early intervention programs for alcohol and drugs
- special attention to the needs of specific groups: people in poverty, ethnic minority groups and gender differences

Due to the regional elections in June 2009, the plan was not yet put into action.

#### ♦ **Drug Policy in the French Community**

As previously mentioned, the intervention strategies in matters of drug-addiction are defined in the "five-yearly programs of health promotion" in the French Community. These are then implemented in "Operational Community Plans" (PCO). The PCO 2008-2009 proposes, among 10 priorities, drug-addictions.

It should also be mentioned that, according to the health ministers' demand in the Walloon Region, French Community and Brussels, a college of experts has drawn up a report prior to a common intervention plan in matter of drug addiction in these areas (2005). This report presented 76 recommendations, which gave birth e.g. to the "support points" in matters of drug-addiction in the CLPS, but are also supposed to inspire the making and the implementation of the PCOs.

#### ♦ **Drug Policy in the Walloon Region**

According to a new act published on November 6 2008, the Walloon Region is starting in 2009 the implementation of the "Social cohesion plans". The latter are the "heirs" of the former "Drug plans" and "Security contracts" of the Internal affairs Ministry. The evaluation of the latter having stressed some lacks, especially in matters of transparency, these new plans have been defined and politically adopted.

The idea of the plans is to base the funding (granted by the Internal affairs Ministry, but managed by the Walloon region government) on two transparent tools: the “synthetic indicator of access to fundamental rights”, and the “diagnosis of social cohesion”.

The “synthetic indicator of access to fundamental rights” measures the access of the population to fundamental rights such as a decent income; the right to health protection; the right to social and medical welfare; the right to work; the right to a decent place to live and to a sane environment, etc. To do so, it takes into account concrete and verifiable factors such as social welfare income clients’ rate, an indicator of lower wages, life expectancy at birth, the percentage of insufficient quality housing, etc.

Also composing this “synthetic indicator of access to fundamental rights” is a risk factor on the stability of social cohesion on the territory of the commune. This risk factor takes into account e.g. data such as the rate of isolated persons above 65, the rate of mono-parental households and the number of persons in the run of asylum procedure.

The second tool, the “diagnosis of social cohesion”, is made by the applying communes themselves, in order to draw up an inventory of the local needs, the local weaknesses and strengths in matters of social cohesion. By that diagnosis, one must understand the diagnosis of the public or private initiatives already implemented on the communal territory, of the expectations of the population and of the lacks appealing a solution in matters of environment, infrastructures, services, etc.

For the implementation of a plan, the elected commune designs a person head of project and builds a commission of accompaniment of the plan. The commission is composed of representatives of the Walloon government, of the communal college (executive power of the commune), of the CPAS (public centre for social welfare), of the partners of the plan (institutions, organisations...) of the social network of the commune. The Walloon government can also propose any other representative to that commission. These can be for example representatives of the specialized youth help or of the official “Help and care networks in matters of drug-addictions”, which are the framework of intervention in drug-addictions in Wallonia. Representatives of a “strategic plan of security” of the ministry of Internal affairs might also be included in the commission.

As to the follow-up and evaluation of the plans, these are granted for a renewable period of six years. The last year of the (also) six year communal legislature, the plan is evaluated by the commission. Two services are chosen by the government to follow-up the implementation of the plan and its evaluation on one hand, and to ensure the financial follow-up on the other hand. Depending on the global evaluation report finally drawn up by the government and transmitted to the parliament, the plan might be renewed, or stopped, if necessary with progressively diminishing funds, during a transition period.

#### ♦ **Drug Policy in the German-speaking Community**

Since the issue of the decree stating the 2006-2007 health promotion guidelines (7 March 2006), no further legal text tackling drugs was published.

#### ♦ **Drug Policy in the Brussels-Capital Region**

The drug policy in the Brussels-Capital Region still focuses on the three main following topics: data monitoring, information diffusion about services, and support to first line workers. A special attention to alcohol consumption by youngsters should also be mentioned.

## 1.2.b Implementation and evaluation of national action plan and/or strategy

### ➤ Federal level

In 2008, there were no substantial changes towards the national drug policy. The federal drug note of 2001 still forms the structure of the Belgian drug policy

### ➤ Federate levels

#### ◆ **Flemish Community**

A call for projects was launched in September 2007, to support various implementation programs that supported the outcome of the 2006 Health Conference on tobacco, alcohol and drugs (TAD). Sixty-eight projects were introduced out of which 6 projects were selected that involved alcohol and drugs (and 2 involved tobacco). The projects started in April 2008 and a number of them will be continued in the course of 2009.

The implementation of evidence based strategies and programs in the field of alcohol and drugs is supported by the cooperation agreement between the Flemish Minister of Health, the VAD and the Centres of Mental Health with prevention workers. These actors guarantee a Flemish implementation of a policy driven prevention approach in the main sectors such as education, youth work, workplace, welfare and health sector.

## 1.2.c Other drug policy developments

There's no other drug policy development to report.

### ➤ Federate levels

#### ◆ **French Community**

A recent decree of the French Community (July 20th 2006) modified a former decree (December 20th 2001) on the PSE structures (services/centres of health promotion at school).

The new decree *modified the duration of the conventions* between the PSE centres/services and their school (from 3 to 6 years). Moreover, measures were taken to *facilitate network interventions*: beyond the collaboration with the PMS (psychological – medical – social) centres, already launched by the former decree, the collaboration with the ONE (Office for birth and childhood) is founded, in order to ensure continuity in the children file. Also, CLPS (Local centres for the promotion of health) and SCPSS (Community services of health promotion) representatives were invited to the Commission for Health Promotion at School (umbrella institution for the PSE services/centres). This to guarantee the integration, in the PSE activities, of the priorities in health promotion defined by the French Community, e.g. in the five years plan in health promotion and in the PCO (Operational Community Plan, which includes, among ten priorities, drug-addictions).

Besides, a “project of service” must now be elaborated by each PSE structure, targeting the school they are related to, instead of the former “health-project”, this one being now included in that one. The “project of service” is more an identity drawn by the structure, defining e.g. which priorities will be developed, again among priorities of the five years plan and of the PCO. The “projects of services” are also granted for a 6 year period.

## **1.2.d Coordination arrangements**

The Federal Political Note on Drugs and the cooperation agreement of September 2 2002 between the State and the different federate levels (realisation of a global and integrated drug policy) establish the creation of the "General Policy Cell on Drugs". This Cell gathers representatives of all Ministers with a competency in drug related matters. This Cell has competencies in policy for legal (tobacco, alcohol, psychoactive medication) and illegal substances. After necessary agreements by all Parliaments, the General Policy Cell on Drugs had preparatory meetings in 2008 and 2009. It will be fully made effective at the end of 2009 by formal agreement by an Inter-ministerial Conference on Drugs. This Conference will gather regularly for approving proposals of the Cell and orienting its further work.

A Health Policy Cell on Drugs, gathering representatives of all Ministers of Public Health, is made effective since 2001. This Cell has the coordination of policies and exchange of information as main objectives<sup>4</sup>.

## **1.3. Economic analysis**

### **1.3.a Public expenditures**

The latest figures on drug-related public expenditures (2002 versus 2004) show a trend towards an increase in the Belgian funds dedicated to prevention, assistance and security (De Ruyver et al 2007). However, the methodology change in the study of 2004 in comparison with the study of 2002 mainly explains this increasing.

### **1.3.b Budget**

With regard to public expenditure, it became clear in the public expenditure studies that the most substantial expenditures relate to law enforcement, followed by treatment and then prevention (De Ruyver et al., 2004; De Ruyver et al., 2007).

The Minister of Public Health has also established a Federal Addiction Fund. For the year 2006-2007, 36 projects were financed for a total amount of EUR 4,665,000. In 2008 23 projects were continued and 15 new projects started for a total amount of 3,286,000 €.

As presented in previous annual reports, below are given the budgets for the drug demand reduction activities.

In 2008, the budget supported by the Brussels Region was EUR 4,028,000

In 2008, the budget supported by the Walloon Region was EUR 1,771,000.00

In 2008, the annual budget supported by each Community was the following:

Flemish Community: EUR 3,137,964.81

French Community: EUR 1,562,307.99

German Community: EUR 379,903.00

### **1.3.c Social Costs**

No study on social costs is available in Belgium.

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<sup>4</sup> The annual and triennial reports of this Cell are available on [www.health.fgov.be/drugs](http://www.health.fgov.be/drugs)



## CHAPTER 2.

### **Drug Use in the General Population and specific sub-groups**

Most of the surveys carried out in 2007 and 2008 show that cannabis is still the first illegal substance used.

It should be noted though, that the comparison between the different sources of information should be done cautiously since the data analysis and collection methods may vary considerably.

#### **2.1. Drug use in the general population**

In 2004, the third edition of the National Health Interview Survey was carried out (HIS 2004, 2001, 1997). The objective of this survey is to give a description of the Belgian population's health status. The 2004 module only included questions on cannabis (lifetime-, last year- and last month prevalence and starting age).

The next National Health Interview Survey is currently being carried out (2008-2009) and its results should be available in the beginning of 2010.

#### **2.2. Drug use in the school and youth population**

##### **2.2.a ESPAD (Flanders)**

Since 2003, Belgium is participating in the "European School Survey Project on Alcohol and other Drugs" (ESPAD), an international study in 35 European countries focusing on the 15 and 16 years old adolescents. Since the study was limited to Flanders in 2007, we could only present trends for Flanders.

From October 2007 to November 2007, the "European School Survey Project on Alcohol and other Drugs" (ESPAD) was carried out for the second time (Lambrecht et al., 2008) in Flanders. Of the 7,736 questionnaires (11 – 19 year old) that were collected, 1,889 respondents (15 -16 years old) were processed for data analysis for the cross-national ESPAD-study.

**Table 1:** Trends in perceived availability (%) of illicit substances, ESPAD 2003 - 2007

Flanders	2003			2007		
	Boys	Girls	Total	Boys	Girls	Total
N =	663	654	1.317	969	920	1.889
Cannabis	67.8	53.8	60.7	48.0	41.8	44.7
Amphetamines	20.7	16.7	18.8	24.7	24.8	24.7
XTC	33.5	23.2	28.3	25.2	24.2	24.7
Inhalants	67.3	55.2	61.2	47.3	41.3	44.4
Cocaine	20.8	17.2	19.0	20.4	21.5	20.9

Note: Percentages responding 'fairly easy' or 'very easy' to obtain  
Exclusive 'don't know' answers

Although there is a decrease of perceived availability of cannabis and inhalant use among 15 -16 year olds, they remain the illicit substances that are perceived as being easiest available (44.4% – 44.7%) (Table 1). In 2003, the availability rates were significantly higher for boys than for girls but this gender difference disappeared in 2007 for

amphetamines, XTC and cocaine, and became smaller for cannabis and inhalants. The higher availability of cocaine (20.9%) and amphetamines (24.7%) in 2007 compared to 2003 is explained by a higher perception of availability among girls (respectively from 17.2% to 21.5% for cocaine and from 16.7% to 24.8% for amphetamines).

**Table 2:** Last month, last year and life time prevalence of illicit substances among 15-16 year olds (%)

Flanders	2003			2007			
	N =	Boys 663	Girls 654	Total 1.317	Boys 969	Girls 920	Total 1.889
<b>Last month prevalence</b>							
Cannabis		18.5	9.5	14.0	14.9	9.6	12.4
XTC		0.8	1.2	1.0	1.8	1.1	1.4
Amphetamines		0.3	0.6	0.5	1.8	1.4	1.6
Inhalants		2.3	1.1	1.7	1.6	1.9	1.7
<b>Last year prevalence</b>							
Cannabis		32.7	19.5	26.1	22.6	14.8	18.8
XTC		2.5	2.7	2.6	4.2	2.7	3.5
Amphetamines		1.1	1.4	1.3	3.8	2.6	3.2
Inhalants		5.0	2.9	4.0	4.4	3.7	4.1
<b>Life time prevalence</b>							
Cannabis		37.0	25.0	31.0	28.3	19.4	23.9
Ecstasy		4.6	4.3	4.4	5.7	4.9	5.3
Amphetamines		2.7	2.9	2.8	5.1	4.5	4.8
LSD		4.6	1.7	3.1	3.4	2.6	3.0
Cocaine		2.9	1.8	2.4	3.8	4.0	3.9
Crack		2.6	0.6	1.6	2.3	1.1	1.7
Heroin		0.8	1.4	1.1	1.0	1.3	1.2
Magic mushrooms		8.2	3.5	5.9	3.7	2.1	2.9
GHB		0.0	0.2	0.1	1.0	1.1	1.1
Anabolic steroid		0.8	0.0	0.4	1.0	0.1	0.6
Alcohol together with cannabis		24.9	14.4	19.7	17.2	11.3	14.3

Life time, last year and last month prevalence of cannabis use and the combined use of cannabis together with alcohol decreased with respectively 7.1, 7.3, 1.6 and 4.6 percentage points (Table 2). This decrease is steeper among boys compared to girls. Unlike the prevalence rates that increase for amphetamines, ecstasy and cocaine. A remarkable decline shows for 'Magic mushrooms' from 5.9% in 2003 to 2.9% in 2007. The use of heroin, crack, LSD and inhalants remains the same. GHB use increases significantly from 0.1% in 2003 to 1.1% but is limited to one for every hundred respondents at age 15 – 16 year. Over all, the gender difference became smaller or disappeared in most of the other illicit substances (except cannabis).

About one out of three (31.0%) respondents indicated having used cannabis in their life in 2003 and more than one out of five (22.1%) admitted having used it 3 times or more (Table 3). In 2007, this frequency declines with 7.1 percentage points. The decline in the higher frequent cannabis use during the last month is only found among boys, but the gender difference remains. Not only more boys than girls use cannabis, they use it also more frequently than girls, although this gender difference became smaller.

The 2007 results of life time, last year and last month prevalence of illicit substances use for the global secondary population (aged 11 to 19 years old) in Flanders (VLASPAD) can be found in the previous Belgian national report on Drugs. The next European School Survey Project on Alcohol and other drugs should be carried out in 2010/2011 and the Belgian results should be available in 2012.

**Table 3:** Frequency of cannabis use during lifetime, last year and last month (%), ESPAD 20003 – 200707- Flanders

Flanders	2003			2007		
	<b>Life time</b>			<b>Life time</b>		
	0	1-2	3 or more	0	1-2	3 or more
Boys	63.0	9.1	27.9	71.7	9.9	18.4
Girls	75.0	8.7	16.3	80.6	7.4	12.0
Total	69.0	8.9	22.1	76.1	8.7	15.2
	<b>Last year</b>			<b>Last year</b>		
	0	1-2	3 or more	0	1-2	3 or more
Boys	67.3	11.6	21.1	77.4	8.7	13.9
Girls	80.5	9.8	9.7	85.2	5.3	9.5
Total	73.9	10.7	15.4	81.2	7.0	11.8
	<b>Last month</b>			<b>Last month</b>		
	0	1-2	3 or more	0	1-2	3 or more
Boys	81.5	6.6	11.9	85.1	7.7	7.2
Girls	90.5	4.1	5.4	90.4	5.3	4.3
Total	86.0	5.4	8.6	87.6	6.5	5.9

## 2.2.b HBSC

The Health Behaviour in School-aged Children aims to gain new insight into, and increase understanding of young people's health and well-being, health behaviours and their social context. This cross-national research study is conducted in collaboration with the World Health Organization (WHO) Regional Office for Europe and is repeated every four years. In the last HBSC study (French Community: Piette et al., 2007 (University of Brussels) – Flemish Community: Hublet et al., 2007 (University of Ghent)), secondary school students (12-18 years old) were asked about their use of drugs and frequency of use. There was a slight increase in cannabis lifetime prevalence for pupils aged 17-18 year. Lifetime prevalence of XTC increased slightly between 2002 and 2006 in the Flemish Community. In the French Community, lifetime prevalence decreased between 2002 and 2006. LTP of amphetamines remained more or less stable between 2002 and 2006 in the Flemish Community.

The next HBSC study results should be available in 2010.

## 2.2.c Survey in Flemish secondary schools

Since 1999, VAD has been conducting a large study in the secondary schools (11-22 years) of the Flemish Community. The three main goals of this study are to draw attention to the importance of drug policy in schools, to study lifestyles of students and to evaluate drug policies in schools. Students are questioned anonymously, in their own classrooms by non familiar teachers. Schools select themselves because they ask to participate. During the period January 1st - June 30th 2008, 24988 students were questioned. From these, a sample of 6,601 questionnaires, representative for grade (age), sex and type of education was analyzed (Kinable, 2009<sup>5</sup>).

Of all illegal drugs, cannabis is - as in other countries - the most widespread, also in secondary school students. The results of the study show a lifetime prevalence of cannabis use of 20.0%. In addition, the last year prevalence of cannabis use amounts to

<sup>5</sup> Kinable, H. (2009). *Bevraging van Vlaamse leerlingen in het kader van een drugbeleid op school. Syntheserapport schooljaar 2007-2008*. Brussel: VAD.

11.8% and last month prevalence to 7.6%. 8.9% uses cannabis occasionally (=less than once a week); 2.9% does this regularly (=at least once a week) (Table 4).

Prevalence as well as frequency of cannabis use varies by sex: significantly more boys than girls use cannabis. 24.5% of boys and 15.6% of girls ever used cannabis; respectively 15.6% and 8.1% used cannabis last year. Significantly more boys than girls use cannabis on a regular basis (respectively 4.6% and 1.3%) (Table 4).

Median age of onset of cannabis use is 15 years and does not differ between boys and girls.

**Table 4:** Prevalence and frequency of cannabis use among students in secondary schools (%), VAD, by gender, 2008

	All students	Boys	Girls
<b>Lifetime prevalence</b>	20.0	24.5	15.6
<b>Last year prevalence</b>	11.8	15.6	8.1
<b>Last month prevalence</b>	7.6	10.4	4.9
<b>Occasional use (less than once a week during last year)</b>	8.9	11.0	6.8
<b>Regular use (at least once a week during last year)</b>	2.9	4.6	1.3

Between the school year 2003-2004 and 2005-2006, lifetime prevalence, last year prevalence and frequency of cannabis use declined significantly, in boys as well as in girls. During the last school year a slight increase occurred to the same level as the year before. The next measurement will show if this increase really is an alteration of the recent developments of the last years or a mere fluctuation<sup>6</sup>.

The use of other illegal drugs than cannabis is much lower. 6.4% of all respondents ever used another illegal substance than cannabis; 3.1% did so during the last year and 2.1% during the last month. Lifetime, last year and last month prevalence of use of other illegal drugs than cannabis was again significantly higher among boys than girls (Table 5).

Median age of use onset of other illegal drugs than cannabis is 15 years and does not differ between boys and girls.

**Table 5:** Lifetime, last year and last month prevalence of illegal drug use other than cannabis (%), by gender, VAD, 2008

	All students	Boys	Girls
<b>Lifetime prevalence</b>	6.4	8.5	4.3
<b>Last year prevalence</b>	3.1	4.4	1.7
<b>Last month prevalence</b>	2.1	3.0	1.2

Between the school year 2000-2001 and 2005-2006, lifetime prevalence of illegal drugs use other than cannabis declined significantly (Table 6). As with cannabis, this decline was followed by a slight increase during the school year 2007-2008 to the same level as the year before<sup>7</sup>.

<sup>6</sup> Exceptionally, no survey has been done during the school year 2006-2007 because the questionnaire was adapted thoroughly.

<sup>7</sup> Exceptionally, no survey has been done during the school year 2006-2007 because the questionnaire was adapted thoroughly.

**Table 6:** Lifetime and last year prevalence of illegal drugs use other than cannabis (%), by school year and gender, VAD, 2008

		2000-2001	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2007-2008
<b>All</b>	LTP	8.3%	8.1%	8.2%	6.9%	6.6%	4.8%	6.4%
	LYP	3.6%	3.3%	3.3%	2.9%	2.7%	2.2%	3.1%
<b>Boys</b>	LTP	10.0%	11.2%	9.5%	8.2%	7.9%	6.5%	8.5%
	LYP	4.3%	4.8%	4.2%	3.4%	3.7%	3.4%	4.4%
<b>Girls</b>	LTP	6.6%	5.3%	6.8%	5.5%	5.4%	3.1%	4.3%
	LYP	2.8%	1.9%	2.5%	2.4%	1.5%	.9%	1.7%

Since school year 2000-2001, only lifetime prevalence of amphetamine use decreased significantly (Table 7). Last year prevalence remained stable in this period.

**Table 7:** Lifetime (LTP) and last year prevalence (LYP) of XTC, amphetamines and cocaine (%) use, by school year, VAD, 2008

	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2007-2008
<b>LTP xtc</b>	3.4%	4.2%	4.2%	3.4%	3.9%	2.2%	3.8%
<b>LTP speed</b>	4.6%	4.3%	3.6%	3.8%	3.4%	2.9%	2.6%
<b>LTP cocaine</b>	2.1%	2.1%	2.3%	2.4%	2.7%	2.1%	2.6%
<b>LYP xtc</b>	1.2%	1.4%	2.1%	1.6%	1.5%	1.1%	2.0%
<b>LYP speed</b>	1.5%	1.7%	1.3%	1.3%	1.0%	1.3%	1.4%
<b>LYP cocaine</b>	0.7%	1.1%	0.8%	1.3%	1.0%	0.6%	1.2%

## 2.2.d Survey among university and college students in Antwerp

In 2005, the Association of University and Colleges Antwerp, representing more than 27,000 students, participated in a general survey amongst their students. The main objective of the survey was to provide a reliable base for further strategies in alcohol and drug prevention and counselling in higher education institutions. 5,530 students returned a correctly completed questionnaire. This corresponds to 1/5 of the students. The most significant results were published in 2007.

A second wave of the student survey will take place in 2009. Beside, the Association of University and Colleges Antwerp, the larger Association University Ghent, representing more than 55,000 students, will also participate. The first results of this second survey will appear in next year's national report.

In the meantime, some additional research was conducted on the 2005 survey data. In a secondary data analysis, the 2005 data on stimulant medication use were compared to similar findings in 1965, 1969 and 1993 (Rosiers & Van Hal, in press). The results of this study show that there is no need to perceive the stimulant medication use among students as dramatically high or booming. With prevalence rates constantly below 10%, even in exam periods, there is no evidence to reflect on the extent of students' psychoactive medication use as a worrying situation. The Flemish prevalence figures correspond to the international study results. Nevertheless, attention has to be paid to a minority of frequent

users. As the results of the 2005 survey show, a small minority uses stimulant medication on a daily basis.

The assumed trend of rising stimulant use is not found in the comparison of the four included studies. The 2005 prevalence figure is lower than those in the two studies of the late sixties. The 1993 study indicates higher prevalence rates, due to the popularity of Catovit®, a product with a so-called mild effect. After indications of serious risks, this product was withdrawn from the market. The results of the retrospective comparative study also indicate the popularity of Ritalin® / Rilatine® in the late sixties. The first study after the restriction of the prescription regulations for this product does not mention this product anymore. But recent trends of increasing methylphenidate use among students in the U.S. could also move to Europe.

No gender differences were found in the four included studies. Concerning living status, significant differences were found between residential and commuter students. Students living in a residence away from home report higher prevalence of stimulant medication use, compared to students still living in the parental home. This finding corresponds to international findings. The lesser degree of parental monitoring among residential students could be an influential factor.

### 2.2.e Young applicants for a post in the army

Each year, selections for new applicants wishing to enter the army (all kind of posts) are organized. These selections consist in different tests (medical, physical, school knowledge...). During this process, the applicants have to fill in forms containing – among others – questions about a potential drug use. Lifetime prevalence of cannabis use was considerable higher than use of all other drugs together (Table 8). The 2008 results aren't available yet; they will be presented in the next national report.

**Table 8:** Percentages of drugs used by the drug-using army applicants, 2006-2007

	<b>2006</b> (N = 1279)	<b>2007</b> (N=1069)
<b>Cannabis</b>	77.39	80.75
<b>XTC</b>	9.57	9.21
<b>Cocaine</b>	6.09	6.51
<b>Speed</b>	5.22	3.25
<b>Hallucinogenic mushrooms</b>	0.87	3.79
<b>Psylocyble</b>	1.74	1.08
<b>GHB</b>	0.32	1.08

## 2.3. Drug use among targeted groups and settings at national and local level

### 2.3.a Drug use among sex workers

In the **French Community**, data on drug use among sex workers<sup>8</sup> are collected since 1998 through vaccination campaigns against hepatitis B. Three large cities and their surroundings are monitored on that occasion by the NGO Espace P: Liège, Namur and Charleroi. The study tackled drug use since injecting is a route for HBV infection.

<sup>8</sup> Analyse des données et évaluation de la campagne de vaccination contre l'hépatite B, Espace P 1998-2008.

From March 1998 until December 2008, 1,786 questionnaires were completed. They were filled in when sex workers were vaccinated and during face-to-face interviews by social workers of the non profit organization Espace P. Since the sample couldn't be selected randomly, the data aren't representative of the prostitutes in general. Moreover, the collected data are declarative, with the uncertainty related to that method. Nonetheless, the results have a definite indicative value.

Respondents were predominantly females (97.3%) with a mean age of 31.3 years (SD=9.1 years). Enrolled sex workers (since 2003) were for 43.5% working in private, for 26.9% in front windows, for 25.2% in clubs or bars and for 4.3% in the streets.

Among the respondents (n=1,164), 18% declared using or having used illicit drugs, with 5% by injection (injecting drug users or IDU), and 35% declared using alcohol daily. Nonetheless, the average percentage of missing answers being about 34%, these results should be interpreted cautiously. This high rate of missing answers comes from the reluctance of the social workers to ask questions on injecting drug use at the first meeting.

Nationality matters, in the sense that non-Belgian sex workers are younger, work more often in bars or street (76% vs. 55% in Belgians), are lacking social insurance (32 % vs. 6 %) and medical access (18 % vs. 4 %), and their abuse rate of alcohol is higher (20% vs. 9%). However, they declare consuming less illegal drugs than Belgian sex workers (12% vs. 20%).

The work place also matters : sex workers working in private show a trend for a higher rate of illegal drugs use compared to others (19% vs. 15%), and their alcohol abuse rate is much higher (17% vs. 7%).

Finally, age is also important since social insurance, medical access, alcohol abuse and illegal drugs use decrease with age. Indeed, the age group under 25 years old is the most exposed to these problems, compared to the group upper 25 years old.

In the **Flemish Community**, two organizations (Pasop in East- and West-Flanders and Gh@pro in the city of Antwerp) deliver preventive medical assistance to sex workers. In 2008, Pasop (Pasop, 2009) had 2,524 different contacts with 794 sex workers. Among these, 2,254 asked questions or asked for help concerning issues. In 1.3% of these cases the questions concerned alcohol or drug use. Gh@pro (Gh@pro, 2009) had contacts with 215 sex workers during 2008 which resulted in 1,415 different contacts: out of these, 1,254 asked for help concerning issues. In 22 cases (1.75%) the issues concerned drugs.

### **2.3.b Drug use in recreational settings**

#### ➤ **VAD «Uitgaansonderzoek»**

Since 2003, VAD conducts research on drug use in different nightlife settings. The main objectives are to study (patterns of) drug use and characteristics of drug users in the nightlife scene.

In 2003, 2005 and 2007 (Van Havere, 2004, 2006, 2008), a total of more than 2,000 respondents completed the questionnaire. Almost half of the respondents used an illegal drug during the last year.

The most used illegal drug is cannabis. But the last year use of cannabis has decreased between 2003 and 2005. Nevertheless, it didn't change between 2005 and 2007. Second most used illegal drug is XTC: one out of five respondents took XTC during the last year. The use of cocaine has increased over the years: one out of six respondents used cocaine in 2007, while in 2003 and 2005 this was one out of eight. The use of GHB and Ketamine is limited in the study population, although there is an increase in 2007.

Almost half of the last year users of illegal drugs regularly combined alcohol with an illegal drug and one out of four regularly combined different illegal drugs.

➤ **Modus Vivendi harm reduction activities**

Thanks to a partnership between the non-profit organisation "Modus Vivendi" and first line associations, Harm Reduction (HR) activities are held for different publics (in recreational settings, in the streets, in prison, in needle exchange programmes – see after) and data are collected in various locations of the French Community<sup>9</sup>.

More specifically, for the public in recreational settings, risk reduction activities generally take place in a space where professionals and jobistes<sup>10</sup> provide information and advice.

The relevance of the harm reduction stand presence in an event is determined by a single criterion: the presence of illegal psychotropic products consumers. The sample of events covered isn't representative of all events organised in Belgium (for example, free parties). In 2008, 73 events or places - festivals (rock, techno, hip hop, house music), megadancings, city parades, rave parties, traditional events - have been covered by 16 associations or grouping of associations.

Through these interventions, data are usually collected through a paper questionnaire. The purpose of the data collection is to check if the harm reduction activities apply to the target audience well. Specifically, the data remain an excellent indicator:

- to facilitate the contact with the public,
- to evaluate the adequacy of the action and tools with the public of the event,
- to adapt the action according to changes/evolution in drug use and behaviours,
- to monitor the characteristics of the population met through harm reduction activities implemented in recreational settings.

Thus, the questionnaire is rather a contact tool than a specific tool of data collection. There is no specific method to select people for responding to the questionnaire<sup>11</sup>. Therefore, the sample may be not representative of the whole event public.

Even though 2008 details on consumption haven't been discussed or approved by Modus Vivendi and its partners yet (and therefore couldn't be shown in the next table), some information is available (Table 9): in 2008, several partners coordinated by Modus Vivendi collected data during their action. 3,917 persons were met during 74 events. Among the respondents, 50.8% were men and 36% women (13.2% of non-responses). 19.6% were less than 18 years old, 58.9% between 18 and 25 years and 17.1% had more than 25 years (4.4% of non-responses). 49% of respondents met during all covered events reported an illicit drug use during the last month. Among these respondents, 1.1% used drug by injection and 15.5% by sniffing.

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<sup>9</sup> Please note that various French harm reduction associations also cover some festivals in Belgium, but without collecting any data.

<sup>10</sup> The jobiste is a person who consumes drugs and who, on a voluntary basis, is specially trained to reduce risks associated with drug use. Following this training, the jobiste can participate to focus group (group Es-pair), in a harm reduction action in recreational settings or in an operation of Snowball Survey. The jobiste is paid according to each participation.

<sup>11</sup> The data collection may be different from one festival to another, from one partner to another. Some people go to the stand spontaneously and voluntarily respond to the questionnaire and some others are reached by jobistes circulating in the campsites.



Please note that changes in reported consumption can also reflect variations in chosen festivals and the topics tackled in the stand (e.g., focus on "illegal products" or "alcohol" or "sexual and emotional life").

