



European Monitoring Centre
for Drugs and Drug Addiction



Belgian monitoring Centre for
Drugs and Drug Addiction

Scientific Institute of Public Health
OD Public health and Surveillance

**2011 National Report (2010 data)
to the EMCDDA
by the Reitox National Focal Point**

**“BELGIUM”
New Development, Trends and in-depth
information on selected issues**

REITOX

Belgian national report on drugs 2011

OD Public Health and Surveillance, Scientific Institute of Public Health, October 2011, Brussels, Belgium

WIV-ISP/EPI REPORTS N°002

ISSN: 2034-6352

Depot number:D/2012/2505/08

Belgian national report on drugs 2011

**Nathalie Deprez
Jerome Antoine
Juan-Francisco Asueta-Lorente
Kaatje Bollaerts
Trudy Van der Linden
Johan CH van Bussel**

Scientific Institute of Public Health
OD Public Health and Surveillance
Substance Use and Related Disorders
Belgian Monitoring Centre for Drugs and Drugs Addiction
Rue J. Wytsmanstraat 14
B-1050 Brussels
Belgium
bmcdda@wiv-isp.be
www.wiv-isp.be/bmcdda

EMCDDA Management Board

Mr. **Claude GILLARD**, Legal adviser, Head of the Department of criminal law, Direction Générale de la législation du Service Public Fédéral Justice

Dr. **Philippe DEMOULIN**, Deputy Director General f.f., Administration de la Communauté française de Belgique

EMCDDA Scientific Committee

Prof. Dr. **Brice DE RUYVER**, Full Professor, Institute for International Research on Criminal Policy (IRCP), University of Ghent

Ministers involved in the global and integrated drug policy in Belgium 2011

For the Federal State:

Mrs. **Laurette ONKELINX**, Vice Prime Minister and Minister of Public Health and Social Affairs, in charge of social integration, resigning.

Mr. **Yves LETERME**, Prime Minister, in charge of the coordination of the Policy of Migration and Asylum, resigning.

Mme. **Joelle MILQUET**, Vice-Prime Minister and Minister of work and Equal Opportunities, in charge the Policy of Migration and Asylum, resigning.

Mr. **Steven VANACKERE**, resigning Vice-Prime Minister and Minister of Foreign Affairs and Institutional Reform.

Mr. **Didier REYNDERS**, Vice-Prime Minister, and Minister of Finance and Institutional Reforms, resigning.

Mr. **Stefaan DE CLERCK**, Minister of Justice, resigning.

Mme. **Annemie TURTELBOOM**, Minister of the Interior, resigning.

Mme **Sabine LARUELLE**, Minister of Small and Medium-sized Enterprises, Self-employed persons, Agriculture and Science Policy, resigning.

Mr. **Pieter DE CREM**, Minister of Defense, resigning.

Mr. **Vincent VAN QUICKENBORNE**, Minister of Enterprise and Simplification, resigning.

Mr. **Michel DAERDEN**, Minister of Pensions and Big Cities, resigning.

Mr. **Melchior WATHELET**, State Secretary for Budget, Policy for Migration and Asylum, Family Policy and Federal Cultural Institutions, resigning.

Mr. **Etienne SCHOUPPE**, State Secretary for Mobility, resigning.

Mr. **Philippe COURARD**, State Secretary for Social Integration and Poverty Reduction, resigning.

For the Walloon Region:

Mr. **Paul FURLAN**, Minister of Local Authorities, Towns and Tourism.

Mme. **Eliane TILLIEUX**, Minister of Health, Social Action and Equal Opportunities.

For the Flemish Community and Flemish Region:

Mr. **Jo VANDEURZEN**, Flemish Minister for Welfare, Public Health and Family.

For the French Community:

Mr. **André ANTOINE**, Vice-Prime Minister, Minister for the Budget, Finance, Employment, Training, Sports and the Airport Policy.

Mme **Fadila LAANAN**, Minister for Culture, the Audiovisual Sector, Health and Equal Opportunities/

For the Brussels Capital Region:

Mr. **Charles PICQUE**, Minister-President of the Brussels-Capital Region.

For the German-speaking Community:

Mr. **Harald MOLLERS**, Minister of Family, Public Health and Social Affairs.

For the communal Community Commission:

Mr. **Benoit CEREXHE**, Member of the Joint Board of the Common Community Commission (Cocom), responsible for Health and Civil Service Policy

Mr. **Jean-Luc VANRAES**, Member of the Combined College of the Common Community Commission (COCOM), responsible for Health Policy, Finance, the Budget and Foreign Relations.

For the French Community Commission:

Mr. **Benoit CEREXHE**, Member of the board of the French Community Commission (CoCof), responsible for Civil Service, Health and Vocational Training for the Self-Employed

Acknowledgements

The editors of this report have many to thank for a lot of information, knowledge, and experience:

Martens Frank, Vandenbempt Isabelle (AZGroeninge), Schelinga Carolin (Arbeitsgemeinschaft für Suchtvorbeugung und Lebensbewältigung), Naji Aziz (Belgian Science Policy Office), Van Dael Ellen (College Procurator-general), Calle Dirk (De Kiem), Lombaert Geert, Raes Veerle (De Sleutel), Pereira Tatiana (Direction Promotion Santé, Ministère de la Communauté française), Mergan Dirk (Federal Agency for Medicines and Health Products), Ricour Koen, Brits Liesje, Dommicent Jessica, Garlement Pascal (Federal Police), Todts Sven, Gillard Claude, Van Malderen Sara (Federal Public Service Justice), Depuijdt Eveline, Doms Kurt, Gorissen Jean-Pierre, Huard Katia, Mertens Ingrid, Windey Francis (Federal Public Service Public Health, Food Chain Safety and Environment), Maryse Wanlin, (Fonds des Affections Respiratoires - Vlaamse Vereniging voor Respiratoire Gezondheidszorg en Tuberculosebestrijding), Mathei Catherina (Free Clinic), Windelinckx Tessa (Free Clinic - Sputenruil Vlaanderen), Hublet Anne (Health behaviour in school-aged children – Vlaanderen), Cops Diederik, Cardoen Dries (Jeugd Onderzoeks Platform Monitor), Coopman Vera, Cordonnier Jan, Fauvart Valerie (Laboratorium Chemiphar), Van Huyck Catherine (Modus Fiesta), Alexandre Sébastien (Modus Vivendi, Brussels), Samyn Nele, Van Durme Filip, Van Haeren Crista, Laeremans Bart (National Institute for Criminalistics and Criminology), Deraedt Koen, Tielemans Joos, De Swaef André (National Institute for Health and Disability Insurance), Mostin Martine (National Poisson Centre), Mazina Déogratias (Observatoire de la Santé et du Social de Bruxelles-Capitale), Casero Lucia, Hogge Michaël, Rwubusisi Miguel (Observatoire socio-épidémiologique alcool-drogues en Communauté Française), Serlippens Annemie (Parket Gent), Hoedt Diederik (Permanent office Statistics and workload measurement), Canfyn Michael, De Beer Jacques, Ducoffre Geneviève, Sasse André (Scientific Institute of Public Health), Berteloot Karel (Service Criminal Policy), Desmet Koen (Universitair Ziekenhuis Gasthuisberg), Verstraete Alain (Universitair Ziekenhuis Gent), Charlier Corinne (Université de Liège), de Smet Patrick (Université libre de Bruxelles), Neels Hugo, van Nuijs Alexander, Vanbroekhoven Carinne (Universiteit Antwerpen), Lambert Willy, Legrand Sara-Ann, Vanderplasschen Wouter, Vandevelde Stijn, Colman Charlotte, Colpaert Kathy, Crement Jelle, De Corte Tom, De Maeyer Jessica, De Ruyver Brice, Goethals Ilse, Lievens Delfine, Vander Laenen Freya (Universiteit Gent), Tytgat Jan (Universiteit Leuven), Kinable Hilde, Rosiers Johan,

Schrooten Jochen , Geirnaert Marijs (Verenig voor alcohol en andere drugproblemen), Cloots Heidi, Witpas Alexander (Vlaams Agentschap Zorg en Gezondheid), Van Deun Paul (Vlaamse Vereniging van Behandelingscentra Verslaafdenzorg), Andries Caroline, Lambrecht Patrick (Vrije Universiteit Brussel), and the many field institutions that provided their annual report.

Table of Content

SUMMARY	13
Part A: New developments and trends.....	19
Chapter 1. Drug policy: legislation, strategies and economic analysis	21
1. Introduction	22
2. Legal framework.....	22
3. National action plan, strategy, evaluation and coordination.....	25
4. Economic analysis	30
Chapter 2. Drug use in the general population and specific targeted-groups.....	35
1. Introduction	36
2. Drug use in the general population.....	36
3. Drug use in the school and youth population.....	41
4. Drug use among targeted groups / settings at national and local level.....	54
Chapter 3. Prevention	61
1. Introduction	62
2. Universal prevention.....	64
3. Selective prevention in at-risk groups and settings.....	73
4. Indicated prevention	80
5. National and local media campaigns	82
Chapter 4. Problem drug use	84
1. Introduction	85
2. Prevalence and incidence estimates of PDU	85
3. Data on PDUs from non-treatment sources	89
Chapter 5. Drug-related treatment: treatment demand and treatment availability	95
1. Introduction	96
2. General description, availability & quality assurance.....	96
3. Access to treatment.....	106
Chapter 6. Health correlates and consequences	125
1. Introduction	126
2. Drug-related infectious diseases.....	126
3. Other drug-related health correlates and consequences	133
4. Drug-related deaths and mortality of drug users	140
Chapter 7. Responses to health correlates and consequences	143

1. Introduction	144
2. Prevention of drug-related emergencies and reduction of drug-related deaths	144
3. Prevention and treatment of drug-related infectious diseases	149
4. Responses to other health correlates among drug users	152
Chapter 8. Social correlates and social reintegration	155
1. Introduction	156
2. Social exclusion and drug use	157
3. Social reintegration.....	168
Chapter 9. Drug-related crime, prevention of drug-related crime and prison.....	171
1. Introduction	172
2. Drug-related crime	173
3. Prevention of drug-related crime	180
4. Interventions in the criminal justice system	180
5. Drug use and problem drug use in prisons	183
6. Responses to drug-related health issues in prisons	191
7. Reintegration of drug users after release from prison	192
Chapter 10. Drug markets.....	193
1. Introduction	194
2. Availability and supply	195
3. Seizures.....	199
4. Price/purity.....	204
5. Other research.....	213
Part B: Selected Issues.....	217
Chapter 11. Drug-related health policies and services in prison.....	219
1. Introduction	220
2. Prison systems and prison population: contextual information	220
3. Organisation of prison health policies and service delivery.....	224
3. Provision of drug-related health services in prison	228
4. Service quality	232
5. Discussion, methodological limitations and information gaps	233
Chapter 12. Drug users with children (addicted parents and children related issues)	235
1. Introduction	236
2. Size of the problem	236
3. Policy and legal framework.....	240
4. Responses	245

Part C: Bibliography.....255

Authors and contributors257
Bibliography261
 List of references 261
 Alphabetic list of relevant databases available on internet..... 274
 Alphabetic list of relevant internet addresses 275
 List of Standard Tables and Standard Questionnaires 278
 List of uncited Belgian research..... 281

Annexes.....285

Annex 1. Methodology Overview of databases used.....285
Annex 2. Methodology Overview of cited studies.....295
Annex 3. List of abbreviations327
Annex 4. List of tables333
Annex 5. List of figures.....336
Annex 6. List of maps339
Annex 7. List of full references of laws in original language340
Annex 8. Index of terms.....346

Summary

Drug policy: legislation, strategies and economic analysis. By adding mephedrone and amfepramone to the list of illicit drugs, Belgium responded to the problem of the so-called 'legal highs'. Also a circular of the Council of Prosecutors-general was issued, concerning the analysis of amphetamine samples, making it obliged for public prosecutors to provide all samples of confiscated amphetamines for analysis. The 'oral fluid drug testing in traffic' became operational in October 2010, also the 'strategic security and prevention plans 2007-2010' have been extended and every private company is now obligated to develop a preventive alcohol and drug policy for its employees. In 2010 the Federal Drug Policy Note of 2001 was actualised: the Communal Declaration of 2010 currently provides the structure for the Belgian drug policy. The essence of this policy remains the recognition that the drug phenomenon primarily is an issue of public health. In the Flemish Community, the guiding document continues to be the Action Plan on Tobacco, Alcohol and Drugs 2009-2015. In the French Community, the Programmes on Health Promotion capture the objectives on public health, including drug-related health issues. Drug-related public expenditures in 2008 correspond to 27.78 euro per inhabitant compared to 28.57 euro in 2004. In 2008 the Federal Public Service Health financed five pilot projects focussed on drug-related health issues. Also the Federal Addiction Fund financed 22 projects that focus on the treatment of (illicit) drug addictions.

Drug use in the general population and sub-groups. In 2008, 14.30% of the general population reported the use of cannabis at least once in their lives. Compared with the 2001 (10.70%) and 2004 (13.00%), the reported lifetime use of cannabis in Belgium increased. Based on the cited school surveys, the reported lifetime prevalence (2010) of cannabis use in school students varied between 2.7% and 5.2% for the youngest (13y) students, and ranged between 39.4% and 52.0% for the oldest (17-18y) school students. Although the reported prevalence's vary, all surveys report a similar increase over the age groups ending at a point where almost half of the school students used cannabis at least once in their lives. The use of illegal psychoactive substances other than cannabis is rather limited in the population of school students. The normative influences from the context or environment of the school student were found to be the most robust factors in determining the use (or decision not to use) of psychoactive substances.

Prevention. Several prevention projects were organised on school level, mainly in secondary schools, but the last few years, attention also goes to primary schools and higher education. Prevention initiatives for parents are either in progress (French Community) or are integrated in programs of adult organisations at local level (Flemish Community). In both cases it is stressed out that they are open to all parents with a broad objective to develop life skills. The helpline 'Druglijn' (the Flemish Community) received slightly less contacts compared to 2009, the number of telephone calls declined while the number of email enquiries increased. In contrast, the helpline InforDrogues (French Community) received 10% more calls compared to 2009; 51% of the contacts originates from the zone "Brussels". Following at risk groups were addressed in 2010 either in Flemish, French or both Communities: Special Youth Care, Young People with a mild mental handicap, migrants, drug users, future parents and children of parents with drug problems. Several campaigns and projects were carried out to improve health and safety of persons in recreational setting: PartyWise, Party Peers, Quality Night, Drogues Risquer Moins, Mobile Team,... To facilitate detection of problematic drug use in primary care, a screening instrument with a linked brief intervention was developed, based on ASSIST, developed by WHO. The project 'Early Intervention' was organised to prevent and detect hazardous substance misuse by youngsters at an early stage. Also the concept 'Too Much' was developed with online self help materials and assessment tests on drug use.

Problem drug use. New estimates of the national prevalence of ever-injecting drug users were obtained using the HIV-multiplier method, yielding an estimated prevalence rate of 1.2 injecting drug users per 1000 inhabitants aged 15-64 years (95% CI = [0.78-1.90]). Information on the characteristics and behaviour of injecting drug users were obtained through Spuitenruil Vlaanderen (Windelinckx, 2011) and through a study by Modus Vivendi-Eurotox in the Walloon region (Sacré, 2010). One of the main findings was the young age at drug initiation. Problem drug use within recreational settings and among university students was found to be rare.

Drug-related treatment: treatment demand and treatment availability. One third of all treatment demands are related to heroin, followed by cannabis (27.1%) and cocaine (14.1%). The age of patients in treatment varies widely in function of the substance concerned. Patients in treatment for hypnotics or opiates are older than patients coming for a cannabis or amphetamine addiction. By treatment facilities differences are also striking. Low-threshold centres welcomes mainly opiates users whereas cannabis users are much more present in centres for Mental Health. The general practitioners network dataset gives an incidence of illegal drug misuse diagnosis of 0.61 per thousand patients. In the minimum psychiatric

database filled in psychiatric hospitals, 13% of the admissions were related to illegal drug use in 2008. At last the national substitution treatment register outline the people receiving a substitution treatment in Belgium. This register collects data from more than 17500 people each year.

Health correlates and consequences. The HIV-prevalence rate among injecting drug users in Belgium was low, with regional estimates based on routine diagnostic testing varying from 3.4 to 6.0% in 2010. The Hepatitis-B and -C prevalence rates varied from 20 to 55.2% (antiHBs) and from 28 to 80% (HCVab). Behavioural research among injecting drug users pointed out that injecting risk behaviours were not ruled out, especially regarding the sharing of injecting paraphernalia. The psychiatric co-morbidity among drug users entering drug treatment was estimated to be 53.8% in 2010. Investigating the psychiatric co-morbidity among psychiatric admissions by substance-related disorder revealed that personality disorders are common among all substance users. Furthermore, mood disorders were found to be most prevalent among sedative users, psychotic disorders among cannabis users, alcohol-related disorders among cocaine users and other drug-related disorders were most prevalent among opioid users. Based on the General Mortality Register, the standardized drug-induced mortality rate (per 1000.000 person years, 15-64yrs) was found to be 24.4 in Flanders (2008) and 19.3 in Brussels (2009).

Responses to health correlates and consequences. Prevention of drug-related emergencies include a.o. crisis care, being organized through the national pilot project for the crisis and case management of substance users, Crisis Intervention Centres and through psychiatric (wards within general) hospitals. The Belgian Early Warning System on Drugs is an important tool for the prevention of drug-related deaths whereas needle exchange is an important measure to prevent drug-related infectious diseases. From October 1st 2010, oral fluid tests are used by the Belgian police to detect drug driving. Simultaneously with the introduction of the oral fluid tests, a large national awareness campaign was launched.

Social correlates and social reintegration. Social exclusion among drug-users is tackled through social networks of cannabis users compared with people not using drugs. Social exclusion among drug users in demand for treatment reveals that one third of all people entering treatment have no or primary level of education and one In two demand of treatment concerns unemployed people. Drug use among sex workers is then tackled. A Belgian study shows that 30% of them had already experienced dependence of one or more substance.. Social reintegration of drug-users is discussed through two studies, one based on a community sample and one among opiates users.

Drug-related crime, prevention of drug-related crime and, prison. Since 2006, there has been an increase in the percentage of drug law offences that are related to cannabis. This is partly due to an increase in number of cannabis plantations detected. For the detection of driving under influence of drugs, a new screenings procedure, including the use of oral fluid samples instead of urine samples, was launched in October 2010. First results show that about 24% of the oral fluid screenings done by the Federal Highway police, are positive. The majority of the blood sample analyses done by the NICC, after a positive screenings test (taken by local or federal police services), show the presence of cannabis. In recent years, several alternatives to prison exists for drug users. The project Proefzorg and Drugbehandelingskamer have been evaluated positively, and serve as an example of good practice. The survey “Drug use in Belgian prisons: Monitoring of health risks” showed that life time prevalence of illicit drug use, defined as both drug use prior and during imprisonment, is reported for 60% to 66% of the prisoners. Life time prevalence of injecting drug use in prison population varies from 15% to 18% over the period 2006-2010. In prison risk behaviour such as tattooing and body piercing, unprotected sexual activities, intravenous drug use and the use and sharing of needles and other paraphernalia is clearly present.

Drug markets. Several surveys among pupils in Flanders show varying estimations of the perceived availability of cannabis (27.6% - 39.4%). This is probably (partly) due to the differences in the formulation of the question and the response categories. More and more cannabis plantations are discovered in recent years, of which about half count less than 50 plants. Mean purity levels for cocaine, cannabis and heroin are similar to previous years, while mean purity of amphetamine and MDMA seems to be increasing. The proportion of tablets containing only MDMA-like substances is declining since 2008, while the proportion of the category ‘miscellaneous’ is increasing. The percentage of MDMA tablets without cutting agents is increasing from 75% in 2007 until 97% in 2010.


Drug related health policies and services in prison. This chapter first proposes information on the penitentiary system and its organization. Data on prison population are then presented by legal status, age and gender using the SPACE I Survey 2009 (2011), the data from the Directorate-General and the two-yearly prison survey “Drug use in Belgian prisons: Monitoring of health risks”. The number of drug(-addicted) offenders is specified. The organization of prison health policies is explained, differentiating between the health perspective and the security perspective. It furthermore details the drug-related health policies targeting prisoners, depicting the legal framework and regulations and the way these policies are implemented and by whom. Attention is then paid to prevention, treatment,

rehabilitation and harm reduction into prison, as well as drug testing. Service quality is discussed, focusing on practical guidelines and standards for drug-related health services as well as training of prison staff. Finally, methodological limitations and information gaps are finally discussed.

Drugs users with children (addicted parents, parenting, child care and related issues).

Recent data, based on the Belgian Treatment Demand Indicator Registry, indicates that on 8130 treatment demands made in 2009, 855 (10.5%) were made by parents living with their children at the moment of the registry. A review of the effects of drugs on motherhood is presented, showing that among cannabis, ecstasy, cocaine and opiates the negatives effects of these latest are well documented, especially the withdrawal syndrome of the child. The Interministerial conference on drugs recently stressed that drug using parents are a target group that needs specific attention because they are at that time not reached and/or because no specific strategy has been developed for them. With regard to the legal framework addressing drug using parents/pregnant women and their children, it appears that it is non-specialized: drug using parents are treated like drug users and judged in that sense when children can be considered as endangered or in a problematic educational situation because of their parents addiction. In that case, through the specialized youth help, a judicial, compulsory-made decision can be taken by the Youth Court against parents and for the children well-being. Finally, several projects addressing drug-using parents/pregnant women are presented, as well as clinical guidelines.

Note

Tables with data are available for figures and graphs with the icon  in their title. These tables can be found (May 2012) on the website of the Belgian Monitoring Centre for Drugs and Drug Addiction: <http://bmcdda.wiv-isp.be/> > BAR > BAR2011.

A decorative graphic at the top of the page features a solid brown horizontal bar. On the right side of this bar, there are two overlapping hexagons: a yellow one on top and a dark red one on the bottom. Below the bar, two more hexagons are visible, one orange and one light orange, appearing to be partially cut off by the bottom edge of the bar.

Part A

New developments and trends



Chapter 1.

Drug policy: legislation, strategies and economic analysis

Cremont, J.; De Ruyver, B.; Vander Laenen, F. and Lievens, D.



1. Introduction

For almost a decade, the Federal Drug Policy Note of 2001 was the backbone of the Belgian drug policy. At the beginning of 2010, the Interministerial Conference on Drugs approved the Communal Declaration, which was prepared by the General Drugs Policy Cell. Although no substantial changes can be reported, this Communal Declaration is an important step in the further implementation of the global and integrated drug policy in Belgium, coordinated by the General Drugs Policy Cell.

As regard to the legal framework, the regulations on oral fluid drug testing in traffic and the restrictions on ‘amfepramone’ and ‘mephedrone’ are worth mentioning. However, new legislations in the field of drug issues are rather limited, particularly on the federate levels. On the federal level, one can refer to the difficult government formation, which has its consequences on the legislative level.

A complete list of references to the legal texts in their original language and sorted by date, can be found in the annexes at the end of this report.

2. Legal framework

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

The Act on public health of December 23th 2009 re-added ‘**amfepramone**’ to the Royal Decree on psychotropic substances of January 22th 1998. On October 6th 2009, the Council of State annulled the provisions regarding this product in the latter Royal Decree. According to the judgement of the Council of State, these provisions had to be laid down by law, instead of by a Royal Decree. From January 8th 2010 onward, this substance is restricted again by the Narcotic Drug Act.

The Royal Decree of June 13th 2010 modified the Royal Decree on psychotropic substances of January 22th 1998, thereby restricting the import, export, production, possession, sale and purchase of ‘**mephedrone**’ (4-methylmethcathinone). This substance was the subject of a **Risk Assessment Report of the Scientific Committee of the EMCDDA** (EMCDDA2011), thereby resulting through the Council of the EU in an adaptation of the national legislation. By adding mephedrone and amfepramone (both ring-substituted cathinone derivatives) to the list of illicit drugs, Belgium responded to the problem of the so-called ‘**legal highs**’. These

products have similar effects as certain illegal drugs (e.g. cocaine, amphetamines and MDMA), but are not listed as controlled substances. They are often promoted through the internet as products with a purpose other than human consumption. By changing certain elements in the chemical composition of a substance, the manufacturers stay ahead of the legislator, thus avoiding criminal prosecution.

On February 9th 2010, a circular of the Council of Prosecutors-general was issued, concerning the **analysis of amphetamine samples**. The sample analysis of all confiscated amphetamines in Belgium was assigned to the National Institute for Criminalistics and Criminology (NICC). Through the **chemical profiling** and their registration in the European database (**European Drugs Profiling System**), amphetamine samples can be linked to registered drug suppliers or criminal networks. As Belgium appears to have a considerable part in the production and distribution of amphetamines in Europe (EMCDDA2010b), this database offers new methods of investigation and control for law enforcement agencies. According to this circular, the public prosecutor is obligated to provide the NICC with all samples of confiscated amphetamines. The examining magistrate on the other hand, is an independent judge and thereby not bound by the circular. Due to the distinction between both procedures, only a particular part of the samples can be processed by the NICC. In order to rectify this problem, an adaptation by law is necessary.

2.2. Laws implementation

2.2.1. Federal level

The Act of July 31th 2009 which introduces the **oral fluid drug testing in traffic**, became operational the first of October 2010. This test replaces the former procedure of urinalysis, which was considered to be too complex and too time-consuming for the police authorities (see also Chapter 9). Besides these objections, questions were raised whether the urinalysis and the ensuing blood sample analysis were reliable. The former detected the presence of THC even when the subject was no longer in a state of modified consciousness. The blood analysis also revealed that 20% of the positive urine tests were 'false positives', consequently resulting in an unjustified suspension of the drivers licence.

The implementation of the procedure on oral fluid analysis was accompanied by two Royal Decrees. The first Royal Decree regulates the **checklist** that precedes the oral fluid test to assess the indications of recent drug use; the second Decree regulates the ensuing **blood analysis** to determine the amount of drugs used.

On September 29th 2010, the Minister of Justice and the Council of Prosecutors-general issued a **circular to harmonize the investigation and prosecution policy on driving under the influence of drugs**. It replaces the previous circulars on this matter and comes into force on October 1st 2010, at the same time as the oral fluid drug testing. The circular also elucidates the former mentioned Royal Decrees.

With the Royal Decrees of December 29th 2010 and April 28th 2011, the **'strategic security and prevention plans 2007-2010'** have been extended twice for a period of six months, up until the end of 2011. Amongst other, these plans are aimed at the prevention, detection and reduction of drug-related public nuisance and they encourage the rehabilitation of drug users. Due to the difficult formation of a federal government Belgium is recently experiencing, its content remains unchanged.

According to the collective agreement no.100, every private company is obligated to develop **a preventive alcohol and drug policy for its employees** before April 1st 2010. Particularly, every private company has to incorporate at least a declaration of intent in their regulations, along with policy objectives and principles. After this 'first phase', the companies can proceed with the elaboration of the adopted objectives. In this second phase, the companies can implement more developed procedures, rules and tests, although this is only optional. In the first place, this collective agreement considers the use of drugs and alcohol in a working environment as a risk for the health and safety of the employees. It also emphasizes the possibilities to refer employees to treatment, rather than using repressive measures.

2.2.2. Federate levels

The Decision of the **Flemish government** of June 5th 2009 regulates the **recognition and financial support of partner organisations in the field of preventive health policy**. By concluding agreements with the Flemish Community, these organisations are assigned to elaborate specific activities in the field of preventive health. Regarding the prevention of drug use, the Flemish government made an agreement with the Vereniging voor Alcohol- en andere drugproblemen (VAD), **the association for alcohol and other drug problems** (one of the sub-focal points of the BMCDDA). In 2010, the VAD received a continuation of its agreement, from January 1st 2011 onwards. This agreement is applying until December 31th 2015 and contains the objectives, tasks and financial support of its activities on drug prevention. Also, appeals have been launched respectively for partner organisations involved with the coordination of syringe exchange in Flanders and for organisations with field work

with regard to syringe exchange and social skills training in schools (Flemish agency for Care and Health 2011).

3. National action plan, strategy, evaluation and coordination

3.1. Coordination arrangements

A first step in the realisation of a global and integrated drug policy was dealing with the fragmentation of the competences in Belgium. In order to integrate the different policy levels, **a cooperation agreement between the State and the different federate levels** was ratified in September 2002. This agreement created the **General Drugs Policy Cell (GDPC)**, which is responsible for the coordination of a global and integrated drug policy in Belgium. The GDPC is fully operational since 2009, its composition and tasks were regulated by the arrangement of April 14th 2010. The activities of the GDPC are supported by three working cells. The Drug Health Policy Cell is already operational since 2001, the Cell Research and Scientific Information came into force in 2011. The permanent coordination of the GDPC is in the hands of a national coordinator and his vice-coordinator, supported by members of the Federal Public Service of Health, Food Chain Safety and Environment (Cell Drugs). As the GDPC supports and advises the different governments, its composition includes the representatives of all competent authorities.

The cooperation agreement stipulates the objectives of the GDPC:

1. The development of a global vision on all aspects of the drug problem, including personal, national, cultural and other characteristics;
2. The continuous prevention and dissuasion of drug use and the reduction of the harm resulting from the use of drugs;
3. The optimization and diversification of the care and treatment offer with regard to drug addicts;
4. The repression of the illegal production and traffic of drugs;
5. The development and implementation of deliberated policy plans aiming at a global and integrated drug policy;
6. The preparation of any type of consultation concerning the Belgian representation on the European and international drug fora.

The GDPC is responsible for the following tasks (Federal Public Service Health 2011):

1. To make up a detailed, complete and up-to-date inventory of all stakeholders that are engaged in drugs issues;
2. To propose reasoned measures to synchronize all actions of the competent public services and the signatories, and to improve the efficacy of these actions;
3. To formulate reasoned advices and recommendations in order to synchronize drugs policies;
4. To evaluate, in cooperation with the EMCDDA:
 - a. the quality of data and other information that is made available to the GDPC by the relevant public services and the signatories
 - b. the time laps of information exchange between the authorities, the competent public services and the GDPC;
5. To prepare cooperation agreements or protocols for the implementation of integrated actions;
6. To prepare reports for the Interministerial Conference on Drugs and for national services;
7. To stimulate consultations and to formulate proposals for the Interministerial Conference on Drugs as to a common Belgian position on European and international fora;
8. To formulate recommendations and proposals concerning the content and the implementation of drugs policies, drawn up by the signatories;

After the preparatory work of the GDPC, the **Interministerial Conference on Drugs** executes its proposals. This Conference consists of the competent ministers of all government levels and pursues a global and integrated drug policy by mutual agreement, considering the respective competences of the represented departments. The minister of Public Health coordinates the Interministerial Conference and chairs its meetings.

3.2. National action plan and/or strategy

3.2.1. Federal level

For almost a decade, the **Federal Drug Policy Note of 2001** has been the key document for the Belgian drug policy. In order to implement a global and integrated drug policy, the Federal Drug Policy Note recommended the creation of the GDPC. As part of its tasks as the organ of national coordination, the GDPC prepared the **Communal Declaration**, which was approved by the Interministerial Conference on Drugs on January 25th 2010 (cf. ST32_2011_BE_01).

By actualising the Federal Drug Policy Note of 2001, the Communal Declaration of 2010 currently provides **the structure for the Belgian drug policy**. The essence of this policy remains the recognition that the drug phenomenon primarily is **an issue of public health**. Therefore, repression, as a last resort (*ultimum remedium*), is preceded by prevention and treatment. By evaluating the accomplishments of the Federal Drug Policy Note and by stipulating action points for future improvements, the Communal Declaration pursues **the global and integrated approach**. This document can be seen as a confirmation of the Federal Drug Policy Note, rather than as its replacement. The Communal Declaration particularly represents the integrated efforts from the different policy levels, preceded by the Federal Drug Policy Note, the cooperation agreement, the GDPC and the Interministerial Conference on Drugs.

The Federal Drug Policy Note of 2001 was based on the conclusions and recommendations of the Parliamentary workgroup Drugs of 1996-1997 and stated **the five main principles of the Belgian drug policy**: (i) a global and integrated approach; (ii) evaluation, epidemiology and scientific research; (iii) prevention for non-(problematic) users; (iv) treatment, risk-reduction and reintegration for problematic users and (v) repression for producers and traffickers. The action plans of 2001 and 2010 both start with an overview of the preceding measures on drug policy. In a second part, the current statement of affairs is assessed, resulting in specific action points for the future. As the Federal Drug Policy Note thoroughly describes its action points, the Communal Declaration mainly assesses to what extent they have been realised. Consequently, the latter stipulates the efforts which should be made in order to further execute the action points of 2001.

The Federal Drug Policy Note of 2001 considers the use of psychoactive substances primarily as a problem of public health. Therefore, the action points concerning 'Prevention' mainly focus on the prevention of drug use as a health threat. The Communal Declaration of 2010 on the other hand, draws a clear distinction between the prevention aiming at public health and the prevention of drug-related public nuisance. On this matter, a few objectives are described, mostly in regard to the local authorities.

On the subject of '**Treatment**', the Communal Declaration remains supportive of a diversified offer of treatment facilities, integrated in coordinating networks. In order to reach a wider range of drug users, the declaration states that an increase in treatment capacity is needed. The support for the cooperation between the criminal justice system and the drug treatment services continues, with special attention for the necessary conditions. In general, the action

points on 'Treatment' are confirmed, as the Communal Declaration promises their continuous optimisation and development. The projects that were implemented as part of the Federal Drug Policy Note continue to be supported. The Communal Declaration differs on the subject of risk-reduction. Although it remains an objective of the Belgian drug policy, its confirmation is rather implicit.

The action points on '**Repression**' of the Federal Drug Policy Note 2001 are confirmed in the Communal Declaration of 2010 as well. The latter plans to enhance the repressive measures on the production and traffic of illegal drugs, as part of the control of the supply. In addition to the request for a cross-border approach for drug tourism in the 2001 policy note, an intensification of the cooperation and consultation with the neighbouring countries was promised in 2010. With regard to the drug users, imprisonment remains an 'ultimum remedium' and alternative measures for drug using delinquents are stimulated. The penitentiary drug policy, as described in the policy note of 2001, is not discussed as part of the action points of 2010.

Following the ambiguity regarding the legal status of cannabis use (Gelders and Vander Laenen 2007), the Communal Declaration chose to emphasise the actual intention of the Belgian drug policy. Rather than a tolerance policy, **Belgium pursues a consequent dissuasion policy**, in which the penalization of drugs shows the disapproval regarding the use of drugs.

In the Federal Drug Policy Note of 2001, specific action points gave direction to the scientific research that supports the Belgian drug policy. For this purpose, the development of the **Belgian Monitoring Centre for Drugs and Drug Addiction** and its contribution to the **Belgian Early Warning System on Drugs** were emphasised (Gelders et al. 2008). The Communal Declaration continues these efforts and refers to the Belgian Science Policy as an instrument for evidence-based policing. The GDPC takes this scientific research into account in the further development of the Belgian drug policy. With regard to the global and integrated approach, both policy documents assure their continuous efforts on the European and international level. On that matter, the Communal Declaration appoints the Cell International Cooperation of the GDPC to advance the coherence with the international level. However, this working cell will not come into force.

3.2.2. Federate level

The ministers on the federate level with a competency in drug policy, are represented in the Interministerial Conference on Drugs. Thus, all federate levels are involved in the Communal Declaration and are therefore co-responsible for the implementation of a global and integrated drug policy.

In the **Flemish Community**, the guiding document continues to be the **Action Plan on Tobacco, Alcohol and Drugs 2009-2015**. The main objective of this action plan is the promotion of public health by reducing the use of legal and illegal drugs. Further information can be found in the previous annual reports.

In the **French Community**, the **Programmes on Health Promotion** capture the objectives on public health, including drug-related health issues. These five-yearly plans are subsequently converted into **Operational Community Plans** (*Plan Communautaire Opérationnel*, PCO) in which the priorities are listed. In order to evaluate the previous programme, the Programme on Health Promotion 2004-2008 has been prolonged until December 31st 2011. Consequently, the programme of 2009-2013 has not yet been drafted. On December 1st 2010, the PCO 2008-2009 has also been prolonged until mid-2012. One of its priorities remains the prevention of drug addiction and risk reduction for occasional and frequent substance users.

3.3. Implementation and evaluation of national action plan and/or strategy

3.3.1. Federal level

As part of the implementation of the Federal Drug Policy Note, the federal state continues its financial support in the budgetary year 2011 to the **three pilot projects** which started in 2002. This involves the crisis intervention units and case-management, the intensive treatment of patients with dual diagnosis and the networks for integrated drug treatment programs with a health coordinator. The project on the medically controlled supply of diacetylmorphine in Liege also preserves the support of the Ministers of Justice and Public Health in 2011.

The Royal Decree of March 19th 2001, modified by the Decree of October 6th 2006, currently provides the **legal framework for substitution treatment** in Belgium. The evaluation of this decree was assigned to the Federal Agency for Medicines and Health Products (FAMHP) and the Federal Public Service Health, Food chain safety and Environment. Their task is to elaborate instructions for a new, optimised Royal Decree on substitution treatment, which

was expected in 2010. However, due to the difficult government formation, the finalisation of this decree is postponed. Besides this evaluation, a current research on the subject project '**Analysis and optimisation of substitution treatment in Belgium**' (SUBANOP) can contribute to its legal framework.

3.3.2. Federate levels

In order to measure its accomplishments, the Action Plan on Tobacco, Alcohol and Drugs 2009-2015 of the **Flemish Community** lists **specific objectives for each substance**. First, the action plan pursues a reduction in the use of illegal drugs among minors, aiming at a decrease from 9.9% minors that used drugs in the last year, in 2004, to 7% or less in 2015. In a survey of students in 2009-2010, 11% of the respondents stated to have used illegal substances in the year prior to the survey. Similar to these results, a survey of 2008 indicates 11.5% users of illegal drugs in the last year between 18 and 35 year old. Concerning this age group, the action plan aimed at a reduction from 10.7% in 2004 to 8% or less in 2015. The third objective concerning illegal drugs implies a decrease in the lifetime prevalence of illegal drug use among minors, from 19% in 2004 to 14% or less in 2015 (Flemish Agency for Care and Health 2011).

The Decision of the **Walloon government** on May 27th 2010 brought the Decree of April 30th 2009 on the **recognition and financial support of care and treatment networks and services specialised in addictions** into effect. This Decree particularly represents the objectives of the Federal Drug Policy Note regarding the coordination and cooperation of drug treatment facilities, organised in regional networks. Hereby, the aim is to improve the quality and accessibility of the drug treatment facilities.

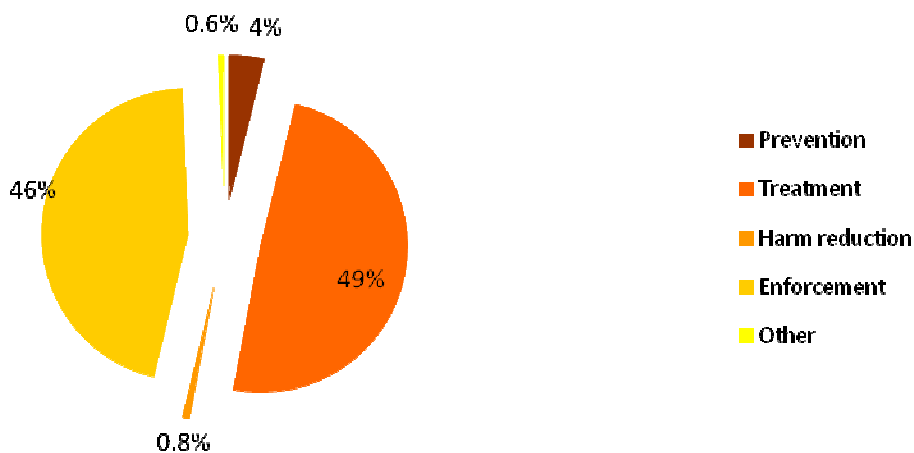
4. Economic analysis

4.1. Public expenditures

The information on drug-related public expenditures originates from the research project '**Drugs in figures III**' (Vander Laenen et al. 2011) (cf. ST_Public_expenditures_2011_BE), which contains the measurement of the public expenditures for the year 2008. In this part, the expenditures of 2008 are being compared to the ones of 2004, derived from 'Drugs in figures II' (De Ruyver et al. 2007), be it that this comparison is rather ambiguous, due to the methodological changes in both studies.

The drug-related public expenditures in 2008 amount to a total of **€296,329,531**, which is 0.09% of Belgium's Gross Domestic Product (GDP, which amounted to 344.7 billion euros on 1 January 2008).. This corresponds to **€27.78 per inhabitant** (on 1 January 2008 Belgium's population stood at 10,666,866) compared to €28.57 in 2004. A subdivision of the expenditures on each specific pillar shows the following proportions:

Figure 1.1: Public expenditures within each pillar, Belgium, 2008.



Source: Vander Laenen et al. 2011

- Prevention: €11 412 257 (3.85%)
- Treatment: €145,611,584 (49.14%)
- Harm reduction: €2 329 752 (0.79%)
- Enforcement: €135,085,125 (45.59%)
- Other: €1,890,813 (0.64%)

The Belgian drug policy, as previously discussed in detail, gives priority to prevention before treatment, with repression as a last resort. However, the latest figures on drug-related public expenditures show a decrease of 7.18% with regard to the expenditures on '**prevention**'. This decrease is attributed to reductions and shifts in the regional expenditures. The public expenditures on '**treatment**' in 2008 on the other hand, show a slight increase compared to the figures of 2004. On the regional level though, the Flemish government and the Walloon region have cut back on the expenditures on 'drug treatment', while the federal level spent more on this pillar in 2008.

Table 1.1: Public expenditures within the criminal justice system (2004 vs. 2008).

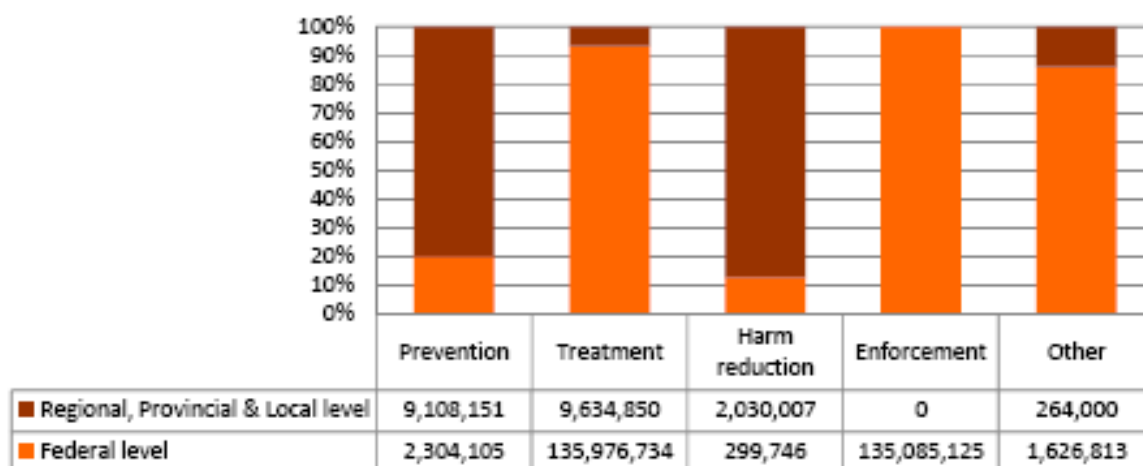
	Expenditures 2004	Expenditures 2008
Detection	152 318 467.88	168 989 940.10
Prosecution	3 832 647.62	6 799 870.05
Sentencing	3 883 307.23	6 229 901.78
Sentence execution	21 836 579.03	57 464 463.56

Source: Vander Laenen et al. 2011

With regard to ‘repression’, increasing expenditures are observed for the four levels of the criminal justice system (detection, prosecution, sentencing and sentence execution) in 2008 in comparison to 2004. Two factors have influenced this evolution. First, the general budget on each level has increased. Secondly, an upward trend in the number of recorded drug crimes is noticed: on the level of detection the proportion ‘drugs’ rises from 4.27% in 2004 to 4.53% in 2008, for prosecution from 4.05% to 5.7% and for sentencing from 2.29% (data from 2003) to 2.99%. The same increases are revealed for two subcategories of the sentence execution: the houses of justice and the prisons.

With the methodological changes in mind, **the division between the different pillars remains similar in 2008 in comparison to 2004**. ‘Repression’ obtains an enlarged share in public expenditures, while the share of treatment decreases. The figure below illustrates the public expenditures on each pillar, with a comparison of the contribution of the federal level and the federate levels. ‘Harm reduction’ and ‘prevention’ are primarily financed by federate levels, ‘treatment’ and ‘enforcement’ by the federal level.