**Table 9:** Percentages of "current"\* drug use in recreational settings, French Community, 2005-2008

	2005	2006	2007	2008
<b>Number of events</b>	52	82	61	74
<b>Number of persons</b>	N=1,950	N=2,403	N=2,618	N=3,917
<b>Products (%)</b>				
Amphetamines	16	16	14	n.a.
Cannabis	41	42	37	n.a.
Cocaine	11	10	9	n.a.
Crack	4	3	3	n.a.
GHB	4	2	2	n.a.
Heroin	3	3	3	n.a.
Ketamin	2	2	2	n.a.
LSD	5	5	4	n.a.
Hallucinogens	9	9	8	n.a.
Mushrooms				
XTC	16	14	10	n.a.
Benzodiazepines	7	6	6	n.a.
Tobacco	44	45	41	n.a.
Alcohol	71	75	71	n.a.
Any illegal drug (%)	50	50	44	49
Any illegal drug w/out cannabis (%)	28	27	24	22.9
<b>Mode of drug use (%)</b>				
Injection	3	3	1	1.1
Sniff	n.a.	n.a.	16	15.5

\* In 2000, "current" = last 6 months prevalence. As from 2001, "current" = last month prevalence.

### 2.3.c Drug use among ethnic minorities

#### ➤ BELSPO project

A study project of the Federal Scientific Policy (BELSPO) about the treatment trajectories of drug users from ethnic minority groups was carried out in 2007 by the KUL (Katholieke Universiteit Leuven) and ULB (Université Libre de Bruxelles)<sup>12</sup>.

The research question addressed in the study was whether drug abusers from ethnic minority groups do use the existing services less and/or differently, and-related to this – to what extent they use "alternative" treatment methods.

According to the quantitative analyses, approximately 12 to 20% of all clients in drug treatment have non-Belgian origins. A significantly lower number of non-Belgian origin female clients as compared to the Belgian origin group was also found. Drug users from ethnic minorities seem to be older and in more precarious situations as well when they

<sup>12</sup> [http://www.belspo.be/belspo/home/port\\_en.stm](http://www.belspo.be/belspo/home/port_en.stm)

come into contact with the drug treatment system. Drug users of non-Belgian origin report more often heroin, cocaine and methadone use while Belgian clients use more often alcohol, XTC and amphetamines.

Concerning the treatment service utilisation, some clear indications that non-Belgian users contact drug treatment to a similar extent as drug users from Belgian origin were found, although some subgroups differences can be observed (e.g. women, adolescents...).

Finally, the qualitative research part highlighted the importance of so-called “alternative coping mechanisms” (stay in the country of origin, religious devotion, alternative medication...) for persons from ethnic minority groups.

#### ➤ **Substance use among Iranian refugees**

From 2005 to 2007, a qualitative study was carried out on substance use among Iranian migrants in Belgium, funded by the Special Research Fund of Ghent University. Data collection occurred through ethnographic fieldwork methods. Contact was established with 129 Iranians. The most remarkable results of this study concern opium use. Traditionally, Iranian men use opium as part of a social event: opium use is considered as the basis for social contacts and part of making fun together and enjoy each other’s company. When Iranian refugees cannot connect to the mainstream native culture of the host country Belgium, opium is used as part of a (ghetto) tradition, thereby reinforcing the habit.

#### **2.3.d Drug use among prisoners**

A follow-up of the study “Drug use in Belgian prisons. Monitoring of health risks.” was performed in 2008 (Todts, Glibert, Van Malderen, Saliez, Hogge, & Van Huyck, 2009).

Its aim was to estimate the drug use prevalence and the related risk behaviours among prisoners. A representative sample of 1,078 prisoners could be interviewed.

Sixty-five per cent of the interviewees stated having used illicit drugs at least once in their lifetime: lifetime prevalence of substance use was 58.3% for cannabis, 42.9% for cocaine, 29.4% for amphetamines, 28.7% for ecstasy and 27.9% for heroin.

## CHAPTER 3.

### Prevention

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

In 2008, most of the prevention activities took place in the educational sector, targeting students and young people in general.

#### 3.1. Universal prevention

##### 3.1.a School

###### ➤ Situation

Prevention activities in schools are identified in the Federal Drug Policy Note as essential. This document also stresses the necessity to continue developing prevention in this area. It also recommends organizing coordination of prevention activities as actors are numerous and operating at different levels.

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

The decree of the **French Community** related to Health Promotion of December 20 2001 reorganized the mission of the health promotion service in schools (PSE). This policy contains three main axes: "regulations"; "information" and "sensitization & training".

In 2006, a draft circular was made by both the Minister of public health and the Minister of education, on the prevention of drug addiction at school. This circular refers to the federal drug note of 2001. It provides the recommendations of the Government of the French Community relative to the prevention of the addictions in schools. Four points are developed in the circular:

- The approach of the prevention of the addictions at schools: the whole educative community is assigned as "adults-relays" in order to ensure a long-term development of the prevention.
- The aims of prevention at school: Inform and give responsibilities and refer to adequate structures.
- The methods and quality criteria of the preventive action: these preventive measures require a global, positive and continuous approach of the addictions and not a negative, repressive and punctual approach.
- The structures and the services resources in the French Community: the natural relays of the school: the centres PMS and the PSE services; the associative relays (the six "Support points at schools in prevention of the addictions ") and the documentation centres.

In 2004, prevention programmes in schools funded by the Ministry of Health were mostly the initiative of a large number of different NGO's. Following the decree, the projects are based on health promotion, training of adults (teachers, educators, psycho-social workers) and need to be evaluated. These services assist school authorities in solving problems related to drug use, in developing policies regarding the use of drugs and in providing a

methodological support to develop tailor made school projects of prevention, involving all actors: students, directors, teachers and parents. Besides these projects, a wide range of local initiatives exist, which are implemented by local authorities.

In the **Flemish Community**, the “school drug policy” is a prevention concept based on ‘regulation’, ‘education & structural measures’, and ‘counselling’. The part ‘regulation’ indicates the limits of what is acceptable, describes the rules concerning drug use and defines the procedures to deal with drug related incidents.

The part ‘education & structural measures’ 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 ‘counselling’, 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 together with all partners involved in the school setting: students, teachers, other school personnel, parents (associations), school health service, etc. It should also include 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.

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 didactic material and educational projects.

In the **German Community**, priority is still given to prevention projects on alcohol and tobacco use.

### ➤ **Evaluation**

In the **French Community**, all health promotion projects funded by the French Community must have an evaluation built in the project. In addition, one department in the University of Liege - APES<sup>13</sup> - could provide technical support and advise the promoters of health promotion projects.

In 2008, Eurotox asbl carried out a study describing the prevention and harm reductions activities in the French Community (“Etat de lieux des actions de prévention des assuétudes et de réduction des risques liés à l’usage de drogues en Communauté française »). The evaluation topic was tackled in the study. Most of the projects (including school projects) were evaluated and most evaluations were “process evaluations” and “qualitative and qualitative evaluations” led by a member of the organisation. The study showed that most of the organizations have no specific budget dedicated to evaluation<sup>14</sup>. Moreover, the research also showed that most of the prevention activities took place at school.

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<sup>13</sup> Appui en Promotion et Education pour la Santé

<sup>14</sup> For further details please see Eurotox report available on [www.eurotox.org](http://www.eurotox.org)

In the **Flemish Community**, monitoring data from the Ginger programme 2008 showed that three out of ten prevention activities took place in the educational sector (Rosiers, 2009). It is the most reached sector. About two third of the activities in the educational sector are organised in secondary schools. Prevention activities in schools mostly consist of training students and teachers, and organising consultation with teachers and the school board. Also noteworthy is the increasing attention for prevention in higher education.

The health sector is the second most important partner. With regard to prevention activities that are organised in or with the health sector, prevention workers of the regional Centres for Mental Health remain the main actors.

Compared to the previous year, two issues become more important: alcohol and drug prevention in workplaces and local prevention activities in collaboration with policy makers.

About one out of six alcohol and drug prevention activities in Flanders take place in a context of inter-sector-based collaboration (different sectors participate in one activity).

In 2007, VAD and CAT Preventiehuis (a specialised health organisation) launched a new ready-made didactic package "Maat in de shit" (Friends in trouble). 'Maat in de shit' offers an original and effective way to work in the classroom with 14-16 year old students on the topic 'cannabis and friends'. The package, containing a teacher guide and a connecting student brochure, allows the teacher to work with the students on the recognition of and the response on problem situations concerning drug use. It offers concrete methods to work around social norms and communication skills.

In the school year 2008 - 2009, VAD evaluated the project (Autrique et al, in press). The evaluation includes two components. One study focuses on the students: their appreciation of the lessons and of the student brochure, the effect on their social norms, the effect on their attitudes towards cannabis use. For this evaluation part, VAD organised 6 focus groups with students (14-16 year old) in three different education forms (general, technical and professional oriented education). The results were very promising: the students reflected on their own behaviour concerning cannabis use, they realise that there's a major difference between behaviour intention and actual behaviour and they show more willingness to help a friend in trouble. Important conditions to reach these objectives are the maturity of the students and the fact that minimum the first three lessons are given.

The other component focuses on the teachers: the degree of implementation of the material, the appreciation of the teacher guide, the difficulties they experience when using the teacher guide and student brochures, suggestions to improve the (use of) lessons. The majority of the teachers who responded appreciated and worked with the material. The most important reason why some teachers didn't use the material was lack of time.

## ➤ **Actions**

### ◆ **Flemish Community**

In 2009, VAD developed an individual screening instrument to assess teenagers' substance use problems: the SEM-J (individueel Screeningsinstrument Ervaringen met Middelengebruik voor Jongeren). This brief self-report questionnaire indicates the presence of problematic alcohol or other drug use. A positive score on the SEM- J is also an argument for alcohol and drug specific counselling. This instrument can be used in a quick, cost-effective way by 12- to 18-year-olds in clinical settings such as the school advisory services and the juvenile social health care. The SEM-J helps these service providers to make appropriate referrals to the specialised alcohol and drug care.

The Flemish institute De Sleutel delivered training and distributed prevention materials to primary and secondary schools in a programme subsidized by the Flemish Community, contributing to the health objectives to reduce the drug consumption at an early age. Teacher training modules 'the hole in the fence' for children 5 to 7 years old and 'Contact sleutels' for 8 to 11 were implemented. For pupils from secondary schools De Sleutel delivered training and materials from the Social Influence programme 'Unplugged' at age 13-14, 'Unplugged project' at age 15-16 and lessons integrated in biology or chemistry at age 17-18, always supported by interactive teaching methods. The institute reached 36.506 new pupils in 2008 with these interventions, through teachers as intermediaries.

The University College of Ghent leads from 2008 on the EU-Dap Faculty. Since 2004, the European Drug Abuse Prevention network contained centres in 9 EU states. The Faculty coordinates the international network of trainers and the adaptation processes in new countries, such as the Russian Federation, Romania, Lithuania, Kyrgyzstan, Croatia, Lebanon, Morocco, Egypt, Jordan, Kuwait and the UAE.

#### ♦ **French Community**

The study carried out by Eurotox in 2008<sup>10</sup> showed that a majority (34.1%) of the prevention activities were carried out in schools. The types of activities led in schools were mainly information, consciousness-raising and resource distribution.

#### **3.1.b Family**

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

##### ➤ **French Community**

Training modules on "Addiction and parenthood" continued to be organised, targeting the professionals of the pre- and postnatal clinics of the ONE (National office for childhood), i.e. social and medical workers, nurses, welfare officers.

Parents could also be informed through pedagogical school prevention activities.

Moreover, the 24/7 telephone helpline of Infor-Drogues answers numerous "FAQs" on its website, specifically targeting parents.

An "action-study" in parental coaching (organised by Nadja asbl in Liège): an experimental coaching programme for relatives in crisis situation with their teenagers, regular consumer and/or presenting behaviour to risk associates: early school leaving, small crime, violence intra and extra-family, behaviour at vital risk ... The project proposes specific communications tools and emphasizes the role of the relatives (parents) which has, at the same time, to structure and put limits and support the young person in his research for evolution.

This program, introduced in November 2008, is foreseen for one year.

Another NGO, "the pelican" organizes in Brussels "Self support groups" for parents (entourage): parents meeting difficulties in front of a close having problems with alcohol use, drugs, medicines and games. The meetings take place every 15 days and all year long, according to the demands. The number of participants does not exceed 8 people.

"Parentalité-Addiction" ("Parenthood-Addiction) is a multidisciplinary team created in the framework of a public clinic (Saint-Pierre, public hospital of the Public Centre of Welfare in Brussels).

The « Parentalité-Addiction » objectives are on the one hand, to stabilize the drug consumption of the parents (especially the mother) during the pregnancy and the post-partum and, on the other hand, to prevent the damages suffered by the baby, including withdrawal syndrome after the birth. Other aims are the improvement of the early relationship between the baby and his family circle, the reduction of neglecting or ill-treatment behaviours as well as the social insertion of the family.

In order to reach these goals, interventions tackling different aspects are foreseen: medical aspect (e.g., substitution treatment, withdrawal), social aspect (social assistance), psychological aspect (e.g., affective preparation to the birth, accompaniment in case of hospitalization of the baby). In 2008, 74 patients were followed by the project.

- Number of pregnancies followed in 2008: 20
- Number of births in 2008: 17
- Situations sent by: ambulatory Centre for drug users (5); former file Parentalité-Addiction (4); antenatal Consultation of the C.H.U. Saint Pierre (4); Gynaecologist / General practitioner (4).
- Age of the mother: > 34 years: 8; < 34 years: 9
- Nationality: Belgian: 10; foreigner: 7

### ➤ **Flemish Community**

In 2008, VAD developed the following projects targeting families:

- In cooperation with counsellors of parent support groups, the brochure 'Recht op Antwoord. Kinderen, drugs en de wet, informatie voor ouders' (Right to answer. Children, drugs & the law. Information for parents). The target group is parents with children using drugs.

Parents of children using drugs experience a lot of pressure. A juridical approach can bring some relieve. This brochure contains 19 cases, frequently asked questions by parents, such as "can I refuse a house search?, Am I obliged to pay the debts of my adult children?, Can I desinherit my child?" Beside this the brochure contains information about legislation and usefull adresses where parents can get juridical advice.

- In cooperation with the Druglijn, VAD organised a conference '(Z)onder invloed' (Without influence) for parents with children using drugs. This conference met the needs of these parents. Topics were: the influence of drug use on the family; to care and to set limits, a difficult balance, and juridical questions. There were 150 participants. Evaluation showed a great satisfaction score.

- In the same year the organization also developed a manual for a training session about alcohol and illegal drugs. The concept is set up for parents who are confronted with experimental drug use. The manual was developed on request of KVLV (a social non-profit organisation in Flanders). This organisation has trainers who work in the community. In this way, they can reach a lot of parents. VAD organised a train-the-trainer session for their trainers.

Since parents are an important target group for the DrugLijn, the Flemish drug information and helpline, the organization traditionally puts large amounts of information on its website. Besides the common information about the products, the law, the risks, and other random information, parents can also find some specific information on how to address the drugs use of their child.

Along with VAD and a range of drug counselling centres, the DrugLijn organised a one day conference focussing on drugs and the family. The conference called "Under the influence/Without any influence?" was held on 11 October 2008 in the Flemish parliament. It was aimed at parents, family members as well as counsellors working with families, was attended by 160 participants and received considerable media attention.

➤ **German Community**

For several years the ASL offers education-trainings for interested parents. In this project the parents are used to further distribute the training's content. 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. In addition, the "Ligue des familles" (Families association) organizes other educational trainings.

**3.1.c Community**

➤ **Helplines**

Infor-Drogues and the DrugLijn are respectively the drug helplines for the French and Flemish Communities. These services not only operate a telephone helpline. Since a few years, both provide an e-mail counselling service through their website

In both communities, results indicate that most questions are asked about cannabis (Table 10).

**Table 10:** Frequency of substances in related calls (%), Infor-Drogues, Druglijn 2007-2008

	Infor-Drogues		Druglijn*	
	2007	2008	2007	2008
<b>Number of calls</b>	3,955	3,460	6,385	6,903
<b>Males</b>	35.0	n.a.	39.7	40.0
<b>Females</b>	64.8	n.a.	60.3	60.0
<b>Involved substances in calls</b>				
Cannabis	34.2	35	37.8	35.0
Cocaine	18.5	19	17.0	17.1
XTC	3.5	1	6.3	6.0
Heroin	7.5	9	7.5	6.9
Alcohol	12.1	12	23.3	23.5
Psychoactive medicines	6	6	11.2	11.4
Crack**	5.5	5	n.a.	n.a.
Methadone	5	5	3.5	3.1
LSD	1.1	1	1.1	0.9
Amphetamine	2.35	2	10.9	9.6

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

\*\*Since 2004, crack is distinguished from cocaine since the consumption of cocaine keeps rising.

◆ **DrugLijn**

In 2008, the number of inquiries made at the DrugLijn reached a record high (Evenepoel, 2009) (n=6,093, see Table 10). These inquiries consisted of telephone calls and e-mails. Compared to 2007 there was an increase of 8%. The number of telephone calls (n= 4,672) however increased only slightly (+111), the overall increase was mainly due to a strong rise in the number of e-mails (n=2,231). The helpline answered 20% more e-mails (+407) than in 2007.

In fact, out of every three questions the DrugLijn answers, one question is sent via e-mail. The record high number of inquiries will no doubt be influenced by the impact of a nationwide sensitising campaign which was run in spring 2008 and which promoted the helpline. Still the DrugLijn noticed an increase throughout the whole year.

The DrugLijn is no emergency helpline and is therefore not operated 24 hours per day. Outside of the staffed hours (Mon-Fri 10h00-20h00), 2294 callers reached the IVR (Interactive Voice Response system) which provides information on the opening hours as



well as basic emergency advice. Apart from these figures, the DrugLijn also received 434 hoax calls.

The number of inquiries on cannabis showed a decrease compared to 2007, which was a year with a lot of media attention for this drug. The number of questions on alcohol keeps increasing slightly from year to year. Cocaine is substances on which the third most questions are asked. The percentage of questions however stays stable since 2005. Just like in 2007, the number of questions on psychoactive medicine increased in 2008 as well. The continuous increased has led this category of substances to become the fourth most asked about substances. It is equally striking that the number of questions on XTC keeps decreasing year after year.

As a consequence of the success of the e-mail service, the DrugLijn now reaches more young people than a few years Table 11 illustrates that the helpline's biggest target groups are people from 18-25 years and 36-50 years old. The first group has a strong preference for the e-mail service (2 mailers out of 3 is younger than 30 years old), whereas the 36-50 year old prefer contacting the helpline via telephone. The group of 18-25 year old contains more drug users, whereas the 36-50 year olds contain a large number of parents. Compared to previous years however, the number of contacts by -18 year olds decreased. In fact, for the third year in a row, the number of e-mailers in the very youngest age groups decreased. This may be caused by the claimed attitude of teenagers towards e-mail: they have grown to consider it as a communication tool for adults and they prefer text messages or online chat applications.

Overall, parents have been the largest target group for several years. Drug (and alcohol) users or ex-users where always the second largest group. This however recently changed. Due to the fact that (ex-)users tend to e-mail more than to call and also due to the fact that the number of e-mails has become increasingly important in the total number of inquiries, (ex-)user are now the largest target group. They represent 27% of all people contacting the helpline in 2008; 26% were parents; 21% family other members, partners or friends; 13% were students, 11% were intermediates and 2% were labelled as 'others'. In eight contacts out of ten some kind of emotional or relational problems is discussed (mostly child-parent-relations, problems with one's own use and problems in partner-relations). Referrals to drug prevention and treatments facilities were made in 60% of all contacts.

Moreover, in January 2008, VAD launched a website (<http://www.hoeveelisteveel.be/>) with online tests for cannabis, amphetamines, cocaine and XTC. After answering a number of questions, respondents get an estimation of how much they use and some other brief advice.

#### ♦ Infor-Drogues

In 2008, 3,899 contacts were registered by Infor-drogues. This number of contacts is appreciably lower (-6 %) than the number registered in 2007. The phone contacts which are the main contacts dropped by 3% since last year and 30% since 2002. This decrease can find an explanation through two main elements: a decrease of the interest for the theme of drugs in the profit of other topic such as the violence of the young people or the crime and the success of the e-mail service and the visits of the web site (many persons can find directly a first information, on a product, on an active centre etc, through the web). Each contact can result in several demands (for instance on the product, on a cure centre, on how to stop consuming, etc.). In 2008, 6.135 were registered (- 7% since 2007).

Concerning the period of contact (working hours, weekend and nights), we saw that the calls during working hours are the most important (2,899) followed by weekend calls (539) and nights calls (471). Since 2005, we note a sensitive decrease of the night and weekend calls. This date coincides with the implementation of the web site and thus, the

possibility offered to adults (mainly the relatives) to resort during their spare time to the IT tool to inquire instead of phoning.

68% of all people contacting the helpline in 2008 were relatives/ friends (entourage) and users (44% entourage and 24% users).

More than 60% of the contacts were initiated by women. These are highly over represented by in the age groups 36-50 and 50+. These women are generally mothers who call up to obtain information, advice for their sons.

In 2008, there are 3,460 products evoked during the contacts. Let be a 13 % decrease with regard to year 2007. This decrease is observed for all the products except the heroin and the solvents. For these products, it is important to underline the impact of the press which widely commented an accident occurred in 2008 (two groups of young people consuming gases of lighter and having provoked of the accidents).

Cannabis is (as in 2007) the most mentioned substance (35%) follow by cocaine (19%) and alcohol (12%). It is interesting to notice that, this year, the number of inquiries on heroine increase a little (+ 8 %). Finally, since 2004 Infor-drugs distinguish the crack of the cocaine because of its constant increase. As for this year the tendency is slightly reversed with - 6 % and - 10 % respectively for the crack and the cocaine. These two accumulated products keep however the second place of products the most mentioned in the phone service of Infor-Drogues.

The following table shows the distribution 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.

**Table 11:** Frequency by age of callers (%), Infor-Drogues, Druglijn, 2008

	Infor-Drogues	Druglijn*
<b>Under 18</b>	2.1	9.5
<b>18-25</b>	10	22.7
<b>26-35</b>	23.2	21.1
<b>36-49</b>	40.3	30.0
<b>50 and older</b>	19.1	16.8

\*Figures mentioned refer to a sample of 76% of all callers and 86% of all e-mailers.

In the **German Community**, a special drugs telephone helpline does not exist.

### ➤ **Ethnic groups**

#### ◆ **French Community**

Specific actions for ethnic groups are seldom or not available.

However, the Espace P<sup>15</sup> organization - although it has no specific project for ethnic groups - takes into account the specific characteristics related to the origin of its public: specialized workers known as “cultural relays” (outreach workers of same origin and language) are hired to ensure appropriate contacts with sex workers coming from the former East Bloc (males and females), from Africa (French-speaking and English-Speaking women) and South-America (women, transsexuals and transvestites (“drag queens”).

<sup>15</sup> Espace P is a centre that gives orientation and assistance to sex workers, their customers and their entourage.

#### ♦ **Flemish Community**

In Ghent, the organisation 'De Eenmaking' focuses on migrants and drug use. They do drug prevention in prisons, counselling, training and they want to develop a diversity policy in institutions.

In the province of Limburg, employees of "Centra voor Alcohol en andere Drugproblemen" (CAD) organised prevention activities towards the Moroccan and Turkish community. Some of the activities that took place in the centre were:

- Information evening for Turkish women associations
- Awareness poster in Turkish language
- Projects towards youngsters of foreign origin in deprived neighbourhood
- Disclosure of prevention and aid support towards grass-roots organisations
- Europarents towards multicultural group of women
- Tuppercare-project: low-threshold drug prevention for women of foreign origin

### **3.2. Selective prevention in at-risks groups and settings**

#### **3.2.a 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.

##### ➤ **French Community**

##### • **Snowball Survey for at-risk groups**

Noting some increase in the phenomenon of polydrug use, use by sniffing and use of substitution products purchased on the black market, a peer prevention project was created by the NGO Modus Vivendi. That Snowball Survey focused specifically on any drug user lacking social integration. The Snowball project is a project of participative prevention: it suggests to users passing on information to their peers not benefiting from prevention means.

But over the years, the project was adapted and "pilot operations" have been launched to reach consumers of a particular product (and not exclusively precarious public) and reach specific groups such as migrants, women and youth.

This "Snowball Surveys for at-risk groups" project is a part of the "classical Snowball Survey" program and has the same aims.

**Table 12 : Modus Vivendi Snowball Surveys, 2005-2008**

Year	N contacts	N jobistes	Total Snowball Surveys	«Classical Survey »	Snowball Survey for at-risk groups
2005	1047	39	4	3	-Cannabis
2006	357	11	2	0	-Hepatitis C -Men Bulgarians Turkish-speaking in the male prostitution
2007	618	17	3	2	-Squat « Collectif 123 »
2008	648	n.a.	3	3	n.a.

### • Snowball Survey in prison

Snowball Surveys in prison are a part of the “classical snowball survey” prevention program, with the same aims but they’re held in prison (see 4.2.a).

The 3 operations held in 2008 have enabled the NGO Modus Vivendi (with the collaboration of various partners and with financial support from the Ministry of Justice) to collect through jobsite detainees, 80 questionnaires in 3 prisons.

As for traditional operations, the results should be interpreted with caution. Indeed, they are not representative of drug users in these prisons: only 8% of the total population from these 3 prisons have been met (N= 1,065) and no sampling plan has been settled (people were met randomly by the jobiste-investigators). The 2008 prevalence of use will not be therefore presented here, especially as a more systematic study has already yielded prevalence use in prison for 2008 (see 2.3.d).

Different prevention projects are getting underway:

- Edition of the booklet “Vogue la galère”. This brochure tries to answer the questions of the prisoners in consumption of drugs, transmission of hepatitis and HIV / AIDS, health and well-being in prison (and translated into various languages and adapting in video format). The third edition was published in 2006 in 5000 copies thanks to the financial support of the Minister of justice,
- setting up annual operations in some prison to establish a monitoring system,
- strengthening the dialogue between professionals, institutions and Modus Vivendi, thinking around the “tattooing wild” practice in prison and so on.

However, needle exchange programmes are not available in prison due to fund lacking.

### 3.2.b At-risk families

#### ➤ Flemish Community

Bubbels & Babbels is a prevention project in Antwerp focusing on the problems of children of (ex) drug dependent parents. 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. The family is engaged both in identifying and meeting its own goals, so that the traditional case management approach of simply arranging services is expanded significantly. The case manager assists families in developing their goals, identifying their needs, and obtaining these services.

In 2008, Bubbels & Babbels supported 22 families affected by drug abuse (Rombouts,

2009). In addition to the client work, Bubbels & Babbels organized 21 training sessions (15-20 caretakers/session) about drug abuse and pregnancy-parenthood and answered around 35 questions of social workers about this topic. Bubbels & babbels created a brochure<sup>16</sup> for parents on the Neonatal Abstinence Syndrome (NAS) and also publishes newsletters with relevant information for professionals. Finally, Bubbels & Babbels in association with the Antwerp University, conducted an explorative study<sup>17</sup> into drug use during pregnancy in the maternity clinics in the Antwerp region.

De Sleutel institute participated in the European ENCARE network ([www.encare.net](http://www.encare.net)) and hosted an international meeting and conference in this framework, disseminating project results in order to link organisations in the Flemish Community. As a partner, the international project 'Kinship carers' coordinated by the Mentor foundation UK, De Sleutel selected and interviewed grandparents who took care of their grandchildren in situations of drug abusing parents. First steps to create a network of organisations around this target group were taken.

➤ **French Community**

The centre for mental health (CSM) of the Charleroi public centre of social help (CPAS) has a « drug-addiction » department, which targets among others weakened families. This department aims to reach these families in a particular neighbourhood of Charleroi called Dampremy, through a collaboration with a structure called “Espace citoyen de Dampremy” (“Citizen place of Dampremy”).

For more information on this topic, please refer to previous national reports.

### **3.2.c Recreational settings**

#### **3.2.c.1 Parties, festivals...**

➤ **French Community**

For the public in recreational settings, harm reduction activities are still performed by two types of projects: "Drogues Risquer moins" (DR-) (in English: “Drugs, taking less risks”) and “Mobile Team”.

In 2008, 41 events were covered in 20 different places. 2,774 brochures were distributed by the project. For the first time, the Brussels student environment was covered and was noticed a strong demand of information. In 2006, another organisation “the Schaerbeek prevention service Sepsud” joined the local project of harm reduction in recreational settings. Sepsud handles places with a more heterogeneous, less electronic public and appreciably older than the public handle by Modus Vivendi.

All these places produce events of electronic music but the public who frequent them are appreciably different: from 15-25 years to 25-45 years old. The products and their mode of consumption vary also strongly from one place to another.

The “Quality Nights” project developed in 2007 (currently in Brussels only) is still present in nightlife settings. Year 2008 was dedicated to the development of the project: new places, new communications tools, study on possible extension on the rest of the French Community, the launch of an evaluation.

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<sup>16</sup> [http://users.skynet.be/am275740/zorgen\\_voor\\_je\\_baby\\_met\\_ontweningsverschijnselen.pdf](http://users.skynet.be/am275740/zorgen_voor_je_baby_met_ontweningsverschijnselen.pdf)

<sup>17</sup> <http://users.skynet.be/am275740/leeronderzoekua.pdf>

**Table 13:** Modus Vivendi “drogues risquer moins” project, 2002-2008

Year	Number of events	Number of places	Number of brochures distributed
2002	3	-	-
2003	37	-	-
2004	42	14	-
2005	31	10	-
2006	36	16	-
2007	42 (including « Sepsud » collaboration)	17	2,886
2008	41 (including « Sepsud » collaboration)	20	2,774

The brand new booklet on the Quality Nights label stresses health and security matters; lists the available services and the clubs that signed the “wellbeing charter in recreational settings”; maps the addresses of these places and gives other useful addresses on health matters, STI, information on drugs, etc.

All Harm Reduction activities (in recreational settings, in the street, in prison, in needle exchange programmes) coordinated by Modus Vivendi are being carried out by trained jobistes.

➤ **Flemish Community**

In 2003, VAD-The DrugLijn developed a global prevention concept for nightlife called Partywise. Partywise stands for: going out in a safe and healthy way. Since the start of the Partywise concept, several techniques were developed to inform and sensitize revellers, party promoters, club owners and prevention workers in the nightlife scene.

The revellers are predominantly reached through the Partywise website, the heart of the concept. The general Partywise website hosts different topics like ‘EWS and nightlife’, party tips, Partywise topics, history, drug information, combined-drugs module, news, checklist to go out, etc. Since 2007 VAD developed a new Partywise campaign + website focussing on peers in the nightlife scene called: Partyfriends. The Partyfriends website emphasizes the role of friends and the responsibility they have towards each other. The community spirit is emphasized by the Partyfriends Myspace page and a contest where party people can send in a party picture and win party gadgets.