Figure 1.2 Financing for each sector, by the federal of the federate levels, Belgium, 2008.



Source: Vander Laenen et al. 2011

4.2. Budget

In 2008, the Federal Public Service Health financed several pilot projects as part of the Federal Drug Policy Note of 2001. The budget of these projects amounted to **€4,984,146.06**. Besides the project on 'Alcohol and pregnancy', five pilot projects focus on drug-related health issues:

- Project 'crisis intervention units and case-management' – €3,405,812
- Project 'dual diagnosis' – €933,610.26
- Project 'coordination and care' – €374,177
- Evaluation of the project 'medically controlled supply of diacetylmorphine (TADAM)' – €72,768.18
- Project 'International Cannabis Need of Treatment (INCANT)' – €197,778.62

In 2008-2009, the Federal Addiction Fund also financed 22 projects that focus on the treatment of (illicit) drug addictions. For this period, the budget amounted to a total of **€1,909,363**. Table 1.2 provides an overview of the concerned projects and the assigned budget.

Table 1.2: Funded projects by Federal Addiction Fund, Belgium, 2008-2009.

Project title	Organisation	New / existing project	Budget	Type of project
Actomove	Actolux	Existing	33 000€	Treatment
Free medical consultations and clinic nursing for drug users	Comptoir	Existing	70 720€	Treatment
Part-en-relais	CPAS Charleroi	Existing	39 252€	Treatment
Prevention and care offer for immigrants with drug-using children	De Kiem	Existing	67 000€	Treatment
Abstinence-focused treatment for drug addicted adolescents based on Contingency Management	De Sleutel	New	48 183€	Treatment
CASA : Home support for persons who suffer(ed) (an) addiction(s)	Ellipse	Existing	118 436€	Treatment
The competence of dependent patients as a vehicle for change	ESPACE SANTE	Existing	39 440€	Treatment
Collaboration project FEDASIL and LAMA – M.A.S.S. – Interstices C.H.U. Saint-Pierre	Fédasil	Existing	79 589€	Treatment
Gender specific activity for women within drug treatment facilities	Free Clinic	Existing	97 600€	Treatment
Preventive work on substance misuse with high-risk groups: children, adolescents and their parents	Kliniek Sint-Jozef (Pittem)	Existing	45 260€	Prevention
Management of addictions in the front line "Implementation of a proactive model of care" ARSUETUDE	Maison Médicale Arsouilles	Existing	35 800€	Treatment
Clinical Case Management and intervision for social workers for drug-addicted pregnant women and drug-addicted parents with young children	MSOC Gent	Existing	64 250€	Treatment
Shelter for opiate dependents in the primary health care	MSOC Gent	Existing	87 050€	Treatment
ASSUDOC: Creation of an on-line library specialised in addictions	Prospective Jeunesse	Existing	20 350€	Treatment
Social support in favor of the network Hepatitis C – Bruxelles	Réseau Hépatite C	New	35 500€	Treatment
Secondary prevention after a residential detoxification treatment for youngsters	Sint Camillus	Existing	44 878€	Prevention
Parenthood on the trampoline: being a drug addict and a parent	Trempline	Existing	39 700€	Treatment
Benzodiazepines: Training of GPs and other health stakeholders	ULB & Collab.		318 750€	Treatment
Screening of risky or problematic substance use through online 'self test' questionnaires	VAD	Existing	43 700€	Treatment
Early intervention through group work with young people with a risky or starting problematic use	VAD	Existing	194 480€	Treatment
Development and implementation of a webbased learning path	VAD	Existing	31 025€	Treatment
Medically controlled supply of diacetylmorphine		Existing	355 400€	Treatment
Total			1 909 363€	

Source: Federal Public Service Health, Food chain safety and Environment



Chapter 2.

Drug use in the general population and specific targeted-groups

van Bussel, JCH. and Antoine J.

1. Introduction

In Belgium, there is no recurring general population survey specifically on drugs and drug use. General population data on drug use is mostly derived from the Belgian Health Interview Survey (BHIS), the Belgian branch of the European Health Interview survey initiative (EHIS) launched by Eurostat. However, the BHIS covers a broad range of health topics such as health status, life style, prevention, medical consumption, etc. (Van der Heyden et al. 2010). As a result, only a few questions on substance use are included. At the request of the Belgian Federal Science Policy Office (BELSPO), Decorte and colleagues (2009) investigated the feasibility of a recurring survey on drug use in the Belgian general population. Based on this report, the Research and scientific information sub-cell of the General Cell Drugs Policy has set the implementation of a recurring national population survey on drugs and drug misuse as one of its priorities.

As policy on education, youth and culture are competences of the Communities in Belgium, surveys in for example schools and the party scene are supported by the competent administrations and regional focal points. Sometimes, more local large-scale surveys are administered with the support of the competent city administration.

In this chapter, we describe the results of a recent large-scale general population survey (BHIS) and several school surveys (European School Survey Project on Alcohol and other Drugs, ESPAD; Health Behaviour in School-aged Children, HBSC; VAD Leerlingenbevraging, VAD-LLB; De Sleutel; and the "In hogere sferen 2"-study). Data on drug use was also available through studies in specific contexts like the party scene (VAD Uitgaansonderzoek; Drogues Risques Moins), and prisons (Drugs Monitor). Further, this chapter also relies on data collected in subgroups like Belgian army applicants (Medical Registration Belgian Defence) and sex workers (Espace P; Gh@pro). Information on the data collection methods of these sources can be found in the annexes at the end of this report.

2. Drug use in the general population

Based on the most recent BHIS (2008; n= 11026; 15-64y) (Gisle 2010a;2010b) 14.30% of the general population reported (self-completion questionnaire) the use of **cannabis** at least once in their lives. Compared with the surveys of 2001 (10.70%) and 2004 (13.00%), the reported lifetime use of cannabis in Belgium increased (Buziarsist et al. 2002a;2002b;Bayingana et al. 2006a;2006b). The last year prevalence of cannabis use reported in 2008 was 5.10% and remained stable compared to the reported use in 2004

(5.00%). The last month prevalence of cannabis use in Belgium also remained stable since it was first surveyed in 2001 (2001: 2.70%; 2004: 2.80% and 2008: 3.10%). Of the latter group of users, about one in three respondents used cannabis on a daily basis in 2008 (i.e., on at least 20 days of the past month), whereas only a fifth of this group used it on a daily basis in 2004 (Gisle 2010a;2010b) (See Figure 2.1.).

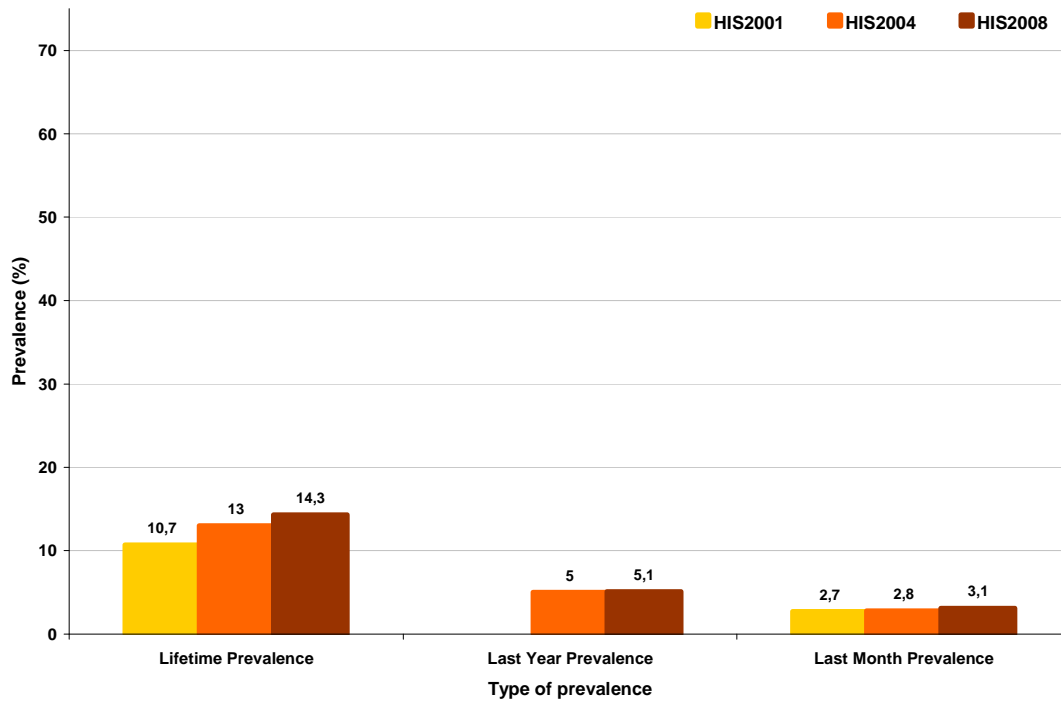
In 2008, more **men** (18.00%) reported ever cannabis use than women (10.80%) did (Gisle 2010a;2010b). The same gender difference was found for the last year (men: 7.20%; women: 3.20%) and last month (men: 4.40%; women: 1.90%) prevalence. In men, an increase of the lifetime (2001: 12.90%; 2004: 15.70%) and last month (2001: 3.60%; 2004: 4.00%) prevalence was found whereas only an increase in lifetime prevalence (2001: 8.40%; 2004: 10.30%) was found in women (See Figure 2.2).

Young adults, i.e. those between 25 and 34 years old (30.10%) reported the highest lifetime prevalence of all age groups in 2008 (Figure 2.3) (Gisle 2010a;2010b). The lifetime prevalence in all age groups increased between 2001 and 2008 (Figure 2.3). The largest increase was found in the age group 25-34 years (2001: 17.50%; 2004: 24.90%; 2008: 30.10%). The last year prevalence and the last month prevalence, on the other hand, remained fairly stable in all age groups, except for the age group 25-34 years where an increase in last month prevalence was found between 2001 (3.9%) and 2004 (7.2%).

The mean age of first cannabis use found in 2008 was 18 years 11 months, and remained stable compared to the mean age reported in 2004 (Gisle 2010a;2010b). Gisle (2010a) found no significant differences by gender (women: 19y 5m; men 18y 7m), educational level, region or degree of urbanisation. However, the mean age of first cannabis use increased with the current age of the respondent (Gisle 2010a;2010b).

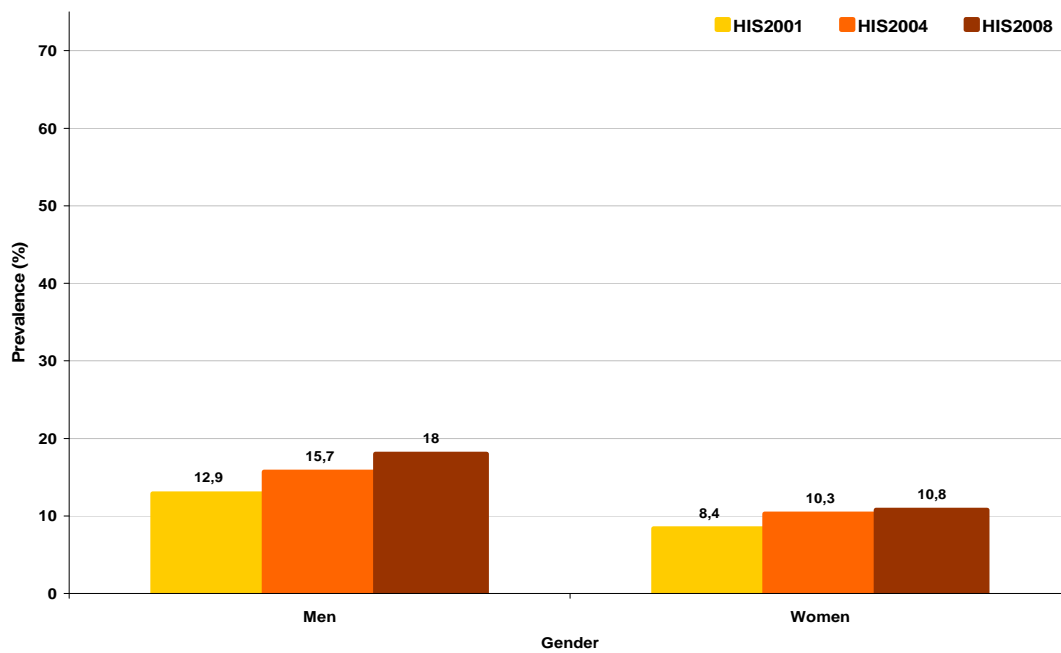
A crude indication of the extent of people who use cannabis in a continuous way (i.e. the **continuation rate**) can be obtained by comparing the current use of cannabis (last month prevalence) in a population with the total number of people who have ever used cannabis in their lifetime (lifetime prevalence). Since the lifetime prevalence was higher in 2008 compared to that in 2001 and the last month prevalence remained stable, the continuation rate in 2008 was lower (21.68%) than in 2001 (25.23%). This suggests that two thirds of those who used cannabis were either experimenting or doing it for a limited period when younger.

Figure 2.1: Lifetime, last year and last month prevalence (%) of cannabis use in Belgium (15-64years), 2001, 2004, 2008. 📊



Source: BHIS 2001, 2004, 2008 (Gisle 2010a;Gisle 2010b)

Figure 2.2:: Lifetime prevalence (%) of cannabis use in Belgium (15-64years), by gender, 2001, 2004, 2008. 📊



Source: BHIS 2001, 2004, 2008 (Gisle 2010a;Gisle 2010b)

In all **educational levels**, the Lifetime prevalence of cannabis use increased between 2001 and 2008 (Gisle 2010a;2010b). At the lower secondary school level, the increase was more pronounced (2008: 11.40%; 2004: 9.70%; and 2001: 6.20%). Contrary, the last year prevalence and the last month prevalence reported in 2001, 2004 and 2008 remained fairly stable at all educational levels.

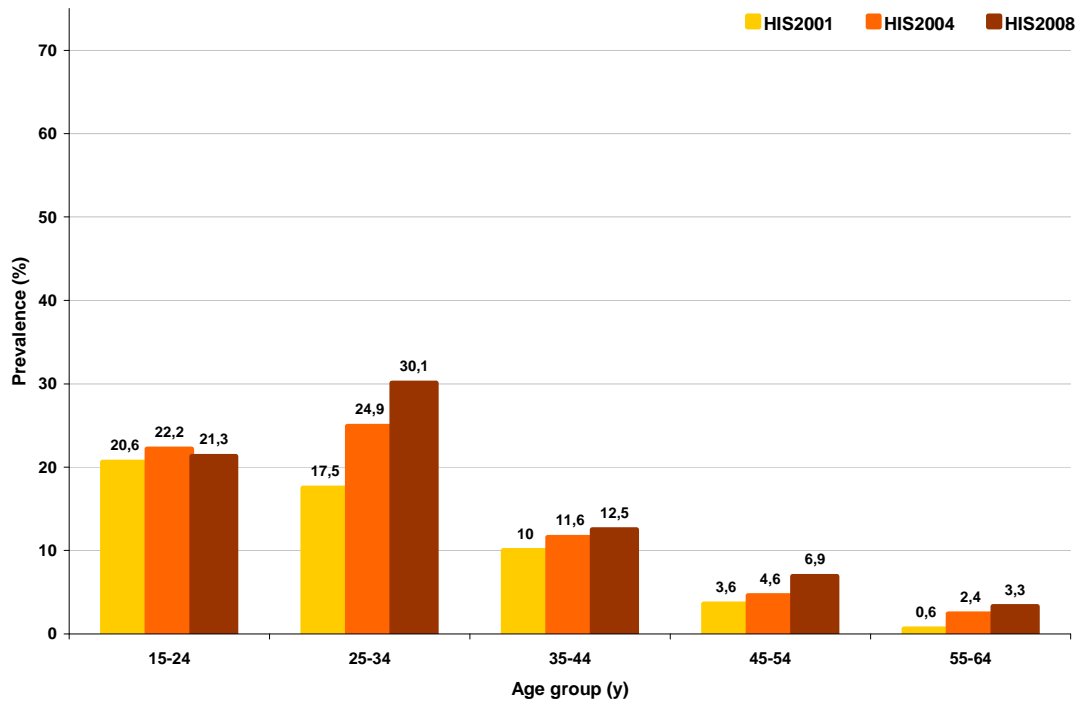
In 2008, more residents of the **Brussels Capital Region** (23.40%) reported cannabis use in their life than residents of either the Flemish (13.40%) or the Walloon (13.30%) region did (Gisle 2010a;2010b). This regional difference was also found in the 2008 last year (Brussels: 8.80%; Flanders: 4.60%; Wallonia: 5.00%) and the last month (Brussels: 6.50%; Flanders: 2.80%; Wallonia: 2.80%) prevalence. Overall, only the lifetime prevalence increased in all regions since 2001 (Brussels: +5.60%; Flanders: +2.80%; Wallonia: +4.70%).

The high prevalences reported for the Brussels-Capital Region could be attributed to its high degree of urbanisation. Indeed, individuals living in **urban municipalities** reported having used cannabis more frequently in the past (17.20%) than individuals living in Belgian sub-urban (12.10%) and rural (11.70%) municipalities (Gisle 2010a;2010b). This difference was less pronounced for the last year (Urban: 6.30%; Sub-urban: 4.70%; Rural: 3.70%) and the last month (Urban: 4.10%; Sub-urban: 2.70%; Rural: 2.00%) prevalence in 2008. Since 2001, the lifetime prevalence increased at all three levels of urbanisation whereas the last month prevalence remained fairly stable. However, regarding for the last year prevalence, a small decrease was found in the urban municipalities between 2004 (7.20%) and 2008 (6.30%), although this difference was not statistically significant after correction for age and gender (Gisle 2010a;2010b).

Less than one percent (0.90%) of the individuals participating in the BHIS in 2008, reported using amphetamines or XTC in the previous 12 months (Gisle 2010a;2010b). Men (1.40%) and individuals of the two youngest age groups (15-24: 2.10%; 25-34: 1.80%) reported more often the past year use of amphetamines or XTC compared to women (0.40%) and the older age groups (35-44: 0.80%; 45-54: 0.00%; and 55-64: 0.10%) respectively. No differences were found between the different educational levels, regions or the degrees of urbanisation (Gisle 2010a;2010b).

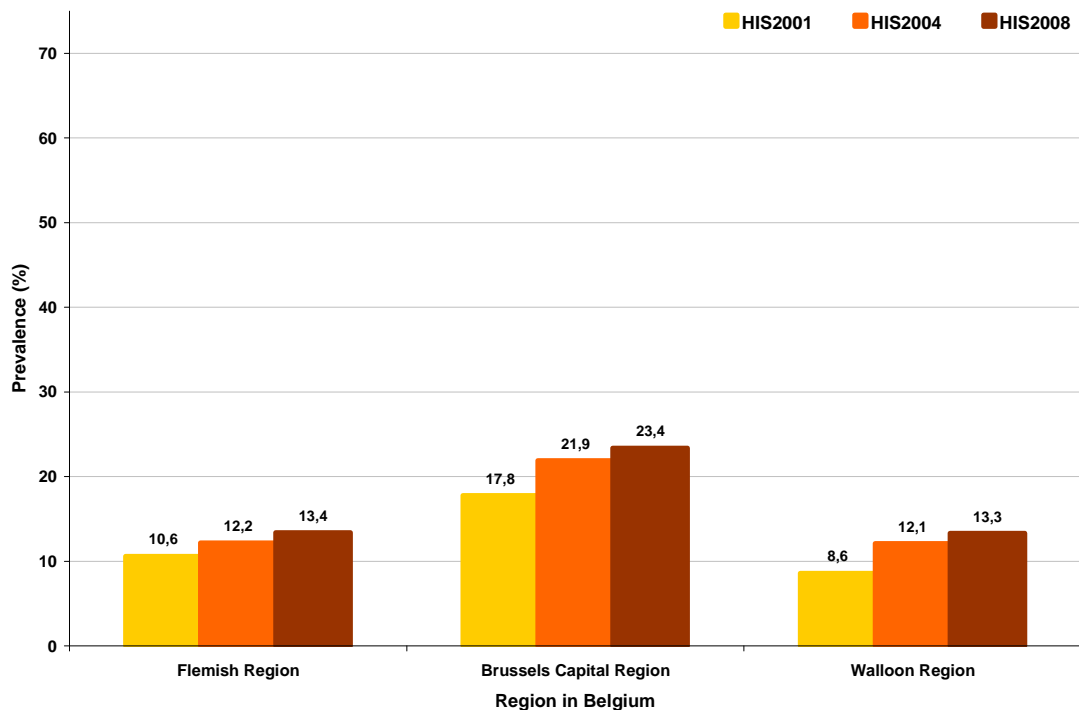
The last year prevalence of **cocaine** use reported in 2008 was lower than one percent (0.90%) (Gisle 2010a;2010b). The Belgian cocaine user tended to be male (1.30%) and younger than 35 years old (15-24: 1.80%; and 25-34: 2.20%) and no differences were found

Figure 2.3: Lifetime prevalence (%) of cannabis use in Belgium (15-64years), by age group, 2001, 2004, 2008. 📊



Source: BHIS 2001, 2004, 2008 (Gisle 2010a;2010b)

Figure 2.4: Lifetime prevalence (%) of cannabis use in Belgium (15-64years), by region, 2001, 2004, 2008. 📊



Source: BHIS 2001, 2004, 2008 (Gisle 2010a;2010b)

between the different educational levels, regions or the degree of urbanisation (Gisle 2010a;2010b).

The past year use of opiates like heroin and its substitutes is rarely (0.20%) reported in the BHIS 2008 (Gisle 2010a;2010b). Because of these small numbers, associations with sex, age, education, region and level of urbanisation are not discussed here.

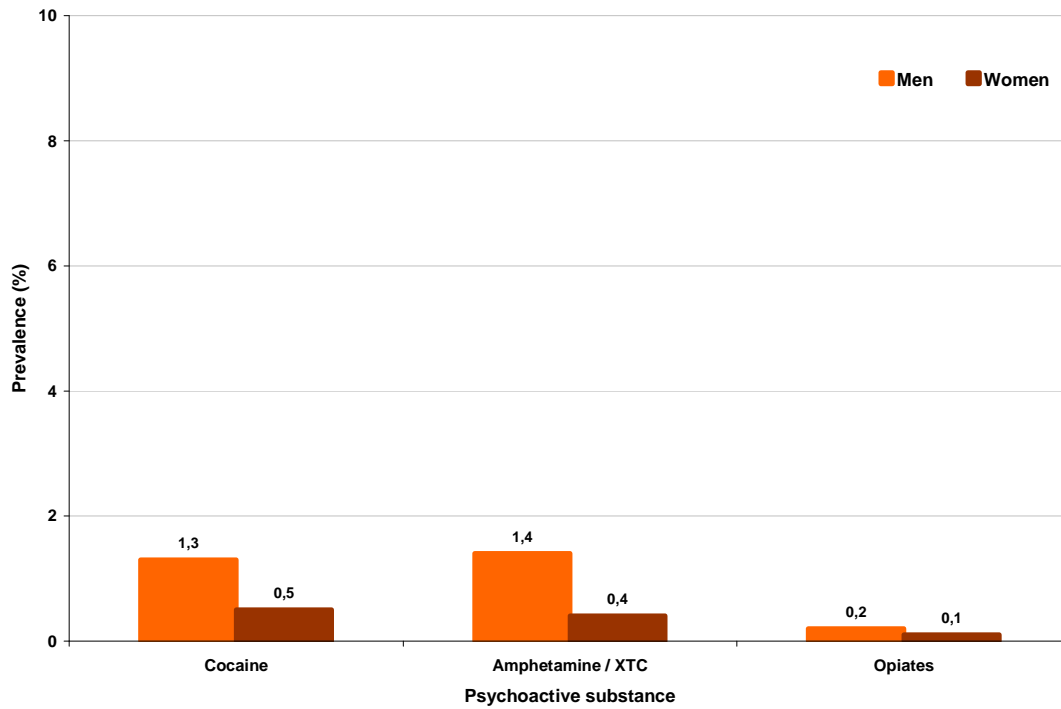
3. Drug use in the school and youth population

3.1. Drug use in Belgian school students

In 2010, several large-scale surveys (using self-completion questionnaires) were conducted in school students of the Flemish and French Communities. The **Health Behaviour in School-aged Children survey** (HBSC) has been conducted every four years in Belgium since 1985 (1993 in Flanders) and coordinated by the department of Public Health of the University of Ghent (UGhent; Maes and Vereecken 2011) and the School of Public Health of the Université libre de Bruxelles (ULB, for the French Community; Favresse and De Smet 2008;Godin et al. 2011). Another international project, the European School Survey Project on Alcohol and other Drugs (ESPAD) has also been conducted in Belgium, but since 2007 only in a sample of Flemish Community Schools (**Vlaams schoolonderzoeksproject naar alcohol en andere drugs**, VLASPAD). This study was coordinated by the Department of Clinical and Lifespan Psychology of the Vrije Universiteit Brussel (VUB; Lambrecht and Andries 2011). The more recent **VAD Leerlingenbevraging** (VAD-LLB; Kinable 2011) is an annual survey (since 1999) by the Flemish Vereniging voor Alcohol- en andere Drugproblemen vzw, the regional focal point for drugs and drug addiction. A comparison of the results of these surveys should take into account their different objectives and methodologies (See Appendix 1 for an overview). To bridge these differences, a working group with researchers of the three surveys was established (2007) to harmonize a core module on the prevalence of substance use in future waves of the respective surveys (Lambrecht et al. 2011).

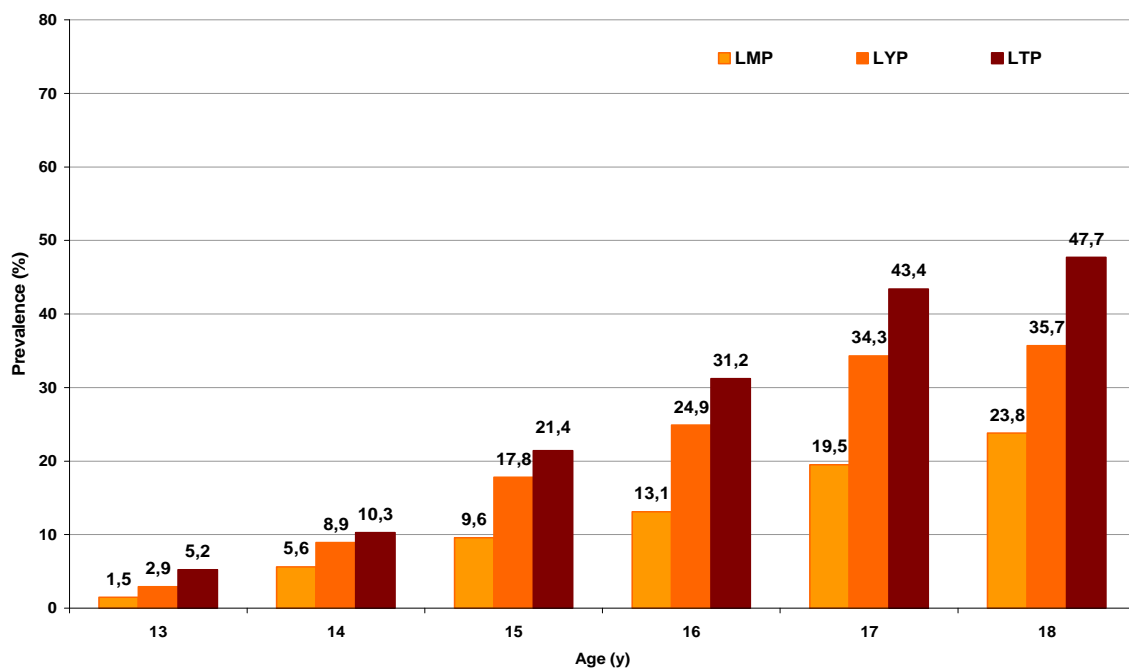
Data on substance use in the 2010 school population was also available through the local study "**Middelengebruik bij middelbare scholieren Brugge**" of the Department Scientific Research of De Sleutel (Lombaert 2010), and through the **Brussels JeugdOnderzoeksPlatform (JOP)-Monitor** (Cardoen et al. 2011), a collaboration between the research group Tempus Omnia Revelat (Vrije Universiteit Brussel), the research group

Figure 2.5: Last year prevalence (%) of the use of cocaine, amphetamines or XTC, and opiates in Belgium (15-64year), by gender, 2008. 📊



Source: BHIS 2008 (Gisle 2010a;2010b)

Figure 2.6: Lifetime, last year and last month prevalence (%) of cannabis use in Flemish Community school students (VLASPAD study), 2010. 📊



Source: VLASPAD 2010 (Lambrecht and Andries 2011)

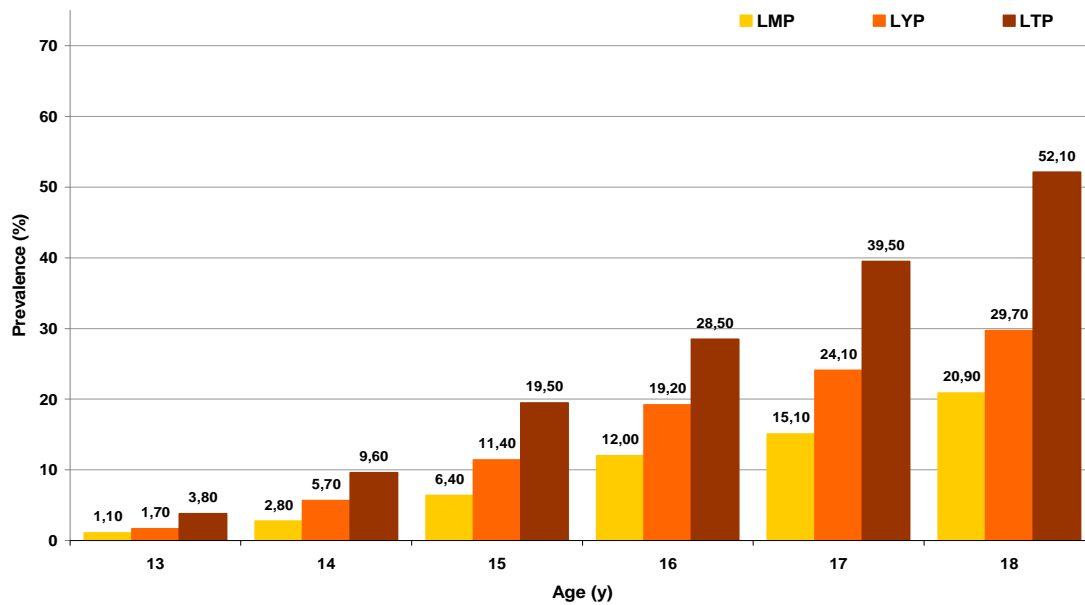
Sociale Agogiek (UGent) and the research group Youth Criminology of the Katholieke Universiteit Leuven (K.U.Leuven). Finally, data was also available through the **Leuven Adolescenten- en GezinnenOnderzoek** (LAGO), a survey by the Family and Population Research Group of the Centre for Sociological Research (Faculty of Social Sciences, K.U.Leuven) in 12 to 18 year old Flemish pupils within their school context about their family background, family relations and several aspects of their well-being (Vanassche et al. 2011). A European survey on **Youth attitudes on drugs** was conducted in 2011 by EOS Gallup Europe at the request of the Directorate-General Justice and Home Affairs of the European Commission (The Gallup Organisation. 2011). The results for Belgium will be presented in next year's Belgian report on drugs.

Based on the cited school surveys, the reported lifetime prevalence (2010) of **cannabis use** in school students varied between 2.7% (Lombaert 2010) and 5.2% (Lambrecht and Andries 2011) for the youngest (13y) students, and ranged between 39.4% (Maes and Vereecken 2011) and 52.0% (Kinable 2011) for the oldest (17-18y) school students (Figures 2.6 - 2.10). In the LAGO-survey, 16.8% of the school students aged between 12 and 18 reported having used cannabis at least once in their lives (Vanassche et al. 2011).

Between 1.2% (Maes and Vereecken 2011) and 3.1% (Godin et al. 2011) of the youngest school students used cannabis at least once in the 12 months before the survey was conducted. Between 29.4% (Maes and Vereecken 2011) and 38.7% (Lombaert 2010) of the oldest school students used cannabis in that same period. About 1.0% of the youngest school students reported using cannabis in the previous month whereas a last month prevalence of about 20.0% was found in the oldest students (Lombaert 2010;Godin et al. 2011;Lambrecht and Andries 2011;Kinable 2011;Maes and Vereecken 2011). Although the reported prevalence's vary, all surveys report a similar increase over the age groups ending at a point where almost half of the school students used cannabis at least once in their lives. Both bivariate (Cardoen et al. 2011;Godin et al. 2011;Kinable 2011;Maes and Vereecken 2011) and multivariate (Lombaert 2010) analyses revealed a higher proportion of male cannabis users than female users in the population of school students. Male school students were also found to use cannabis more frequently (Cardoen et al. 2011;Kinable 2011).

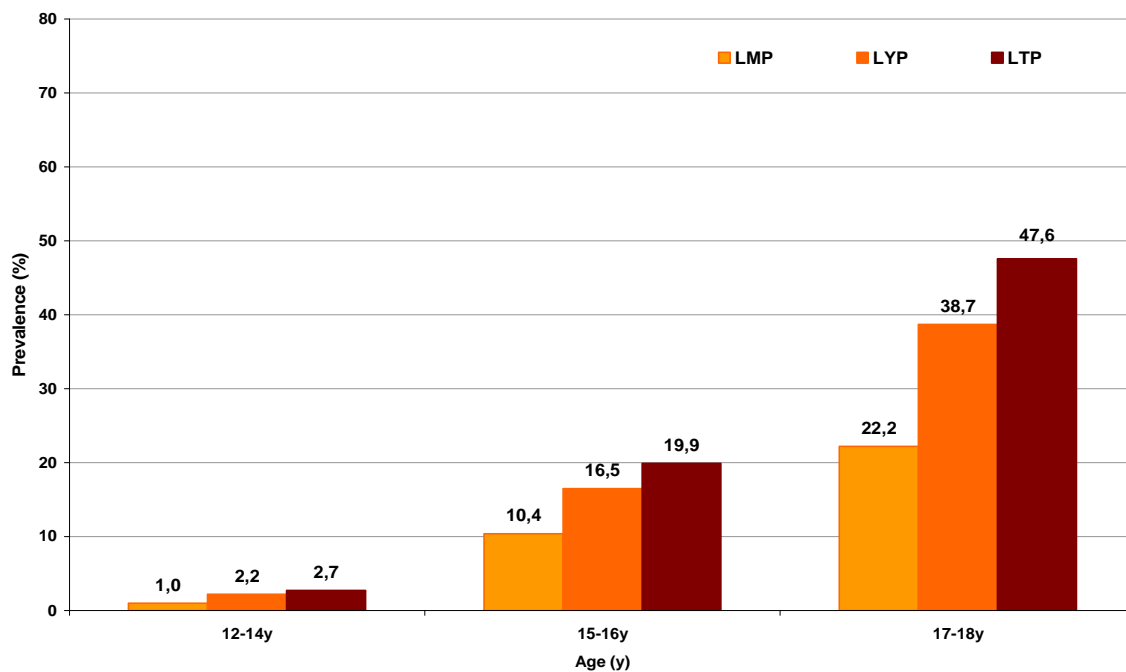
The **age of first cannabis use** in the population of school students, according to Lombaert (2010), ranges between 14 and 16. In contrast with the results found in the general population (Gisle 2010a), Kinable (2010) found that in 2009, the reported age of first use was higher in female students than in male students. Lombaert (2010) does not mention such a

Figure 2.7: Lifetime, last year and last month prevalence (%) of cannabis use in Flemish Community school students (VAD-LLB study), 2010. 📊



Source: VAD-LLB 2010 (Kinable 2011)

Figure 2.8: Lifetime, last year and last month prevalence (%) of cannabis use in school students of Bruges (Flemish Community), 2010. 📊



Source: De Sleutel 2010 (Lombaert 2010)

gender difference. Recent HBSC and VLASPAD data on the age of first cannabis use was not available before the publication of this review.

Lombaert (2010) calculated the **continuation rate** of cannabis use in school students in Bruges (Flemish Community). For the total school population, this continuation rate was 48%, meaning that one out of two school students who had ever used cannabis had used it recently. The continuation rates of the 15- and 16- year-olds (52%) were higher compared to those of the 17- and 18-year-old school students (47%). Own calculations of the continuation rate based on the data of the VAD Leerlingenbevraging 2010 (Kinable 2011) and the Health Behaviour in School-aged Children survey in the French Community (Godin et al. 2011) confirm the trend reported by Lombaert. Especially the continuation rates for the French Community school students (15y: 54.23%; 16y: 50.16%; 17y: 49.39%; and 18y: 43.44%) were high compared to the rates for the Flemish Community school students in the VAD-LLB sample (15y: 32.82%; 16y: 42.11%; 17y: 38.23%; and 18y: 40.12%).

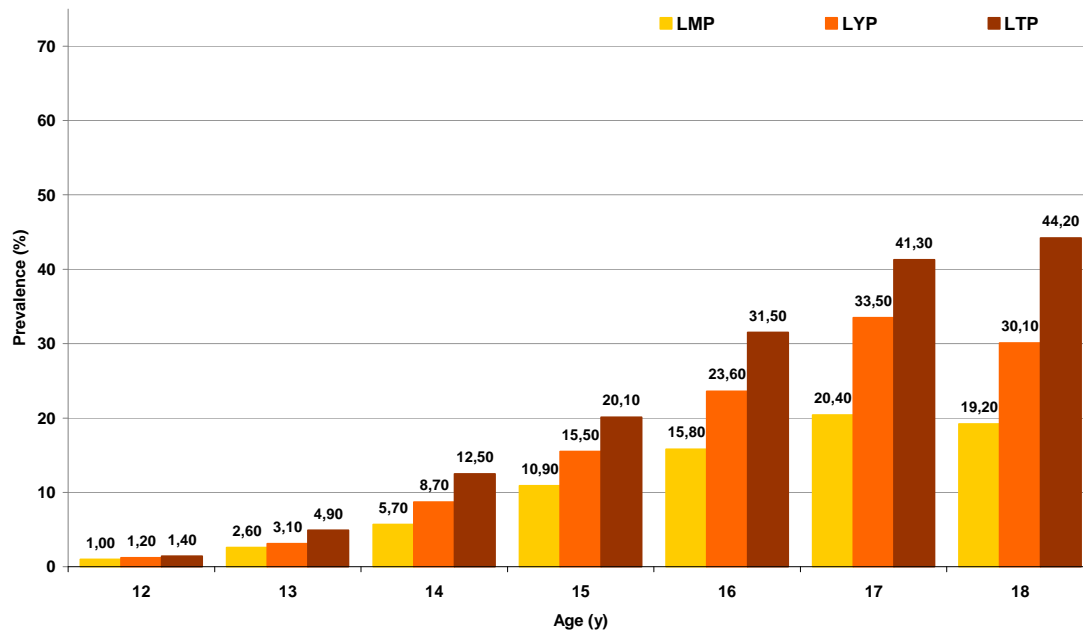
The local study of De Sleutel (Lombaert 2010) also surveyed the **place of cannabis use**. Most school students (89.30%) used cannabis outdoors (e.g. street) while about two third (67.30%) used cannabis at someone else's home. Festivals (59.3%) and parties (57.3%) were also frequently reported locations of cannabis use (Lombaert 2010).

Kinable (2010) and Lombaert (2010) also studied the **reasons why school students use cannabis**. The most frequently reported reasons were sociability, relaxation, curiosity, "to get stoned", "because it was offered to me", "to forget problems" and "to feel good". Interestingly, Kinable (2010) also reported reasons why school students don't use cannabis: they "don't need it", "cannabis is dangerous", "it's unhealthy", they have "a strong personality", or they are "not interested in the effects" of cannabis. Also, cannabis was found to be "too expensive". Furthermore, students found themselves sportive and feared dependency or the reaction of their parents (Kinable 2011)

According to Kinable (2010a) the use of illegal psychoactive substances other than cannabis is rather limited in the population of school students. Indeed, the highest lifetime prevalence's among the oldest school students (17-18y) were reported for **Amphetamines** which varied between 3.10% (Godin et al. 2011) and 6.50% (Lombaert 2010), and **XTC**, which varied between 1.90% (Godin et al. 2011) and 12.20% (Lambrecht and Andries 2011) (Figure 2.12 – 2.16). Interestingly, the last year prevalence of amphetamine use (2.70% - 5.20%) was

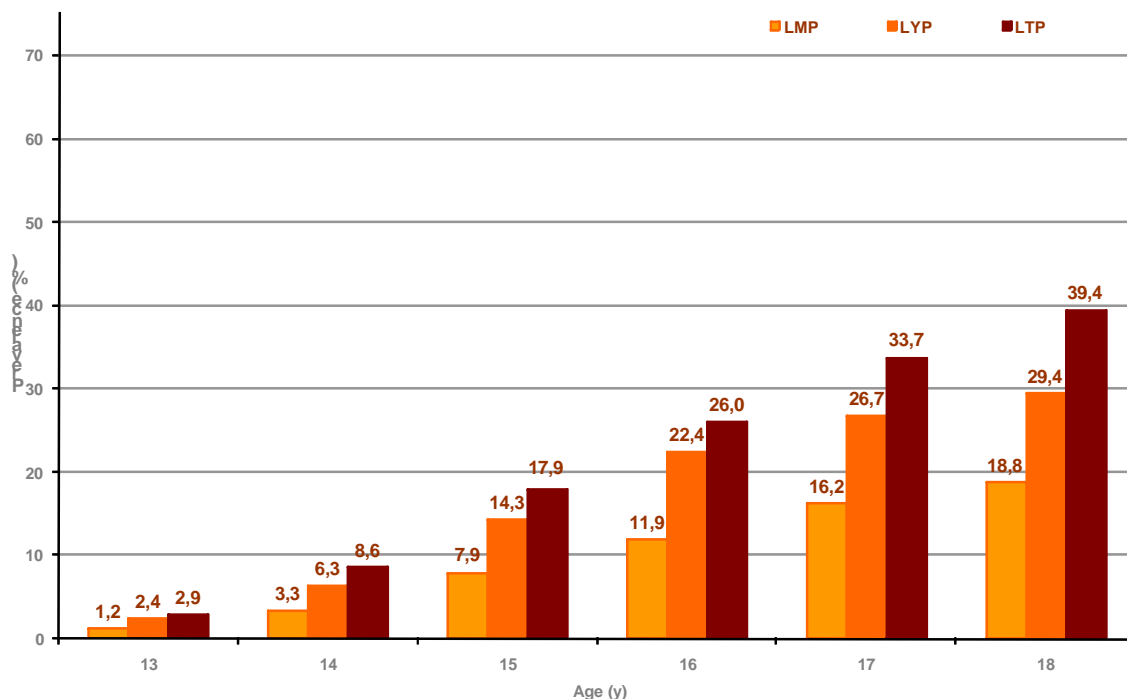
only slightly lower than its lifetime prevalence. Furthermore, the recent use (past 30 days) of amphetamines was still 4.0% of the oldest (18y) French Community school students

Figure 2.9: Lifetime, last year and last month prevalence (%) of cannabis use in French Community school students, 2010. 📊



Source: HBSC French Community 2010 (Godin et al. 2011)

Figure 2.10: Lifetime, last year and last month prevalence (%) of cannabis use in Flemish Community school students, 2010. 📊



Source: HBSC Flemish Community 2010 (Maes and Vereecken 2011) (Godin et al. 2011). In the local sample (Bruges, Flemish Community) of Lombaert (2010), the recent use of amphetamine dropped to a marginal proportion (0.1%) in the oldest age group (17-18y).

The reported lifetime prevalence of **cocaine use** in Belgium for the oldest school students (17-18y) varied between 2.60% (Godin et al. 2011) and 5.30% (Lombaert 2010). In the school surveys with a regional coverage (Godin et al. 2011; Kinable 2011) the past year use of cocaine by this age group was about 3.50%, whereas the local study of Lombaert (2010) found a last year prevalence of 1.70%. As for the oldest students in the French Community schools, 3.10% reported using cocaine recently (Godin et al. 2011), whereas only 0.30% of the oldest school students in Bruges reported using cocaine recently (Lombaert 2010).