In 2007 two different brochures with guidelines on safer nightlife were developed: a comprehensive version for the prevention workers and a shorter version for club managers and promoters of events. These brochures were disseminated and implemented also in 2008.

Every year, Partywise informs and sensitises revellers to party ‘wise’. This is mainly done with party tips, videos, posters, banners, etc. (Rock Werchter, Tomorrowland, Ilovetechno, Reverze, Bassleader, 10daysoff ...).

Four times a year, a newsletter with information on party drugs, relevant research, news items on party drugs, party tips and an interesting E-link is also disseminated (one for the revellers and one for club managers and promoters).

‘Streetwise’ is an information page to inform the revellers concerning alcohol and drugs and the health risks in nightlife. Since 2006 streetwise has appeared each two months as a one page article in the trendy nightlife magazine Release (illustrated magazine of ID&T - Belgium). In 2008 we also published two articles of Partywise in ZAP magazine (target group: 16-25).

The EWS (early warning system) for the nightlife scene was maintained. Revellers and party promoters are informed through this system when there are dangerous drugs on the market and are provided with information on this topic.

In 2008 we a training was organized for professionals to cope with health problems in the nightlife environment and an introduction training for new prevention workers to work on prevention in recreational settings was settled.

### **3.2.c.2 Sports**

#### **➤ French Community**

The health promotion in sport and the prevention of (and fight against) doping practices are ruled by a decree (8 march 2001).

The responsibilities in terms of health promotion in sport and fight against the doping have known an evolution these last years in the French community. During the legislature 2001-2005, the Minister of Health in the French community had the “complete” responsibility of the doping topic. She assumed the aspects of prevention and control as well as the more technical aspects. Under the legislature 2005-2009, the responsibilities have been divided between the Ministers of sports and the Minister of Health:

- Prevention of doping (diffusion of booklets and other prophylactic measures) and the anti-doping controls are now the prerogative of the Minister of sports.
- Promotion of health in sport is now the prerogative of the Minister of health.

According to that logic, the prevention of doping practices and the promotion of health are two different topics.

Under the previous government, in addition to the anti-doping controls (targeting as well amateurs as professionals), booklets on the prevention of doping were spread. Today, these practices are set aside, despite the statement made by some that repression alone is insufficient to reduce the drug demand.

In the Brussels-Capital region it exist an “act” (19 July 2007) relative to the promotion of the health in the sport and the prevention of (and fight against) doping practices. This text is rather close to the legislation of the CF. it processes in particular the problems of the controls in the Brussels region which were not made by the Community because of territoriality reasons.

#### **➤ Flemish Community**

Prevention in sports is still a low priority in the Flemish Community. That means that there were no new initiatives or trainings to support the work in this setting in 2008. Nevertheless some field workers continued their prevention activities in sports.

#### **➤ German Community**

Since the nineties, projects in close collaboration with the “Mondorf group” (Luxembourg, France, Germany) were set up. They organise adventure camps for young people between 16-18 years. In cooperation with the Directorate-General, Germany and The Netherlands, ASL still organizes a sport day for persons aged 16 years old (“Climbing instead of smoking a joint”).

### **3.3. Indicated prevention**

#### **3.3.a Children at risk with individually attributable risk factors**

Although such a specifically targeted approach is quite rare in Belgium, some initiatives like the one described below exist.

##### **Flemish Community**

“Mussennest” is an approach of indicated prevention connected to the ambulatory service of De Sleutel institute. It is targeted to pupils in a partly apprenticeship and partly school situation. Youngsters with indications of school dropout and/or drug abuse are identified and referred to the service in order to spend their apprentice or job time at Mussennest, monitored by work leaders and prevention workers.

### **3.4. National and local media campaigns**

In the framework of the Belgian Early Warning System, all the warnings of the Institute of public Health are still published in the media (often involves TV, radio and Print media).

Furthermore, VAD organized two campaigns/press-conferences in Flanders in 2008. The first one, launched on April 10<sup>th</sup> concerned the launch of a campaign (with TV-clip) with the central message that if you have issues with drugs is always better to talk about it. The second campaign was launched on July 18<sup>th</sup> and concerned cocaine in the outgoing scene.

In the **French Community**, the « permanent training » department of the NGO Infor-Drogues spreads nowadays four large posters (A3 template) tackling some controversial topics in order to overcome prejudices. The front of each poster shows a deliberately shocking question and a catchy visual, in order to initiate the debate. The back of the poster proposes some hints on a possible reflection about the subject, and a proposal of activity to bring the process further.

The topics of these posters are: “Talking about drugs, can it be an incentive?”; “In order to know if someone takes drugs, the best is to take a urine sample.”; “Once you start with drugs, you cannot stop.”; and finally “If drugs are not legally forbidden, it will be ‘no holds barred’ for the Youth”.



## **CHAPTER 4.**

### **Problem Drug Use**

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For several reasons (lack of definition applicable on the field, lack of funding and lack of available database), no study aiming at assessing directly problem drug use incidence was recently carried out in Belgium.

Nevertheless, indications on problem drug use can be obtained through other data sources (needle exchange, snowball surveys...): they reveal, for example that heroin and cocaine seem to be the most commonly injected rugs.

#### **4.1. Prevalence and incidence estimates of PDU**

##### **4.1.a Indirect estimates of problem drug users**

The information from last year is repeated in the following as new analyses will be finalised in the near future. The Sub-Focal Point of the French Community 'Eurotox' and the treatment centres grouped by the organisations 'Vlaamse Vereniging voor Behandelingscentra Verslaafdenzorg' and 'De Sleutel' delivered data that allowed the National Focal Point to estimate problem drug use based on treatment demand data (Roelands et al, 2008). The estimate concerned the Walloon Region and the Flemish Community during the year 2005. Data on the Brussels Region were only available at the aggregated level and were therefore not included. Persons in low threshold centres, inpatient and outpatient drug treatment centres were included. Data on treatment demands in psychiatric wards of general hospitals, in psychiatric hospitals and related environments could not be included. Information on treatment contacts in centres for outpatient mental health care in the Flemish Community was provided, however not on persons in treatment; therefore, this type of centres was not included in this analysis. Due to these limitations regarding geographic area and the treatment centres included, the figures are underestimations of problematic drug use in Belgium in 2005. In the following, data on low threshold agencies are included in the data on outpatient treatment services. Most treatment demands in both inpatient and outpatient settings were related to opiates (44.4% of all inpatient demands; 52.8% of all outpatient demands). In second order came cocaine (14.1% of inpatient demands; 10.1% of outpatient demands).

81.5% of the opiate users and 86.4% of the cocaine users was between 20 and 39 years old. In the age group 40 to 49, the large majority of persons demanding treatment were opiate users, demanding treatment in outpatient centres. Opiate or cocaine users demanding treatment were almost never 50 years or older.

Most opiate users with a treatment demand were daily users (80.8% of the inpatient users and 75.7% of the outpatient users). Regarding cocaine, persons demanding treatment in inpatient centres were also mostly daily users (59.4%). Frequency of cocaine use in persons in outpatient centres was more evenly distributed (31.1% used it daily (valid percentages)).

In 2005, 1,181 men and 278 women demanding treatment had a history of injecting drug use (lifetime prevalence), which is 29.0% of women and 29.5% of men, all persons demanding treatment included. About one in three of the persons demanding treatment in an inpatient centre had a history of injecting drug use (36.3% in women and 34.4% in men), whereas this was the case in one in four persons demanding treatment in an outpatient centre (26.6% in women and 27.5% in men).

#### 4.1.b Incidence estimates of problem drug use

For several reasons (lack of definition applicable on the field, lack of funding and lack of available database), no study aiming at assessing directly problem drug use incidence was recently carried out in Belgium.

#### 4.2. Data on PDUs from non-treatment sources

##### 4.2.a PDUs in data sources other than TDI

###### ➤ Needle exchange programs (Flemish Community)

In the Flemish Community, 237 IDUs frequenting the needle exchange facilities were interviewed in 2008 (Windelinckx 2009). The most important results are presented below.

1. Socio-demographically:
  - 79.5% are male, 20.5 % are female;
  - Average age is 34.6 year with a range from 19 till 63 years old
  - 0.87% is under 21, 12.5% is under 25 years old
  - 88.5% are over 25; amongst those 42.25% are older than 35 and 5.60% is over 50 years old;
  - 51% live alone, 30% live with partner or partner and children,
  - 29.2% live in an unstable situation; 10% are homeless, 3.8% live in squads, 10% live together with friends, 1.28% attend a night shelter.
  
2. Drug use
  - Polydrug use is common; on the average they use 4 illegal substances (when injected, more than 2 products);
  - Heroin is still the most commonly injected drug in 77.94% of the cases, followed by cocaine (60.78%) and amphetamines (41.67%);
  - The combined use of heroin and cocaine is clearly prevalent in the Flemish cities, 33.82% are injecting these speedballs (snowballs);
  - The exchange programme currently reaches every year more speed and/or cocaine users than previous years.
  - Age of first time injecting drug use: 43% was under 18, 62.4% was under 21 when first injected (16.2% was under 15 year when they first injected) (Table 14)
  - The average age of the first injection is 21 years old

**Table 14:** Injecting drug use among needle exchange population, Flemish Community, 2008

Age first injection	<=15	16-18	19-20	21-25	26-30	31-35	36-40	41-45
Number of IDUs	36	59	28	58	24	7	5	4
%	16.29	26.7	12.67	26.24	10.86	3.17	2.26	1.81
Cumulative %	16.29	42.99	55.66	81.9	92.76	95.93	98.19	100

3. Risk behaviour
  - The majority (55%) of the IDUs interviewed did not share injection materials in the last month;
  - Sharing occurs more frequently with sex partners than with strangers or friends;
  - Back loading and front loading (using one syringe to squirt drug into the

back of other syringes) are not common;

- 55.16% of the IDUs never share the spoon;
- 60.85% never share their filter;
- 56.81% did not share water;
- 43.56% still use their syringes more than once.

#### 4. Evaluation syringe exchanges

- Syringe exchanges, pharmacists and drug services are most commonly used to get syringes;
- 41.70% also get syringes for friends, 19.15% 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. 1.72% of the IDU's sometimes throw them on the street;
- Most of the interviewed IDUs got their information about the exchange from drug services (61.54%), 45.30% got the information from other IDU's, 0.85% from media. 3.85% got the information about needle exchange through tier dealer
- 80.85% had no problem to buy syringes from pharmacists;
- 64.04% prefer day time opening hours.

#### 5. Health

- 57.21% had been tested for HIV in the previous year;
- 59.24% had been tested for HBV in the previous year;
- 66.09% had been tested for HCV in the previous year;
- 53.2% had been tested for TBC in the previous year;
- Most of the interviewed IDUs already had drug treatment in the past, mostly in residential institution;
- 16.67% never had a drug treatment in the past
- 62.44% are still in a drug treatment while contacting the syringe exchange programme, 56% of them followed a methadone programme.

#### 6. Free-base cocaine

- 48.70% of 193 are using freebase-cocaine and are attending the needle exchange;
- Most of the users clean their cocaine with ammonia (77.42%), 3.23% with bicarbonate, 4.3% use both cleaning methods, 7.53% buys it prepared at the dealer
- Most of the interviewed IDUs are both injecting cocaine and using freebase cocaine.
- 5.56% of 90 IDUs smoke freebase cocaine on a daily base, 22.22% smoke weekly, 25.56% a few times a week and 36.67% smoke on a monthly base.
- 21.79% of 78 IDUs inject cocaine on daily base, 29.49% a few times a week, 17.95% once a week and 30.77% inject cocaine monthly.

#### 7. Location of IV (intravenous) use

- Most of the IDU's (N=229) use IV happens at home (79.04%), but a great deal of them use also in a different location: mostly at a friend's house, but also at the dealers, on the street, in squads, etc.
- 60.69% use on a (semi)public location: on the streets (20.09%), in a bar (5.24%), in a squad (13.97%), other specific (3.5%).
- Other specific locations are: at the dealers (10.05%), in the night shelter (5.82%), in the drug service (1.58%)

- This is an important signal for the need of a users-room (shooting gallery) in the Flemish part of Belgium (more specific for Antwerp, where the need is the highest)

➤ **Needle exchange programs (French Community)**

In the French Community, a needle exchange network under the coordination of the NGO Modus Vivendi exists. The network includes fixed needle exchange desks, mobile needle exchange desks, social workers in street, distribution systems of recovery syringes and pharmacists.

Depending on the structures, exchange is done in different ways: free exchange of syringes and street equipment, strict exchange (1 syringe up against 1 syringe distributed), sale of syringes or Stérifix<sup>18</sup> in some pharmacies, and sometimes recovery of syringes.

Currently, no personal or consumption data is collected from users.

➤ **“Classic” Snowball survey (French Community)**

Snowball Surveys are peer prevention programs for drug users concerning AIDS, hepatitis and other risks associated with drug use, coordinated by the NGO Modus Vivendi. Their aim is to convey a message of prevention suited to a category of people barely reached by regular prevention campaigns because of their marginality. These Snowball surveys have the advantage of cumulating prevention and dissemination of information and data collection on the evolution of knowledge and attitudes of drug users, based on their active participation in prevention.

These peer prevention projects exist since 1993. Users are interviewed in different regions but these regions vary each year.

The figures presented below pertain only to "classic" Snowball Surveys (snowball surveys in prison and pilot snowball survey for at-risk groups also exist). In 2008, they have enabled to interview 163 drug-users in Charleroi and 327 in Liege.

The 2008 results should be interpreted with caution because the drug use prevalence only represents drug use of persons encountered during Snowball Surveys by jobistes. The samples are mostly determined by the jobistes social network and are therefore not representative of drug users in the French Community. In addition, the questionnaire is not a tool embedded within a dynamic "statistical" fully-fledged study with proper methodology.

However and despite the selection bias related to the objective of this project, the results allow drawing some indicative tendencies and focus on some new trends or specific patterns.

Among all persons encountered during operations in 2008 (N = 490), 93,1% are current drug users (Table 15). More than half of the interviewed current drug users (67%) declared having injected a product during their lifetime and 50% say having injected a product in the last month. Among the lifetime injectors interviewed in 2008 (N=312), 27% are women. These injectors are mostly (60%) aged over 30 years and Belgians (74%).

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<sup>18</sup> The Sterifix is a kit containing 2 alcohol swabs, 2 flasks of injecting sterile water, sanitary advice and useful local addresses. It is made by "jobsites" (volunteers and users involved in the project, usually formed by the partners or by Modus Vivendi on harm risk reduction and remunerated for their HRR activities.) and pharmacists. They are provided for free by Modus Vivendi, which recommends to drag 2 syringes and sell it for 0.5 euro. Eventually, two ©Stéricups and condoms should be included. The pharmacists can purchase directly from distributors.

**Table 15:** Percentage of lifetime and current IDUs and of syringes sharing among current IDUs, Snowball surveys, French Community, 2003 -2008

	2003	2004	2005	2006	2007	2008
<b>N</b>	689	1,140	1,053	357	618	490
<b>N of current UD</b> s	614	1032	985	322	573	456
<b>Mean age of UD</b> s	30	32	31	31	31	33
<b>% males of UD</b> s	66	62	65	68	68	70
<b>Lifetime IDUs/current UD</b> s (%)	63	60	56	57	58	67
<b>Current IDUs/current UD</b> s (%)	46	43	41	42	41	50
<b>Borrowing used needle / current IDUs (%)</b>	32	29	30	30	42	31
<b>Use of needles found in the street / current IDUs (%)</b>	6	3	9	11	12	9
<b>Sharing needles / current IDUs (%)</b>	46	42	40	42	48	43
<b>Sharing injecting materials / current IDUs (%)</b>	57	52	55	52	57	61

Among the current drug users participating in the Snowball Surveys, the two most consumed products by injection in 2008 are cocaine (52%) and heroin (44%) (Table 16).

**Table 16:** Percentage of injection by drug among current users, Snowball surveys, French Community, 2003-2008

	2003	2004	2005	2006	2007	2008
<b>Heroin</b>						
<b>N</b>	442	765	758	231	472	422
<b>%</b>	53	48	44	53	45	44
<b>Cocaine</b>						
<b>N</b>	426	674	637	226	414	334
<b>%</b>	50	49	50	42	43	52
<b>Amphetamines</b>						
<b>N</b>	97	187	203	61	200	84
<b>%</b>	27	18	16	13	18	11
<b>Methadone</b>						
<b>N</b>	166	362	383	88	224	228
<b>%</b>	27	22	21	28	20	11
<b>Buprenorphine</b>						
<b>N</b>	57	122	121	23	75	58
<b>%</b>	12	12	22	13	17	2
<b>Morphine</b>						
<b>N</b>	62	150	140	30	87	49
<b>%</b>	24	18	20	37	23	29

➤ **Injecting and polydrug use at Festivals**

♦ **French Community**

**Injecting during an event**

Among the people interviewed in 2008 (N = 3,917), 3.3% are lifetime injecting drug users (IDU), which represents 4.3% of all drug users encountered (Table 17). About two thirds of the IDUs are men (76%) versus one third (24%) of women (valid percentages; 20% of non response in total sample). IDUs are mostly between 18 and 25 years (52%), 21% are less than 18 years and 27% over 25 years (valid percentages; 9% of non response in total sample).

**Table 17:** Percentage of current drug users and IDUs, during their life; French Community, 2006 - 2008

	<b>2006</b>	<b>2007</b>	<b>2008</b>
<b>N total</b>	2,403	2,618	3,917
<b>N UD</b>	1,846	1,917	3,004
<b>IDU/n (%)</b>	2.7	3.2	3.3
<b>IDU/UD(%)</b>	3.5	4.4	4.3

UD: lifetime drug users (except alcohol and tobacco), IDU: lifetime injecting drug users

In 2008, 1.1% of all interviewed persons reported having injected in the last month and 0.6% (24 persons) report an injection during the event.

**Polydrug use during an event**

Unlike previous years (results presented according to a single event), the following results are derived from data collected in all festivals and events. They relate to the consumption “during the event”. The main bias of these results is that they aren’t a systematic assessment of consumption at this event because people have been interviewed at any time during the festival.

For all persons interviewed in 2008 (N=3,917), about one out of three (32%) declare having used cannabis during the event, 8% speed, 7% ecstasy, 5% cocaine and 1% heroin (not available on Table 18).

**Table 18:** Polydrug use (including alcohol) during the event; French Community, 2006 – 2008

	<b>2006</b>	<b>2007</b>	<b>2008</b>
<b>Number of events</b>	49	61	74
<b>Number of persons</b>	2,313	2,618	3,917
<b>Polydrug use</b>			
no product	31%	34%	29%
only 1 product	37%	38%	36%
2 products	19%	17%	23%
3 products or more	13%	11%	12%

Among all respondents in 2008, 71% consumed at least one product during the event (including alcohol but not tobacco). 36% consumed only one product during the event, while 23% consumed 2 products and 12% consumed 3 or more products during the event. Among the polydrug users (N=1,405), the most common association is alcohol and cannabis (82%; with or without other products). The ecstasy-users (N=282) use an average of 3 other products, while the cocaine-users (N=191) use an average of 4 other products.

About one drug user (during the event, alcohol included) out of 7 (15%) intended to leave the event by driving his own car.

#### ♦ **Flemish Community**

Since 2003, VAD conducts research on drug use in different night life settings (Van Havere, 2004, 2006, 2009). Concerning cocaine, speed or heroine, a small increase was found in the proportion of persons interviewed in night life settings having used 2 or 3 of these substances during last year (Table 19).

The results of the 2009 study will be available in the next report.

**Table 19:** Polydrug use during last year; Flemish Community, 2003 - 2005 - 2007

	2003	2005	2007
<b>Number of persons</b>	645	670	775
<b>Polydrug use</b>			
No cocaine, speed or heroine	72% (464)	74% (495)	73% (568)
Cocaine, speed or heroine	22.3% (144)	20.0% (134)	19.5% (151)
2 of the 3 drugs	5.0% (32)	5.7% (38)	6.5% (50)
All 3 drugs	0.8% (5)	0.5% (3)	0.8% (6)

### 4.3. Intensive, frequent, long-term and other problematic forms of use

#### 4.3.a Description of the forms of use falling outside EMCDDA's PDU definition

##### ➤ **French Community**

Since 2001, the mobile team of Modus Fiesta (MF) developed in Brussels a series of projects aiming the reduction of drug-related risks in festive events. One of the project suggested is the "relax zone" (RZ). The main mission is to ensure a reception in a specific place installed on the site of the event for all drug users presenting minor psychic and/or physical problems involved in the use of psychotropic products. These people are accompanied by the team of MF but also by professionals (doctors, nurses, etc.). If needed, they will be directed towards the Red Cross service. However, symptomatology related to drug use is not the only admission criteria. The team of MF also moves in the camp-sites or in the concerts-site to accompany a person in bad trip.

For each contact established in the RZ, a questionnaire is filled out. The main mission being the contact with the person, the data collecting is not a real objective for the team. Thus, an important rate of non-responses is observed. The results are presented without the non-responses. Moreover, from one year to another, the sample strongly varies. Indeed, the recourse to the RZ is extremely depending on the localisation of the tent.

In 2008, 178 people were met during 3 events. The average age of the people for which information is available is 23 years and the large majority (67%) were men. More than one person out of two (57%) was a student. Almost one person out of two came via the Red Cross (40%), while 32% of the people came by own initiative and 10% via a friend.

The main symptoms reported were tiredness (61%), coldness (32%), nausea (19%), anguish (13%), and disorientation (13%). The most consumed products by people met at the Relax Zone were alcohol (58%), ecstasy (21%) and cannabis (16%).

#### **4.3.b Prevalence estimates of intensive, frequent, long-term and other problematic forms of use, not included in PDU definition**

No information on prevalence estimates of other drug use not included in PDU definition is available in Belgium.



## CHAPTER 5.

### Drug-related treatment: treatment demand and treatment availability

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In Belgium, the treatment offer is very broad and differentiated (residential settings, low-threshold programmes, e.g.), but varies geographically.

The last analysis on treatment demands show that both in inpatient and outpatient settings, the demands were mainly related to opiates.

#### 5.1. Strategy/Policy

The information from last year is repeated in the following as new analyses will be finalised in the near future. In Belgium a large diversity of treatment settings exists, also with regard to the specific methods of treatment used. Furthermore, due to the political structure different types of statutory regulations and financial rules co-exist. Often several authorities are involved at the same time and this leads sometimes to a lack of clarity in terms of the division of competencies.

In first instance a number of treatment centres specialised in (illegal) substance abuse treatment have gradually entered into a so-called 'revalidation agreement' with the National Institute for Invalidity and Health Insurance and consequently fall under the authority of the federal policy level. These centres are often referred to as the '*specialised substance abuse treatment centres with RIZIV/INAMI<sup>19</sup> convention*'. Most of these centres are exclusively oriented towards people with illegal drug problems. Some of them are allowed to treat people with primary alcohol problems.

A second group of services is composed by the *psychiatric hospitals* and the *psychiatric units in general hospitals*. Overall, these treatment centres are not exclusively oriented towards people with illegal drug problems; on the contrary, a variety of psychiatric 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 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).

These groups of treatment centres can be considered to take up a large part of drug users starting treatment. However, other treatment facilities should not be ignored or underestimated i.e. initiatives in the general health or social welfare sector, general practitioners, emergency departments, self-employed psychologists or psychiatrists, non-subsidized initiatives, halfway houses, sheltered living, temporary projects, etc.

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<sup>19</sup> The "*Rijksdienst voor Invaliditeit en Ziekteverzekering*" (RIZIV) and "*Institut National d'Assurance Médicale et Invalidité*" (INAMI) are the respective Dutch and French terms for the National Institute for Invalidity and Health Insurance in Belgium.

Moreover, concerning the Walloon Region, a fourth group should be added: many specialized treatment centres receive indeed an optional grant from the Walloon Region government.

## 5.2. Treatment systems

### 5.2.a Organization and quality assurance

#### ➤ Organization

In the **French Community**, the Treatment Demand Indicator is collected in volunteer inpatient and outpatient centres. Three main groups are involved: treatment centres specialized in illegal substance abuse treatment that have a convention with the national institute for invalidity and health insurance (RIZIV-INAMI), centres for mental health care with a drug addiction agreement in Walloon region and ambulatory treatment centres in Walloon region with a facultative drug subvention from the Walloon government.

Eurotox asbl merges all databases coming from Walloon region and French Community of Brussels together in order to analyse the data<sup>20</sup> for the whole French Community. The databases are from 4 systems of data collection (CTB-ODB system for Brussels, Sentinelles system for Charleroi- Walloon region, Citadelle network for Tournai- Walloon region and Eurotox system for the rest of the Walloon region).

In 2008, there were 32 treatment centres from the Walloon region participating to the Treatment Demand Indicator collection:

- 27 treatment centres specialised in illegal substance abuse treatment (alcohol centres not included). These centres have a convention with RIZIV-INAMI or are ambulatory treatment centres in the Walloon region with a drug facultative subvention from the Walloon government.
- 4 MASS mental health care with a drug addiction agreement (centre of low-threshold, therapeutic community, day centre, crisis centre).
- 1 psychiatric hospital.

Data coverage in these 3 groups of centres didn't reach 100% but participation rate was high considering that technical problems occurred every year in some centres which consequently made data unavailable.

No computerized system for data collection actually exists. The centres have created their own tool or use the paper questionnaire.

Moreover, other treatment facilities which do not participate to TDI data collection (general practitioners, self-employed psychologists or psychiatrists) shouldn't be underestimated.

The information from last year is repeated in the following as new analyses will be finalised in the near future. Registration systems in the **Flemish Community** collect data for some years. In 2004, TDI data were collected by 4 of the 5 low threshold agencies (Medisch Sociale Opvang Centra) and all fifteen treatment centres specialized in illegal substance abuse treatment that have a convention with the national institute for invalidity and health insurance. All 9 ambulatory treatment centres participated in TDI registration. Local divisions ("satellites") were not counted separately. Each of these 28 centres is supported by the VVBV ("Vlaamse Vereniging Behandelingscentra Verslaafdenzorg") or the daughter organisation De Sleutel. All 97 centres for mental health care (outpatients) of the Flemish Community collected TDI data. In 2005, the 3 organisations that were responsible for data collection in the centres were VVBV (mainly with the computer programme DARTS), De Sleutel with the programme DUX and the centres for mental

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<sup>20</sup> This global analysis is presented in the report of the French Community (only data from the Walloon region are presented in that document).

health care using the programme ARCADE. Because registration in hospitals (including among others psychiatric hospitals and psychiatric services in general hospitals) is a federal competence, these data will be included in the data on the Flemish Community when made available by the federal government.

In 2007, data about the Flemish Community were merged for the first time to assess drug-related treatment demand in the Flemish Community and in Belgium. The data concerned the year 2004. In 2008, data about treatment demand in 2005 were merged.

➤ **Quality assurance**

In Belgium, standard and formal systems of quality assurance aren't used by common consensus in the field of treatment. Since different practices exist, it is impossible to list them here.

However, the Europ-ASI (Europ Addiction Severity Index) is a still common tool for different treatment centres. In Belgium, the Europ-ASI questionnaire is used since 1998 as a standard in the total network of De Sleutel in Flanders. It is also used in several other Flemish facilities.

## **5.2.b Availability and diversification of treatment**

➤ **Drug Free Treatment**

### **Inpatient treatments**

There are Therapeutic Communities, specialized crisis centres, psychiatric units in general hospitals and units for substance abuse problems in psychiatric hospitals and psychiatric units in emergency services (see 5.1.).

### **Outpatient treatments**

Part of outpatient treatment consists of drug free treatment centres. The medical-social care centres on the other hand, which have an agreement with RIZIV/INAMI, 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.

➤ **Assisted treatment**

### **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.

In Belgium, very few withdrawal centres exist but they are still part of the offer.

## **Substitution treatment**

Substitution treatment aims to prescribe, administer and 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 of August 22 2002). It is stated that psychosocial counselling and assistance to patients are factors improving the results of substitution treatment. Substitution treatment should be part of a medical-psychological-social approach; this is stated to be an essential component to make substitution treatment work.

In the last Royal decree on substitution treatment (6 October 2006, see 1.2.c), Methadone and buprenorphine are both mentioned as substitution substances. Methadone is being prescribed throughout Belgium, through a consensus reached amongst partners concerned (1994 and updated in 2000). For buprenorphine a similar national consensus does not exist yet. Buprenorphine is newly (since 2003) reimbursed by the Social Security and data on its prescription are not yet available.

In the **Flemish Community**, most methadone maintenance programmes are being provided by low threshold drug services. Also the outpatient treatment centres of De Sleutel provide substitution therapy, although always within a global medical-psychological-social approach, combining substitution with counselling and guiding activities. In smaller towns and rural areas, if existing at all, methadone is being prescribed by GPs under the supervision of drug services.

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

SSMG-Alto is a network of General Practitioners giving care to drug users in the French part of Belgium. They also offer "intervisions" and training on how to take care of addicted patients in several towns of Wallonia.

## **Other pharmacologically assisted treatment**

Since several years, the city of Liege's council wants to apply, as a pilot-project, the medically controlled treatment with diacetylmorfine. The project aims to evaluate the efficiency of this treatment for patients for whom all other treatments have shown inadequate. Up to now, a foundation gathering some hospitals in Liege was created, the building where the delivery should take place was chosen and a researcher from the University of Liege is currently working on the project. The inclusion of patients should start in the beginning of 2010. This pilot-project is funded by the ministries of Justice and Public Health.

## **5.3. Characteristics of treated clients**

### **➤ TDI**

The information from last year is repeated in the following as new analyses will be finalised in the near future. In 2005, the profile of clients starting a treatment in the **French Community** is essentially male (81%), Belgian (62%) and means of their age is 31 years old.

Opiates are designed in 63% of treatment demands as principal product by clients, then Cocaine for 15% of clients and cannabis for 10%.