Compared with the regional school surveys (Kinable 2010a; Godin et al. 2011; Kinable 2011; Maes and Vereecken 2011) the ever use of **solvents**, **hallucinogens**, and **LSD** in older school students of Bruges was rather high, 8.10%, 7.70% and 5.90% respectively (2010). The lower last year prevalences (1.80%, 2.50%, and 3.10%, respectively) and last month prevalences (0.60%, 0.70%, and 0.60%, respectively) could indicate the rather experimental use of these substances.

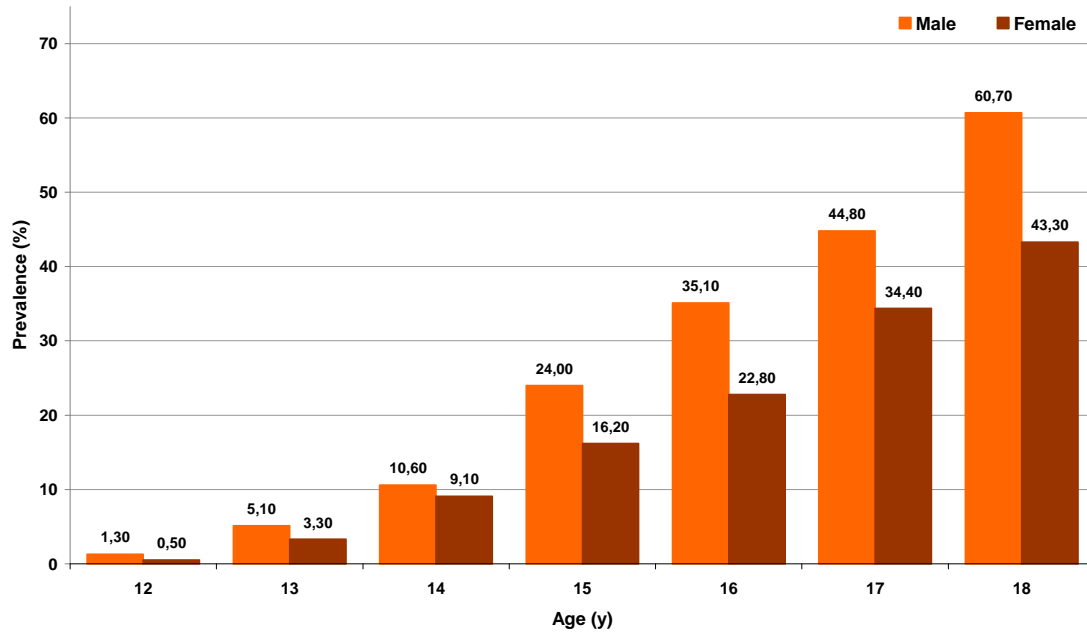
Both the regional and local school surveys held in the Flemish Community (Kinable 2011, Lombaert 2010) found a lifetime prevalence of **opiate** (heroin) use of about 1% in the oldest school students. None of them reported the recent use (past 30 days) of opiates. In the French Community school survey, 1.6% of the 18 –year-old students reported the recent use of heroin (Godin et al. 2011).

Given the small numbers, no further divisions related to the use of non-cannabinoid illegal substances are reported here. As for **trends**, based on the previous waves of the VAD Leerlingenbevraging, Kinable (2010) concluded that, for each psychoactive substance other than cannabis, no increase or decrease was found in the lifetime, last year or last month use by school students.

In a multivariate analysis Lombaert (2010) identified several **risk and protective factors** related to the substance use of school students and ranked these factors according to the extent of their contribution to the explanatory model (Figure 2.13). Overall, the **normative influences** from the context or environment of the school student were found to be the most

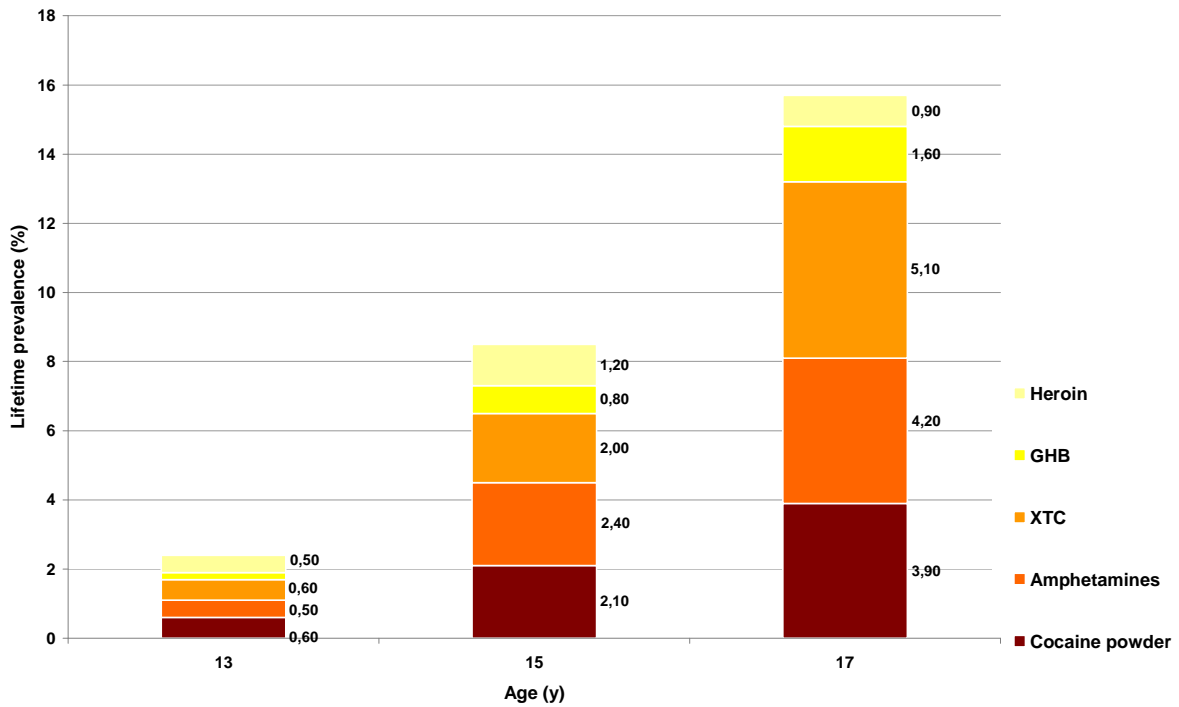
robust factors in determining the use (or decision not to use) of psychoactive substances. In first instance, Lombaert (2010) referred to the disapproval by parents and friends of the

Figure 2.11: Lifetime prevalence (%) of cannabis use in Flemish Community school students, by gender, 2011. 📊



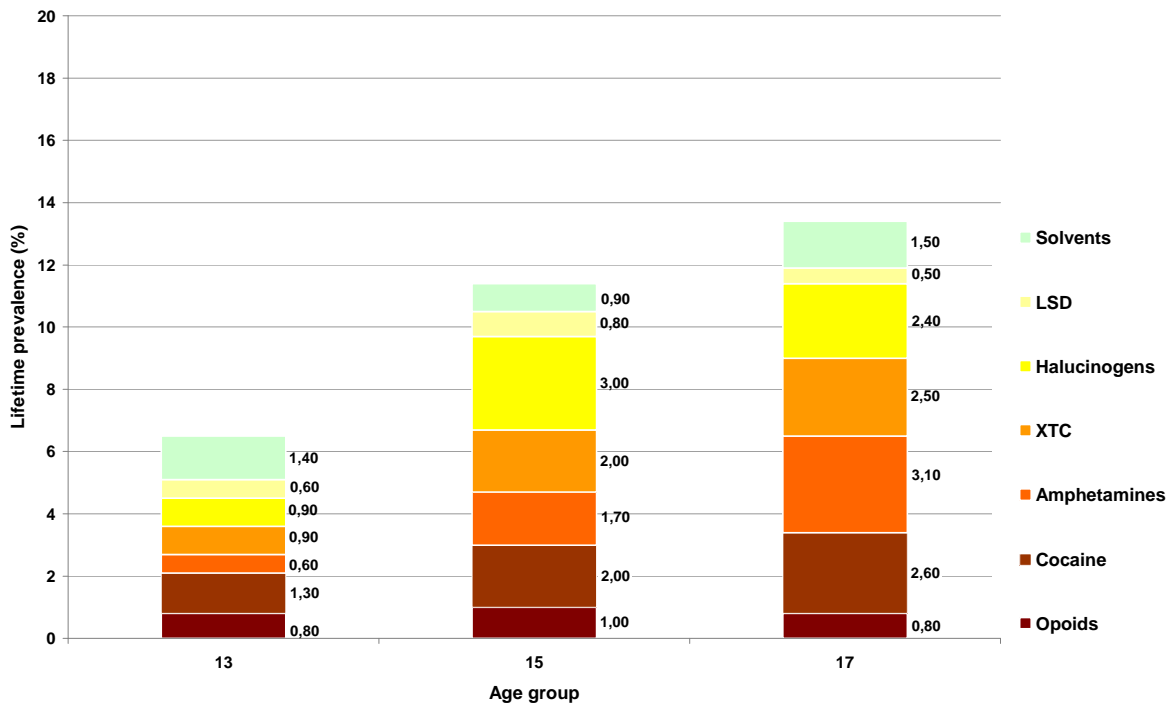
Source: VAD-LLB 2010 (Kinable 2011)

Figure 2.12: Lifetime prevalence (%) of the use of psychoactive substances (other than cannabis) in Flemish Community school students, by age, 2010. 📊



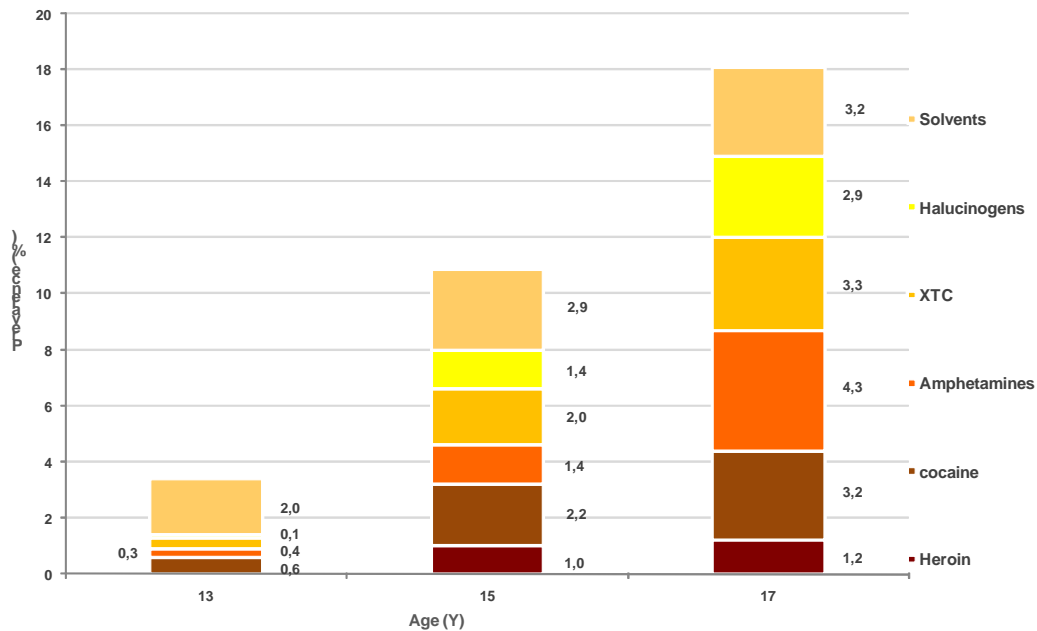
Source: VAD-LLB 2010 (Kinable 2011)

Figure 2.13: Lifetime prevalence (%) of use of psychoactive substances (other than cannabis) in French Community school students, by age, 2010. 📊



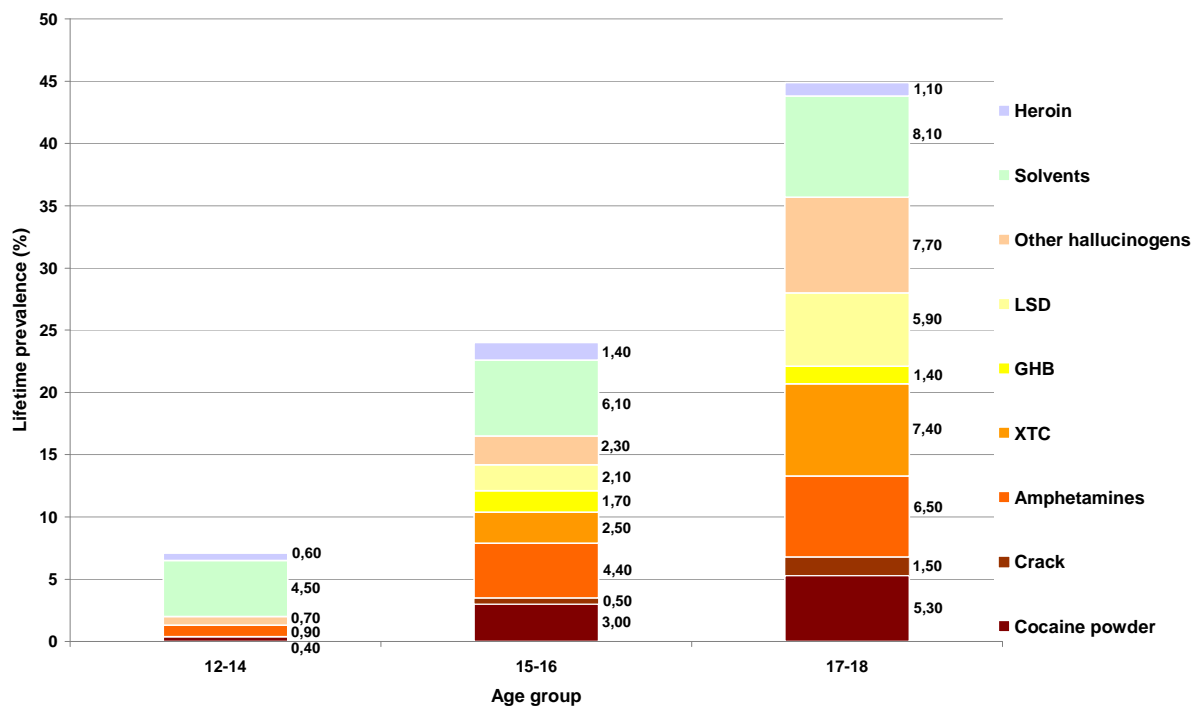
Source: HBSC French Community 2010 (Godin et al. 2011)

Figure 2.14: Lifetime prevalence (%) of use of psychoactive substances (other than cannabis) in Flemish Community school students, by age, 2010



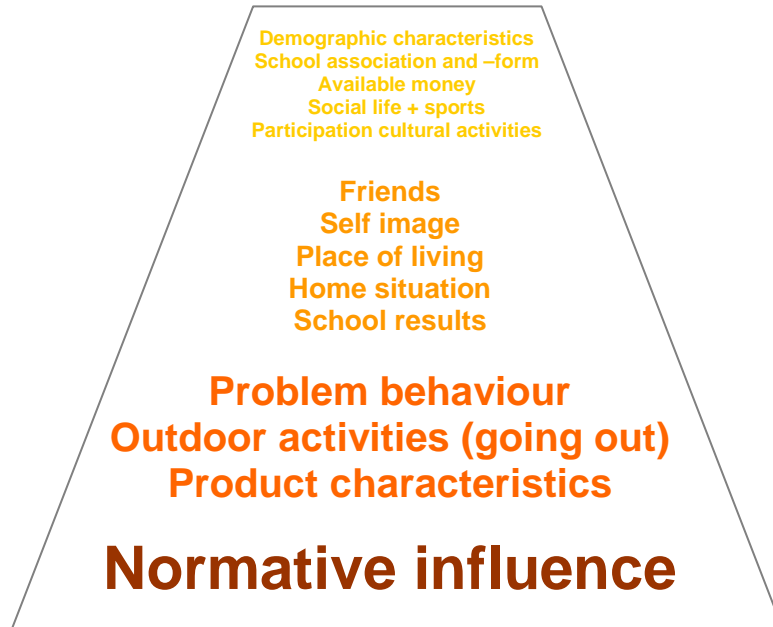
Source: HBSC Flemish Community 2010 (Maes and Vereecken 2011)

Figure 2.15: Lifetime prevalence (%) of use of psychoactive substances (other than cannabis) in school students of Bruges (Flemish Community), by age group, 2010. 📊



Source: De Sleutel 2010 (Lombaert 2010)

Figure 2.16: Risk and protective factors of psychoactive substance use according to their importance



Source: De Sleutel 2010 (Lombaert 2010).

substance user: “the more parents and friends disapprove the use of a certain substance, the less risk there is for the use of that substance.” In addition, Lombaert (2010) highlighted the behavioural normative influences, namely, the use of psychoactive substances by friends and (to a lesser extent) parents. The more substance-using friends a school student has, the higher the risk that that student will use that substance, and the more frequently he will use it.

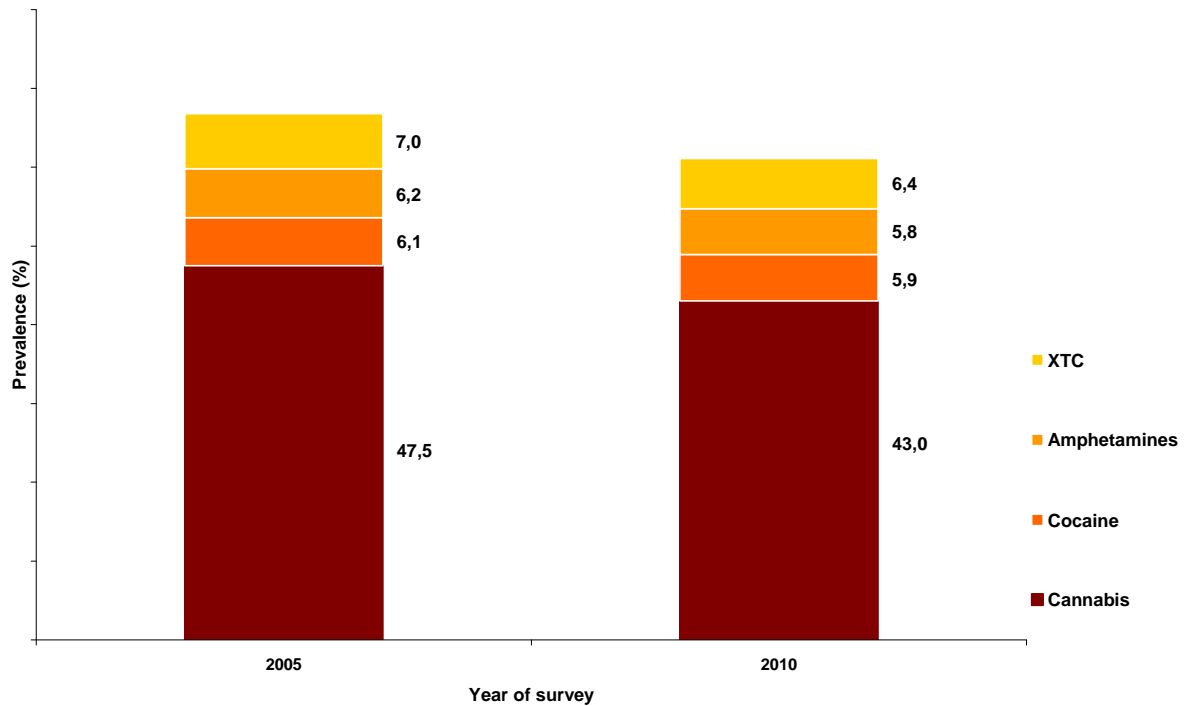
3.2. Drug use in Belgian university and university college students.

The use of psychoactive substances in university and high school students was recently (2009) surveyed in students (sample (n) = 3537 out of 18543 respondents) of the universities and university colleges of Antwerp and Ghent (Rosiers et al. 2011). This “**In hogere sferen 2**” survey by the Universitair Wetenschappelijk Instituut voor Drugproblemen (UWiD) of the Antwerp University, the research group “Health promotion” of the University of Ghent, and the VAD, was a sequel of the Antwerp survey in 2005 (Van Hal et al. 2007). The study aimed to describe substance-related epidemiological indicators that could be of use in prevention initiatives of the university and the university colleges. Like the 2005 survey, the 2009 survey was a web-based questionnaire on the (problem) use of psychoactive substances (both legal and illegal), the causes and consequences of substance use, mental health, the context of substance use and the available network of preventive and treatment facilities (See the Annexes for methodological information).

In the study of Rosiers et al. (2011), 43.0% of the Antwerp and Ghent students reported having used **cannabis** at least once in their lives (Figure 2.17). About half of this population (22.9% of the total sample) had also used cannabis in the year before the survey was conducted (Figure 2.18). Compared to male students (LTP: 51.0%, LYP: 36.5%) the lifetime and last year prevalence rates of female students (LTP: 32.2%, LYP: 17.2%) were significantly lower. As in the general population (Gisle 2011) and the school population (Kinable 2011, Lombaert 2010, Godin et al. 2011), the use of illegal **non-cannabinoid substances** was also less prevalent in the population of Antwerp and Ghent students. The ever use of amphetamines, XTC and cocaine was about 6.0% whereas the reported last year use was about a half (3.0%) of this prevalence rate (Figure 2.16) (Rosiers et al. 2011). Again, the use and frequency of use of these substances is significantly more reported by male than by female students (Rosiers et al. 2011).

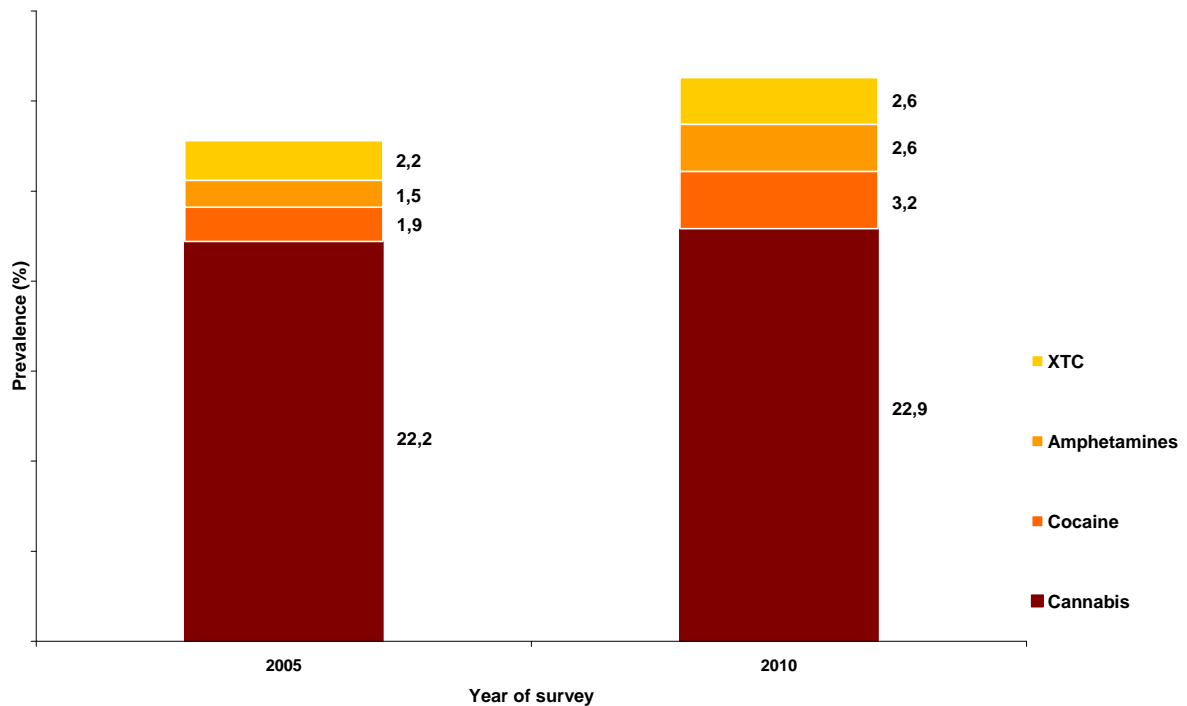
Rosiers et al. (2011) also investigated the **period of substance use** by the university and university college students. They found that during vacation, the use of cannabis was slightly higher than during the academic year, and substantially higher than the period of exam-

Figure 2.17: Lifetime prevalence (%) of use of psychoactive substances in Flemish university and university college students, 2005, 2010. 📊



Source: University Antwerp & University Ghent, 2010 (Rosiers et al. 2011); University Antwerp 2005 (Van Hal et al. 2007)

Figure 2.18: Last year prevalence (%) of use of psychoactive substances in Flemish university and university college students, 2005, 2010. 📊



Source: University Antwerp & University Ghent, 2010 (Rosiers et al. 2011); University Antwerp 2005 (Van Hal et al. 2007)

-inations. As for the non-cannabinoid illegal substances, the use was also higher during the vacation period although the frequent use of these substances was rather exceptional (Rosiers et al. 2011).

In addition to the prevalence and frequency of substance use, Rosiers and colleagues (2011) also studied the so-called **problem use** of these substances. Using the DSM-IV-based questionnaire on cannabis dependency of Decorte et al. (2003), they found that 31.30% of the last year cannabis users expressed at least one symptom of problematic cannabis use. As for the non-cannabinoid substance users, 39.1% of the last year users were identified (using the Drug Abuse Screening Test Skinner 2001; de Graaf et al. 2010) as limited risk users whereas 42.8% were found to have an increased risk and 14.4% a high risk for problem use (Rosiers et al. 2011).

The most frequently reported **reasons for cannabis use** during the academic year in the population of Antwerp and Ghent university and university college students were “sociability” (80.8%), “relaxation” (72.4%), “getting high” (57.1%), “for pleasure” (49.6%), and “having a good feeling” (40.5%). Most of these reasons were also mentioned for the vacation period; “getting high” was the most important reason of the (few) users during the examination period (Rosiers et al. 2011).

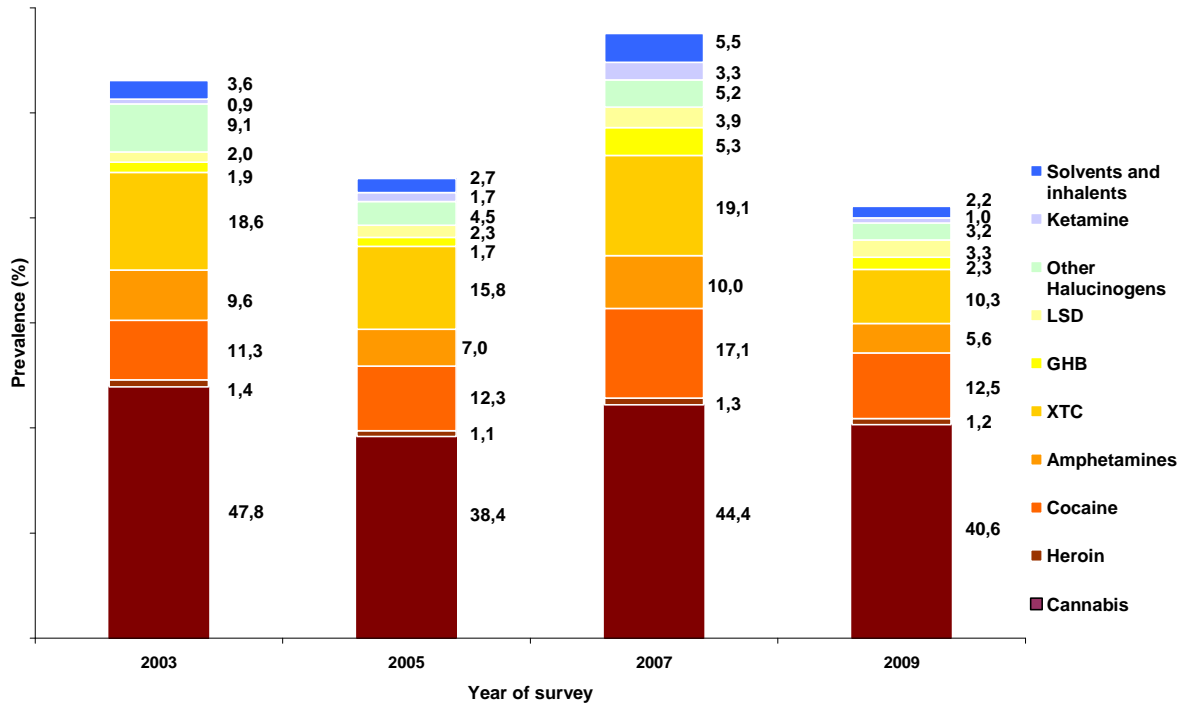
University and university college students preferred to use cannabis in **private** and, compared with non-cannabinoid substances, less frequently in pubs, clubs or at parties (Rosiers et al. 2011). It is noteworthy that students more often reported using illegal substances in a car than they reported using alcohol (Rosiers et al. 2011).

4. Drug use among targeted groups / settings at national and local level

4.1. Drug use in recreational settings in Belgium

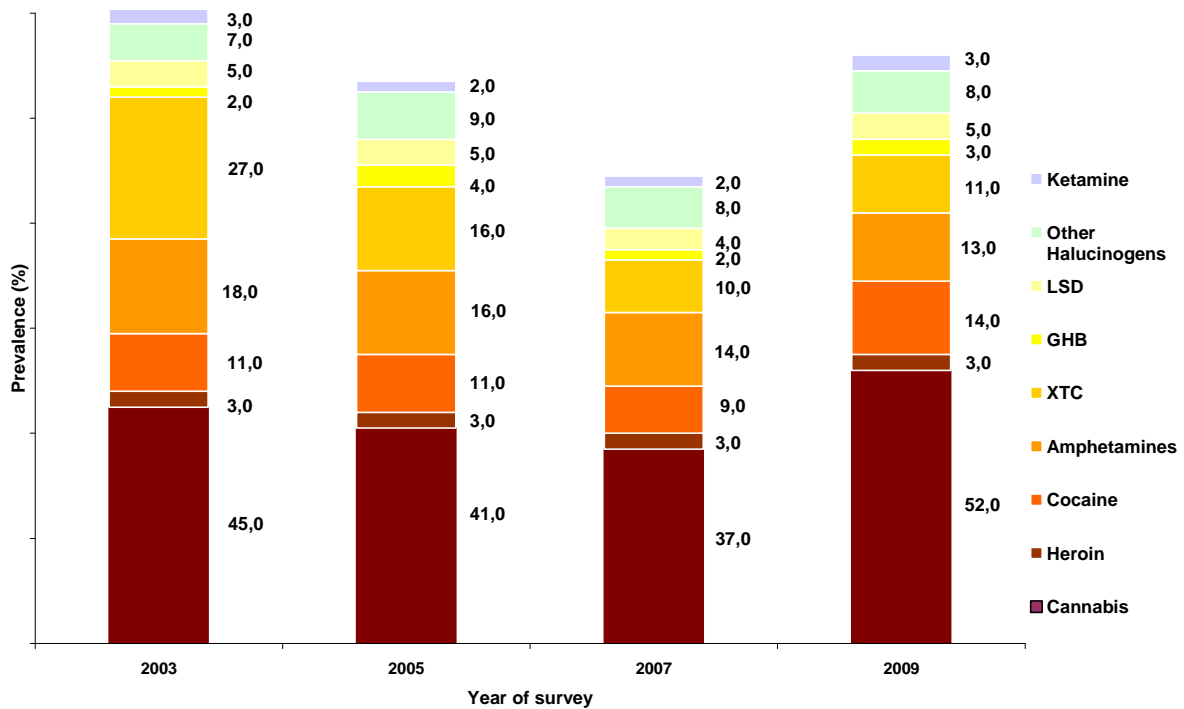
The previously mentioned student surveys (Kinable 2010, Lombaert 2010, Rosiers et al. 2011) highlighted the fact that recreational settings like pubs, clubs, parties, etc. are preferred settings for the use of illegal substances. The (patterns of) use of psychoactive substances and the characteristics of users in these settings are therefore regularly monitored in the Flemish and the French Communities. The methodological approaches of

Figure 2.19: Last year prevalence (%) of use of psychoactive substances in recreational settings of the Flemish Community, 2003, 2005, 2007 and 2009. 🏠



Source: VAD Partywise uitgaansonderzoek, 2009 (Rosiers 2010)

Figure 2.20: Relative proportion (%) of 'current' use of psychoactive substances in recreational settings in the French Community, 2003, 2005, 2007 and 2009. 🏠



Source: Modus Vivendi, courtesy of Eurotox 2009

these monitors are significantly different and were described in detail in previous reports (Lamkaddem and Roelands 2011) (See also Annexes at the end of this report for a summary). The biannual **Partywise Uitgaansonderzoek** of the VAD collects data in different nightlife settings in the Flemish Community. Data are collected using a questionnaire completed by individuals (n= ca. 650, mainly between the ages of 15 and 30) selected randomly in more discrete and quiet locations at the events. Although the Partywise project covers a broad range of prevention initiatives in the party scene, the selection of the respondents was independent from these activities. The annual survey in the French Community is conducted as part of a large-scale risk reduction project ("**Drogues Risques Moins**") - a joint action of more than 30 organisations active in recreational settings, coordinated by Modus Vivendi (Casero et al. 2010). There, professionals and jobistes provide information and advice to users and those interested. The primary objective of the accompanying survey (paper questionnaire; in 2009 n = 818, mainly between 15 and 25 years old) is to verify whether the harm reduction activities apply well to the targeted audience. The survey is therefore not representative of the whole party scene and, thus not interpretable as prevalence data (Casero et al. 2010).

Cannabis is by far the most used illegal psychoactive substance in the monitored population in the Belgian recreational settings. In 2009, the last year prevalence of cannabis use reported for the outgoing population of the Flemish Community (Rosiers 2010) was 40.8%, while the 'current' use found in the French Community was 52.0% (Casero et al. 2010). (Figures 2.19 & 2.20). In preceding years, the prevalence of cannabis use in both communities fluctuated to some extent. Changes in the coverage of number, type and location of recruitment settings could have attributed to this fluctuation, especially in the French Community (Casero et al. 2010).

Interestingly, in 2009 **cocaine** became the second most used illegal substance in the outgoing population, both in the Flemish and the French Community (Figures 2.19 & 2.20). The last year cocaine use was reported by 12.5% of the respondents in the Flemish recreational settings (Rosiers 2010) whereas 14.0% of the French outgoing respondents reported the use of cocaine in the month before the survey was conducted (Casero et al. 2010).

Compared to the 2007 survey, a substantial decrease (2009: 10.4%, 2007: 19.1%) was found in the reported use of **XTC** by visitors of Flemish recreational settings (Rosiers 2010). The last month XTC use reported in the French Community was rather stable since 2007 (2009: 11%, 2008 and 2007: 10%) (Casero et al. 2010).

Hallucinogenic mushrooms, volatile substances (poppers) and **amphetamines** were found to be less used in 2009, compared to 2007, by the Flemish outgoing population, whereas the reported last month use of respondents in the French recreational settings remained rather stable for the same period (Figures 2.17 & 2.18) (Casero et al. 2010;Rosiers 2010).

In the Flemish Community survey, respondents were asked to specify whether they used the substance(s) **before, during or after** visiting a pub, club, party or concert. XTC (87.3%), amphetamines (86.7%) cocaine (70.8%) and, to a lesser extent, cannabis (59.0%) were more often used during the outgoing activity rather than before or after that activity (Rosiers 2010). Congruent with this finding is that these substances were mostly used in group: XTC (93.5%), cannabis (92.1%), cocaine (89.5%) and amphetamines (77.3%) (Rosiers 2010).

Casero et al. (2010) found that 15.4% of the respondents who had used either alcohol or an illicit substance intended to **drive a car** after visiting the recreational setting (French Community). Most of these respondents were men (62.7%). In the study of Rosiers (2010), about one third (33.8%) of the outgoing respondents reported that they would not drive a car after leaving the event (for Drugs and driving, see also Chapters 7 and 10).

4.2. Drug use among the Belgian Army applicants

Applicants for a function in the Belgian Army are intensively tested (medical, physical, intellectual...). During this process, applicants complete questionnaires surveying their lifestyle, including substance use. In 2010, a sample of 5962 applicants between 17 and 28 years old were tested (urine test) by the medical selection unit of the Belgian Army for the recent use of illegal psychoactive substances. Of these applicants, 509 (8.53%) tested positive (Decrem and Ponthier 2011). Compared to 2009 (8.69%) and 2008 (7.86%), the number of identified substance using applicants remained stable. No differentiation by substance was available.

4.3. Drug use among sex workers in Belgium

Information on substance use in the population of sex workers in Belgium is available through the activity reports of organisations that provide medical and social support to this population. In the Flemish Community, Pasop is active in the provinces East- and West-Flanders, whereas Gh@pro/Connecta is active in the city of Antwerp. Espace P is active in three large cities in the Walloon Region: Liège, Namur, and Charleroi. Estimations of the prevalence of substance use by sex workers based on the reports from these organisations

are rather indicative and not representative. Indeed, not only because of the limitations inherent to the type of registrations but also because of the lack of a reliable estimation of the denominator.

In 2010, **Gh@pro/Connecta** was contacted by 323 sex workers for *information* on various topics (Ghapro vzw. 2011). One (0.31%) of these sex workers was referred to a treatment centre that specializes in substance-related disorders. The *psychosocial services* of Gh@pro/Connecta (total contacts: n= 2882) were contacted 48 times (1.67%) by sex workers for problems related to the use of psychoactive substances.

During the 2009 vaccination campaign of **Espace P**, 154 sex workers in Liège, Namur and Charleroi (French Community) completed a questionnaire in the course of a face-to-face interviews with a social worker. High rates of missing answers were reported, often because of the reluctance of the social workers to ask questions about injecting drug use at the first meeting. Of the respondents (mainly Belgian (51%) women (97%)), 27% reported the recent use of illicit psychoactive substances. Belgian sex workers (20%) sex workers younger than 25 years old, and sex workers working in private reported a more frequent recent use of illegal substance compared to Non-Belgian sex workers (12%), sex workers older than 25, and sex workers working in bars or on the street.

In 2008, a study started on **drug use among female sex workers in Belgium (DRUSEB)**. The study, funded by the Federal Science Policy (BELSPO) as part of the Research programme in support of the federal drugs policy document, was a collaboration between the Instituut voor Sociaal Drugsonderzoek of the UGent, the Centrum voor de Evaluatie van Vaccinaties (CEV), and the research unit Epidemiologie en Sociale Geneeskunde, both of the Antwerp University. The main objectives were the study of the nature and the extent of legal and illegal drug use in Belgian female sex workers; the mapping of the most frequent drug-related health problems, the specific needs for preventive and curative drug-related health care, and the evaluation of previous objectives against existing initiatives and practices. Detailed results were described in Chapter 8 of this report.

4.4. Drug use among prisoners in Belgium

A follow-up study of the project “Drug use in Belgian prisons: Monitoring of health risks” (Todts et al. 2009) by the Federal Public Service Department Health Care in Prisons and Modus Vivendi was conducted in 2010 (Van Malderen et al. 2011). The prevalence of the

current illegal substance use found in the population of Belgian prisoners (sample n= 1,251) was 31.3% for cannabis, and 13.3% for heroin. Further results of this study were presented in more detail in Chapter 9 and Chapter 11 of this report.

4.5. Drug use among other targeted groups

Previous Belgian National Reports reported on the use of psychoactive substances in **ethnic minorities** (Derluyn et al. 2010) and, more specifically, among Iranian migrants (Muys 2009). More recent data on substance use in these populations was not available when the current report was published.

Recently, a study on **substance use in the population of homeless youths** was conducted by the Instituut voor Sociaal Drugsonderzoek of the UGhent (Tieberghien and Decorte 2011). As no data was available when the current report was published, results will be reported in the next Belgian Annual Report on drugs.

A decorative horizontal bar in a vibrant orange color spans across the top of the page. On the right side of this bar, there are two overlapping hexagonal shapes: a yellow one on top and a dark red one on the bottom. Below the bar, there are two more hexagonal shapes, one yellow and one light orange, which appear to be the bottom parts of the shapes above.

Chapter 3.

Prevention

Laudens, F., Casero, L. and Schelinga, C.

1. Introduction

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

The Vereniging voor Alcohol- en andere Drugproblemen (VAD) and Arbeitsgemeinschaft für Suchtvorbeugung und Lebensbewältigung (ASL) are the official co-ordination structures in respectively the Flemish and German-speaking Community. The *Observatoire socio-epidemiologique alcool-drogues* (EUROTOX asbl) is the monitoring centre for alcohol and drugs in the French Community.

1.1. Flemish Community

Monitoring data from the Ginger programme (<http://www.vadginger.be>) give a good view on the alcohol and drug prevention activities in the Flemish Community (Rosiers 2011). More than 80 prevention workers take part in this annual registration. More than 5.000 alcohol and drug prevention activities were registered in 2010.

Prevention in the Flemish Community is mainly oriented towards actors in the health and educational sector. In the educational sector, about two third of the activities are organised in secondary schools. Prevention activities in these schools mostly consist of training students and teachers, and organising consultation with teachers and the school board. Prevention in higher education is becoming more important.

In the health sector most prevention activities take place with the regional mental health centres (CGG). Early interventions and consultations are the main activities.

Three out of four prevention activities in the Flemish Community are aimed at intermediary target groups, like professional prevention workers, health experts or teachers. When a final target group is present at a prevention activity, they are mostly represented by young people (e.g. training in schools, early intervention activities).

One out of three prevention activities is subject of evaluation. This is a high percentage if you take into account that the Ginger registration is monitoring single prevention activities and not prevention projects or processes.

Since 2006, the Flemish government formulated goals concerning the use of tobacco, alcohol and drugs in a region-wide health conference with all the actors involved in prevention (Vlaams Agentschap Zorg en Gezondheid 2006). In 2008 a Flemish Action Plan on tobacco, alcohol and drugs 2009-2015 was developed and accepted by the Flemish parliament. Apart from 3 structural objectives related to the organisation of the prevention actors and structures, registration and evaluation, 4 major strategic objectives were defined:

- (1) To improve the impact of existing prevention activities (especially in field of universal prevention)
- (2) To integrate activities related to tobacco, alcohol and illegal drugs (universal prevention)
- (3) To develop strategies for smoking cessation and early intervention for alcohol and drug problems (indicated prevention)
- (4) To pay systematic attention to specific and vulnerable groups and gender differences (universal and selective prevention).

A number of pilot projects were set up. Projects focussing on illegal drugs are a universal prevention programme in education (Unplugged, based on EU-DAP – De Sleutel) and the support of the alcohol and drug policy in the workplace (based on a Collective Labor Agreement). They are implemented in 2010-2011.

1.2. French Community

Prevention actions in **French Community** are articulated around the concept of “health promotion” (WHO1986). The strategies of interventions are defined in the quinquennial programmes of health promotion, which are then translated into Operational Community Plans (*Plan Communautaire Opérationnel*, PCO).

The Minister of Health in the French Community launched in 2010 an evaluation of the health promotion sector (Communauté française de Belgique 2011). This evaluation concerns the PCO, the agreed services and the measures of decrees. The evaluation focused on 6 points: the coherence of the actions; the transparency and the legibility of devices; the transversal areas; evaluation of the organisation and the structures; the relevance of the operational means and finally, the evaluation procedures.

At the same time, at the end of 2010, the French Community decided to launch a new project called “concerted strategies in prevention and harm reduction actions in addiction in the French Community”. The project, based on a bottom-up process, aims to elaborate by the end of 2012, an action plan for prevention and harm reduction actions for services financed by the French Community. This project is coordinated by Eurotox.

The **Walloon Region** supports projects which join the ambulatory curative domain. We find thus, the ambulatory care, the elaboration of initiatives of reintegration, harm reduction actions but also trainings and researches in addictions. During the year 2010, the social cohesion projects (*Plans de Cohésion Sociale*, PCS) were developed in many municipalities of the Walloon Region (Service public de Wallonie 2008). The PCS's actions must aim the social development of the district and the fight against the precariousness. The activities

focussed on 4 axes: the socio professional integration, the access to a decent housing, the access to the health and treatment of the addictions and the establishment of social links.

Other preventive actions related to the addictions have been developed in the French Community by the Strategic security and prevention plans (*Plans Stratégiques de Sécurité et de Prévention*, PSSP). The PSSP are developed by the municipalities with a financing of the Ministry of the Interior.

1.3. German-speaking Community

In the German-speaking Community there is one organisation in charge of prevention and early intervention, planning and implementing activities and evaluation: the ASL. More than 4,000 inhabitants of the German-speaking Community were reached in 2010. Most of them are pupils from the secondary school. In 2011 the activities of ASL will be further developed and optimized.

The prevention services offered are: information and advice for all target groups; qualification and training of professionals; projects for children and young people; campaigns and public relations.