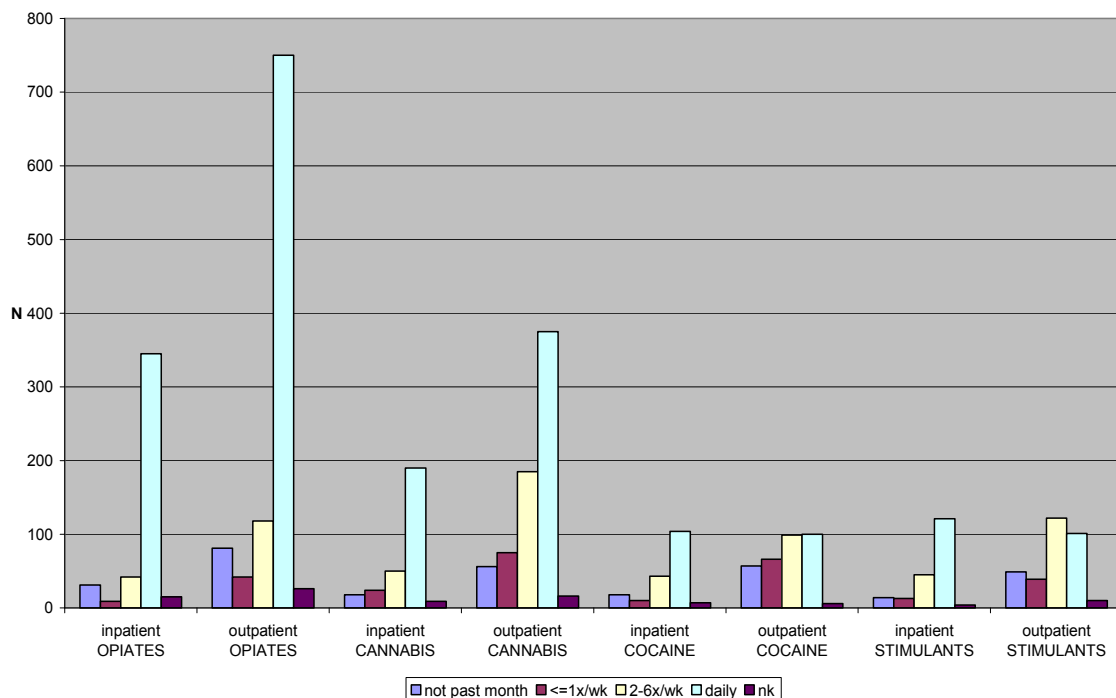
The geographical area 4 and types of centres included in this analysis were described extensively above (see PDU estimates based on TDI). Due to the fact that not all regions

and health care organisations in Belgium were included, the demand for drug related treatment is underestimated.

In this area in 2005, 4966 drug-related treatment demands were registered: 1397 persons in inpatient centres (17.2% women) and 3569 persons in outpatient centres (including low-threshold centres) (20.1% women). Treatment demands in both inpatient and outpatient settings were mainly related to opiates (44.4% of the inpatient demands; 52.8% of the outpatient demands; 50,4% of all demands). Cocaine was the third most important primary substance for treatment demand in inpatients (14.1%) and in outpatients (10.1%) (11% of all demands). Other stimulants apart from cocaine (e.g. amphetamines) were the primary drug related to a demand for treatment in 15.8% of inpatients and 10.0% of outpatients. Cannabis was the primary drug in 23.2% persons demanding inpatient treatment and 25.2% of persons demanding outpatient treatment, making it the second most important substance as related to all treatment demands (24.7%). Treatment demands related to the use of hypnotics, sedatives, hallucinogens and inhalants were rare.

Demand for treatment existed already in the age group 15 to 19 years old. In this age group, the demand for treatment related to cannabis use was higher than the sum of the treatment demands related to opiates, cocaine and stimulants. This was found in both inpatients and in outpatients and persons attending low threshold services. Cannabis-related treatment demand was gradually decreasing over the next age groups, whereas in all subsequent age groups the large majority of treatment demands was related to the use of opiates. From the age group 40-44 on almost all treatment demands were related to opiates. Treatment demands by persons 50 or older were scarce.

Most users with a treatment demand were daily users, regardless whether the primary substance was opiates, cocaine, stimulants or cannabis (Fig 1; value of outpatients opiates “not known” is 890). Exceptions were cocaine and stimulant users demanding treatment in outpatient services. In these centres treatment was asked equally by cocaine users who were daily users and by persons who used the substance 2 to 6 times a week. In outpatient services treatment was asked more by stimulant users (other than cocaine) who used 2 to 6 times a week than by persons who used daily.



**Figure 1:** Number of treatment demands (all treatments) in Belgium by frequency of substance use, substance and type of treatment centre, 2005

#### **5.4. Trends of clients in treatment**

The TDI registration system is still under development. Therefore, data are not suited to be used for trend analysis.

## CHAPTER 6.

### Health Correlates and Consequences

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According to the AIDS/HIV Belgian database, the decrease in the proportion of IDUs in HIV cases is confirmed once again by the 2008 data. Moreover, regional data concerning hepatitis show HCV is still the most frequent type of hepatitis among drug users.

In the frame of the Federal Police “Road safety action plan”, controls focusing on drivers under the influence of alcohol and drugs are performed. The 2008 results are comparable to the previous years’ ones: a majority of the analysed samples were positive and the most important substance detected was cannabis.

#### 6.1. Drug-related infectious diseases

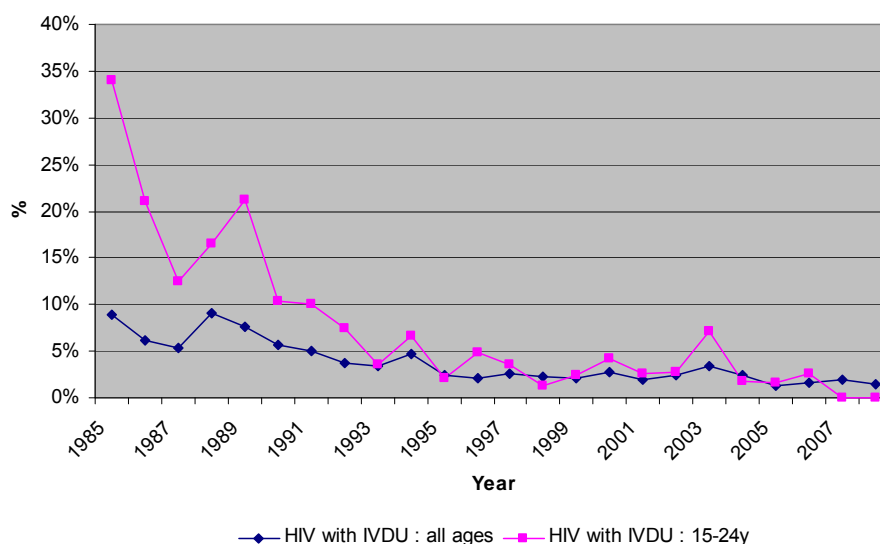
##### 6.1.a HIV/AIDS and viral hepatitis

###### 6.1.a.1 Injecting drug use among HIV/AIDS patients

In Belgium, diagnosed HIV seropositive people and AIDS cases are registered in two integrated databases at the Scientific Institute of Public Health in Brussels<sup>21</sup>.

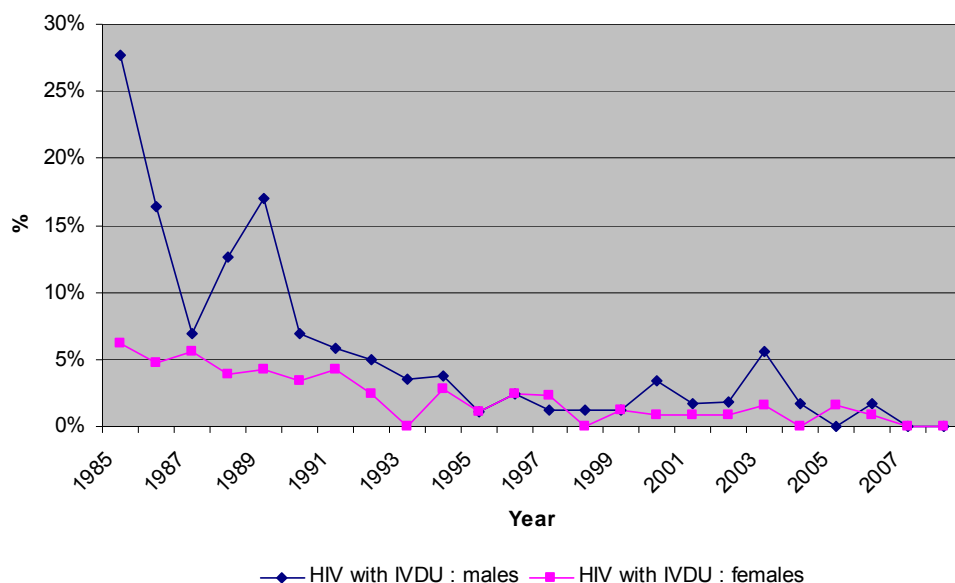
From the beginning of the epidemic to December 2008, 21,099 HIV infected patients were registered.

The proportion of all IDUs among HIV cases (cases of HIV with intravenous drug use as risk factor) decreased from around 9% in 1985 to approximately 1% in 2008 (Figure 2). Infection via intravenous drug use was higher among young people, but in recent years it has become comparable to the observations among older people. Among infected people aged between 15 and 24 years, no new case was registered in 2008.



**Figure 2:** Percentage of IDUs among new HIV-cases from 1985 to 2008 in Belgium (Sasse, personal communication 2009)

<sup>21</sup>A unique code is used to record each case, whether HIV-positive or AIDS, it is possible to avoid multiple counting and to link the two databases. Detailed information on these systems is available in Sasse and Defraye 2004.



**Figure 3:** Percentage of IDUs among new cases aged between 15-24 years from 1985 to 2008 in Belgium, according to sex (Sasse, personal communication 2009)

Trends of IDUs among HIV new cases according to gender are quite similar since 1995 (Figure 3). In 2008, no new case was registered.

### 6.1.a.2 HIV seropositivity among drug users

Among all people met through the Snowball Survey (French Community, already described in 4.3.b) in 2008 (n=490), 71% have had an HIV test during their lifetime and 47% during the last year. Among the persons tested for HIV, 7% have a positive result (Table 20). Mostly, they were tested by their general practitioner (38%) or at a hospital (31%). A minority were tested in prison (17%) or in a follow-up centre (16%).

**Table 20:** Percentages of self-reported positive results among tested IDUs and non-IDUs for HIV, Snowball surveys, French Community, 2006 -2008

	2006	2007	2008
<b>N</b>	357	618	490
<b>n IDU</b>	190	346	312
<b>n IDU tested for HIV</b>	126	236	229
<b>% IDU HIV+</b>	5.6	4.2	8.7
<b>n non-IDU</b>	167	272	178
<b>n non-IDU tested for HIV</b>	81	167	120
<b>% non-IDU HIV+</b>	2.5	3.6	4.2

### 6.1.a.3 HIV seropositivity among treated patients

The next table provides the same kind of information than Table 20 for the French Community for the years 2003-2008: since a data collection tool change process was initiated in 2000 by Eurotox in order to better match the TDI requirements, the 1994-2002 data shouldn't be compared with the more recent ones.



Moreover, the infectious disease data (HIV, hepatitis B and C) are collected on a voluntary basis: not all the French Community centres deliver data on infectious diseases. Indeed, only about 15 centres in the Walloon region include the infectious disease indicator in their questionnaires. Moreover, these data are not systematically collected for each patient in some of these centres. The table below, which present the numbers of current/past IDUs asking for treatment, should therefore be interpreted with caution.

**Table 21:** Percentage of self-reported HIV-seropositivity among IDUs asking for treatment in 15 centres of the Walloon region, 2003-2008

Year	2003	2004	2005	2006	2007	2008
<b>Walloon region</b>						
Number of treatment demands from IDUs	288	263	190	182	503	469
Number of IDUs self-reported	144	127	90	45	116	139
% HIV + (self-reported)	5.2	8.1	4.7	4.4	6.0	3.6

In 2008, the percentage of self-reported HIV-seropositivity among IDU seem to have dropped lower then ever before in the previous years.

In the Flemish Community, the outpatient centre “Free Clinic” (medico-social centre in Antwerp) offer blood screening on a regular basis to all attending patients. (Free Clinic, 2009, personal communications).

In 2008, 21 patients were tested positive for HIV (Table 22).

**Table 22:** Percentage of sero-prevalence of HIV in an outpatient centre, Antwerp, Free Clinic 2003-2008

IDU	2003	2004	2005	2006	2007	2008
Number of IDUs	408	416	512	478	467	492
Number of IDUs tested	287	295	24	19	19	21
% HIV+ (tested)	5.6	6.1	7.1	5.7	6.0	4.2

#### 6.1.a.4 HIV seropositivity among prisoners

Every two years a study in all Belgian prisons is undertaken to estimate the drug use prevalence and the related risk behaviours among prisoners (see 2.3.d).

In 2008, the knowledge of HIV transmission risks was good or very good in about 50% of the detainees.

Nevertheless, sanitary risks exist: one out of six detainees get a tattoo in prison and 3.4% get a piercing. Until today, no information or equipment allowing safer practices is available. Moreover, 5.3% of the prisoners declared having had sexual intercourse in prison and among them; almost one out of two never used a condom.

#### 6.1.b STIs and tuberculosis

##### 6.1.b.1 Hepatitis B and C

The Belgian surveillance network for infectious diseases registers hepatitis cases through around a hundred microbiology laboratories widespread in 33 district of Belgium out of the 43 existing. In 2008, 459 hepatitis B cases and 980 hepatitis C cases were registered (Geneviève Ducoffre, personal communication, 2009).

However, no information on the patient's drug use is taken into account in the register.

➤ **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. Taking into consideration the methodological limitations, the table presented below should be interpreted with caution.

Data on prevalence of HBV in the Flemish Community are available from "De Sleutel" (De Sleutel, 2009, personal communications). There doesn't seem to be a clear trend in the data (Table 23). One should be cautious in interpreting these data because biological testing is performed only for the clients seeing a physician; the physician follows at least all clients in substitution and / or other medication treatment.

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

Moreover, between 2003 and 2005, the percentage of hepatitis B among IDUs screened for this disease remained high and seemed to rise slowly; the prevalence is lower from 2006 to 2008.

**Table 23:** Percentage of hepatitis B infected among IDUs asking for treatment, in De Sleutel and in centres of the French Community, 2003-2008

<b>HBV</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>
<b>De Sleutel (Flemish institution)</b>						
Number of treatment demands from IDUs	269	295	164	228	198	166
Number of IDUs tested	58	66	37	38	28	38
Number of hepatitis B + (anti-HBc+)	10	11	3	6	7	1
<b>Prevalence rate (%)</b>						
<b>All IDUs</b>	<b>17</b>	<b>17</b>	<b>8.1</b>	<b>15.8</b>	<b>25.0</b>	<b>2.6</b>
Males	21	16	9.4	17.6	22.7	2.9
Females	0	18	0.0	0.0	33.3	0.0
<25 years	7	0	0.0	0.0	25.0	0.0
25-34 years	100	21	6.7	11.1	12.5	4.3
>34 years	33	36	14.3	50	50.0	0.0
IDUs using opiates	18	15	6.3	21	40.0	3.8
IDUs not using opiates	13	22	20	6.7	23.8	0.0
<b>French Community</b>						
Number of treatment demands from IDUs	288	263	186	182	503	469
Number of IDUs (self-reported)	131	110	87	44	107	132
% of hepatitis B + (self-reported)	30.8	31	33.7	18.1	23.4	23.5

Among lifetime IDUs, i.e. IDUs having injected at least once, hepatitis C is more prevalent than hepatitis B. Between 2003 and 2008, the number of lifetime IDUs registered through the monitoring system of De Sleutel and of the French Community, seems to fluctuate with no clear trend.

The prevalence of HCV infection among tested IDUs (having injected at least once) registered by De Sleutel increases with age (Table 24).

**Table 24:** Percentage of hepatitis C infected among IDUs asking for treatment, in De Sleutel and in centres of the French Community, 2003-2008

<b>HCV</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>
<b>De Sleutel (Flemish institution)</b>						
Number of treatment demands from IDUs	269	295	164	228	198	166
Number of IDUs tested	80	96	38	69	53	63
Number of hepatitis C + (biological testing)	28	36	19	25	18	17
<b>Prevalence rate (%)</b>						
<b>All IDUs</b>	<b>35</b>	<b>37</b>	<b>50</b>	<b>36.2</b>	<b>34.0</b>	<b>27.0</b>
Males	35	37	45.5	35.6	32.6	27.3
Females	33	38	80	40	40	25.0
<25 years	28	9	37.5	19.2	10	20.0
25-34 years	0	43	29.4	38.7	26.7	21.6
>34 years	50	78	84.6	66.7	69.2	54.5
IDUs using opiates	41	32	48.5	38.3	40	25.0
IDUs not using opiates	24	50	50	26.7	34.2	33.3
<b>French Community</b>						
Number of treatment demands from IDUs	288	263	186	182	503	469
Number of IDUs (self-reported)	141	120	93	53	117	136
% of hepatitis C + (self-reported)	71.6	62.9	32.9	47.2	50.4	47.1

The data below are the results of the blood testing diagnosis in Free Clinic (the context is already described in 6.2.a.3). In 2008, 82.7% of the patients tested at Free Clinic were tested positive for hepatitis C and 57% of the tested patients were positive for HBV (anti-HBc+) (Table 25).

**Table 25:** Percentage of hepatitis B and C infected among IDUs asking for treatment, in Free Clinic, 2003-2007

<b>Free Clinic Antwerp</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>
<b>HBV</b>						
Number of treatment demands from IDUs	408	416	512	478	467	492
Number of IDUs tested	281	252	323	329	303	323
Number of hepatitis B + (biological testing) (anti-HBc+)	174	147	190	181	162	185
<b>Prevalence rate (%)</b>						
<b>All IDUs</b>	<b>61.9</b>	<b>58.3</b>	<b>58.8</b>	<b>55.0</b>	<b>54.0</b>	<b>57.0</b>
Males	64.6	59.7	60.1	58.3	56.8	59.0
Females	56.5	55.3	56.0	47.5	45.6	53.2
<25 years	33.3	57.1	25.0	33.3	42.9	14.3
25-34 years	54.9	51.4	22.1	40.0	37.9	37.1
>34 years	67.4	61.4	64.6	60.4	58.3	63.4
<b>HCV</b>						
Number of treatment demands from IDUs	408	416	512	478	467	492
Number of IDUs tested	287	258	337	342	311	335
Number of hepatitis C + (biological testing)	227	196	272	269	249	277
<b>Prevalence rate (%)</b>						
<b>All IDUs</b>	<b>79.1</b>	<b>76.0</b>	<b>80.7</b>	<b>78.7</b>	<b>80.0</b>	<b>82.7</b>
Males	81.5	78.0	82.6	81.3	80.9	81.5
Females	73.9	71.1	76.2	72.5	78.0	85.6
<25 years	50	64.3	40.0	60.0	85.7	85.7
25-34 years	76.9	82.7	72.0	67.5	70.0	73.0
>34 years	82.4	74.0	85.9	82.9	82.9	84.9

➤ **Hepatitis among drug users- Snowball survey (French Community)**

The Snowball Survey, for which details are given in section 4.3.b, provides additional information on hepatitis for the French Community. Among all the respondents in 2008 (n =490), more than two of three (71%) state that they have been tested for hepatitis. IDUs report more often that they have been tested (75%) than the other respondents (62%).

In 2008, among all persons interviewed who have been tested for hepatitis (n=346), hepatitis C infection seems to be most prevalent: 35% for hepatitis C, 29% for hepatitis B, and 14% for hepatitis A. Moreover, the seropositivity rate is significantly higher for IDUs than for non-IDUs (Table 26).

**Table 26:** Percentages of self-reported positive results among tested IDUs and non-IDUs for Hepatitis, Snowball surveys, French Community, 2003 -2008

	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>
<b>N</b>	689	1,140	1,048	357	618	490
<b>n IDU</b>	393	642	564	190	346	312
<b>n IDU tested for Hepatitis</b>	295	485	415	126	244	235
<b>% IDU HBV +</b>	31.5	34.8	30.8	19.8	29.5	33.2
<b>% IDU HCV +</b>	54.6	63.5	56.1	42.9	59.4	48.9
<b>n non-IDU</b>	296	498	484	167	272	178

<b>n non-IDU tested for Hepatitis</b>	123	246	239	62	140	111
<b>% non-IDU HBV +</b>	13.0	12.6	15.5	6.5	7.1	24.3
<b>% non-IDU HCV +</b>	13.8	13.0	21.8	11.3	10.0	11.7

➤ **Hepatitis among prisoners**

In the 2008 prison study (see 2.3.d), 17.3% of the sample declared being infected by HBV and/or HCV and 82.7% stated not being infected. Moreover, women with HCV are five times more numerous than men.

**6.1.b.2 Tuberculosis**

In 2007, 1,028 tuberculosis cases have been registered in Belgium (incidence rate: 9.7/100,000 inhabitants) (FARES/VRGT, 2008).

In the French Community, 15 cases (2.5%) stated intravenous drug use.

Since the Flemish Community doesn't take into account the variable "drug consumption" in their register anymore, no Flemish data could be presented here.

**6.1.c Other infectious morbidity**

In the Flemish outpatient centre "Free Clinic", all attending patients are offered a blood screening on a regular basis. In 2008, 11 out of 492 patients (2.2%) were tested positive for syphilis.

**6.1.d Behavioural data**

The available information concerning behavioural data has already been described in the paragraphs tackling needle exchange programs (4.2.a).

**6.2. Other drug-related health correlates and consequences**

**6.2.a Psychiatric co-morbidity**

➤ **Minimum Psychiatric Summary**

In Belgium, no national specific estimation of the number of double diagnosed patients has been implemented yet.

Nonetheless, thanks to the Minimum Psychiatric Summary, we can approximately evaluate the percentage of dually diagnosed patients: in 2006, 3.8% (2,953 on 78,336) of the patients admitted for a psychiatric trouble presented also a drug problem and 0.8% (494/78,336) of the patients admitted for a psychiatric trouble presented a drug induced problem. A drug problem is defined as abuse and addictions to opiates, cocaine, cannabis, amphetamines, hallucinogenic products, inhaled products or poly-substances.

Due to a technical switch currently operated in the registration system, the latest data are not yet available (Gorissen, personal communication).

➤ **De Sleutel estimation**

De Sleutel made an estimation based on patients documented with EuropASI between 1998 and December 2008. Percentages were 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 (e.g. depression, anxiety and tension). During the period 1998-2008, 47.8% of the patients (N=6532) could be assigned to moderate (36.1%) or severe (11.7%) double diagnosis (Table 27). For the period 2004-2008 De Sleutel found 51.4% (N=3341) patients with double diagnosis. In 2008, 49.6% (N= 651) of patients were labelled with double diagnosis.

**Table 27:** Psychiatric co-morbidity in the Flemish Community (De Sleutel, 2009, personal communication)

	<b>1998-2008</b>	<b>2004-2008</b>	<b>2008</b>
	N=6.532	N=3.341	N=651
<b>Non</b>	52.2%	48.6%	50.4%
<b>Moderate DD</b>	36.1%	38.7%	32.9%
<b>Severe DD</b>	11.7%	12.7%	16.7%

## **6.2.b Somatic co-morbidity**

➤ **Minimum Clinical Summary (RCM)**

From January to December 2007, in 142 general hospitals of Belgium, a drug-related problem (primary or secondary diagnosis) was mentioned in 0.51% of all hospitalizations (stays spent entirely in psychiatric services not included)

Data come from the RCM (Minimum Clinical Summary) database, selection on the basis of ICD9 codes (drug addictions and drug abuses in non-addicted patients). Because the use of ICD9 is not mandatory for ambulatory patients, this percentage is probably an underestimation (Legrand, personal communication).

## **6.2.a Non-fatal overdoses and drug-related emergencies**

➤ **Anti-poison centre**

In 2008, 312 calls were received by the anti-poison centre regarding drug intoxications. For 212 calls only one substance was involved. In order of importance, 41 calls were related to cannabis and derivatives, 25 to solvent-type substance (lighter gas, ether, glue...), 19 to cocaine, 15 to heroine or methadone and 10 to XTC. Moreover, an additional 100 calls concerned the use of multiple substances.

## **6.2.b Other topics of interest**

### **6.2.b.1 Driving and other accidents**

➤ **Data from police services**

In October 2002, the Federal Police launched a "Road safety action plan". This plan aims 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 releases).

Table 28 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 2006-2008.

**Table 28:** Results of the controls in the framework of the “Road safety action plan”, 2006-2008. Ricour, personal communication, 2009

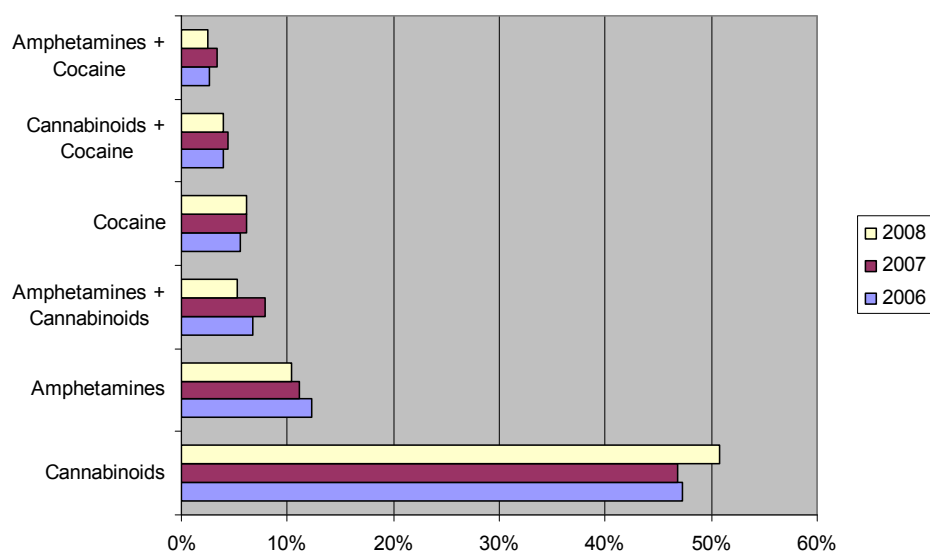
	2006	2007	2008
<b>Controls</b>	599	683	814
<b>Urine tests</b>			
<b>Positive</b>	171	200	213
<b>Negative</b>	79	126	115
<b>Total</b>	250	326	328
<b>Blood tests</b>	171	200	213
<b>Refusals</b>	2	15	2
<b>PV's</b>	173	215	215
<b>Driving license revocation</b>	11	10	3

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.

Figure 7 presents the results of the blood analysis performed in 2006-2008 (Gert De Boeck, NICC personal communication). Blood samples were taken during police road controls (both local and federal police services). In 2008, out of 1970 tests, 1632 were positive and 338 were false positive.

Half of the samples contained only cannabis, followed by amphetamines and then cannabis associated with amphetamines.



**Figure 4:** Results of positive blood tests in the framework of road controls done by local and federal police services, N= 1337, N=1720, N=1970 NICC 2006-2008

➤ **Road traffic accidents**

In 2007, the IBSR-BIVV (Belgian Institute for Road Safety) issued prevention leaflets targeting young people ("Young but not dumb! Survival kit: alcohol, speed, drugs..."): the document aims at explaining the weekend road accidents problematic and how to avoid them. One of the topics tackled is "driving under drugs influence".

In 2008, another information leaflet targeting the general population was issued ("Drugs and driving, there you go for a bad trip"). The document explains the potential legal sanctions and controls as well as the driving under drug influence effects.

### **6.3. Drug related deaths and mortality of drug users**

#### **6.3.a Drug-induced deaths**

Using the EMCDDA's "Selection B", general mortality register data on drug-related deaths could be extracted for the Flemish Region and the Brussels Capital Region. The analysis for the years 1998 through 2004 revealed no specific trend.

For more information, please refer to the study report (Jossels, Govarts & Roelands, 2006).

#### **6.3.b Mortality and causes of deaths among drug users**

In Belgium, no cohort studies have been carried out recently. Therefore, there are no data available on the causes of death among drug users.

#### **6.3.c Specific causes of mortality indirectly related to drug use**

No information is available on the specific causes of mortality among drug users.



## **CHAPTER 7.**

### **Responses to Health Correlates and Consequences**

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Needle exchange programmes are implemented since several years in Belgium: these organizations usually get a pretty satisfactory syringes exchange rate (around 90%). Although prevention projects targeting specific groups exist (e.g. pregnant women...), it could be underlined that special emphasis is given to counselling and testing for hepatitis C and HIV. It seems that less prevention projects are dedicated to other drug use consequences or specific vulnerable groups.

#### **7.1. Prevention of drug related emergencies and reduction of drug related deaths**

##### **7.1.a Drug related deaths**

An Early Warning System (EWS) was developed by the Focal Point aiming at exchanging information on 'new and/or dangerous drugs'. Dangerous is defined as a 'substance that could cause permanent injuries, coma or death'. Information on such drugs is disseminated in a broad national 'early warning network'. This network consists of judicial and police institutions, Sub-Focal Points, toxicological, forensic and clinical laboratories, emergency departments, helplines (drugs and poison control centre), the Narcotic Drug Service, DG SANCO and the Cabinets of the Minister of Public Health and Justice.

In 2008 a warning was send on high dosed MDMA. Further, several information-mails were send to the network of SFP's, laboratories and police, in case new drugs or dangerous combinations of substances were detected in other European countries.

In the **French Community**, the NGO Modus Vivendi re-edited two flyer-trailers on harm reduction.

The re-edition of the brochure on cocaine allowed stressing some points:

In relation with a new act on road security, the flyer points out that driving under the influence of psychotropic drugs is forbidden, and is the object of specific judicial prosecutions. Beyond that, avoiding driving under the influence of cocaine is advised, especially if mixed with alcohol.

The duration of action is also developed, since there is a difference, depending on the consumption mode, between the actual effects on the body and the effects consciously experienced by the user.

The dependence phenomenon is the next renewed topic. The interaction between three factors is identified as determining the dependence: the user (his expectations, his lacks, his desires...), the product and the context.

The symptoms of the dependence are described as mainly psychological (craving, hyperactivity to find oneself the product), but also physical (fatigue, depressive mood...).

The risks related to smoking cocaine (crack/free base) were also newly exposed (namely the risks of transmission of STI due to the wounds occasioned in the mouth and to the sharing of material), along with the risks for pregnant women (it is in fact advised not to consume during pregnancy, and not to breast-feed the baby in case of consumption).

Finally, a "zoom" is made on the risks related to crack/free-base smoking, and how to reduce them.

The booklet on methadone was updated too. Three topics were added to the ancient version: pregnancy; new-born babies and prison. It is stated that a stable substitution

treatment with methadone during the pregnancy is preferable for the baby to the consumption of heroine.

The prison topic aims at informing the detainees that the law gives them the right to equivalent treatments inside and outside the penitentiary system. Nonetheless, they should stay in possession of a recent medical attest of their general practitioner if they are following a substitution treatment outside, in order to have it pursued inside without any delay. If not in possession of such an attest, the detainee will give the prison's GP the contact details of his own GP, who will transmit a methadone follow-up certificate.

In the **Flemish Community**, a local training in overdose prevention for drug workers was set up through the provincial co-ordinators of the needle exchange programmes (it was also formerly addressed to drug users, but not anymore).

An information brochure on overdose prevention is also available and distributed through drug services, street corner workers and needle exchange programmes (Windelinckx, 2009).

### **7.1.b Emergencies**

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** a new crisis unit was set up. The units are part of five general hospitals. This project still went on in 2008.

Some novelties were implemented in the outreach and emergency services offered by the NGO DUNE in **Brussels**.

Since the summer of 2008, coupled with a "shower accommodation" set up in the buildings of a medical house, a "laundry service" (a boiler and a dryer) was settled. Indeed, one of the difficulties of the shower accommodation (along with the appointments, the distance factor, etc.), was that homeless people sometimes come to the shower in such dirty clothes that it was almost not worth the pain taking a shower and going back to the street without abandoning those for new donated clothes. So first, a second hand clothes reserve had been set up. But then, the users asked for a personal locker in the buildings, in order to leave there some extra-clothes that they could use for example after a shower. But space was lacking, so that the users were re-directed towards specialized places. Then again, the latter turned out to be overwhelmed by demand. The new laundry service allows thus the users to wash themselves and to go back to the street with their own clothes, washed and dried. Besides, some users occasionally come with clothes infested with louses, which cannot be put away without boiling the laundry.

The systematic coupling with the shower-accommodation had to be abandoned, though, since Dune clients disposing of a private residence wished to make use of the boiler and the dryer as well.

## **7.2. Prevention and treatment of drug-related infectious diseases**

### **7.2.a Prevention**

#### **➤ Needle exchange programmes**

Different types of needle exchange programmes are available in the country except in the German-speaking Community: stationary exchange places, street programme and programmes in pharmacists. Safe injection rooms do not exist in Belgium.

♦ **Flemish Community**

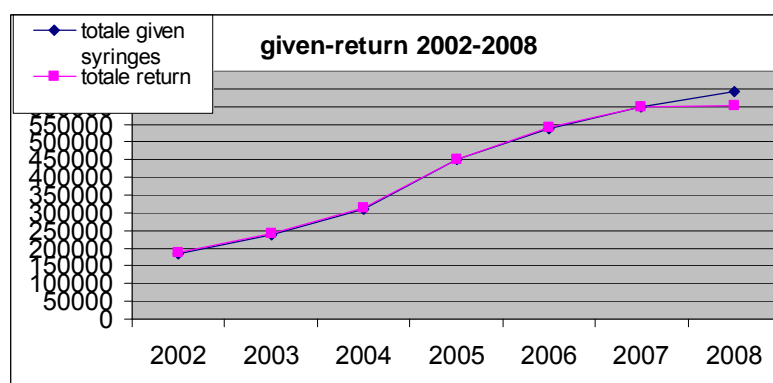
In every province of the Flemish Community a coordinator for syringe exchange was appointed and several exchange places exist (low threshold organizations, pharmacies, outreach workers ...). Via the projects, syringe exchange injection kits are spread among users, including: syringe, sterilized water and alcohol swabs (to clean the spoon). Collaborators of the project also distribute baking soda (for cooking base-cocaine) and inform users about 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). A CD-Rom was also developed for making crack cocaine with baking soda (this is available in low threshold services). The needle exchange program has started to give aluminium foil to drug users (promoting a switch to an alternative way of using drugs).

For the whole Flemish Community, 642.897 syringes were distributed and 604.164 were given back in 2008 (Table 29) (Windelinckx 2009).

**Table 29:** Number of given and returned syringes (Flemish Community, 2005-2008)

	2005	2006	2007	2008
<b>given</b>	448,502	538,783	598,731	642,897
<b>returned</b>	431,377	527,789	596,320	604,164

A noticeable increase in the number of syringes given and returned is observed between 2001 and 2008 (Figure 5).



**Figure 5:** Volume of the exchanged syringes, Flemish Community, 2001-2008

♦ **French Community**

The needle exchange programme in the French Community (available in 5 cities: Brussels, Charleroi, Liege, Dinant and Arlon) proposes sterile syringes and all related injection equipment to drug users in determined places (needle exchange desks) or through mobile structures (street educators, mobile desks in recreational settings or events).

The following equipment is available: syringes, filters (Stéricup©), ascorbic acid, spoons, alcohol swabs, flasks of injecting sterile water, individual or collective containers recovery syringes and also sniff kits, condoms, lubricant, etc.

Particular attention is paid to other equipment promoting consumption patterns reciprocating injection as inhalation or sniff. Adapted Harm Reduction messages are then issued.

In 2007, the amount of distributed syringes through needle exchange programmes in the French Community was around 319,707 and 277,220 syringes were recovered.

The exchange rate has been pretty satisfying since 2000, and even higher than 100% on two occurrences. This is due to the fact that more syringes were brought back than taken away.

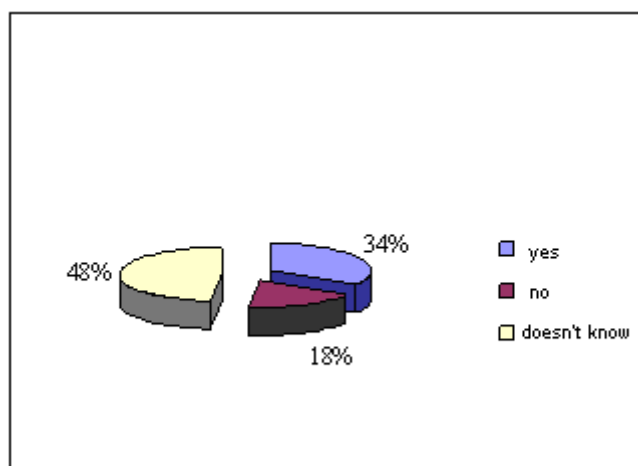
The 2008 data aren't available yet due to internal structure reorganization of the association.

### ➤ Prevention of HIV/hepatitis in prison

In Belgium, the infectious diseases matter in prison, as well as the other health care services, is taken care of by the Justice Ministry. Health in prison is thus rather contemplated from a security point of view. Moreover, the harm reduction activities are often perceived as a drug use incentive by the prison staff (Todts, Glibert, Van Malderen, Van Huyck, 2009).

### **Access to condoms**

In the 2008 Belgian prisons study (Todts et al., 2009); the detainees were asked about their perception of condoms availability.



**Figure 6:** Perceived access to condoms via the prison medical service, Belgian prisons, 2008

Almost half of the interviewees didn't know they could ask for condoms at the prison medical service and almost 20% thought there were no condoms available at the infirmary. In total, there are thus 66.5% of the detainees who potentially won't try to get condoms at the infirmary.

However, it seems important to point out that in 2008; some prisons didn't have available condoms and lubricant because they were supposed to buy these in local pharmacies, making the prices unaffordable. In 2009, a sleeve with a condom and lubricant was elaborated by the health education Service in Huy in collaboration with the Justice Ministry. This sleeve is now available in all infirmaries.

### **Access to substitution treatment**

Even if it is possible to have a substitution treatment in prison nowadays, 18.5% of the detainees declared having been obliged to quit their treatment because of the medical team prescriptions and 24.1% declared having been obliged to progressively reduce it.

## **Access to injecting material**

Injecting drug use in prison isn't only performed by injecting drug users outside prisons: because the drug prices are too high inside prison, some detainees choose to inject available products in order to "make them profitable as much as possible".

Moreover, injecting in prison is a clandestine practice, which makes the users even more vulnerable (use of old syringes, sharing of the material...).

## **Access to screening**

Detainees have the right to ask for AIDS and hepatitis screening in prison. Nevertheless, detainees don't have access to that information and consequently don't get screened.

## **Access to information**

Few detainees have access to the informative leaflet « Vogue la galère » (see 3.2.a). Paradoxically, the persons who declared having received it are the ones taking more risks (tattoo, piercings, prostitution...). One possible explanation is that the detainees taking more risks are particularly interested in information about health in prison. Another hypothesis is that the medical team tends to distribute these leaflets to people who are known for taking risks.

### **7.2.b Counselling and testing**

In **Flanders**, drug users have many places to be tested for infectious diseases. The screenings (HIV, HCV, and HBV) are mostly offered in outpatient and inpatient treatment centers. For TBC-screening, there is cooperation between the MSOC's and the VRGT (Flemish association for respiratory health and prevention of tuberculosis) (Windelinckx, 2009)

In **Belgium**, treatment of hepatitis C infection costs the patient who has no medical insurance about 1700 Euro per month. If the patient has a social insurance it costs him EUR 30.

The criteria for reimbursement of the hepatitis C treatment by the social security were revised in 2004. They haven't changed since then.

## **7.3. Responses to other health correlates among drug users**

### **7.3.a Psychiatric co-morbidity**

The project "Effectiveness of inpatient treatment programs for dually diagnosed patients"<sup>22</sup> (funded by the federal authorities) examined the functioning of dually diagnosed patients with coexisting severe psychotic and substance use disorder.

Sixteen dually diagnosed patients participated in a long-term residential treatment : they were examined at the beginning of the treatment and three month afterwards.

After three months, the assessment showed that the psychotic symptoms became less significant whereas the scores on the Addiction Severity Index showed that the substance use did not change (although, according to the Drug use Scale, the cannabis use might diminish).

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<sup>22</sup> Results of the first phase of this research are available at <http://www.belspo.be/belspo/fedra/proj.asp?l=fr&COD=DR/08>

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

### 7.3.b Somatic co-morbidity

In the MSOC in Ghent every new client is still screened for HIV and hepatitis B and C (Swinnen, personal communication). With hepatitis B seronegative persons the MSOC starts an active immunisation. Since the start of this immunisation they managed to decrease the active hepatitis B prevalence and incidence in their population.

Hepatitis C seropositive persons are referred to Ghent university hospital if eligible for therapy. HIV-positives are also referred to Ghent university hospital.

### 7.3.c Driving accidents related to drug use

Driving under the influence of drugs is specified in a law other than the Drug law. This involves the law of 16 March 1968, also referred to as the Road Traffic law, which makes it possible to treat drivers who are found to have certain illegal drugs in the body in the same way as persons who drive under the influence of alcohol. This involves the following illegal drugs: cannabis, amphetamines, XTC, methamphetamines, heroin/opiates and cocaine.

For the sentencing of driving under the influence of drugs, a zero tolerance approach is opted for (as opposed to alcohol where a specific percentage is allowed in the blood). As soon as the presence of illegal drugs is observed in the body, motoring performance is punished, regardless of the substance content.

When the police records such a case, after completing standard testing and taking a urine and/or blood sample, they impose a 12-hour driving ban on the driver, taking effect from the time of the finding (which is twice as long as the ban for driving under the influence of alcohol). The driving ban is only lifted after a new test is administered. If the latter is negative, the driving ban is lifted. If it is still positive, the driving ban will be extended each time for a period of 6 hours and each time accompanied by a police report.

As of 1 September 2007, persons (who have been the holder of a driving licence B for less than 2 years), caught while driving a motor vehicle under the influence of alcohol and/or drugs, will be punished more severely as a result of the law of 21 April 2007<sup>23</sup>. The judge is to pronounce the dissolution of the right to drive and make the restoration of the right to drive at least dependent upon the successful completion of theoretical and practical tests.

### 7.3.d Pregnancies and children born to drug users

In the **Flemish Community**, the Tipi-project (De Kiem, therapeutic community) provides housing and care for woman, man and their children in separate studios. The mean duration of a stay in the Tipi is approximately one year.

The specific counseling at the Tipi consists of a weekly group session. During this gathering, participants extensively speak about topics concerning the evolution of the children, the planning and organization of the household and the feelings of parenthood. Besides, separate trainings concerning specific topics are organized on a regular basis. Each mother makes up a plan regarding the education of her child(ren), this plan is regularly evaluated and adjusted. Individual educational support and video-interaction-counseling are provided.

Additional to the specific counseling at the Tipi, the mothers work on their drug dependence and drug-related problems in the therapeutic community.

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<sup>23</sup> Law of 21 April 2007 amending the coordinated laws of 16 March 1968 on the road traffic policy.

Table 30 shows a survey on the amount of specific registrations in function of the Tipi

**Table 30:** Number and percentages of admissions in therapeutic community and Tipi, 1998-2007

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
General	208	195	208	200	241	216	174	228	226	267
Tipi	15	22	17	19	26	19	16	13	17	30
%	7.2	11.3	8.2	9.5	10.8	8.8	9.2	5.7	7.5	11.2

In the **French Community**, the twin organizations “Parentalité-Addiction” and “Alizés” ensure some prevention missions for pregnant drug users and their new-born babies, sometimes as well as for their older children.

Beyond these, they also offer medical care, facilitated by their location (in a public hospital). This in collaboration with the following services: obstetrics; antenatal clinic; neonatal clinic; paediatrics and maternity.

Every patient receives a balance sheet of his psychological and medical problems and is oriented towards the most accurate follow-up possible. The psychiatric follow-ups are completed, if necessary, by a pharmacological treatment fitting the particular conditions of the pregnancy. A substitution treatment might be applied or a withdrawal might be completed.

A psychological follow-up aims at establishing a profitable relationship between parents and children. It begins before the birth but goes on after. These interviews also allow measuring the pertinence of the parents care for their child and of the parental skills, in order to determine a framework of departure.

A psychologist also ensures a follow-up of older children. It offers them a place of expression where they can look back on their experience. Beyond the psychological follow-up, the psychologist can also propose some specific tests such as psychomotor balance sheet. These can feed the reflection on the framework of departure, by bringing some objective elements as to the evolution of the child. A specific test is applied in order to involve the parents in the process (otherwise they sometimes have the feeling that the psychologist intervention is meant to control them): the “Brunet-Lerine” test. It rates the evolution of the baby at 3, 6 and 12 months with an objective methodology, and helps the parents to perceive what makes their baby feel comfortable, which games they can initiate with him, his abilities or difficulties, his evolution.

Sometimes, though, the interviews with the psychologist amount to bare guidance meetings, where some matters are discussed, such as the markers and framework a parent can give to secure the evolution of the child.

The paediatrician ensures a weekly outpatient follow-up when the parents go back home with their child. She can also still be the reference paediatrician in case the child is placed in a specialized nursery. She ensures the classical follow-up (vaccines, weighing...) but also the follow-up of the baby’s withdrawal if necessary.

### 7.3.e Other health consequences reduction activities

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 2009).

In June 2002, a first “charter of well-being in recreational settings” was signed in **Brussels** by owners of discotheques (Minister Gosuin 2002). Several places agreed on offering a series of services (free water, condoms...) and were gathered under the “Quality nights” label. These places endorsed the charter under a variety of qualifying criteria.

Recent important evolutions of that label should be mentioned:

- Inventory and control of the criteria: The Modus Fiesta harm reduction mobile team verified the effectiveness of the qualifying criteria in the 11 labelled nightlife places, between February and June 2008. 9 announced controls were completed. These verifications are a guarantee of quality and credibility. The first verification is announced, while the second is not. 7 unannounced controls were achieved after a first control and a feed-back to the labelled places. Here is a table with the results of those:

**Table 31: Criteria controls’ results of the Quality nights places, Brussels, 2008**

1st verification (9 places)			2nd verification (7 places)		
Criteria	Effectiveness	Visibility		Effectiveness	Visibility
Water	89%	55%	Water	100%	57%
Condoms	78%	29%	Condoms	86%	86%
Ear stoppers	89%	41%	Ear stoppers	86%	86%
Filled flyers display	78%	87%	Filled flyers display	72%	92%

As to the training of the crews, 10 out of the 11 places have followed it.

- Process evaluation: The “Local Centre for Health Promotion” (CLPS), is conducting a process evaluation of the label setting up, since Augustus 2008. It is a qualitative evaluation, realised with the managers of the clubs, in order to receive their opinions on what is feasible or not, and to understand what functions or malfunctions, for what reason and how to solve it. That evaluation is qualitative and is not meant as a control. On one hand, it is made of an individual interview that must enlighten the effective or non-effective processes; on the other hand, it is completed by a focus-group led with the crew members who followed the training.

- Recruiting of new clubs/places: Two new places were integrated to the labelled pool and have signed the charter, in September 2008. One of them joined the list of labelled places which host a stand of harm reduction at least twice a year. In these stands, free information and counselling on drugs and their uses, as well as on STI can be found. The stands are animated by peer-to-peer actors trained in harm reduction. The stands find themselves in passage ways (entry halls, corridors).

- Updating of existing communication and information tools: All the existing tools have been updated (flyers display; website [www.qualitynights.be](http://www.qualitynights.be) ; a newsletter addressed to more than 200 persons, inscribed during the animations or “online”; promotional ear stoppers; t-shirts; a page on the community network “myspace”: <http://www.myspace.com/labelqualitynights>; etc.

- Creation of new information and communication tools: At its beginning, the communication on the label was mainly reactive, responding to the demands of the press and of actors of the specialized youth help (articles on the website of [www.student.be](http://www.student.be) :



<http://www.student.be/fr/node/29945> ; on the site of the “white night”:  
<http://www.nuitblanchebrussels.be/spip.php?page=bycat&ida=217&lang=fr>, etc.

In the meantime, new tools were elaborated:

- A page on the social network “facebook”:  
<http://www.facebook.com/group.php?gid=13543273053>
- A leaflet targeting the parents of partygoers (October 2008). It aims at promoting the label and the labelled places by the adult-relays (parents and educators), influent in the choice of nightlife places. It was spread towards the target publics, among which parents and educators, 23 youth houses in Brussels, 28 family plannings in Brussels, websites of parents’ federations, etc.
- Stickers than can be put anywhere (car, agenda, etc.).
- A metal panel to be screwed at the entry of the labelled place. 7 out of 10 places accepted to use it.
- A city map is being realised at the time being. It aims at helping the partygoer to find useful information geographically placed, for example in terms of health: labelled places; family planning; STI screening places; SOS doctors, etc. More “lifestyle” information appears such as “hype” music retailers, etc.

In general, the label and its services seem to meet a certain success by the public. On the other hand, responsible of nightlife places need to be regularly re-motivated, since their adherence to the project does not quite persist by itself.

## CHAPTER 8.

### Social Correlates and social reintegration

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Few quantitative studies focusing specifically on drug-related social consequences exist. Qualitative, ethnographic research is more common. However, partial data are available from active organizations on the field.

#### 8.1. Social exclusion and drug use

##### 8.1.a Social exclusion among drug users

###### ➤ Homelessness

In **Belgium**, there is no national registration system of homeless people and no national recent study was carried out on the particular issue of drug use among this specific group. A large variety of welfare settings exist for homeless people, e.g. night shelters, day centres and emergency centres.

In the **Flemish Community**, the registration system 'Tellus', operated by the CAW (centers for general welfare care) provided a profile of the homeless. In 2008, 4588 clients were registered at their admission identifying any addiction problem (Mendonck, 2009). Most of these homeless drug users, the majority of which is unemployed, are accommodated in residential centers.

In the **French Community**, the organization Dune (harm reduction), is namely active with squatters. Dune establishes cooperation with, on the one hand the squat movement and on the other hand the ministry of housing crisis. The organization's philosophy is to develop a specific knowledge, of which the specificity is to intervene "in context": the worker inserts himself in the life environment of the drug user, and *then* acts.

Another organisation, "Carolo rue" (Charleroi), also invests namely squats as a place of action to reach a weakened public. "Carolo Rue" targets "every person who invested the street as a place of living, and especially marginalized legal and illegal drug users in trouble".

As to social correlates and consequences, the organization reports that the main problem faced by the targeted population (socially weakened people) are problems related to drug use (77%).

###### ➤ School drop out

The associations « Canal J » and « Citadelle » are still leading a common project targeting among others school drop-outs. It is developed in various environments and, among them; specialised youth help institutions and schools.

In the school environment, one line of intervention consists in improving the level of consciousness of the causes and consequences of the consumptions, and to find alternatives to that consumption.

###### ➤ Social networks

The NGO Modus Vivendi is still carrying on a local reception point for drug users. Its whole action points towards weakened people, whatever the elements of their life that can

be described as “weakened” (economic, social, psychological, sanitarian...). Nonetheless, in the facts, more and more socially weakened people (e.g. homeless) have become regular “clients” of that reception point, taking part especially to cultural activities such as role playing.

### **8.1.b Drug use among socially excluded groups**

In her latest research, Pascale Jamouille (Jamouille, 2009), showed how disadvantaged minorities living in a ghetto can be driven into risky behaviours such as drugs misuse.

In the customary societies, the teen boys are separated from the feminine world at once, to enter the world of men. The father plays a small role before puberty, but is a central actor of that passage. The author shows how de-structured, mono-parental families can lack that relay and cause the boys to seek substitutes to it, in vain.

In the ghetto “hoods”, the boys make their “corner” a male territory that they are ready to defend. In weakened mono-parental families (families with the sole mother), those boys can suffer a lack of self-esteem due to the departure of the father. They then occasionally turn that failure into active risky behaviours (delinquency, drug use). And this as easier as they have a smaller role “at home”, unable of making themselves recognized as “the man”, and lacking a masculine ally (the father) to do so.

The young boys of such neighbourhoods can be quite desperate, thinking that they don't have the power to determine their own fate. They then get easily used to live in a “modified consciousness state” that can linger even after school-age, when these children become fathers on their turn. At first cut from the school world, then from the culture of their parents, then from the professional world and from the culture of the land where they grew up, these men can sometimes go on anesthetizing themselves with drugs.

The migrants in difficulties with themselves and their families seldom express their suffering and hardly seek help or the intervention of mental health services. Life in the cafés is easy an outlet, where money games too often structure the schedule, eating away the public welfare allocation.

One of the outlet ways evoked by the author is the opening up of typical ghetto mono-cultural schools. The lack of variety in the origins of the pupils in these neighbourhoods lowers the chances of mixing of cultures, and of finding “new ways” between ancient and local traditions. Besides, these schools are of lower level than average, which makes the pupils vulnerable, once in the professional world. They then go and work rather in the local non-formal sectors and in ethnic networks, which, as a snowball effect, again lowers the chances of enlarging their horizons.

Another conflict erupts in the life of these “sons of migrants”: the tension between life in nuclear family or in community clusters. The tutorship of the elder goes again the desire of emancipation of the youngsters, especially as the weakened parents often promote set up weddings (sometimes between “cousins”), while the youngsters aspire to more love and liberty.

The body becomes the primary field of expression of these frustrations, which put the health care actions in first line of the trans-cultural work. One essential proposal would be to offer these youngsters spaces of expression of their desires and dreams, in respect of the inherited tradition, and of their own projection in the future. These transition spaces of creativity should function on the community mode, rather than on the individual one, since individual help seems to be seldom sought by them.

## 8.2. Social reintegration

### 8.2.a Housing

Housing is a regional matter but at the federal level, it is under the competence of the Minister of social integration.

In 2005, an inter-ministerial conference was held to discuss housing problems. Work groups were created: one of these tackled the homelessness issue and the creation of new kinds of « solidarity housing ». In order to examine this particular topic, a study about solidarity housing was carried out (Mignolet & al 2007)<sup>24</sup>: in addition to the existing registered type of solidarity housing, other kinds of unofficial housing have been developing (e.g. collective housing for socially disadvantaged people). These types of housing might be useful and therefore shouldn't be penalised by the authorities.

In the **French Community**, the Actolux organisation holds housing activities. It provides individual accompaniment to drug users aiming at finding a place to live (accompaniment to the Public Centre for Social Welfare to ensure a good understanding of the rights and obligations of the person; training the person to phone contacts and prepare future meetings with landlords ...)

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 welfare care) 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 (reception centres, night-shelters, accompanied living).

### 8.2.b Education, training

In the **French Community**, the “support points” created in the framework of the draft circular on prevention of drug addiction at school have started working in September 2007.

They are entrusted with three missions:

*Informing the schools, the Psychological-medical-social Centres (CPMS) and the services of Health promotion at school (SPSE).*

These schools and structures can apply to the supports points if:

- they need a specialized organization to come and propose an activity, to prepare a lesson, to build a program of prevention of drug abuse, etc.;
- they seek inspiration in some examples of activities led in schools by the specialized organizations;
- they need some pedagogic tools in prevention of drug abuse in the school environment;
- They need any other information related to drug abuse in the school environment.

*Create or reinforce networks.*

The “support point” of one zone is entrusted to contact the schools, CPMS and SPSE of the same zone to create a specific network on drug-addiction in the school environment by introducing them to specialized structures in the field of drug (ab)use.

The purposes of this network building are:

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<sup>24</sup> An extended summary of the research is given on the web site: <http://www.politiquedesgrandesvilles.be>

- to lead, with the concerned operators, a dialogue and a reflexion on a possible common philosophy and ethics of intervention, but with respect for the specificity of each one;
- to imagine common solutions to improve the conditions of intervention in the school environment;
- to exchange “good practices” between school actors on one hand; school actors and specialized actors of the drug-field on the other hand.

*Spreading information.*

Each “support point” must realise an appropriate medium (cd-rom, Dvd, directory...) targeting the school actors and listing the specialized organizations.

Each one must also offer a website proposing an introduction to the project, its purposes, the services planned, the partners, the resources, links towards the other 8 “support points”, etc.

### **8.2.c Employment**

In the **Flemish Community**, the social workplace from ‘De Sleutel’ offers a job to (ex) users. Working in the social workplace gives (ex) users the opportunity to reintegrate slowly in the normal structures of life. Meanwhile the clients are guided in their personal problems like dependence, financial problems and relational problems.

The ‘Smid-project’ (cooperation social reintegration drug addicts) in the province of Limburg is a cooperation between CAD Limburg and Katarsis. 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 moving between treatment and employment is realised.

The centre for mental health care in Turnhout has a project for job course accompaniment. This project focuses on (ex) users who experience problems in finding or keeping a job.

The Centre for Mental Health (CSM) related to the Centre for Public Welfare (CPAS) of Charleroi (**French Community**) led an action in the framework of training and socio-professional insertion activities in the town of Gosselies (please refer to last national report for further detail).

“Actolux” (accommodation and help to drug addicted persons) also continued to develop training and re-insertion activities.

## CHAPTER 9.

### Drug-related crime, prevention of drug related crime and, prison

In most of the drug-law offences registered by the Police, cannabis remains the most commonly involved substance. Moreover, in prison, around a third of the detainees declared having experienced drug-related problems during their current detention.

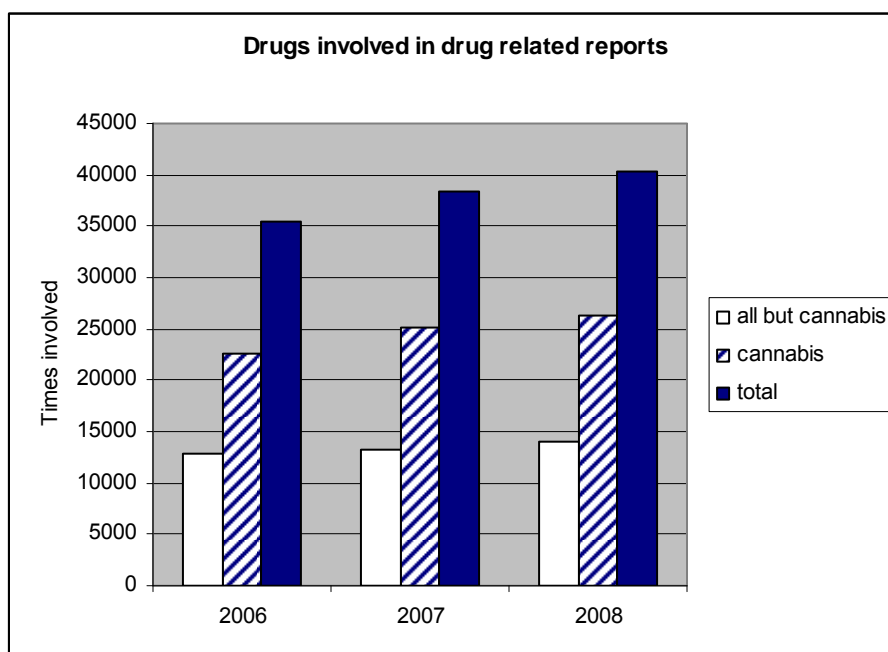
#### 9.1. Drug-related Crime

##### 9.1.a Drug law offences

In 2008, 40,357 drug related reports (use, possession, traffic...) were registered by police services (Dommicent, personal communication).

Persons who were intercepted were not arrested (i.e. held in custody) when the person was in possession of a minor quantity of drugs (for example, less than 3 grams of marihuana).

Cannabis remains the most commonly involved drug in all drug related reports throughout the years (Figure 7). In a second and third place we have cocaine and heroin. This remains the same throughout the different years (standard table 11, 2009; Dommicent, personal communication).



**Figure 7:** Number of drug-related reports, Belgium, 2006-2008, standard table 11, 2009 (Dommicent, personal communication)

If the evolution of the number of police reports related to illicit drugs is an indicator of the activity on the illicit drug market, it is also, and far better, one for the police services activity and efforts to control the situation. In addition, there is of course a hidden population but the way it could affect the interpretation of the available data is unknown.

For further insight on this topic, please refer to Chapter 11 of last year's national report.

### 9.1.b Other drug related crime

In 2004, chapter 13 of the national report was dedicated to “public nuisance” and chapter 1.4 provided results of the study “drugs and nuisances <sup>25</sup>”(Ponsaers & al. 2005). This information will not be repeated in this year’s report. Moreover, for more details on this topic, please refer to Chapter 11 of this report.

#### ➤ Drug related crime BELSPO study

A study project of the Belgian Science Policy (BELSPO) about drug related crime has been carried out between October 2006 and December 2008 by the universities of Ghent (UGent) and Liège (ULg).

The project aimed at developing a method that allows regular measurement of the nature and scope of drug related crime in Belgium. In order to achieve that goal, 1,435 police files were studied throughout ten research locations. The results showed that 13.6% of the property, violent and sexual crimes were drug-related: 19.9% of the studied property offences, 7.3% of the studied violent crimes offences and 14.2% of the sexual offences could be classified as drug-related. Moreover, cannabis followed by heroin were the most commonly quoted product in the researched files.

More information on this study project can be found on the BELSPO website<sup>26</sup>.

### 9.2. Prevention of drug related crime

The research team of the drug related crime BELSPO project (aforementioned), made the following related policy recommendations:

- Drug treatment should take place in different lifestyle domains
- A more integrated and comprehensive drug policy is needed
- Stressing the need for alcohol and drug tests on the roads
- Optimizing referrals to drug treatment services
- Optimizing the drug treatment facilities in prison
- Working on the expansion of social services and psychological counselling for prostitutes

### 9.3. Interventions in the criminal justice system

#### 9.3.a Alternatives to prison

Different laws are used to organise alternatives to prison. With a few exceptions, none of these are specifically targeted to drug users. The Belgian drug law was thoroughly reworked in 2003 (4/04/2003). As a consequence, the field of application for (conditional) probation is enlarged, allowing for probation, regardless of the criminal record of the concerned person and even in the case of retail sale to support personal use, be it for (young) people aged 16 and older (Vander Laenen and Dhont 2005).