The groups addressed are: children and adolescents; parents and carers; professionals, particularly in the areas of youth work and schools; multipliers; cooperation partners from the fields of youth and addiction and general public.

2. Universal Prevention

2.1. School

2.1.1. Flemish Community

There is a strong tradition in universal prevention in schools. For many years, a structural policy framework for drug prevention in secondary schools (Drug policy at school) was developed and has a very wide uptake in the Flemish region. Each school develops its own global and structural framework for the implementation of universal, selective and indicated prevention programmes and activities, tailored to each individual school setting.

For more than 10 years VAD offers an instrument for schools to evaluate their drug policy at school, with the input of their pupils. The *Leerlingenbevraging* (Pupils questionnaire) collects data of all the pupils of a school and renders an individual report with tips and tools to improve the drug policy of a school. In the school year 2009-2010, 76 schools (and 41.378

pupils) took part in this project. Since 1998 817 secondary schools and more than 430,000 pupils were involved in this evaluation.

Within the framework of the drug policy at school, there is a wide range of universal prevention programmes that are being used in secondary education, mainly by the teachers themselves. They receive support from prevention workers and prevention organisations, mainly through training and consultation.

In the last few years, more activities are being introduced in primary schools (with main focus on delay of onset of drinking) and higher education (universities and schools for higher education with focus on alcohol and binge drinking, cannabis and misuse of medication).

2.1.2. French Community

The French Community adopted two decrees reorganising the school medicine (the decree of 12-20-2001 concerning the promotion of health at school and the decree of 05-16-2002 concerning the promotion of health in higher education, except universities). The missions of the new decrees are assured by the health promotion service in schools (*P.S.E services, Service de promotion de la santé à l'école*) for the subsidized education and by the psychological, medical and social centres for establishments recovering from the French Community. For instance there are 26 PSE services in Brussels Capital Region.

The Decree of December 20th 2001 set up the 'Promotion committee of the Health at the School' which has for missions to give to the Government an opinion on any project of decree or problems concerning the promotion of the health at school.

Within the French Community, there is no official coordination structure at Community level. However, coordination exists at local levels. The Support Points at schools, in prevention of addictions (*Support Points Addictions PAA*) created in 2007, are an experimental 3-year-old project under the responsibility of the Local Centres of Health Promotion (CLPS, *Centre Local de Promotion de la Santé*). The PAA plays the role of interface between the school actors and the structures specialized in the prevention and the follow-up of young people in addictions. They have different objectives:

- Strengthen the knowledge of the school actors of the French Community concerning the offer of prevention provided by these structures.
- Facilitate the adaptation of the offer of prevention to the needs of the school
- Allow an exchange amongst schools and between schools and specialized structures
- Involve the specialized structures and the schools in a network.

At school level a big variety of actors are involved in preventive actions: the police who comes to speak about drugs, or still to propose programmes of personal fulfilment; the representatives of certain municipal organisations; the associations of prevention of the addictions and still others actors in a more punctual way. They can review for example the drug matters, prepare a meeting with parent's association, and prepare a session for teachers, educators for the prevention of addictions. These services can also propose information, tools, training, methodological help to set up a specific project, etc.

The study carried out by Eurotox in 2008 (Casero et al. 2008) showed that a majority (34.1%) of the prevention activities were carried out in schools. The types of activities organised in schools were mainly information, consciousness-raising and resource distribution.

In 2011 the PAA of Brussels realized a survey among the actors of the secondary school in the Brussels Capital Region (Vérgairginsky 2011). The purpose of the study was to identify the expectations and the needs of the school actors concerning risk behaviours and addictions of the pupils. The information was collected by semi-directive interviews. Teachers mention consumption of products: first of all alcohol (especially during the school journeys), then the consumption of cannabis and its side effects directly perceived in class (aggressiveness, fatigue, absence, incapacity to attend the course). Teachers feel responsible morally and legally. The educators, the PMS's agents (*Centre Psycho-Médico-Social*), the PSE's actors and the mediators are worried by the psychological, medical and social aspects and some consider risk behaviours as being connected to adolescence.

2.1.3. German-speaking Community

In the German-speaking Community, the following projects were organised:

- Smoke-free school
Continuation of the project "Towards a smoke-free school" with subsequent participation in the "Be Smart Don't Start" Party in the club at Himmerich. The project reached 160 pupils from the German-speaking Community and 800 students of the district Heinsberg.
- KOPS
In the first year of secondary education, the students have been informed about legal drugs and life skills. In the second year of secondary education, the ASL lectures about illegal drugs for two hours per class. The project reached 1,148 pupils and students.
- General preventive lessons such as: future plans, communication, conflict resolution, life skills, addiction, alcohol, tobacco, etc.
- Introducing a smoking control management in cooperation with the teachers and the secondary school board
- Klettern statt Kiffen (Climbing instead of Potsmoking)

160 students from the German-speaking Community, 50 students from Heinsberg and 50 students from the Netherlands participated in the activity around climbing, “death-riding” and prevention in the sports barracks (Institut Royal Militaire d'Education Physique, IRMEP) in Eupen.

- Secondary school team and educational conference for teachers
During the school year, coordination-teachers from almost all secondary schools meet to discuss prevention and early intervention topics with the ASL.

2.2. Family

2.2.1. Flemish Community

Universal prevention initiatives for parents are mainly integrated in programmes of adult organisations and at a local level. Training in parental skills (a.o. *Op zoek naar een kick* programme for parents) are available, but not broadly used. In addition, most prevention interventions about young people and drugs are not restricted to parents with drug using children. They are open to all parents with a broad objective to develop life skills.

2.2.2. French Community

The specific projects targeting families of drug users are under way in the French Community. Nevertheless, it is important to mention that they are open to all parents with a broad objective to develop life skills.

The drug-addiction department of the mental health of Charleroi (Walloon Region) which targets among others weakened families develops also a project in a particular neighbourhood of Charleroi called Dampremy, through a collaboration with a structure called “Espace citoyen de Dampremy” (“Citizen place of Dampremy”).

The 24/7 telephone helpline of Infor-Drogues answers numerous FAQ on its website, targeting specifically parent.

2.2.3. German-speaking Community

In the German-speaking Community, the following training and service were offered:

- Erziehungstraining

The educational training for parents has been an integral part of the ASL concept for 29 years.

- Family-based services for parents and children: for parents as part of a recreational and educational stay at the Belgian seaside with their children. In 2010 it took place with 36 families.

2.3. Community

2.3.1. Helplines

Infor-Drogues and the DrugLijn are respectively the drug help lines for the **French and Flemish Communities**. These services do 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 3.1).

DrugLijn

The annual figures for the DrugLijn in 2010 show a small decrease of 191 contacts compared to 2009 (Evenepoel 2011) (n=5,548, see Table 3.3). These inquiries consisted of telephone calls and e-mails. This overall decrease of 3.3% is completely due to the decline in the number of telephone calls (n= 3,745). This number fell back with 8.3% as compared to 2009. The number of e-mail-enquiries (n= 1,803) increased with 8.8% compared to 2009. These figures illustrate a shift from the more traditional telephone work to more online contacts, which are often considered to be even lower threshold than telephone contact. The online service has become a consistent part of the help lines work: one enquiry in three is made online.

The DrugLijn is no emergency helpline and is therefore not operated 24 hours per day. Outside the staffed hours (Mon-Fri 10h00-20h00), 1,781 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 476 hoax calls.

The percentage of inquiries on cannabis decreased in 2010 after a remarkable increase in 2009, bringing it back to the levels of the years before. The reasons for the increase in 2009 remain unclear. The number of questions on alcohol and psychoactive medicines increased, the latter showing a considerably higher percentage than a few years before. The number of inquiries on medicine even outnumbered the number of questions on cocaine for the first time in the existence of the helpline. The percentage of most illegal substances such as heroin, amphetamine, XTC or LSD show a decrease. The number of inquiries related to cocaine showed a strong increase since 2000 and remained quite stable from 2005 to 2009. In 2009 it showed a minor drop. The figures for 2010 confirm this decrease more clearly.

Table 3.1: Frequency of substances in related calls (% and n), Infordrogues, Druglijn, 2009-2010.

	Infor-Drogues				Druglijn**			
	2009		2010		2009		2010	
	%	N	%	N	%	N	%	N
Number of calls/contacts*		3,272		4,168		5,739		5,548
Males****	35.7	1280	43.2	1994	39.0	2237	41.6	2,306
Females****	58.9	2115	51.3	2367	60.3	3462	57.5	3,190
Unknown****	5.4	193	5.4	251	0.7	40	0.9	52
Involved substances in calls								
Cannabis	33	1,110	34.4	1,196	39.2	1,800	36.8	1,729
Cocaine	18	606	15.2	528	16.7	767	14.5	679
XTC	2	61	1.1	37	3.1	143	3.0	140
Heroin	10	351	9.3	323	6.6	305	5.2	243
Alcohol	15	526	15.8	548	23.0	1,059	24.9	1,169
Psychoactive medicines	6	202	8.2	286	11.5	528	14.8	694
Crack***	3	97	2.1	74	n.a	n.a	n.a	n.a
Methadone	5	178	5.5	193	2.8	130	2.7	126
LSD	1	38	0.6	22	1.5	68	1.0	46
Amphetamine	2.3	77	2.8	99	9.8	449	9.4	440
Others (tabac, solvent,...)	4.0	135	4.7	162	-	-	-	-

*Figures for the DrugLijn include telephone calls as well as enquiries by e-mail; data from Infordrogues only include number of calls. **Because the gender of some callers and e-mailers remained unknown, the sum of males and females does not equal the number of total inquiries; *** Since 2004, crack is distinguished from cocaine since the consumption of cocaine keeps rising; **** Figures mentioned for Infordrogues for 2010 are calculated with a total N= 4612 (sample of callers and e-mailers)

Sources: Infordrogues, 2010; Druglijn, 2010.

As a consequence of the success of the e-mail service, the DrugLijn now reaches more young people than a few years ago. However, the help line's main target group are people from 36-50 years old. Younger people contacting the helpline (mainly e-mailers) are more often drug users and students, whereas the 36-50 year olds (and mainly callers) contain a large number of parents. Still, 2010 showed an increase of the number of users making an appeal to the telephone line. In 2010, the DrugLijn launched a pilot project providing a Skype service. People can now talk to the helpline counsellors via the internet, which is an

innovation in helpline work in Flanders as well as amongst the members of the European Foundation of Drug Helplines (FESAT).

De DrugLijn also provides an online early intervention services via a website (www.hoeveelisteveel.be) for adult alcohol and drug users. The website provides online assessment tests as well as knowledge tests for cannabis, amphetamines, cocaine and XTC as well as an online self-help programme for cannabis users which allows them to cut down or stop their cannabis use over a period of four to six weeks. In 2010 a similar self-help programme for cocaine users was launched. This selfhelp programme mainly appealed to young adult cannabis users (27 years old on average). In 2010 a total of 62,796 self assessment tests and 33,432 knowledge tests were filled in on the website. Each week on average 43 cannabis users and 11 cocaine users signed in on the online selfhelp which runs anonymously and free of charge.

The website of the Druglijn was restyled in 2010 and offers a large amount of information for drug users as well as for parents, partners, friends and children of drug users. These groups are addressed on a personal level and answers that are being given through the telephone calls are made available to a larger group of people who come into contact with drugs (themselves or in their environment). There is a direct link to the e-mail service where people can formulate their personal questions. There is also a link to the self tests that offer people a personal feedback on their use of different drugs (hoeveelisteveel) and to the self help modules for cannabis and cocaine users.

Infor-Drogues

In 2010, 4,168 telephone calls were registered by Infor-drogues (Infor-drogues 2011). Compared to 2009 there was an increase of 27%. Nevertheless, it is necessary to specify that among these 4,168 contacts, 600 were made by "a single person". Disregarding the 600 contacts, we obtain a total of 3568 calls. So, we saw an increase of 10% compared to 2009 (3,272 contacts).

As every year, we observe that the majority of calls are concentrated during working hours (2,707 calls, 65% of the calls). 16% of the calls are made during night (n=649) and 19% during weekends and bank holidays (n=807). Statistics show that demands made at nights and during weekends emanate mainly from users (46%).

The target group of the helpline of Infor-drogues is: users, relatives and professionals. Of the people contacting the helpline in 2010, 47% were users (n=1,746), 43% relatives or friends (n=1,609) and 10% professionals (n=377) (based on N= 3732, corresponding with the priority

target groups). Disregarding the 600 calls made by a single person, there was an increase of 14% in the number of calls made by users.

Of the relative's calls (n=1609), 45% are made by mothers (n=728) followed by other family members (n=290, 18%), partner (n=233, 15%), father (n=198, 12%) and others (friend, colleague,...) (n=160, 10%). Concerning the calls made by professionals (n=377), the statistics show that the health sector is the most represented with 49% of the calls (n=185). 12% were made by educational sector (n=98), 12% by journalist (n=47), 9% by the justice sector (n=33) and 4% by public authorities (n=14).

Of the users who contact the helpline, 55% are 26-35 year old. The age group 36-50 represents 20% of the user's calls. If we analyse the age of the users correlated to the gender, we notice a very strong dominance of the male group aged 26 to 35.

Most of the requests concern the "health structures" (26% of the calls) and "products" (17% of the calls). The first category increased particularly compared to 2009.

The geographical origin of the contacts remains very stable compared to 2008 and 2009.

Brussels remains the first zone (51% of the calls). This has two reasons: on one hand, "drugs" stays a rather urban theme, and on the other hand, there is a geographical nearness of the Infor-drogues centre bringing more opportunities in terms of consultation, documentation ...

In 2010, there were 3468 quote of products. As in 2009, cannabis is the most evoked product (34%). Questions about alcohol are the second most mentioned (16%) followed by cocaine (15%).

Furthermore, in a five-year period (2006-2010), we do not observe a big difference concerning the products evoked. "Medicines" is the only category which seems to increase rather appreciably (8% of calls in 2010 and 6% in 2009). Generally, it is an old feminine population (50 and more) that contact the helpline medicines requires.

Infor-drogues has also an e-mail service (e-permanence). The association received 324 e-mails in 2010. Cannabis is the first product evoked via the e-mail service (35.2 % of the mails), cocaine and crack remain very present with 19.7 % of the mails.

The Table 3.2 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 3.2: Frequency by age of contacts (% and n), Infordrogues and Druglijn, 2010.

	Infor-Drogues**		Druglijn*	
	%	n	%	n
Under 18	2.0	94	6.5	359
18-25	6.2	290	16.7	926
26-35	24.5	1130	18.7	1035
36-49	32.2	1489	24.4	1353
50 and older	11.5	530	13.3	740
Unknown	23.4	1079	20.5	1135

* Figures mentioned refer to a sample of 77.4% of all callers and 84.0% of all e-mailers

** Figures mentioned refer to a sample of callers and e-mailers (N=4612)

Source: Infordrogues, 2010; De Druglijn, 2010.

2.3.2. Local alcohol and drug policy

In April 2011 VAD launched 'Omdat iedereen erbij wint! Samen voor een lokaal alcohol- en drugbeleid'. This concept is a stepping-stone method to create a integral and inter-sectoral-based policy of alcohol and drugs in communities or cities. Working with the local network of the community or city and local partners, starting from a local analysis, a mix of goals can be formed in four areas:

1. Rules and regulation,
2. Structural measures,
3. Informing and sensibilisation
4. Early intervention and Primary healthcare and welfare services.

The method published on <http://www.vad.be/sectoren/lokaal-beleid/een-beleid-opzetten/waarom.aspx> provides a structural guideline with tools and examples. This process of a local alcohol- and drug policy in communities or cities is supported by regional and local prevention workers.

There is a growing number of local prevention workers who are co-financed by the province and the local authorities (in 3 out of 5 Flemish provinces) and who organise and support local actions on alcohol and drugs, mainly focusing on the general population.

2.3.3. German-speaking Community

Information is provided to the general public through presentations, training, public relations, Internet (4,470 visitors in 2010), press, television, radio, etc.

3. Selective prevention in at-risk groups and settings

3.1. At-risk groups

3.1.1. Flemish Community

A needs assessment conducted among 164 staff members working in Flemish institutions for **Special Youth Care** (*Bijzondere Jeugdzorg*) revealed some particular alcohol and drug-related issues (Baeten and Rosiers 2010). 44.2% of the respondents indicate that they are regularly confronted with minors having problems with cannabis use and 14.6% indicate that this is the case for minors with problems related to the use of other illegal drugs. A majority of these respondents assesses these problems as being severe.

Most institutions have an internal drug policy plan, including rules and measures when the rules are obstructed, which they communicate to their clients. If the institutions are confronted with slight problems concerning substance use, they can mostly handle the situation. When the problems are more severe, the clients are generally referred to specialized drug counselling services. Despite the fact that the rate of drop-outs among the clients is quite high, the collaboration with these external specialized services is generally evaluated as positive.

The most prevailing needs in handling drug-related problems in the institutions are a better structured network and collaboration with specialised organisations in drug prevention and counselling and training (expertise- and skill-enhancing activities, information) for staff members.

In 2011, VAD launched a new didactic package ‘Alcohol en cannabis zonder boe of bah’ (Alcohol and cannabis, no nonsense). It is a package tailored to **Young people with mild mental handicap**. It offers an effective way to make them more aware of the effects, risks and consequences of alcohol and or cannabis use. Taking into account the specific vulnerability of this young people, it encourages them not to use alcohol or cannabis.

The materials can be used in different settings (schools, special youth care, ...) and in different manners (in an individual interview or in a group).

In Ghent, the organisation “De Eenmaking” focuses on **migrants** and drug use. Their main activities are drug prevention sessions in prisons, tuppercare-sessions for parents, development of diversity policy and prevention sessions given by ex-users.

In the province of Limburg, employees of *Centra voor Alcohol en andere Drugproblemen* (CAD) organise prevention activities towards the **Moroccan and Turkish community**. Some

of the activities that took place in the centre were: (1) projects towards youngsters of foreign origin in deprived neighbourhood; (2) disclosure of prevention and aid support towards grass-roots organisations; (3) Europarents towards multicultural group of women and (4) the Tuppercare-project: low-threshold drug prevention for women of foreign origin

3.1.2. French Community

The “**Snowball operations**” (*Boules de Neige*, BDN) are a peer prevention programme created in 1993 and coordinated by the NGO Modus Vivendi. The operations in the field are implemented by different NGO’s in the French Community. The main objective of the operations is to reduce the risk linked to the use of drugs. To achieve this, the programme focuses on raising awareness and gives information to the most marginalized public. The data collection itself is not a main objective of this project. The questionnaire is rather a contact tool than a specific tool of data collection. However, it is used to evaluate the implementation of the programme, to follow the evolution of the consumptions, to identify the risk-takings, new tendencies, etc (see also Chapter 6). The programme benefits to a process evaluation.

Table 3.3: Modus Vivendi Snowball Surveys, 2005 – 2010.

Year	N contacts	N jobistes	Total Snowball Surveys	Snowball Survey Pilot operations*
2005	1,047	39	4	-Cannabis
2006	357	11	2	-Hepatitis C -Men Bulgarians Turkish-speaking in the male prostitution
2007	618	17	3	-Squat « Collectif 123 »
2008	648	n.a.	3	n.a.
2009	674	64	7	n.a.
2010	597	58	6	n.a.

*operations said "classics" concern specifically on any drug user lacking social integration. Furthermore, "pilot operations" are organised around a theme: consumption, HCV... and to specific groups such as migrants, women and youth.

Source: Modus Vivendi, 2010.

From March 2010 to February 2011, 6 BDN operations have been organised in the French Community (Modus Vivendi asbl. 2011). The target population are the consumers “in the street” (often marginalized people). 597 drug users were contacted in 2010, among which

540 were active consumers. 76.8 % of the public reached by the operations are men. The mean age of the respondents is 34.2 year. The category «>35 years» is the most represented (46.5%) (see also Table 3.3).

Gender question will be one of the priorities for 2011. So, an operation “100% women” will be setup in collaboration with a needle exchange service and another BDN operation should take place in a penitentiary for women.

Since 2006, **Snowball operations** are also organised in **prison**. Besides the objectives of the “classical Snowball surveys”, the operations in prison set additional objectives: Confide a mission to prisoners: give responsibilities - to value – learn; to approach the harm reduction under the angle of the prison reality and to sensitize the professionals in the necessity of leading harm reduction projects in prison.

Three snowball operations were organised in prison in 2010. This means, 142 contacts with prisoners throw 35 “jobistes” (peer consumers)

During the operations, the team distributes of harm reduction messages. It is mainly via the brochure “*la santé en prison, gardons le cap!*”. It is distributed in prison via the central Pharmacy of penitentiaries. In February, 2011, 2000 brochures were distributed in different prisons. However, needle exchange programmes are not available in prison due to fund lacking.

Specific actions for **ethnic groups** are seldom or not available. However, the Espace P organisation - although it has no specific project for ethnic groups - takes into account the specific characteristics related to the origin of its public (sex workers). For more information on this topic, please refer to Chapter 5 of this report and last year’s national report.

3.1.3. German-speaking Community

Suchtsprechstunde (addiction consultation) aims at preventing damage of clients whose substance use is hazardous or harmful. It is characterized through the low-barrier harm reduction, relapse prevention, self-help, etc.

Individual counselling is given through individual interviews with the ASL drug-advisers and people from the local population that come with individual requests to us. The issues addressed are: co-dependency, addictions of any kind, help for living with a dependency and / or a jail problem, counselling for a targeted placement in a detoxification centre, etc. In 2010 we reached nearly 100 people, including drug addicts, children and parents but also people who want to check if they are addicted or those who want to reduce their drug and alcohol use, or just talk about it.

3.2. At-risk families

3.2.1. Flemish Community

In 2010-11 VAD developed a booklet for **children of parents with a drug problem** aimed at children between 14 and 18 years old. The booklet is the 3rd in a series (the others aiming at children of parents with an alcohol problem). The booklet aims at supporting the children with tips and tricks and contains information and exercises to come to terms with the drug use of their parents. Special attention is being paid to their own attitudes and behaviour concerning drug use. The materials are implemented through the treatment centres for adult drug users. MSOC Vlaams-Brabant developed 2 children books for the same target group. These are story-books for children (4-8 years old and 9+) which are used in the treatment programmes of their parents (to support their parental skills and open discussions with their children about their drug use).