Emphasis is now on a primordial orientation toward rehabilitation, with prison remaining as an ultimate remedy.

Depending on the stage of the case, there are different possible alternatives to a prison sentence: an amicable settlement, conditional probation, mediation, conditional release

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<sup>25</sup> An extended summary of the research is given on the web site:

<http://www.belspo.be/belspo/fedra/prog.asp?l=fr&COD=DR>

<sup>26</sup> [http://www.belspo.be/belspo/home/publ/pub\\_ostc/Drug/rDR30r\\_en.pdf](http://www.belspo.be/belspo/home/publ/pub_ostc/Drug/rDR30r_en.pdf)

from remand, suspended sentence, suspended conviction, conditional release (or “parole”) and electronic surveillance. Sometimes therapy is part of the condition(s). Justice assistants exercise control over suspects and convicts in different alternative regimes.

### **9.3.b Other interventions in the criminal justice system**

Two circular letters (one of the Minister of Justice, one of the Board of the Attorneys General) concerning disciplinary sanctions and the criminal prosecution of drug-related offences at the entrance and in Belgian prisons, are put into force since 16 February 2009. These two circular letters are the result of a multidisciplinary working group authorised by the Central Steering Committee of Drug Policy. This working group has analysed the existing methods and different practices concerning this subject in prisons and within the Public Prosecutor in the 27 judicial districts in Belgium.

The main objective was to deal with this type of offences in a more systematic, uniform, and coherent manner.

An additional, important objective is to carry out an unequivocal message with regard to those for whom this regulation is applicable. These circular letters reflect the determination of the prison administration and the judicial authorities to generally prosecute and punish offences against the drug legislation and in particular offences related to drug dealing.

The regional drug coordinators assist the prisons with the implementation of these circular letters.

### **9.4. Drug use and problem drug use in prisons**

The study “Drug use in Belgian prisons. Monitoring of health risks.” performed every two years in Belgian prisons since 2006 (Todts et al. 2007, see 2.3.d) includes various sets of items investigating the effects of drug use on prison life. The study was thus repeated in 2008 (Todts, Glibert, Van Malderen, Saliez, Hogge, & Van Huyck, 2009).

All the respondents (using drugs or not) were asked if they’ve ever experienced problems with drug users during their current detention. 21.5% of the 2006 sample said they had indeed experienced such problems. The 2008 follow-up study shows an increase: 29.2% of all respondents declared having experienced such problems.

Table 32 makes an inventory of the kind of problems prisoners experience for both research periods. Since more than one answer was possible, the total exceeds 100 %. Most of the respondents refer to the category “other problems”. Different kinds of drug-related problems and nuisance are experienced. Examples are nuisance caused by the smell of drugs (smoking cannabis), ‘community problems’, ‘negative atmosphere’, ‘disturbing behaviour’, boisterous behaviour’, ‘disputes’

Several respondents also indicate that ‘demand for drugs’ or ‘demand to deal drugs’ is experienced as problems resulting from the drug scene in prison. Finally, some respondents mention that the presence of drugs in prison is ‘confronting’ and there is ‘fear of relapse’.

In 2008, 32.7% of the problems experienced are related to the pressure to consume drugs. In 2006, this percentage was of 29.4%.



**Table 32:** Experienced drug-related problems in Belgian prisons, 2006-2008

NATURE OF THE PROBLEM	2006 (N=194) %	2008 (N=315) %
I was physically threatened	24.2%	18.1%
I was robbed	22.2%	16.2%
I was pressured to give up money or goods	16.0%	11.1%
I was pressured to use drugs (but refused)	13.4%	20.3%
I was pressured to use drugs (and gave in)	8.3%	12.4%
I was forced to give up my medication	10.8%	4.8%
Other problems	35.6%	52.1%

### 9.5. Responses to drug-related health issues in prison

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

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

Two drug policy coordinators are also active in prisons service administration: one for the Flemish Community and the other one for the French Community. These two professionals are currently helping to prepare the implementation of a central intake unit in all Belgian prisons. The aim of that unit is to improve the through-care for prisoners. In this project, prison staff and specialised drug workers cooperate to link prisoners with treatment upon release.

In the **Flemish Community**, a structured cooperation ("strategisch plan") between the prison service and the complete range of services offered by the Flemish government (culture, education, psychosocial treatment, job training and assistance in procuring a job) has been initiated in a pilot region.

Moreover, in 2008, all Flemish prisons had a multi-disciplinary training in implementing a alcohol & drug-policy in prisons

The « Medical Centre Enaden » is active with (ex-) prisoners in **Brussels**: patients in penitentiary vacation preparing their liberation; in a semi-detention scheme; in alternative top custody; parole prisoners or prisoners on electronic bracelet.

Nonetheless, the penal policies seem to send ever more new populations to that type of centre. For example, the "tolerance zero" for marital violence often imposes a follow-up under legal constraint, some of them not justified. Others come for delinquent facts with

violence. But in both cases, the drug consumption seldom reveals to be the target symptom to be focused on. The drug consumption itself seldom falls into an addiction.

It appears that in that field, the rise of social splits worsens the use of violence, the latter seeming to be, at a certain point and for some persons, the ultimate recourse. Nonetheless, the apprehension of the relation that the patient has established with the product, and beyond, the other responses that he brought to his problems up to that point, can bring some sizeable therapeutic effects.

In general, it seems that the awareness of the dangers related to some types of consumptions leads the patients to consult spontaneously. Moreover, they take the “opportunity” of the pressure they receive from their relatives, or even from the legal constraint, to rethink the way they lead their existence.

#### ➤ **Community Links**

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

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

Moreover, in 2006, a new project aiming at a better drug policy implementation in prisons started with the VAD collaboration (financed by the Federal and Regional government). A first part of this project, the composition of a course in order to increase the knowledge concerning drugs of the local experts’ commission leaders, was completed in 2006. In 2007, trainings for other experts’ commission were implemented. The second part of the project, the development of a synopsis for the local experts’ commissions in order to get to a concrete worked out policy, started in 2007. During 2007-2008, almost all prisons in the Dutch speaking part of Belgium have taken the course composed in this project. This year, 2009, the course is organised for the remaining prisons. In the autumn of 2009 this drug course will be part of the permanent offer of trainings and courses organised by the Federal Department of Justice for its personnel.

### **9.5.a Drug treatment (incl. number of prisoners receiving opioid substitution treatment)**

#### ➤ **Drug free sections**

A drug free, therapeutic community-like program (B.Leave-project) exists in the prison of Ruiselede since 1995. A training program for guards, prison staff and prisoners has been realised. It focuses on drug use, HIV, hepatitis...

At the autumn of 2009, a drug free section is planned to open in the prison of Bruges. A drug-free section is also operational in the French speaking part of Belgium (Verviers prison).

#### ➤ **Substitution treatment**

The Federal Department of Justice, Prison Health Service, provides health care in prisons. GPs or psychiatrists may choose or reject available therapies (Stöver et al. 2004). Substitution treatment is available in prisons. Although the possibilities were rather limited, there is more and more acceptance of substitution treatment (including maintenance treatment) in the field.

Maintenance is now recommended for all prisoners who enter the prison while already in treatment, and who won't stay longer than one year. In case of longer penalties, trying tapering is recommended. Initiation of substitution treatment is also possible.

The 2006 study in Belgian prisons (Todts et al. 2007) dealt also with the treatment issue. 9.6% of all respondents (N=902) had a history of drug use and were in substitution treatment (methadone or buprenorphine) when they started their current detention. One third of the considered group (35.6%) could maintain the treatment. A follow-up study in 2008 shows a similar result (Todts, Glibert, Van Malderen, Saliez, Hogge, & Van Huyck 2009). 10.0% of the respondents who have a history of drug use were in substitution treatment (methadone or buprenorphine) when they started their current detention. 41.7% of the considered group could maintain the treatment.

Overall, for both research periods compared, about 10% of all respondents say that they followed a substitution programme before they went to prison, but only in 6,6% of the cases medication is actually prescribed in prison, a maintenance programme (4,2%) or tapering (2,4%). For the prescription of methadone or buprenorphine a technical protocol has to be taken into account.

### **9.5.b Prevention and reduction of drug related harm**

#### **➤ Harm reduction measures**

Educational information material developed for outside prison can be distributed in prisons. In most of them, when entering, the detainees receive a package including several information materials on HIV, hepatitis, tuberculosis and harm reduction linked to drug use. However, there is no strategy on informing prisoners of STDs and drug consumption. Activities of this type exist in certain institutions, sometimes under the supervision of an external NGO. The availability of information material depends on each individual prison and its medical service and/or on the possible presence of an NGO (e.g. "Conseil Education de Huy" which places material at the disposal of the prisoners and gives various information and advices).

Moreover, specific information material on AIDS and hepatitis prevention for drug users in prison has been developed by NGOs in coordination with health services of the penitentiary administration of the Federal Department of Justice and has been widely distributed in prisons<sup>27</sup>. A second edition has been developed, in 2000 including a specific chapter for women. This version has been translated in Dutch. This information booklet is currently being updated in order to distribute the new version in Belgian prisons.

The condoms and lubricants distribution is also possibly done via the medical departments. Condoms might be available in prison canteens, as well as in the medical services, where they can be obtained for free. Condoms are also available free of charge in the rooms for conjugal visits. In practice, the canteens do not have their own stocks but have to procure them on demand at the local pharmacy. This expensive and hardly discreet mode of distribution actually limits accessibility. In the French Community, a specific packaging has therefore been developed. Each packaging is composed of one condom and one attached lubricant. Different alternative ways of distributing have been studied according to each prison. In 2009, the promotion of this packaging also started in prisons situated in the Dutch speaking part of Belgium.

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

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<sup>27</sup> « Vogue la Galère » Modus Vivendi Question santé 1998.

« Wat als je binnen zit? » Free Clinic 2000.

There is no needle exchange programme in prison.

A new protocol for the detection of viral infections and for the treatment of hepatitis C started in 2004.

Prison nurses have been trained on HIV, and hepatitis prevention. Managing HIV and hepatitis risks is part of the basic training of every prison worker.

In a few prisons, there are specific follow-up in service training sessions on harm reduction organised for guards. However these activities are limited to the French-speaking prisons, as this training is an initiative of the French Community government

#### **9.5.c Prevention, treatment and care of infectious diseases**

No additional information is available on prevention, treatment and care of infectious diseases.

#### **9.5.d Prevention of overdose-risk upon prison release**

No information on prevention of overdose-risk upon prison release is available.

#### **9.6. Reintegration of drug users after release from prison**

No information on reintegration of drug users after release from prison is available

## CHAPTER 10.

### Drug Markets

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The two main produced drugs in Belgium are cannabis and synthetic drugs: that production is meant for national and foreign market. A large variety of drugs are also imported in the country. In 2008, the drug retail prices seemed to remain rather stable. When taking a closer look at the composition of the seized drugs, one remarkable change concerns the MDMA tablets concentration: between 2006 and 2008, the analyzed tablets' concentration tripled.

#### 10.1. Availability and supply

##### 10.1.a Perceived availability of drugs, exposure, access to drugs

###### ➤ General population

In 2003-2004, a study was initiated by a provincial organisation on e.g. health, health representations and health promotion in the Province of Hainaut (**French Community**) (Observatoire de la Santé du Hainaut (OSH)). Exposure to and/or experimentation of drugs among youngsters was surveyed (please refer to previous reports for further details).

This study hasn't been repeated since 2004.

###### ➤ Schools

The new questionnaire of the **Flemish** student survey in secondary schools (see 2.2.c) contains a question about the perceived availability of cannabis and of other illegal drugs.

38.8% of all students assume that they could easily get cannabis and 28.6% assumes the same of other illegal drugs. Most of the youngsters who use cannabis / other illegal drugs (at least a year) responded positively to this question whilst a quarter of the students who never used them assume that they could get cannabis (26.1%) or other illegal drugs (24.5%).

Perceived availability is higher among boys than among girls. This difference has only occurs between boys and girls who never used cannabis / other illegal drugs respectively.

##### 10.1.b Drugs origin: national production versus imported

Two different kinds of drugs are produced in Belgium: on the one hand, cannabis (marijuana), and on the other hand, synthetic drugs (mainly XTC and amphetamines). This production isn't only meant for the drug users in the country but it is also exported to other countries, in Europe and in the rest of the world.

The drugs that are imported in Belgium are all sorts of drugs. Notwithstanding the local marihuana, XTC and amphetamines production, these drugs are also imported in the country.

##### 10.1.c Trafficking patterns, national and international flows, routes, modi operandi; and organisation of domestic drug markets

When taking a look at drug trafficking within the borders of Belgium (for example: someone who lives on the coast and who buys drugs in Antwerp), we notice that drug transports (especially the small amounts) are often combined. When searching for a vehicle, police can often confiscate some marihuana, hash and mushrooms. Also the

combination of cocaine and heroin is apparent. This isn't quite surprising because drug users might use different kinds of drugs at the same time. When they are checked on drugs, police finds them.

➤ **Heroin**

The trafficking of heroin to, through and from Belgium is not very clear. Latest information from France suggests that Belgium is a main source country for heroin in France. A great amount of the heroin seized in France has travelled through Belgium according to their information. The heroin on its route to Belgium comes from Turkey or Afghanistan and is smuggled to Germany or The Netherlands by means of vehicles. Also Italy and the Balkan countries are apparent in these smuggle routes. There are also indications that heroin is smuggled from Belgium towards the Scandinavian countries.

➤ **Cocaine**

The smuggling route via West-Africa isn't holding. In 2006 and 2007 we saw a real uprising of the smuggling of cocaine from South-America through West-Africa to Europe/Belgium. In 2008 these route wasn't used that often anymore. It seems the smugglers have turned again to the Dominican Republic and other Central-American States to provide Europe with cocaine. There is no clear explanation for this shift in routing.

Cocaine is mainly smuggled by air and sea. Sea transports contain large amounts of cocaine, which isn't abnormal because they can stock the cocaine in the sea containers. The air transports consist of couriers smuggling in corpore or in their luggage. Also post parcels are used to smuggle cocaine.

➤ **Cannabis**

Large-scale Moroccan hash importation in Belgium and the Netherlands is organized by Moroccan criminal groups. Products are transported by a variety of transports means (car, minibus, camper, coach, lorry and containers). The drugs come from Morocco and go through Spain and France. The so-called "go-fast", seen in France, is a still used smuggling method.

Last year we reported that police discovered more cannabis plantations. In 2008 we saw an even greater increase of the number of discovered cannabis plantations. These plantations keep spreading throughout Belgium. Some of these plantations are only discovered when a fire breaks out. This is an extremely dangerous situation because a lot of the plantations are located in common houses or apartments.

➤ **Synthetic drugs**

The number of discovered laboratories remains stable the last years. After the uprising at the end of the 90's we can say that the situation hasn't worsened. Still the problem is acute because of the dangers that are implied with drug laboratories (fires, explosions, damage to nature...), so awareness and good police research are required. The discovered drug laboratories show an increased professionalism and greater production capacity.

➤ **Precursors PMK and BMK**

Precursors PMK and BMK found in Belgian illegal laboratories don't come anymore from China. Indications show that Russia should be the replacement source country of precursors, although there is no hard evidence for this statement. Many chemical substances used in the production of synthetic drugs are easy to buy in Belgium as they could be used for legal applications. On the contrary, in The Netherlands some precursors are not freely available so Dutch traffickers cross the border to buy them in Belgium. Actions to inform chemical companies and distributing ones on the risk of chemical misuse have been carried-out by police services.

### ➤ **GHB**

GHB is also a popular drug. It seems to be produced at small scale in so-called “kitchen laboratories”. The making is very easy and can be found on the internet. Rumours in news papers suggest that GHB is becoming more and more popular and is more and more produced, even in alarming amounts. Police information shows there is a small increase, but not alarming.

## **10.2. Seizures**

### **10.2.a Quantities and numbers of seizures of all illicit drugs**

Large yearly variations exist in the quantities seized in Belgium. There is not always a clear-cut explanation for these yearly variations. One large seizure can for example influence the figures, as can certain international law enforcement actions or stock piling of drugs. The huge amount of seized hash in 2007 is explained by one huge seizure in the port of Antwerp.

### **10.2.b Quantities and number of seizures of precursor chemicals used in the manufacture of illicit drugs**

No information on quantities and number of seizures of precursor chemicals is available.

### **10.2.c Number of illicit laboratories and other production sites dismantled; and precise type of illicit drugs manufactured**

In 2008 six illicit synthetic drug laboratories were dismantled in Belgium. Four of them produced amphetamine, one produced XTC and the last one produced GHB. All these illicit synthetic drug laboratories were located in the North east part of the country. The number of discovered illicit synthetic drug laboratories remains stable for the last five years.

Also, there were 666 cannabis plantations dismantled in Belgium in 2008. These plantations were spread throughout the country. As already said this number keeps increasing. In 2007 police dismantles 466 cannabis plantations. In 2006 they dismantled only 248 cannabis plantations.

## **10.3 Price and purity**

### **10.3.a Price of illicit drugs at retail level**

Table 33 contains information on the prices of illegal substances collected by the police services for 2007 and 2008.

Comparing 2007 and 2008, the prices for all drugs remained rather stable, decreases and increases were small and the range between minimum and maximum prices considerable for all substances. Worth mentioning is the cocaine price: looking at these data it seems there is an end to the price drop of this drug.

**Table 33:** Mean price\* in Euros at street level of some illegal substances: Belgium, 2007-2008 (standard table 16, 2009)

<b>DRUG</b>	<b>2007</b>	<b>2008</b>
<b>Cannabis resin (per gram)</b>	6.53 (2-12)	7.35 (3-15)
<b>Herbal cannabis (per gram)</b>	5.97 (2-12.5)	6.98 (2.63-25)
<b>Heroin (type unspecified) (per gram)</b>	24.98 (10-60)	24.58 (5-50)
<b>Cocaine powder (per gram)</b>	48.23 (20-100)	49.28 (5-87)
<b>Amphetamines powder (per gram)</b>	10.52 (3-25)	7.61 (1.5-20.0)
<b>'XTC' (per tablet)</b>	4.01 (1-10)	3.62 (1.14-10.0)

\* Minimum and maximum price are given in parentheses.

In April and May 2009, a data collection about prices at street level of different drugs through outreach work and syringes exchange desks in the **French Community** has been settled through punctual ad-hoc survey.

The geographical coverage is local, including the French Community and Brussels. The sampling of associations is 4 for Brussels, 1 for Hainaut, 3 for Liege, 3 for Namur and 2 for Luxembourg. Note that no data was gathered from Walloon Brabant.

Prices are approximations, mainly estimated from non-weighted samples. The target public are mainly drug users met in the streets or at syringes exchange desks by social workers. For each association, information was collected among minimum 10 % of their public of drug users.

After having calculated the price for 1g of each product, the arithmetic mean of all the reported prices was computed, and we also reported the minimum and maximum. We have included in our calculations both the prices reported for large or small quantities purchased. This point may explain why the minimum and maximum reported prices are so far from each other and from the mean price. Another point that should be kept in mind is that the reported prices are not only related to drugs purchased on the street and in Belgium. Indeed, it seems that some users have reported the price of drugs purchased abroad (France, Luxembourg, Netherlands) or in Dutch coffee shops.



**Table 34:** Mean price in Euros at street level of some illegal substances: Belgium, 2005-2009 (standard table 16, 2009)

DRUG	2005	2006/7	2008	2009
<b>Cannabis resin (per gram)</b>	5.5 (2.8-10.0)	6.8 (1.5 – 20.0)	8.7 (0.6-16)	8.2 (1.5 – 35)
<b>Cannabis herb (per gram)</b>	5.7 (2.0-10.0)	6.3 (2.0-15.0)	9.2 (1-20)	8.1 (3 – 15)
<b>Heroin (per gram)</b>				
• <b>Brown</b>	28.7 (10.0-50.0)	33.2 (10.0 – 75.0)	24.6 (10 – 52)	26.4 (10 – 50)
• <b>White</b>	68.0 (44.0-230.0)	31.4 (15.0-70.0)	24.2 (20 – 30)	33.9 (12 – 80)
<b>Cocaine powder (per gram)</b>	50.5 (35.0-125.0)	48.4 (20.0-75.0)	49.9 (25 – 81)	53.0 (25 – 120)
<b>Crack (per gram)</b>	24.0 (3.0-45.0)	30.9 (5.0-60.0)	45.0 (5 – 70)	55.0 (40 – 60)
<b>Amphetamines powder (per gram)</b>	7.8 (1.0-12.0)	10.9 (5.0-30.0)	9.5 (3 – 20)	11.6 (2 – 40)
<b>'XTC' (per tablet)</b>	5.2 (3.0-10.0)	6.2 (1.0-20.0)	6.1 (2 – 20)	6.2 (1 – 25)
<b>LSD (per dose)</b>	8.8 (1.5-17.5)	8.9 (1.0-20.0)	10.5 (4 – 30)	9.5 (1 – 25)

According to these figures, prices seem to have fallen for the following substances in 2009: cannabis resin, cannabis herb, XTC and LSD. On the contrary, the prices of cocaine powder, crack, brown and white heroin and amphetamines powder have risen in 2009. In the street, products such as cannabis, heroin and cocaine are not often sold by weight but rather by instalment (10, 15, 20 or 50 euros).

#### ➤ **Cannabis**

The price of cannabis varies a lot according to quantity, quality, and place of purchasing. For example, cannabis is often less expensive in Dutch Coffee Shops, and much less when purchased in quantity (at least 100 grams) directly from the producers.

#### ➤ **Brown heroin**

Heroin is generally sold in the form of balls of 0.2 g or 0.3g.

Some respondents reported that the quality of heroin is not good and declining with years in Belgium. Indeed, respondents reported that the balls are a mix pure-cut of 1 / 1 in rare cases, and more often 3 / 5 or sometimes 1 / 4. Conversely, the price is relatively cheap.

In some regions, heroin is found more easily than other drugs.

#### ➤ **White heroin**

White heroin is almost not available in Belgium.

#### ➤ **Cocaine**

Cocaine is often sold per gram but can also be found in the form of balls of 0.2 g. Some consumers say that speed was sometimes sold for cocaine.

➤ **Crack**

Stone shaped crack is rarely sold in Belgium. Drug users usually prepare a smoke free-basing version themselves with cocaine and ammoniac.

➤ **Amphetamines**

Amphetamines are found more easily in the border areas with France.

➤ **Ecstasy pills**

The price varies a lot according to the quantity of pills, which explains why drug users often buy large quantities of XTC.

These pills are usually more expensive when bought in a festive place or at events.

➤ **LSD**

Comparatively to ecstasy pills, LSD is rarely consumed in the streets. But generally, LSD and XTC are more often used in night life settings (parties, clubs).

### 10.3.b Purity/potency of illicit drugs

Table 35 shows the results of analyses performed on substances seized by police services and customs and reported through the Early Warning System. It concerns both seizures at user's level as well as seizures from large drug traffics. Some of these seizures are done at the national airport. At that level, the seized drugs present usually high levels of pure substance because they have not been cut yet.

For the data of 2007, results are based on the analysis of 4 laboratories, while for 2008, 11 laboratoria sent their results.

**Table 35:** Mean purity of some illegal substances (%), Belgium, 2007 - 2008  
(standard table 14, 2009)

DRUG	2007*		2008*	
	Number of cases**	Mean (Minimum-maximum)	Number of cases**	Mean (Minimum-maximum)
<b>Cannabis resin ***</b>	27 (27)	9.6 (0.6-26.6)	133 (132)	10.1 (0.03-25.3)
<b>Cannabis herb***</b>	159 (123)	10.1 (0.1-40.2)	271 (262)	9.5 (0.03-55.1)
<b>Heroin ****</b>	261 (93)	20.8 (0.8-72.2)	156 (132)	24.6 (0.3-66.5)
<b>Cocaine</b>	525 (249)	61.3 (0.7-86.4)	183 (162)	59 (0.1-95.6)
<b>Amphetamine</b>	305 (173)	24.5 (0.3-73.4)	137 (67)	15.1 (1.8-63)
<b>Methamphetamine</b>	3 (1)	0.6 (0.6 – 0.6)	13 (3)	80 (80-80)
<b>Ecstasy (mg of MDMA base per tablet)</b>	89 (82)	55.49 (0.3-132.9)	111 (90)	94.8 (0.05-175.8)

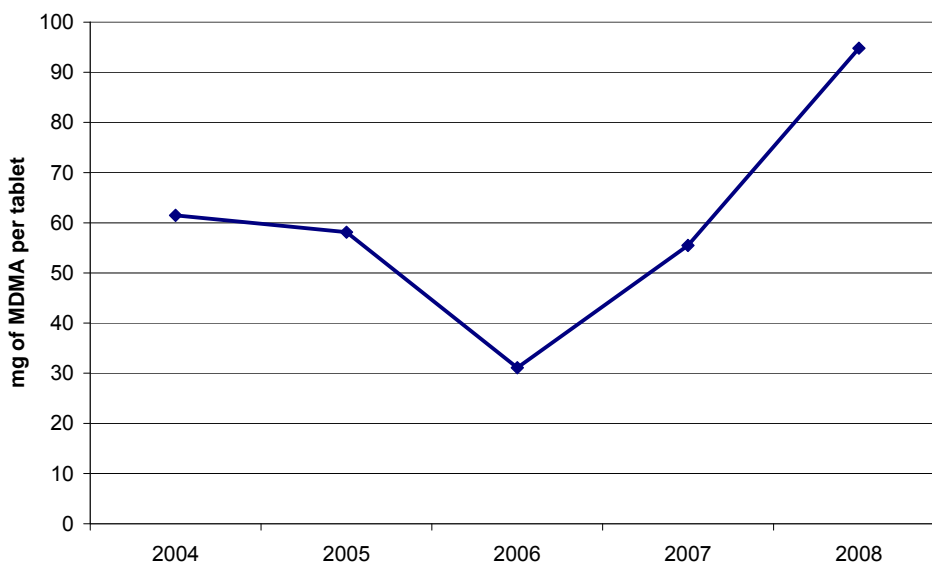
\* the percentages are not weighted because the exact amount of sample on which the analysis was done is not known.

\*\* Between brackets is the number of cases on which the mean, min and max are calculated.

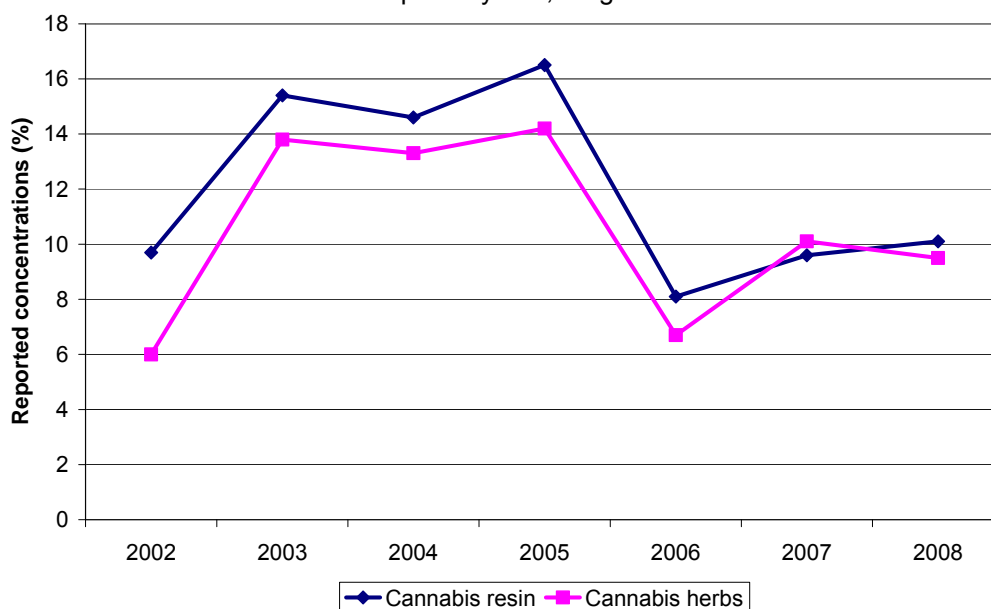
\*\*\* % THC content.

\*\*\*\* brown and white heroin.

In 2007 only two results from MDMA tablets (i.e. 2.4% of the samples for which the concentration was calculated) showed concentrations higher than 120 mg, while in 2008 21 samples of MDMA tablets (i.e. 23%) showed these elevated concentrations. When looking at an overview of the past 5 years (Figure 8), the increase in mg of MDMA in tablets is remarkable. Whether this increasing trend will continue or stay stable on this higher level will have to show in the results from 2009.



**Figure 8:** Evolution of the mean reported mg of MDMA in tablets, during the past 5 years, Belgium

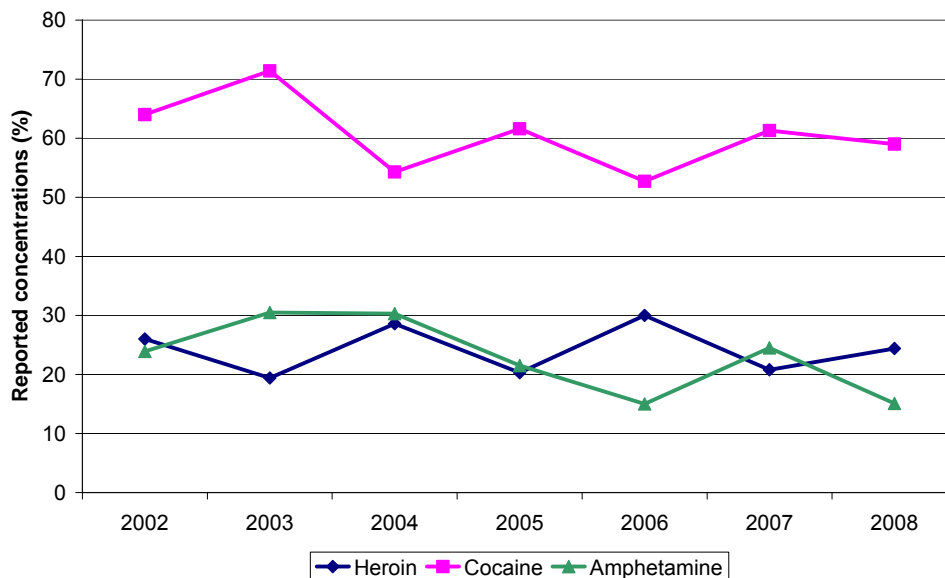


**Figure 9:** Evolution of the reported concentrations of THC in cannabis resin and herbs during the last 7 years, Belgium

As Figure 9 shows, the evolutions of THC-concentrations in herbs and resin show a very similar course. After the more elevated concentrations reported in the period 2003 – 2005, concentrations of THC seem to have declined again in 2006. They seem to stay almost stable at that level in the last 3 years.

mCPP, which is found since 2005 in Belgium, was reported in 37 samples of tablets in 2008. On the base of 32 samples of tablets containing mCPP, a mean amount of 78.6 mg of mCPP base was found (min. 0.77 mg, max. 128.5 mg).

For other reported drugs, variations in concentrations over the past 7 years are shown in Figure 10.



**Figure 10:** Fluctuations of concentrations of heroin, cocaine and amphetamine over the past 7 years, Belgium

### 10.3.c Composition of illicit drugs and drug tablets

Table 36 and 37 show the results for the tablets analysed after seizures by police services and customs and reported through the Early Warning System. Sometimes these tablets were part of a larger seizure. However, as information on the total size of the seizures is not always available results are given here in number of samples, and not in total amount of tablets.

For the data of 2007, results are based on the analysis of 4 laboratories, while for 2008, 11 laboratories sent their results.

Tablets containing MDMA-like substances count for 46.4% (n = 83) of the reported tablets in 2007. In this category combinations with caffeine and mCPP are reported respectively 8 and 3 times. Also in the categories '(meth)amphetamine' and 'MDMA-like substances and (meth)amphetamine' caffeine and mCPP are reported as cutting agents.

Almost half of the tablets seized in 2007 (47%; n = 84) are to be classified as miscellaneous, as the reported compounds did not contain any of the substances scheduled under the 1971 UN Convention on Psychotropic Substances Schedules I and II. In this *miscellaneous* category:

- 23 of these samples (27.4%) contained benzodiazepines (alone or in combination with other medicines);
- another 41 samples contained (one or more) other medicines (e.g. paracetamol);
- ephedrine (an amphetamine precursor) was found in 1 sample;
- opiates were found in 2 samples (alone or in combination with medicines);

- cocaine was found in 2 samples (alone or in combination with medicines);
- mCPP was found in 6 samples (7.1%), 2 times in combination with caffeine;
- 7 tablets contained only other substances, such as vitamins or hormones; for 2 tablets, compounds were not specified, but no drugs were found.

**Table 36:** Composition of tablets seized in the context of the Early Warning System, 2007 (Standard Table 15, 2009)

<b>2007</b>	
	<b>Number of samples (%)</b>
MDMA-LIKE SUBSTANCES {as the only scheduled <sup>1</sup> substances} <sup>2</sup>	<b>83 (46.4%)</b>
(METH)AMPHETAMINE {as the only scheduled <sup>1</sup> substances} <sup>3</sup>	<b>2 (1.1%)</b>
MDMA-LIKE SUBSTANCES AND (METH)AMPHETAMINE {as the only scheduled <sup>1</sup> substances} <sup>4</sup>	<b>10 (5.6%)</b>
OTHERS {scheduled <sup>1</sup> substances} <sup>5</sup>	<b>0 (0%)</b>
MISCELLANEOUS <sup>6</sup>	<b>84 (47%)</b>
<b>Total</b>	<b>179</b>

<sup>1</sup> Scheduled drugs refer to substances controlled under the 1971 UN Convention on Psychotropic Substances Schedules I and II and under European legislation (Council Decisions).

<sup>2</sup> The category 'MDMA-like substances (as the only scheduled substances)' refers to tablets containing MDMA and/or other MDMA-like substances (MDEA, MDA) as the only scheduled substances, together with or without non-scheduled substances (e.g. mCPP, caffeine).

<sup>3</sup> The category '(meth)amphetamine (as the only scheduled substances)' refers to tablets containing only amphetamine and/or methamphetamine, together with or without non-scheduled substances (e.g. mCPP, caffeine).

<sup>4</sup> The category 'MDMA-like substances and (meth)amphetamine (as the only scheduled substances)' refers to tablets containing only MDMA-like substances and amphetamine and/or methamphetamine, together with or without non-scheduled substances (e.g. mCPP, caffeine).

<sup>5</sup> The category 'Others (scheduled substances)' refers to tablets containing other scheduled substances (than MDMA-like substances or (meth)amphetamine), alone or in association with MDMA-like substances and/or (meth)amphetamine, together with or without non-scheduled substances (e.g. mCPP, caffeine).

<sup>6</sup> The category 'Miscellaneous' refers to tablets seized/submitted as illicit drug tablets but containing none of the scheduled substances under the 1971 UN Convention on Psychotropic Substances Schedules I and II or under European legislation (Council Decisions).

In 2008, 174 analysed samples consisted of tablets. Table 38 shows the substances that were detected in these tablets, using the classification of ST 15 (EMCDDA).

**Table 37:** Composition of tablets seized in the context of the Early Warning System, 2008  
(Standard Table 15, 2009)

<b>2008</b>	
	<b>Number of samples (%)</b>
MDMA-LIKE SUBSTANCES {as the only scheduled <sup>1</sup> substances} <sup>2</sup>	<b>107 (61.5%)</b>
(METH)AMPHETAMINE {as the only scheduled <sup>1</sup> substances} <sup>3</sup>	<b>0 (0%)</b>
MDMA-LIKE SUBSTANCES AND (METH)AMPHETAMINE {as the only scheduled <sup>1</sup> substances} <sup>4</sup>	<b>1 (0.6%)</b>
OTHERS {scheduled <sup>1</sup> substances} <sup>5</sup>	<b>3 (1.7%)</b>
MISCELLANEOUS <sup>6</sup>	<b>63 (36.2%)</b>
<b>Total</b>	<b>174</b>

<sup>1</sup> Scheduled drugs refer to substances controlled under the 1971 UN Convention on Psychotropic Substances Schedules I and II and under European legislation (Council Decisions).  
<sup>2</sup> The category 'MDMA-like substances (as the only scheduled substances)' refers to tablets containing MDMA and/or other MDMA-like substances (MDEA, MDA) as the only scheduled substances, together with or without non-scheduled substances (e.g. mCPP, caffeine).  
<sup>3</sup> The category '(meth)amphetamine (as the only scheduled substances)' refers to tablets containing only amphetamine and/or methamphetamine, together with or without non-scheduled substances (e.g. mCPP, caffeine).  
<sup>4</sup> The category 'MDMA-like substances and (meth)amphetamine (as the only scheduled substances)' refers to tablets containing only MDMA-like substances and amphetamine and/or methamphetamine, together with or without non-scheduled substances (e.g. mCPP, caffeine).  
<sup>5</sup> The category 'Others (scheduled substances)' refers to tablets containing other scheduled substances (than MDMA-like substances or (meth)amphetamine), alone or in association with MDMA-like substances and/or (meth)amphetamine, together with or without non-scheduled substances (e.g. mCPP, caffeine).  
<sup>6</sup> The category 'Miscellaneous' refers to tablets seized/submitted as illicit drug tablets but containing none of the scheduled substances under the 1971 UN Convention on Psychotropic Substances Schedules I and II or under European legislation (Council Decisions).

In 2008 most of the reported tablets contained MDMA-like substances (61.5%; n = 107). Apart from the MDMA-like substances, 21 of these tablets also contained caffeine. One tablet contained the combination of MDMA and mCPP.

In the category 'others' 1 sample contained THC alone, one THC in combination with a benzodiazepine and one sample contained a scheduled psychostimulant.

In the 63 samples of tablets categorized as 'miscellaneous' CPP/mCPP was the most reported compound:

- in total (m)CPP was found in 36 samples (57.1% of the miscellaneous category), alone or in combination with caffeine or domperidone;
- caffeine was the second most found substances: apart from 4 samples in which it was found in combination with mCPP, it was found another 10 times (1 with lidocaine);
- 1 sample contained cocaine;
- 8 samples contained (one or more) benzodiazepines;
- 5 other samples contained (combinations of) medicines (other than benzodiazepines) and for 3 samples it was only mentioned that there was no drugs found.

## **PART B. Selected issues**

## CHAPTER 11.

### Cannabis markets and production

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B. Van Camp, J. Dommicent

The Central Drug Service (Cannabis desk)<sup>28</sup> reports that illegal cannabis cultivation in Belgium has been growing seriously in the past few years.

A great variety of cannabis cultivation methods are used, both indoor and outdoor. Moreover, the number of seizures made by the police show that Belgium is more affected by herbal cannabis than by cannabis resin.

#### 11.1. Markets

##### 11.1.a Contextual information

Illegal cannabis cultivation in Belgium has been growing seriously in the past few years. From a seemingly minimal problem in 2003 it has, in a few years time, turned into one of the new priorities of the new National Security Plan (2008-2012). In 2003, for instance, only 35 cannabis plantations were discovered in Belgium. In 2008, however, 666 cannabis plantations were dismantled.

This increase in the cannabis production can be explained by several factors:

\* The recent stepping up of the Dutch repressive judicial policy and the implementation of armed governance in several big cities (agreements and cooperation between several partners such as justice, police, tax authorities, housing associations and electricity companies) were mainly aimed against the concentration of “home-growers” in one particular neighbourhood. This has pushed back home cultivation and the supply of coffee shops by small growers tremendously, which has decreased the market supply of herbal cannabis or weed drastically. The acute shortage of marijuana was one of the reasons for a large increase in wholesale or purchase prices and this situation immediately created a hole in the market for organised cultivation and criminal organisations.

\* The distance between the Netherlands (southern region) and Belgium (Flanders) is small and both countries have an extensive road system. Moreover, there is no language barrier.

\* The last couple of years, many Dutch nationals have settled in the Belgian border regions. The presence of Dutch nationals in Belgian cities and towns is quite normal and does not alarm the local social control.

\* In Belgium, contrary to the Dutch situation, there is still a large offer of real estate for sale or to let, i.e. houses and/or other usable locations (such as former factories etc.).

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<sup>28</sup> The Central Drug Service (Cannabis desk) of the Belgian Federal Police is mainly experienced in and focuses on the establishment of a general picture, the coordination of district and/or cross-border judicial investigations and offering theoretical and practical support on behalf of the operational police services with regard to drug trafficking and production. As far as cannabis is concerned, the Drug Service mainly focuses on wholesale trafficking and production of marijuana.



\* As far as the "cannabis issue" is concerned, there are no covenants or agreements in principle in Belgium with the electricity companies so far. There is no duty to report for these companies when they come across excessive use of electricity or serious electrical failure.

\* On Belgian soil, there are, contrary to the situation in some cities in the Netherlands, no local concentrations of cannabis growers. The locations used in Belgium are much more scattered than in the Netherlands. This possibility to spread their business and to be anonymous has prompted many organisers to move to the Belgian border regions and Germany (region North Rhine-Westphalia). This way, competing organizations avoid their mutual (and often violent) competition and remain temporarily free of breaking and entering, theft of their harvest, intimidation and/or liquidation.

\* The distribution of criminal growing activities over different territories, all with their own different legislations and priorities, complicates the tracing, drawing up of police reports and especially the investigation into the management of the organizations.

### **Cultivation methods and type of cannabis**

In Belgium, all possible cultivation methods are used, both indoor and outdoor.

Indoor cultivation (both soil growing and hydroponics) is the most frequently found method. It allows the growers to guide and control the growing conditions of their harvests. It is a discrete method which decreases the risk of being caught by the police services. Moreover, indoor cultivation is very little subject to the seasons and weather conditions. It yields the best quality, the highest THC content, a large vigour of the used variety or type of plant and it has the huge advantage of yielding 4 harvests per year.

Professional marijuana cultivation in Belgium is done in highly professionally set up indoor plantations in all kinds of buildings (from flats to villas) and in former factories. The cannabis plantations, both by way of soil growing and hydroponics, often work with ultramodern growing equipment.

As far as indoor cultivation in Belgium is concerned, a large variety of very sophisticated growing equipment and high-quality fertilizers and nutriment are found. They are specifically developed for so-called "legal" agricultural purposes by specialised and prominent companies and/or multinationals.

Outdoor cultivation, on the other hand, is also being used in Belgium and cases are often discovered by the Belgian police services: in 2006, 23 outdoor cultivation sites were discovered, 58 in 2007 and 45 in 2008. It is rather done in gardens of small home-growers, yet hardly in a professional setting. Outdoor cultivation is much less interesting because of the greater risk of getting caught by the police services, the substantially lower THC content of the grown marijuana and the fact that one depends on the weather. Furthermore, it only yields one harvest per year.

The number (not the quantities) of seizures made by the police show that Belgium is more affected by herbal cannabis than by cannabis resin. Cannabis oil seems to be marginal: 56% of the reports made by the police involve a seizure of herbal cannabis while resin cannabis is only mentioned in 18% of the reports. There is no specific trend to be mentioned.

## **Growing equipment and plantations**

The growers use various growing techniques (soil growing, in isolation labs, in coconuts, in granules, in growing blocks and exceptionally in specific hydroponics) and various growing patterns (line-up, coliseum plantations, darkrooms...). Cannabis is also grown in scaffoldings, in specially equipped containers, trucks and trailers.

Only very small growers sometimes use seeds, while professional growers buy the necessary cuttings from specialised cutting nurseries or through an intermediary (often illegally at the backdoor of grow shops in the Netherlands).

The necessary and mostly sophisticated growing equipment, carbon filters, nutriments, potting compost, fertilizers and pesticides are for sale in specialised grow shops.

The growers also use specially designed growing lamps. Moreover, the police discovers more and more digitally controlled CO2 generators and exceptionally OZONE generators.

The different organisers or criminal organisations, engaged in cannabis cultivation, are not afraid to resort to violence among them and consequently, breaking into plantations and theft of harvests are part of their normal working methods. This is why used locations are often equipped with security devices such as camera observation and mobile alarm systems. Police often discover sophisticated hidden entrances to professional plantations and recently more booby traps are being found (such as electricity on the doors and/or windows and "pongee pits").

Some growers or organizations even change their usual industrial installation techniques and abandon the use of large-scale plantations. This phenomenon is called "guerrilla farming". It means that organizers set up several small-scale plantations (up to 250 plants) instead of one large-scale project to avoid severe penalties by justice or the loss of their huge investments.

## **Grow shops**

The number of known "grow shops" in Belgium is estimated at about ten.

Grow shops supply all possible growing material and accessories (growing lamps, ballasts, turbines, carbon filters, fertilizers and nutriments, etc...) for growing or producing cannabis. The growing material is perfectly legal, usually specially developed and of very high quality. These products can without any problem be sold and purchased freely. Although some producers of such material constantly argue that their products are only intended for legal growing purposes, it is, however, clearly aimed at cannabis cultivation. "Grow shops" offer, beside their high-quality and often sophisticated equipment, material, literature, security material and all kinds of documentation, also the necessary advice and expertise to obtain the best growing results and successful harvests of high-quality marijuana.

Some grow shops also play an organizing, supporting and/or central part with regard to the sale of illegal harvests across the border or with regard to the supply of marijuana to retail shops in the Netherlands ("coffee shops").

It is common knowledge in the "hemp circles" that some "grow shop" owners, beside their legal activities, offer illegal facilities at a charge.

In Belgium, the present grow shops are closely watched to see whether they do not commit criminal offences and incite to drug use or cultivation. The fact that "incitement to the use of drugs" or "facilitation of the use of narcotics/psychotropic substances by selling a local or any other product" are punishable still has a discouraging effect and possibly limits the proliferation of grow shops in Belgium

## **Growers**

### Home-growers

The Belgian police services consider "home-growers" to be growers who use their home or outbuildings for their "small-scale" growing activities. "Small" home-growers grow marijuana for their own use or for a very limited circle of friends or customers. However, the majority of the home-growers, i.e. the "larger home-growers" do not only grow for their personal use or for social or medical reasons. They are almost always driven by economic necessity or with a view to financial gain. Some home-growers work independently, but a larger group works for organisers of professional cultivation as "caretaker, gardener or maintenance worker for the plantation" or puts the used location or appropriate place at their disposal. They often voluntarily offer suitable spaces in their homes or outbuildings, which sometimes after a few harvests often turn into forced situations through intimidation or violence performed by the financiers or organisers.

### Large-scale growers

The Belgian police considers indoor plantations with a capacity of more than 500 plants as "large-scale growers". In 2003, 18 "large-scale growers" were discovered on Belgian soil. In 2008, this number amounted to 108.

The annual number of judicial recordings of "large-scale" growers on Belgian soil continues to grow. "Large-scale plantations" are mostly run by several persons or organizations and are mainly set up in Belgium in villas, industrial estates, sheds, warehouses, farms and former factories in a highly professional way.

Dutch or Dutch-Belgian organizations are considered to be almost solely responsible for the striking shift of professional and mainly industrial cannabis production from the Netherlands towards Belgium. They adopt a highly specialized approach and are characterized by a specific professionalization and industrialization of the growing methods and the secret involvement of violent and/or organized crime, creating an uninspected and therefore dangerous end product possibly contaminated with pesticides, traces or chemicals. They often work according to a specific hierarchy of financiers, department managers (responsible for different locations or apt people), technicians for setting up the infrastructure and electricity bypasses, teams to cut the plants, etc ...

The weed organisations are also often linked to their origin: Dutch-Belgian, North African, Turkish-Bulgarian and Vietnamese groupings.

The criminal organisers are well-structured and organized. They work with independent departments or managers and are often quite violent. Through intimidation, extortion, force, violence and in some cases even liquidation, they maintain some kind of oath of secrecy or "*omerta*" among their employees or persons involved. This makes it especially hard for the police services or investigators to determine the actual hierarchy or structure of the organisation.

## **Legislation**

The Belgian legislation clearly states that harvesting as well as growing cannabis is illicit (January 10 2006 Cassation Court Judgment). Growing cannabis plants intended for sale and/or for use is punishable, even before the plants are harvested according to section 2bis of the Drug law of August 24 1921 and section 26bis of the Royal Decree of December 31 1930.

Belgium acceded to the Single Convention of New York on narcotic drugs of March 30 1961 (applies to the cannabis plant, its growing and contains a ban on growing cannabis plants) and approved the Convention of the United Nations against the illicit traffic in narcotic drugs and psychotropic substances of 20 December 1988.

In Belgium, hemp cultivation is only allowed when the grower has a license, issued by the Ministry of Agriculture, in accordance with Regulation (European Community) number 796/2004. This Regulation deals with the production of "fiber hemp or hemp used for other industrial purposes with THC content lower than 0.2%". To this end, the competent European Commission provided for a list of authorized hemp varieties (seeds for sowing). Each other type of cannabis cultivation and other kinds of seeds for sowing do not meet this license requirement and may not be used.

### 11.1.b Prices

A very slight increase in the retail prices on the Belgian cannabis market is shown in the next table (Table 38). These prices are obtained from police reports: when a drug user is questioned by a police-officer, the cost of his drug use is usually asked.

**Table 38:** Retail cannabis prices (Euros), 2006-2008, Federal Police

	2006	2007	2008
Minimum	2	2	3
Maximum	18.66	12.5	25
Mean	6.65	6.53	7.35

The average price of 1 kg of ready-to-use weed amounts to about 3,500 €. Depending on the variety, quality or a particularly high THC content, the price may easily amount to 4,000 € or more.

Cannabis wholesale prices are harder to obtain because there are few police reports on traffickers; reports about users are much more frequent. Sometimes a trafficker mentions he had to pay 1,200 Euros for one kilogram of cannabis while another trafficker claims he had to pay 3,000 Euros for one kilogram. It is thus very difficult to assess whether the reported wholesale prices are representative of the whole market.

## 11.2. Seizures

### 11.2.a Seizures of plantations

According to the Central Drug Service, the number of discovered and confiscated cannabis plants would be less important than the production capacity of the discovered plantation. The reports and statistics regarding the number of confiscated plants do not always reflect correctly the actual size and extent of the plantation (e.g. if during a seizure, the police comes across 500 cannabis plants in one room, and in the other room 500 growing pots with remainders of recently harvested plants are discovered; the reports often mention a seizure of 500 plants and not the actual capacity of the plantation).

The number of plantations seized has hugely increased in the period 2003 to 2006, and this was found for all sizes of plantations (Table 39).

**Table 39:** Number of seized plantations in Belgium, 2003-2006, Federal Police

Description (capacity)	2003	2004	2005	2006
mini plantations (2 - 49 plants)	4	5	26	78
small-scale (50 - 499 plants)	11	10	54	70
medium-sized (500 - 999 plants)	7	12	16	48
large-scale (1000 plants and more)	11	11	30	30
installation plants / harvested / no info	2	12	46	20
<b>TOTAL NUMBER</b>	<b>35</b>	<b>50</b>	<b>172</b>	<b>246</b>

In 2007, the Central Drug Service changed the size classification of cannabis plantations (Table 40). The new labels with their specific numbers offer a better description as far as the “nature” or the proportions of the discovered plantations is concerned.

**Table 40:** Number of seized plantations in Belgium, 2007-2008, Federal Police

Description (capacity)	2007	2008
<i>ACTIVE PLANTATIONS</i>		
micro scale (2 - 5 plants)	68	136
mini scale (6 - 49 plants)	135	219
small-scale (50 - 249 plants)	50	125
medium-sized (250 - 499 plants)	37	58
large-scale (500 - 999 plants)	42	63
industrial scale (more than 1000 plants)	40	45
cutting culture	4	2
<i>INACTIVE PLANTATIONS</i>		
ready for use*	27	7
dismantled**	63	11
<b>TOTAL NUMBER</b>	<b>466</b>	<b>666</b>

\*dismantled: partly or completely dismantled

\*\*ready for use: full growing installation without plants or proof of previous harvests

In 2008, 666 cannabis plantations with a total growing capacity of 177,190 plants were dismantled in Belgium. These plantations could produce 4,996 kg of ready-to-use marijuana with a wholesale value (3500 €/kg) of 17,486,000 € after one single harvest (after 8-12 weeks at an average yield of 28.2 grams ready-to-use marijuana per cannabis plant).

On an annual basis, these 666 plantations offered a practicable production capacity (on the basis of 4 harvests/year) of 19,984 kg of ready-to-use marijuana with an average wholesale value of 69,944,000 €.

The retail prices are of course even significantly higher and vary strongly depending on the supply, the distribution possibilities and/or the final destination of sales.

Police services can only trace a fraction of the cannabis plantations on Belgian soil and judicial findings are only the tip of the iceberg: well-hidden and professionally set up and maintained growing locations are inconspicuous and they are, as a consequence – apart

from mistakes made by growers, informers or “unfortunate” coincidence – almost impossible to trace.

### **11.2.b Origin of cannabis products**

Cannabis resin is mostly imported in Belgium from Morocco via Spain, France and the Netherlands. The trafficking and smuggling is mainly run by organizations of Moroccan origin. Family ties or regions of origin are very important.

It is remarkable that harvests grown in cannabis plantations on Belgian soil are mainly intended for the Dutch market such as coffee shops and grow shops and/or for distribution and export abroad by Dutch weed dealers to Great Britain and Scandinavia).

For several years now, marijuana can easily be bought in coffee shops in the Netherlands. Beside their own local Dutch customers, coffee shops in the Dutch border regions also have a very large clientele, the so-called “drug tourists”, mainly Belgian, French and German nationals. This has caused serious nuisance in several border regions (B-NL). The large market has created an increasing demand for “herbal cannabis” or weed. In the past, this led to both “small-scale” cannabis cultivation by “home-growers” and a “professional and/or industrial” cultivation of hemp in the Netherlands, mostly run or supported by a chain of financiers, organisers, weed dealers and criminal organisations.

Until recently, marijuana production was mainly situated in the Netherlands (the presence of the necessary know-how, grow shops, coffee shops, home-growers and the industrial chain of high-tech growing material). Because of several reasons, a number of shifts in professional cannabis cultivation towards the neighbouring countries (Belgium and Germany) have been clearly distinguished.

### **11.2.c Cannabis seizures**

Since 1994, the Central Drug Service has been following the phenomenon checking cars with one or several occupants having a residence in Belgium on their way from Spain or Morocco via France and during which batches of cannabis resin were confiscated. The drugs are hidden in specially built spaces, tanks or walls and in some cases simply between luggages. Although there are different means of import (cars, coaches, trucks, containers...), an increasing use of coaches has been noticed by the police.

Cannabis resin is also smuggled in containers, both by road and across the sea : even for this modus, secret compartments in floors, walls or even inside the transported cargo are built. Within the framework of the fight against organized crime and drug trafficking, the authorities made one seizure of 43,000 kg of hash and 97 kg of heroin and arrested 11 suspects in the port of Antwerp in February 2007. The confiscated drugs were hidden in metal cylinders between batches of scrap transported in ten containers. The street value was carefully estimated at about 225 million euros.

Since no distinction is made between weight classes for the seizures, only total amounts can be presented (Table 41).

**Table 41:** Total amount of cannabis herb and resin seized in Belgium, 2006-2008, Federal Police

	2006	2007	2008
<b>Cannabis resin</b>	10481.26 kg	58544.76 kg	1529.25 kg
<b>Herbal cannabis</b>	4563.17 kg	12758.84 kg	4890.69 kg

The large differences in the seized amounts can be easily explained by one very large seizure of 43,000 kg of cannabis resin in 2007.

Since 2003, the biggest seizures of imported cannabis have been cannabis resin related. It could be explained by the large local production of high-quality marijuana in Europe making the import of foreign marijuana no longer required or needed.

### 11.3. Offences

#### Offences

In Belgium, the following offences are recorded concerning drugs: illegal use and possession, illegal production, illegal dealing and illegal import and export.

The number of cannabis related police reports has increased between 2006 and 2008 (Table 42).

**Table 42:** Number of police reports according to the type of cannabis related offence, 2006-2008, Federal Police

<b>Cannabis related type of offence</b>	2006	2007	2008
<i>Use/possession</i>	14,363	16,844	17,301
<i>Dealing/trafficking/production</i>	8,277	8,200	9,047

#### Dangers and violence

Between 2006 and 2008, 37 fires were reported in Belgium which were immediately linked to cannabis plantations. These were both house fires and fire in (former) factories causing little to serious damage. The fire was almost always due to electricity theft, heating of the used ballasts or the electric heaters in drying spaces or plantations.

A second emergency linked to cannabis plantations is flooding. Cannabis plants need enough water. If the water system is not properly connected, the cannabis plantation may be flooded. This can also affect the neighbouring houses that might also become flooded. There are enough reasons to assume that indoor cultivation damages and soils both the infrastructure of the house and the used growing equipment by the intensive use of pesticides, fertilizers, nutrients, and chemicals. The presence of traces and fungus seems to be a serious problem. To this day, there has been no scientific investigation concerning the matter in Belgium.

Moreover, the Belgian police and justice system are convinced that intimidation and violence are often linked to cannabis cultivation. Arrested suspects, engaged in professional and organised cannabis cultivation, are often very sparing of confessions or targeted information and have often taken an oath of secrecy.

#### **11.4. Missing information**

No information could be obtained concerning the following topics: consumer market shares of different cannabis products, distribution of cannabis at national level, typology of retail outlets for cannabis sale, cannabis sources and transaction sizes and supply reduction organisation and activities.



## CHAPTER 12.

### Problem amphetamine and metamphetamine use, related consequences and responses

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#### 12.1 Epidemiology of amphetamine and methamphetamine use

##### 12.1.a History of (meth)amphetamine use

In Belgium, amphetamine use clearly exists, but was and still is less popular than cannabis and ecstasy use.

Based on indirect information (prevention, treatment and seizures), the prevalence of methamphetamine use in Belgium was and still is very low compared to amphetamine use and ecstasy use. It is not a popular drug at all.

##### 12.1.b Trends and patterns of (meth)amphetamine use

###### ➤ General population

###### Health Interview Survey

The latest general population survey tackling amphetamine use is the 2001 Health Interview Survey (HIS). The main purpose of the HIS is describing the health status of the Belgian population and its determinants.

In 2001, last month prevalence of ecstasy and/or amphetamine use in the age group 15 to 64 years was 0.3% in women and 0.5% in men (Table 1). Last month prevalence was highest in the age group 15 to 24 years old; lifetime prevalence was highest in the age group 25 to 34 years old. No data are available on amphetamine use separately or on methamphetamine use.

**Table 1:** Lifetime and last month prevalence (%) of ecstasy and/or amphetamine use by age group, Belgium, 2001

	Lifetime prevalence N = 7,298			Last month prevalence N = 7,196		
	Men	Women	Total	Men	Women	Total
15 – 24	5.6	1.9	3.8	1.4	0.7	1.1
25 – 34	5.9	3.1	4.5	0.9	0.1	0.5
35 – 44	3.1	2.4	2.3	0.3	0.2	0.3
45 – 54	0.5	0.8	0.6	0	0.4	0.2
55 – 64	0.2	0.3	0.2	0	0	0
15 – 64	3.1	1.6	2.3	0.5	0.3	0.4

## ➤ School and youth population

### ESPAD (European School Survey Project on Alcohol and Other Drugs)

The ESPAD project aims at collecting comparable data on alcohol, tobacco and drug use among 15-16 year old students in European countries. Belgium did not participate in the 1999 data collection. The only ESPAD study carried out nationwide in Belgium (Hibell et al., 2004) took place in 2003. Among the 15-16 years old, lifetime and last year prevalence estimates of ecstasy use were about twice as high as the prevalence estimates of amphetamine use (Table 2). No data were collected on methamphetamine use.

**Table 2:** Lifetime, last year and last month prevalence (%) of ecstasy and amphetamine use, 15-16 years, Belgium, ESPAD 2003

N = 2320		Lifetime prevalence	Last year prevalence	Last month prevalence
<b>XTC</b>	Boys	5.1	3.2	1.5
	Girls	3.7	2.3	1.1
	Total	<b>4.4</b>	<b>2.7</b>	<b>1.3</b>
<b>Amphetamines</b>	Boys	2.5	1.3	0.5
	Girls	1.9	1.3	0.9
	Total	<b>2.2</b>	<b>1.3</b>	<b>0.7</b>

In 2007, ESPAD was only organised in the Flemish Region (Hibell, Guttormsson, Ahlström et al., 2009). Prevalence of amphetamines use was lower than ecstasy use (Table 3). Comparison over time is not possible due to differences in geographical area of both surveys.

**Table 3:** Lifetime, last year and last month prevalence (%) of ecstasy and amphetamine use, 15-16 years, Flemish Community, ESPAD 2007

N boys = 969 N girls = 920		Lifetime prevalence
<b>XTC</b>	Boys	6
	Girls	5
	Total	<b>5</b>
<b>Amphetamines</b>	Boys	5
	Girls	4
	Total	<b>5</b>

### HBSC

The Health Behaviour in School-aged Children aims to gain new insight into, and increase understanding of young people's health and well-being, health behaviours and their social context. This cross-national research study is conducted every four years. In the last HBSC study (French Community: Piette et al., 2007 (University of Brussels) – Flemish Community: Maes et al., 2007 (University of Ghent)), secondary school students (12-18 years old) were asked about their use of drugs and frequency of use. According to the HBSC study, between 2002 and 2006 lifetime prevalence of ecstasy use among the 15-18 years old increased in the Flemish Community and decreased in the French Community (Table 4). Lifetime prevalence of amphetamine use remained more or less stable between 2002 and 2006 in the Flemish Community. No HBSC-data are available on the prevalence of amphetamine use in the French Community in 2006. Ecstasy use is more prevalent compared to amphetamine use in both age-groups, in both Communities and in both data collection years.

**Table 4:** Lifetime prevalence (%) of drug use among the school population aged 15-18 years in Flemish and French Community, 2002-2006

			<b>2001/2002</b>	<b>2005/2006</b>
	<b>N</b>	<i>Fl. Com.</i>	16,560	5,606
		<i>Fr. Com.</i>	5,885	4,698
<b>XTC</b>				
15-16	Males	<i>Fl. Com.</i>	4.0	4.5
		<i>Fr. Com.</i>	5	4.2
	Females	<i>Fl. Com.</i>	2.9	3.0
		<i>Fr. Com.</i>	4	2.5
	<b>Mean</b>	<b>Fl. Com.</b>	<b>3.5</b>	<b>3.8</b>
		<b>Fr. Com.</b>	<b>4</b>	<b>3.3</b>
17-18	Males	<i>Fl. Com.</i>	9.4	12.1
		<i>Fr. Com.</i>	8	8.2
	Females	<i>Fl. Com.</i>	5.6	6.8
		<i>Fr. Com.</i>	7	4.7
	<b>Mean</b>	<b>Fl. Com.</b>	<b>7.5</b>	<b>9.5</b>
		<b>Fr. Com.</b>	<b>8</b>	<b>6.4</b>
<b>Amphetamines</b>				
15-16	Males	<i>Fl. Com.</i>	3.0	3.1
		<i>Fr. Com.</i>	1	n.a.
	Females	<i>Fl. Com.</i>	2.8	2.7
		<i>Fr. Com.</i>	1	n.a.
	<b>Mean</b>	<b>Fl. Com.</b>	<b>2.9</b>	<b>2.9</b>
		<b>Fr. Com.</b>	<b>1</b>	<b>n.a.</b>
17-18	Males	<i>Fl. Com.</i>	8.3	8.7
		<i>Fr. Com.</i>	1	n.a.
	Females	<i>Fl. Com.</i>	4.9	5.1
		<i>Fr. Com.</i>	2	n.a.
	<b>Mean</b>	<b>Fl. Com.</b>	<b>6.6</b>	<b>6.9</b>
		<b>Fr. Com.</b>	<b>2</b>	<b>n.a.</b>

➤ **Applicants for a post in the army**

Each year, selections for new applicants wishing to enter the army (all kind of posts) are organized. During this process, the applicants have to fill in forms containing – among others – questions about a potential drug use. These questions are strictly anonymous and aren't taken into account for the selection. Prevalence of ecstasy use is about 2 to 3 times higher compared to the prevalence of amphetamine type stimulants use (in the questionnaire called "speed") (Table 5). Use of amphetamine type stimulants ("speed") was lower in 2007 compared to the two years before.

**Table 5:** Percentages of drugs used by the drug-using army applicants, 2005-2007

	<b>2005</b>	<b>2006</b>	<b>2007</b>
	N = 1,320	N = 1,279	N=1,069
<b>XTC</b>	10.67	9.57	9.21
<b>"Speed"</b>	4.22	5.22	3.25

### 12.1.c Prevalence estimates of problem (meth)amphetamine users

Because measures of problematic use were not included in the general population survey (such as frequency of use or drug-related problems) or in survey's in teenagers, prevalence estimates are not available.

In the French Community, the NGO Modus Fiesta reports that no methamphetamine chronic users are met during their activities (Catherine van Huyck, personal communication). Some users only report an occasional use, either because methamphetamines are barely available on the market, either because the main product they're interested in is amphetamine. Besides, most of them don't make any difference between the two products and talk rather about more "boosting" or "tripping" speed.

Among the amphetamine users met during Modus Fiesta's activities, the regular ones are probably a minority. Unfortunately, prevalence figures of these consumptions aren't available yet. Nevertheless, two main types of amphetamines users can be distinguished: the occasional users consuming only during festive events and the regular ones consuming on a daily basis.

No information was found on the situation in the Flemish Community.

### 12.1.d Treatment demand for (meth)amphetamine use

#### ➤ TDI analysis

#### Drug-related treatment demand in Belgium, 2005

The TDI data collection system in Belgium is developing and double counting of patients is only avoided between some centres. Data are available about the data collection year 2005 in Belgium (without Brussels Capital Region).

The TDI system registered amphetamines as the primary substance among 283 out-patients and persons demanding treatment in low-threshold services (further referred to as "out-patients"), and among 189 in-patients (Table 6).

Persons demanded treatment primarily for heroine use (firstly) and for cannabis use (secondly) (Table 6). The treatment demands for amphetamine use and for cocaine use were lower. This was found in both groups of treatment settings.

**Table 6:** Primary drug among all treatment demands in two treatment settings, Belgium, 2005.

	<b>Out-patients and low-threshold services</b>	<b>In-patients</b>
<b>Heroine</b>	1505	523
<b>Cannabis</b>	820	301
<b>Cocaine</b>	327	183
<b>Amphetamines</b>	283	189
<b>Methadon</b>	150	38
<b>MDMA</b>	36	14

Most persons demanding treatment for use of amphetamines are between 15 and 34 years old (Table 7). This was found in "out-patients" (89%) as well as in in-patients (94%), in both women and men.

**Table 7:** Age when demanding treatment for amphetamine use in two treatment settings, Belgium, 2005

	Out-patients and low-threshold services			In-patients		
	Men	Women	Total	Men	Women	Total
< 15	1	2	3	0	1	1
15 – 19	31	20	51	26	16	42
20 – 24	76	22	98	58	17	75
25 – 29	49	12	61	36	10	46
30 – 34	28	14	42	11	3	14
35 – 39	11	1	12	5	0	5
40 – 44	4	1	5	1	0	1
45 – 49	0	1	1	0	0	0
50 – 54	2	0	2	1	0	1
55 – 59	0	0	0	0	0	0
60 – 64	0	0	0	0	0	0
=> 65	0	0	0	0	0	0
NK/missing	4	4	8	2	2	4
<b>Total</b>	<b>206</b>	<b>77</b>	<b>283</b>	<b>140</b>	<b>49</b>	<b>189</b>

Most amphetamines users demanding treatment sniff it (Table 8). This was found in “out-patients” (73%) as well as in in-patients (67%), in both women and men.

Amphetamines were injected by 17% of “out-patients” and by 20% of in-patients (Table 8).

**Table 8:** Route of administration among persons demanding treatment for amphetamine use in two treatment settings, Belgium, 2005

	Out-patients and low-threshold services			In-patients		
	Men	Women	Total	Men	Women	Total
Inject	37	11	48	27	10	37
Smoke/ inhale	1	0	1	2	1	3
Eat/ drink	15	6	21	11	2	13
Sniff	150	57	207	93	33	126
Others	0	0	0	0	0	0
NK/ missing	3	3	6	7	3	10
<b>Total</b>	<b>206</b>	<b>77</b>	<b>283</b>	<b>140</b>	<b>49</b>	<b>189</b>

Most persons demanding treatment for amphetamine use used it at least 2 days a week (Table 9). This was found in “out-patients” (69%) as well as in in-patients (82%), in both women and men.

Daily use was found in 32% of “out-patients” and in 62% of in-patients (Table 9).

**Table 9:** Frequency of use among persons demanding treatment for amphetamine use in two treatment settings, Belgium, 2005

	Out-patients and low-threshold services			In-patients		
	Men	Women	Total	Men	Women	Total
Not in past month/occasional	38	9	47	11	2	13
Once a week or less	28	2	30	8	2	10
2 – 6 days per week	73	33	106	24	13	37
Daily	60	31	91	88	30	118
NK/ missing	7	2	9	9	2	11
<b>Total</b>	<b>206</b>	<b>77</b>	<b>283</b>	<b>140</b>	<b>49</b>	<b>189</b>

Most persons demanding treatment for use of amphetamines were between 15 and 34 years old when they used amphetamines for the first time (Table 10). This was found in “out-patients” (87%) as well as in in-patients (90%), in both women and men.

The age range 15 to 19 years old was most prevalent among “outpatients” (33%), the age range 20 to 24 years old among in-patients (39%) (Table 10). This was found in women and men.

**Table 10:** Age at first use of amphetamines among persons demanding treatment for amphetamine use in two treatment settings, Belgium, 2005

	Out-patients and low-threshold services			In-patients		
	Men	Women	Total	Men	Women	Total
< 15	3	5	8	1	1	2
15 – 19	68	24	92	27	16	43
20 – 24	66	21	87	56	17	73
25 – 29	34	11	45	32	9	41
30 – 34	21	2	23	10	3	13
35 – 39	6	1	7	5	0	5
40 – 44	2	0	2	0	0	0
45 – 49	0	1	1	0	0	0
50 – 54	2	0	2	1	0	1
55 – 59	0	0	0	0	0	0
60 – 64	0	0	0	0	0	0
=> 65	0	0	0	0	0	0
NK/missing	4	12	16	8	3	11
<b>Total</b>	<b>206</b>	<b>77</b>	<b>283</b>	<b>140</b>	<b>49</b>	<b>189</b>

#### Population of drug users in treatment in a low-threshold service in Flanders

In Belgium, MSOCs/MAS centres are delivering care to out-patients. They are low-threshold services. The registration of the in-treatment population during 2008 in (MSOC) centre “Free Clinic”, located in Antwerp, was analysed. Antwerp is one of the largest cities in Belgium and possesses an international harbour.

In 2008, only one person had only a treatment demand for amphetamine use; 11 persons who had a treatment demand combined amphetamines with another product and 29 persons with a treatment demand combined amphetamines with two other products (Table 11). Prevalence of amphetamine use was 5.8% in this out-patient population in Antwerp, 2008.

**Table 11:** Prevalence of amphetamine use in the in-treatment population at Free Clinic Antwerp, Belgium, 2008

<b>Amphetamines</b>	<b>N</b>	<b>%</b>
No use	599	94.2
Use	41	5.8
<i>Only amphetamine</i>	1	0.2
<i>Combined with 1 other substance</i>	11	1.4
<i>Combined with 2 other substances</i>	29	4.3
<b>Totaal</b>	640	100

At Free Clinic the drug treatment population consists mainly of opiate users. Therefore, it is no surprise that users of amphetamines are most often also opiate users (47% of all combinations with amphetamines), but amphetamine users use also cocaine and other substances (Table 12).

**Table 12:** Prevalence of polydrug use including amphetamines in the in-treatment population at Free Clinic Antwerp, Belgium, 2008

<b>Substance combined with amphetamines</b>	<b>N</b>	<b>%</b>
Opiates	30	47
Cocaine	14	22
MDMA/XTC	3	5
Hypnotics and sedatives	5	8
Hallucinogens	0	0
Volatile substances	0	0
Cannabis	6	9
Alcohol	6	9
Others	0	0

In the period 2001 to 2008, stimulants (both cocaine and/or amphetamines) were the primary substance group for treatment demand in 8.1% (2001) to 16.1% (2003) of the in-treatment population (Table 13). Since 2004 this proportion fluctuates between 9.0 and 10.9%.

In 2008, one or another stimulant was the secondary substance of 35.9% of the population in-treatment mentioning a second substance; it was the third substance in 24.6% of the population mentioning a third substance (Tables 14). Unfortunately, the data specifically on amphetamines were not available to the authours.

**Table 13:** Primary substances for treatment demand in the in-treatment population at Free Clinic Antwerp, Belgium, 2001 – 2008.

Primary product	2008		2007		2006		2005		2004		2003		2002		2001	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Opiates	538	85.0	526	81.0	510	81.6	478	82.4	449	81.0	388	71.1	439	77.2	578	83.3
Stimulants	57	9.0	67	10.3	68	10.9	55	9.5	56	10.1	88	16.1	83	14.6	56	8.1
Hypnotics and sedatives	14	2.2	18	2.8	8	1.3	10	1.7	16	2.9	14	2.6	14	2.5	14	2.0
Hallucinogens	1	0.2	0	0.0	0	0.0	1	0.2	0	0.0	0	0.0	0	0.0	0	0.0
Volatile substances	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Cannabis	10	1.6	23	3.5	26	4.2	27	4.7	25	4.5	38	7.0	24	4.2	33	4.8
Alcohol	10	1.6	12	1.8	13	2.1	7	1.2	5	0.9	14	2.6	8	1.4	12	1.7
Other psychoactive substance	2	0.3	3	0.5	0	0.0	2	0.3	3	0.5	4	0.7	1	0.2	1	0.1
<b>Total</b>	<b>633</b>	<b>100.0</b>	<b>649</b>	<b>100.0</b>	<b>625</b>	<b>100.0</b>	<b>580</b>	<b>100.0</b>	<b>554</b>	<b>100.0</b>	<b>546</b>	<b>100.0</b>	<b>569</b>	<b>100.0</b>	<b>694</b>	<b>100.0</b>
No substance/unknown	7		8		4		3		1		3		16		0	



**Table 14:** Secondary and third substances for treatment demand in the in-treatment population at Free Clinic Antwerp, Belgium, 2008.

	Secondary substance		Third substance	
	n	%	n	%
Opiates	128	25.7	65	23.1
Stimulants	179	35.9	69	24.6
Hypnotics and sedatives	78	15.7	57	20.3
Hallucinogens	2	0.4	0	0.0
Volatile substances	0	0.0	0	0.0
Cannabis	75	15.1	65	23.1
Alcohol	34	6.8	25	8.9
Other psychoactive substances	2	0.4	0	0.0
<b>total</b>	498	100.0	281	100
No substance/unknown	142		359	

➤ **Studies on the drug treatment population: comparison of primary amphetamine users with other drug users**

We analysed data collected in the years 2005 to 2008 by “De Sleutel” – a large substance abuse treatment network in Belgium – about persons demanding drug treatment in the specific year. Data of these 4 years were combined to increase sample size. The sample consisted of 1376 persons, 285 women and 1091 men. There is no double counting of patients in this register due to a unique identification code per person.

Amphetamine was the primary substance among 21.2% of the users (27.0% in women and 19.7% in men). Cocaine (38.2%) (resp. 34.4% and 39.2%) and heroine (40.6%) (resp. 38.7% and 41.1%) were more often the primary substance (excluding “other substance” = 1.2%).

The mean age of the sample was 28.5 years (median = 27 years; min = 17; max = 59). The mean age of amphetamine users demanding treatment (28.0 years) did not differ significantly from the age of heroine users (27.7 years) or cocaine users (29.2 years) (ANOVA).

Contrary to users of heroine (resp. 53.2% and 42.2%) and cocaine (resp. 46.4% and 42.3%) who mainly demand treatment on their own initiative, this is less often the case among amphetamine users (resp. 26.3% and 25.5%). Most women (36.8%) and men (49.1%) who use amphetamines are demanding treatment because this was ordered by police or justice. This is considerable less the case in women and men using cocaine (resp. 14.4% and 22.2%) or heroine (resp. 19.3% and 21.2%).

Women using amphetamines live predominantly with a partner (27.7%), as do users of heroine (38.5%) and cocaine (28.9%). This living situation is considerably less prevalent among men (resp. 16.1%, 20.1% and 27.4%).

Men using amphetamines live predominantly with their parents (28.3%), as do most cocaine users (27.7%). This is less often the case among women using amphetamines (17.1%). About one in five of the women (21.1%) and men (19.8%) using amphetamines live alone.

The distribution of educational levels among amphetamine users is similar to that of heroine users. Cocaine users are more often higher educated. Less cocaine users have only a primary school education or less (resp. 15.6% and 22.7% in women and men) compared to amphetamine users (resp. 25.7% and 26.7%) and heroine users (resp. 29.8% and 27.4%). More cocaine users have a college or university degree (resp. 14.6% and 6.9% in women and men) compared to amphetamine users (resp. 4.1% and 2.9%) and heroine users (resp. 6.5% and 3.7%).

The social integration and financial independence of women, measured by their work situation, is better among amphetamine users compared to cocaine and heroine users. Among amphetamine users, one in three women (35.5%) have a regular job (full-time or a part-time with regular shifts) and nearly half of them (47.3%) are unemployed (including unable to work). Less cocaine users (29.9%) and heroine users (23.9%) have a regular job. Unemployment is higher, too (resp. 52.5% and 49.6%).

The social integration and financial independence of men is worse among amphetamines users compared to cocaine users, but better than heroine users. Among amphetamine users, one in three men (34.9%) has a regular job and 40.1% is unemployed (including unable to work). However, half of the cocaine users demanding treatment have a regular job (49.2%) and 30.5% is unemployed. Among heroine users, only one in four (26.4%) has a regular job and 42.4% is unemployed.

#### **12.1.e Out-of-treatment populations of (meth)amphetamine users**

The out-of-treatment population of amphetamine users is reached by the needle exchange programs (NEP) in the Flemish part of Belgium. Since 2001, a yearly survey is organised in the population of injecting drug users (IDU) within the NEP. The NEP started in drug services that mostly reach opiate users and therefore, this population was the best reached. In 2003, the reach of the NEP changed. The NEP came in contact with a large group of stimulant users: cocaine or amphetamine users that were mostly not reached by the 'regular' opiate oriented low threshold services. Since 2003 up until now, the NEP were able to keep in touch with this population. In recent years, about one third of these IDU prefer stimulant use (Table 15). In 2008, the survey in the NEP reached 237 IDU; 32% of them preferred to inject a stimulant, 44% opiates and 24% a cocktail.

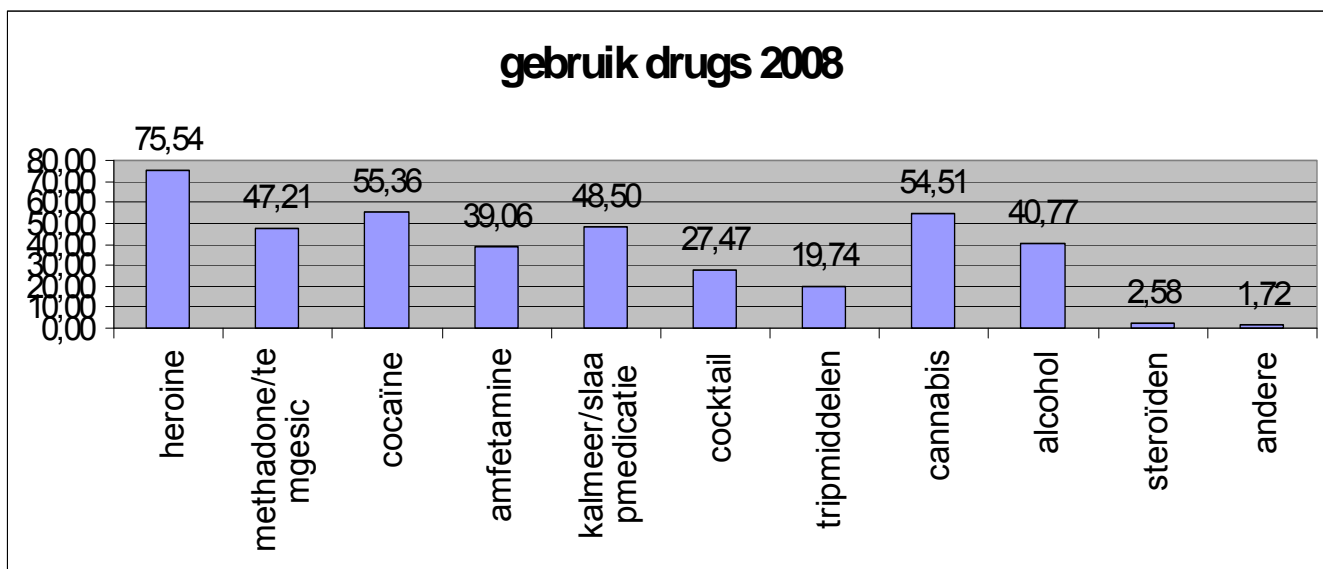
In 2003, the population that was reached by the NEP in the Flemish Community changed (Table 15). In Antwerp, which is an important centre, the proportion of amphetamine users among the IDU attained even 48% in 2004. Not only was the NEP better known in this population, but the NEP in Antwerp started working with two "peers supporters" who were active amphetamine users. Before the peer supporters were opiate users.

**Table 15:** Preference for opiate use, stimulant use and cocktail use among injecting drug users in the Flemish Community, Belgium, 2001 – 2008

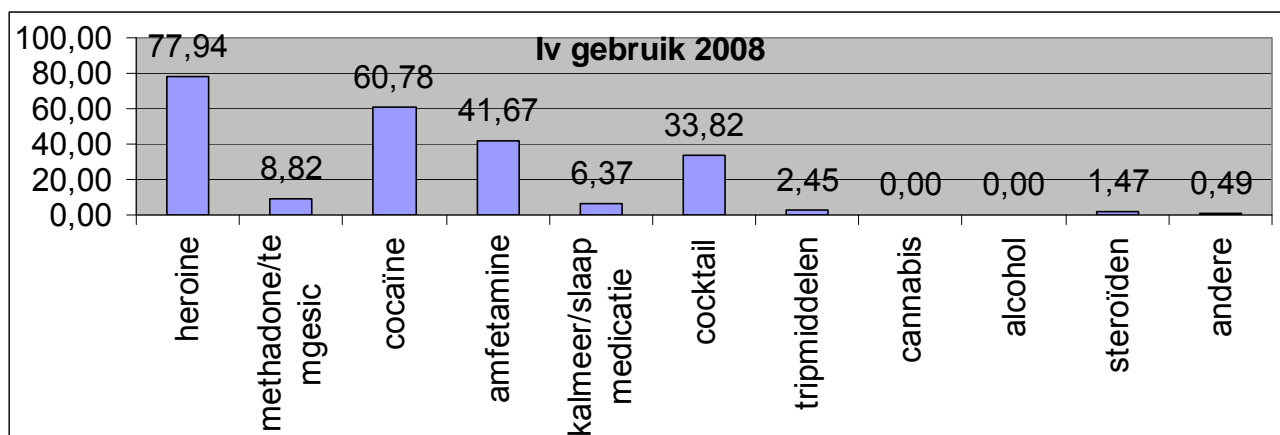
Year	Preference for opiate use	Preference for stimulant use	Preference for cocktail use (snowball – heroine/cocaine or amphetamines)
2001	63.0%	37.0%	
2002	37.8%	24.4%	37.0%
2003	36.0%	39.4%	23.9%
2004	43.0%	37.2%	18.0%
2005	50.0%	34.0%	13.0%
2006	38.0%	38.4%	23.1%
2007	42.8%	38.3%	18.4%
2008	43.8%	32.1%	23.6%

In 2008, 39.1% of these IDU in the Flemish Community had used amphetamines (not necessarily injected) during the past 30 days previous to the survey (Figure 1 (in Dutch)). In this sample of IDU, 42.7% had injected amphetamines 30 days previous to the survey (Figure 2 (in Dutch)).

**Figure 1:** Use of illicit drugs and alcohol among injecting drug users in the Flemish Community, Belgium, 2008.



**Figure 2:** Injecting drug use among injecting drug users in the Flemish Community, Belgium, 2008.



#### 12.1.f Production sites and laboratories, origin of products and trafficking routes, precursors seizures

In 2008, six illicit synthetic drug laboratories were dismantled in Belgium. Four of them produced amphetamine, one XTC and one GHB. All these illicit synthetic drug laboratories were located in the North east part of the country. The number of discovered illicit synthetic drug laboratories remains stable for the last five years. After an uprising at the end of the 90's, the situation hasn't significantly worsened.

The problem is nonetheless still acute because of the dangers drug laboratories imply (e.g. explosions) and the increased professionalism (greater production capacity) showed by the laboratories. Thus, awareness and police research are still acute.

Synthetic drugs found in Belgium are either produced in the country (mainly XTC and amphetamines) or imported. The "national" production is also exported to other countries inside and outside Europe.

The precursors PMK and BMK found in Belgian illegal laboratories used to come from China. Nowadays, indications show that Russia is the replacement source country of precursors, although there is no strong evidence for this statement. Many chemical substances used in the production of synthetic drugs are easy to buy in Belgium as they could be used for legal applications. On the contrary, in The Netherlands some precursors are not freely available, so Dutch traffickers cross the border to buy them in Belgium. Actions to inform chemical companies and distributing ones on the risk of chemical misuse have been carried-out by police services.

Although the number of seizures varies not substantially, large yearly variations exist in the quantities seized in Belgium (Table 16). There is not always a clear-cut explanation for those yearly variations. One large seizure can for example influence the figures, as can certain international law enforcement actions or stock piling of drugs.

**Table 16.** Number of amphetamines and XTC seizures and amount seized in Belgium, 2007-2008, Federal Police

	2007	2008
<b>Amphetamine</b>	2,767 (483.9 kg)	2,646 (410.73 kg)
<b>Ecstasy-type substances</b>	1,798 (541,245 tablets)	1,412 (162,821 tablets)

## 12.2 Health and social correlates of chronic amphetamine and methamphetamine use

Through its nightlife activities and after a first exploratory phase of the treatment demands of problem synthetic drug users in the French Community, the NGO Modus Fiesta notes that the main issues for the users are the following:

- Mood swings
- Use of other drugs in order to manage the unpleasant descent
- Ever growing use desire
- Incapacity to have fun without consuming
- Loosing touch with social network because of the constant nightlife
- Family, sexual and financial problems
- Health problems (ulcers, digestion problems, appetite loss, lack of sleep, teeth crunching...)
- Cognitive problems (memory, concentration...)
- Psychological problems (depression after massive use, personality disorder...)
- Loosing touch with administrative, social and care organizations
- Legal and social problems
- Increased vulnerability
- School drop-out

According to Modus Fiesta, about one in four of the amphetamine users met in 2007 declared having experienced at least one problem linked to their consumption. In 2007, sexual (46.0%) and psychological problems (43.2%), and problems at work (40.1%) were mentioned most often, but problems in other areas of life were not uncommon (Table 17).

**Table 17:** Distribution (%) of the problems experiend by the amphetamine users (multiple choice questionnaire), 2005-2007, French Community.

Year	2005	2006	2007
<b>Number of users experiencing « at least one problem » during lifetime</b>	<b>951</b>	<b>1122</b>	<b>569</b>
<b>Problems (%)</b>			
<b>Sexual</b>	23.8	24.0	46.0
<b>Psychological</b>	40.3	40.1	43.2
<b>At work</b>	38.5	35.1	40.1
<b>In relationships</b>	49.4	48.8	33.6
<b>Physical</b>	45.5	51.4	25.8
<b>Legal</b>	28.5	28.0	28.6
<b>Economical</b>	28.9	24.8	21.4

### 12.3 Responses to chronic amphetamine / methamphetamine use

In the Flemish Community, a specific preventive approach of chronic or problematic amphetamine/methamphetamine users doesn't exist. The assistance to drug users isn't actually organized according to products: problematic drug users are taken care of through psychological and social accompaniment. Only one product-directed approach exists because a pharmacologically assisted treatment is needed; this is the case for opiates.

However, when the needle exchange programs (NEP) in the Flemish Community started to reach the amphetamine population, they developed a specific harm reduction oriented leaflet about amphetamines ("speed") and training for drug service workers. Because the amphetamine population is around 30% of the attending NEP clients, it was decided that it was important to direct specific prevention initiatives to this population.

In 2008, almost 17% of the NEP sample in the Flemish Community (see study above) never had a treatment for their drug use. A large proportion of this group are likely to be amphetamine users since traditionally the drug services are opiate oriented.

The French Community NGO Modus Fiesta states that the responses to amphetamine use are starting to be implemented. At the NGO reception desk, an ever growing portion of people experience problems linked to their drug use. This increased vulnerability shows through the users demands: they look for low budget housing, ask for updating or renewing their social security registration, ask for legal support concerning debts, etc. In order to be fulfilled, these complex demands request an important follow-up of the user, adequate resources and physical care.

Moreover, the "trend" coming along with these "new drugs" hides the risk notion linked to the consumption. Because these drugs are used mainly in festive environments and because they are becoming mainstream, the users don't see themselves as "drug addicts". As a result, the young users, who are globally in good physical condition, don't aim at the usual care structures: very few of them are informed about the risks involved and the available means to lower them. It is thus pretty hard to meet and inform properly that public: the specialised organs who could be meeting them still have to adjust in order to find a way to reach these users.

Nevertheless, the following actions targeting drug users in nightlife settings also reach the amphetamine and methamphetamine users:

#### Modus Fiesta community reception desk for drug users

The desk is a place where drug users who primarily use in festive settings are welcomed, informed and directed to other structures when necessary. Through its activities, it fulfills a prevention, risk reduction and support task. That place is open to anyone, drug user or not, who wants information about illegal drugs. The users are met by a professional and a "jobiste" (non-professional worker).

However, meeting users in festive environments isn't enough anymore: some of them still use drugs outside that specific setting and the professional's presence in the festive setting is also too occasional to be sufficiently effective.

#### Operating basic service ("permanence")

This project was created after a study among new synthetic drug users in nightlife settings (Hacourt, 2002) concluded that users don't go to specialised care structures, even when necessary. The step needed to be done "in the other direction": the specialized care structures needed to go where these users were, for example at Modus Fiesta. A basic

service was thus operated with three addictions specialized centers: “Le Projet Lama”, “le Centre Médical Enaden” and “Infor Dorgues”.

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-Circulaire concernant la reconnaissance et la prise en charge des jeunes pratiquant le « sniffing », **28 avril 2008**.

- Décret relatif au plan de cohésion sociale dans les villes et les communes de Wallonie, **6 novembre 2008**.
- Arrêté Royal fixant les modalités de financement par le fonds de lutte contre les assuétudes, **18 décembre 2008**.  
Koninklijk besluit tot vaststelling van de nadere regels voor financiering door het fonds tot bestrijding van verslavingen, **18 december 2008**.
- Vlaams actieplan alcohol, tabak en drugs 2009-2015, goedgekeurd door de Vlaamse Regering op **6 maart 2009**.
- Decreet van **21 november 2003** betreffende het preventie gezondheidsbeleid gewijzigd door het decreet van **20 maart 2009** houdende diverse bepalingen betreffende het beleidsdomein Welzijn, Volkgezondheid en gezin.
- Avant-projet de loi relatif à l'introduction des tests salivaires en matière de drogues dans la circulation, **13 mars 2009**.  
Voorontwerp van wet rond speekseltest voor de opsporing van druggebruik in het verkeer, **13 maart 2009**.
- Convention collective de travail n° 100 concernant la mise en œuvre d'une politique préventive en matière d'alcool et de drogues dans l'entreprise, **1 avril 2009**.  
Collectieve arbeidsovereenkomst nr 100 betreffende een preventief alcohol- en drugbeleid in de onderneming, **1 april 2009**.