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 2010, Bubbels & Babbels supported 22 families affected by drug misuse (Rombouts 2011). In addition to the client work, Bubbels & Babbels organised 17 training sessions (15-20 caretakers/session) about drug misuse and pregnancy-parenthood and answered around 50 questions of social workers about this topic. Bubbels & Babbels also publishes newsletters with relevant information for professionals (see also Chapter 12).

3.2.2. French Community

The **public centre of social help** (CPAS) of Charleroi (Walloon Region) has a specific drug-addiction cell. Specific projects related to parenthood are developed within this structure. The objectives of these projects are: to help drug using parents to assume their parents role and to assure the well-being of the child. Three projects are under way: “workshop parenthood-drugs users” (the aim is to facilitate the access of the drug users and their children to the services and to the resources of the network as well as to facilitate the coherence and relevant interventions to the families); “part-en-relais” (training by the peers on the theme of

the parenthood- drug use); “objectif parent” (to propose to the users and to his family a social, educational and psychological follow-up and to connect the family with the social and care network).

“Parentalité-Addiction” (“Parenthood-Addiction”) is a multidisciplinary team created within the framework of a public clinic (Saint-Pierre, public hospital of the Public Centre of Welfare in Brussels). The target population of the project are (future) parents, children and families confronted with problems related to drug use.

The team proposes two complementary working axes: the first one takes into account the peculiarity of every family member. The second one works on the "community" of families confronted with the same difficulties. The interventions are developed through different missions: prevention, care, follow-up (antenatal, postnatal, family and children follow-up) and reintegration.

The statistics of 2010 showed that:

In 2010 8 pregnancies were followed. The cases were sent by an ambulatory Centre in Brussels (n=3); former file Parentalité-Addiction (n=4); antenatal Consultation of the University Hospital Centre (C.H.U.) Saint Pierre (n=1). In 3 cases the mother was older than 30.

The project follows the families after deliveries. But the active file of “Parentalité-Addiction” is much more important than the number of deliveries registered in 2010: the number of persons followed by the service is much higher than the number of deliveries.

For an overview of more projects focussing on drug-using parents and their children, please refer to the Selected Issue, Chapter 12.

3.3. Recreational settings (incl. reduction of drug and alcohol related harm

3.3.1. Flemish Community

In 2003, VAD-De DrugLijn developed a global prevention concept for nightlife called **“Partywise”**. Partywise stands for: partying in a safe and healthy way. Since the start of the Partywise concept, several techniques were developed to inform and sensitize revelers, party promoters, club owners and prevention workers in the nightlife scene.

Every year, Partywise informs and sensitizes revelers to party ‘wisely’. This is mainly achieved by providing party tips, videos, posters, banners, etc. at major events such as Tomorrowland, I love techno, Bassleader, 10daysoff ...).

In the first half of 2010 the Partywise cocaine campaign “**How is your friend on coke?**” was maintained in the Flemish nightlife scene. The campaign was launched in October 2009. Revelers were targeted in bars and youth houses using beer mats and posters. Cocaine users were specifically targeted via peer support at dance events.

In 2010 VAD-The DrugLijn developed and implemented a new cross fertilized campaign, called “**Partypeers**”. This campaign was the result of the international project Heroes. The Partypeers campaign, as the name says, was peer driven. In cooperation with the peer support partners Breakline and Vitalsounds, VAD managed to attract 30 highly motivated volunteers (peers). The peers were trained by different experts in the field of alcohol, drugs, road safety and safer nightlife. The partypeers campaign was implemented in four different events spread over four provinces in Flanders, during the second half of 2010.

The volunteers informed drivers on the effects of alcohol, drug use and tiredness on driving skills (using flyers and banners). They motivated drivers not to drink or use drugs during the party and to take some rest from time to time in the relax zone. After the party the sober drivers received a goody bag (with fruit, a drink and some small gadgets). The drivers were also motivated to make a ‘pit stop’ at one of the petrol stations that we selected on the main highways on the way home. If they stopped there (to take a break or do a power nap) they received a leaflet with a ‘pit stop code’. At home they could enter this code on the campaign website and choose their price.

All together the Partypeers reached approximately 300 drivers. 82.1% of them were sober and could drive home safely. The other drivers were motivated to choose for alternatives, like: taxi, friends driving, public transport, ...

See also Chapter 7 (section 4.3) and Chapter 9, for a more information about the related project ‘TEN D by night’ and the campaign “Gene zever” – “Crache test”..

In 2003, **peer support** was introduced in Flanders as a promising new method to work on risk minimisation in the nightlife in Flanders, first by Breakline and later by Vitalsounds. During the years both projects became stronger, more experienced, better equipped and they managed to develop a crew of experienced and motivated peers. In 2010 Vitalsounds and Spiritek (Lille, Fr) started an interregional project, funded by the European commission. Due to this project Vitalsounds expanded its working area to the province of West Flanders and half of the province of East Flanders. They trained new peers and tripled the amount of actions. In 2011 both Breakline and Vitalsounds developed a new website to inform party people about health risks in nightlife settings. Both project are also active via social media like facebook and myspace.

Both projects cooperate closely with Partywise to create a healthy and safer nightlife in Flanders.

3.3.2. French Community

The “**Quality Night**” project is under way since 1997. The main objective of the project is to improve the health and safety of the persons in the “certified” party places. The priorities of the project which is coordinated by the NGO "Modus Vivendi" for 2010 were: the implementation of a partnership with Local Operators (who are going to set up the Label in the region of Charleroi and in the Luxembourg) as well as methodological assistance; the pursuit of the extension of the Label; the development of a common identity and a coherence in the whole Walloon Region and the development of an European reputation of the Label via the European project “Party +” (Modus Vivendi asbl 2010).

In 2010, the VAD got in touch with the NGO Modus-Vivendi to develop a quality label in Flanders. The collaboration between community organisations (VAD and Modus-Vivendi) is in progress.

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**”.

The objective of the “**Mobile team**” project is to reduce the risks linked to drugs: bad trips, overdoses, accidents, sexual risks, risks of exclusion, etc. and to protect the health of the persons who frequent the festive environment. The target population is a young public (included people consuming psychotropic products, alcohol) and which is little in touch with the socio-sanitary sector. Places of actions are festive events selected for their size and/or considered as being potentially high-risk. The activities undertaken are: information stands, distributing brochures; relaxed zone; flying team (“jobistes”); distribution of material such as kits of sniff, condoms, flyers, etc; water distribution; needle exchange and testing.

Seven festivals were covered by the project in 2010. A “Relaxed Zone” was organised during three festivals: Esperanzah, Dour and I Love Techno1. The number of welcomed persons (169 in 2010), increase with regard to 2009 (143 people), and is appreciably equivalent to that of the 2008 (178 people). The public reached are mainly young males, with a mean age of 22 years. The raisons for admission in the “Relaxed Zone” are most frequently fatigue (74%), followed by the presence of fears (12.5%) and nausea (12.5%). The persons who were welcomed in the “Relaxed Zone” mostly declare to have consumed alcohol (75%), then cannabis (34%), then ecstasy (24%).

DR- is a project of distribution of information on harm reduction in festive places. DR- has for objective to make the drug users aware of the risks related to the use of psychotropic products and to inform them about the means to reduce them. The information is spread via a stand held in festival, discotheques, bars, concert halls or an evening, by jobistes as well as socio-medical professionals. The target population is: drug users in festive places and professionals of the sector susceptible to implement the project in their region. The DR-project is coordinated by Modus Vivendi. It groups around 35 partners who develop 11 projects in the field. The coordination assures the coherence and the efficiency, in terms of objectives, approach (to guarantee the respect for the values of the promotion of the health) and of methodology. It was stopped (lack of funding) in 2009, so statistics for 2010 are not available. The coordination re-started at the end of 2010.

Examples of the local projects within the framework of DR- are “dose your dose” in province of western Hainaut which realized 4 interventions in a year. The target population is people between 15 and 25 years. Another project “PRISM” includes the following 3 partners: Periscope project (Canal J - Citadel), the sector of health promotion of Mouscron municipality and SAIS in Tournai. The interventions are planned on average once a month with at least two professionals.

4. Indicated prevention

4.1. Flemish Community

4.1.1. Screening and brief intervention

Primary health care and welfare services are in a unique position to identify and intervene with clients whose substance use is hazardous or harmful and to refer them to treatment when necessary. The population that makes use of primary (health) care has higher odds to show symptoms of harmful substance use than the general population. However, problematic use is often not detected in primary health care and welfare services.

To facilitate screening and early intervention with hazardous and harmful substance use in primary care, a screening instrument with a linked brief intervention was developed. For this purpose the ASSIST, developed by the World Health Organization, was translated into Dutch (Claessens and Defillet 2010).

To promote acceptability, illegal drug use is questioned along with the use of alcohol and tobacco. Every client gets feedback on his results and risk level. People who score in the low risk range receive information. People who score in the moderate risk range receive a brief

intervention (personalized feedback and motivational interviewing). Those whose score indicates that they are at high risk are referred to more intensive treatment.

The instrument exists in a paper version and an electronic version. A separate manual (Defillet and Claessens 2010) was developed for health care services and for welfare services to take the specific characteristics of these settings into account. The intervention and all materials are available online. The developed intervention was largely announced towards all target sectors and training for users of the instrument was provided.

4.1.2. Early intervention

There is an increasing interest in indicated prevention and detection of and intervention with hazardous substance misuse at an early stage. In Flanders we refer to these interventions as 'early intervention'.

Youngsters are for several reasons more sensitive for the risks of substance use and vulnerable to develop drug problems. They often are not motivated to receive any kind of help because they don't see their substance use as a problem. With 'early intervention' a process of motivation is started, as an answer to concerns (of parents, school) or legal actions (police) of the environment.

A concept of group intervention for adolescents was developed, based on psycho-education, feedback and motivational interviewing (Claessens and Raskin 2010). Prevention workers were trained and pilot groups took place. An individual brief intervention was developed for youngsters for whom group participation is not possible. Essential to reach young users is the cooperation with the family and professional environment. They notice the hazardous substance misuse, refer to the intervention and they provide the follow up after the intervention. For the parents informative tools were developed. The referring services were offered training, including the introduction of the screening instrument SEM-J (screening instrument for experiences with substance use – youth).

4.1.3. Self care and self-help

Self-care and self-help are put in the spotlight through the concept of "Te veel" ("Too much"). "Too Much" is there for everyone who questions his drinking, drug use, gambling or internet behaviour. But also the partner, friend, parent or child of someone with a drinking or drug problem is addressed. It groups self help materials (self help groups and online materials) of different organisations. All initiatives can be found on www.druglijn.be/thema/te-veel.aspx. There is also a flyer that is widely distributed.


4.2. German-speaking Community

Initiatives in the German-speaking Community include:

- Motivational interviewing
- A Self Help Group which takes place every week. With an average of 20 participants per week, mostly young adults
- Early intervention
- Training of multiplicities for the early detection of addiction
- Targeted programmes for vulnerable groups
- Short interventions for binge drinking
- Situation analysis as a basis for demand planning of early intervention

5. National and local media campaigns

For information about the campaign 'Gene zever' – Crache test', see Chapter 7 and Chapter 9.



Chapter 4.
Problem Drug Use

Bollaerts, K. and Sasse, A.

1. Introduction

In this chapter, aspects of problematic drug use following EMCDDA's definition as 'injecting drug use or long duration or regular use of opioids, cocaine and/or amphetamines', are presented. National estimates of injecting drug use in Belgium were derived using the HIV multiplier method, combining data from the national AIDS/HIV register with estimates of the HIV-prevalence rate among injecting drug users (see also ST7/8_2011_BE_01). Characteristics of the injecting population are investigated through a yearly survey at syringe exchange in Flanders (Spuitenruil, Windelinckx 2011). and through an ethnographic study in Wallonia (Sacré et al. 2010). Indications of problematic drug use among persons visiting recreational settings were obtained through the surveys 'Partywise Uitgaansonderzoek' (Flanders, VAD) and 'Drogues Risquer Moins (French community, Modus Vivendi) and among university students through the web-based survey 'In hogere sferen 2' (Antwerp-Ghent).

2. Prevalence and incidence estimates of PDU

2.1. Indirect estimates of problem drug use

2.1.1. HIV-multiplier method

Drug users form a 'hidden' population, hiding their membership because it involves illegal and stigmatized behaviour. As a result, classical epidemiological methods (e.g. household surveys) fail and indirect estimation methods are to be used. One of these, is the multiplier method. This method was applied to estimate the prevalence of ever Injecting Drug Users (ever-IDUs) in Belgium, being 0.36% (95%CI: 0.18-0.83%) for the population aged 15-54years in 1995 (Sartor et al. 2001), which is also the latest estimate on problematic drug use available for Belgium. This prevalence of ever-IDUs was estimated using the HIV-multiplier method, dividing the cumulative number of alive diagnosed HIV-patients being ever-IDUs by an estimate of the prevalence rate of HIV seropositivity among ever-IDUs or

$$n_{IDU} = n_{IDU|HIV} / p_{HIV|IDU}$$

with $n_{IDU|HIV}$ being the number of alive diagnosed HIV-patients in Belgium who indicated that injecting drug use was the probable route of HIV-transmission, being obtained from the Belgian AIDS/HIV-register, and with $p_{HIV|IDU}$ being the HIV prevalence rate among ever-IDUs, being estimated based on treatment data. However, the application of the HIV-multiplier method described in Sartor et al. (2001) does not account for the non-AIDS mortality,


implying an overestimation of the number of alive diagnosed HIV-patients, which results in an overestimation of the IDU prevalence with the bias increasing as the time since the onset of the HIV-epidemic (mid-eighties) proceeds.

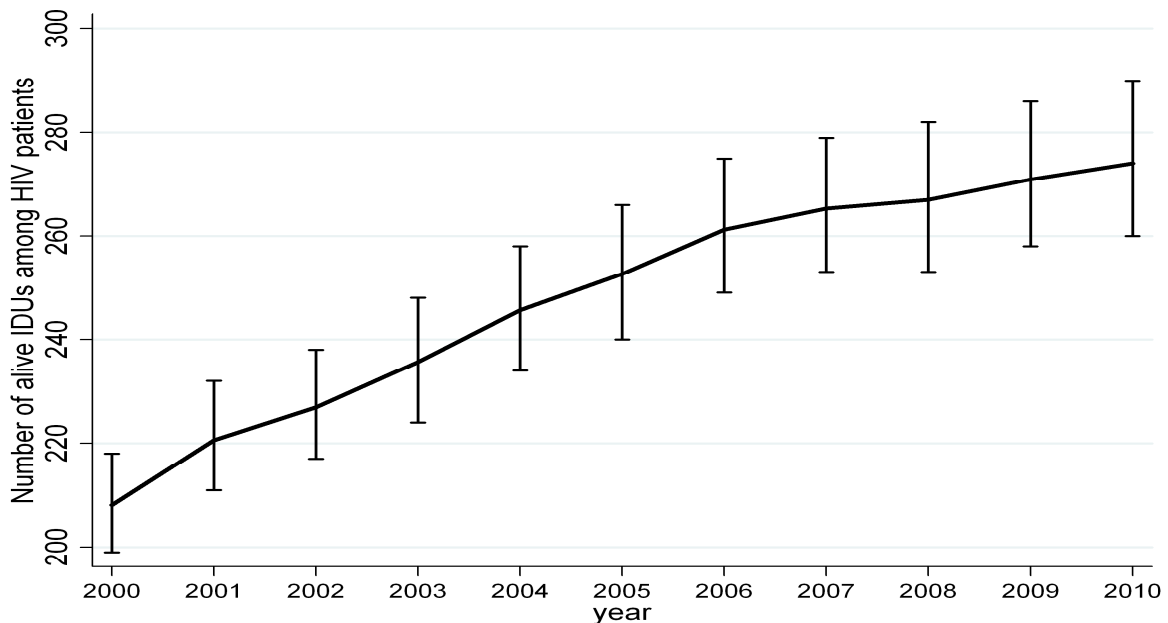
Therefore, the current application of the HIV-multiplier method was adjusted to account for the non-AIDS mortality. To this end, a stochastic mortality model was used, assuming a binomial distribution of the number of non-AIDS deaths among the IDUs with a non-AIDS crude mortality rate of 0.58% per annum. This non-AIDS crude mortality rate was calculated by Degenhardt (Degenhardt et al. 2006) based on 33 cohort-studies, including a total of 179885 injecting drug users and 16593 deaths. Percentile confidence intervals for the prevalence estimates of ever-IDUs were obtained based on Monte Carlo simulation using R = 10000 iterations. These confidence intervals reflect both the uncertainty resulting from the use of the stochastic mortality model and the uncertainty resulting from the estimation of the HIV-prevalence rate among ever-IDUs.

2.1.2. Data sources

The cumulative number of alive diagnosed HIV-patients for whom injecting drug use was the probable route of transmission was obtained from the national AIDS/HIV register, hosted by the WIV-ISP, Brussels (Sasse and Defraye 2009), see also Chapter 6). For the reported AIDS cases, a follow-up study is conducted each year to collect data on last consultation and possible death. The non-AIDS cases lack follow-up, necessitating the use of statistical models (being a stochastic mortality model) to correct for the non-AIDS mortality among seropositive ever-IDUs. The estimated number of alive-seropositive ever-IDUs in Belgium as well as the corresponding 95% Monte Carlo based confidence intervals are given in Figure 4.1. As can be seen, the number of alive seropositive ever-IDUs continued to increase, meaning that the incidence rates still exceed the mortality rate. However, from 2006 onwards, the size of this increase started to diminish.

The seroprevalence rate among ever-IDUs was obtained from a Belgian sero-behavioural study among drug users in contact with drug treatment facilities or imprisoned carried out in 2004-05 (Plasschaert et al. 2005). In total, 1005 drug users in treatment and 117 incarcerated drug users (15-40yrs) enrolled at 65 different drug treatment facilities and 15 different prisons geographically dispersed over Belgium, respectively, participated to the study. Of the drug users in treatment and in prison, 57% (n=573) and 68% (n=80) declared to have injected drugs at least once during their life. Blood samples were taken to determine the HIV- as well as the Hepatitis B and -C status of the participants. The HIV-seroprevalence

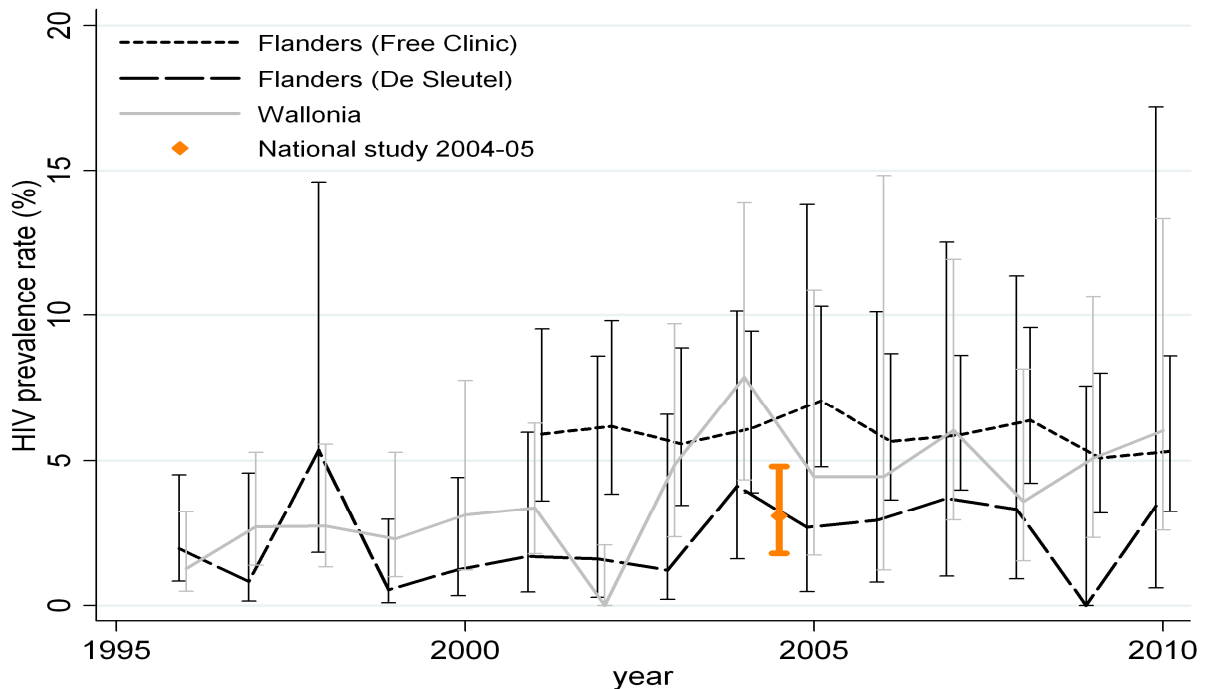
Figure 4.1: Estimated cumulative number of alive seropositive ever-injecting drugs users (15-64yrs) and 95% Monte Carlo confidence intervals based on the Belgian HIV/AIDS register, 2000-2010. 



Source: Belgian HIV/AIDS register

among IDUs in treatment and in prison was estimated to be 2.8% (95%CI: 1.5 - 4.2%) and 5% (95%CI: 0.2 - 9.4%), respectively. These prevalences were not significantly different (p -value= 0.30), yielding an overall estimated prevalence of 3.1% (95%CI: 1.8 - 4.8). In addition to serological studies, estimates of the HIV prevalence rate among ever-IDUs can be obtained from routine diagnostic testing (see also Chapter 6). In Belgium, the prevalence rate of HIV-seropositivity among ever-IDUs was estimated using serological (the Flemish community; De Sleutel, Free Clinic) and principally self-reported data (the French community) collected at low-threshold and drug treatment facilities. The results of routine diagnostic testing are yearly available, allowing the investigation of time trends. However, a concern regarding the (geographical) representativity of the data exists. Figure 4.2 shows the HIV prevalence rates among IDUs and the corresponding 95% Wilson's confidence intervals by source and year. As no significant time trends in HIV prevalence rates were observed based on the data from routine diagnostic testing, the prevalence rate of 3.1% (95%CI: 1.8 - 4.8) estimated from the national seroprevalence study of 2004-05 (Plasschaert et al. 2005) was assumed to apply for the full period 2000-10.

Figure 4.2: HIV-prevalence rates among injecting drug users and 95% Wilson's confidence intervals by year and source, 1995-2010. 



Source: Walloon Region: l'Observatoire socio-épidémiologique alcool-drogues (EUROTOX), Flemish region: VAD – De Sleutel – Free Clinic, Plasschaert et al. (2005)

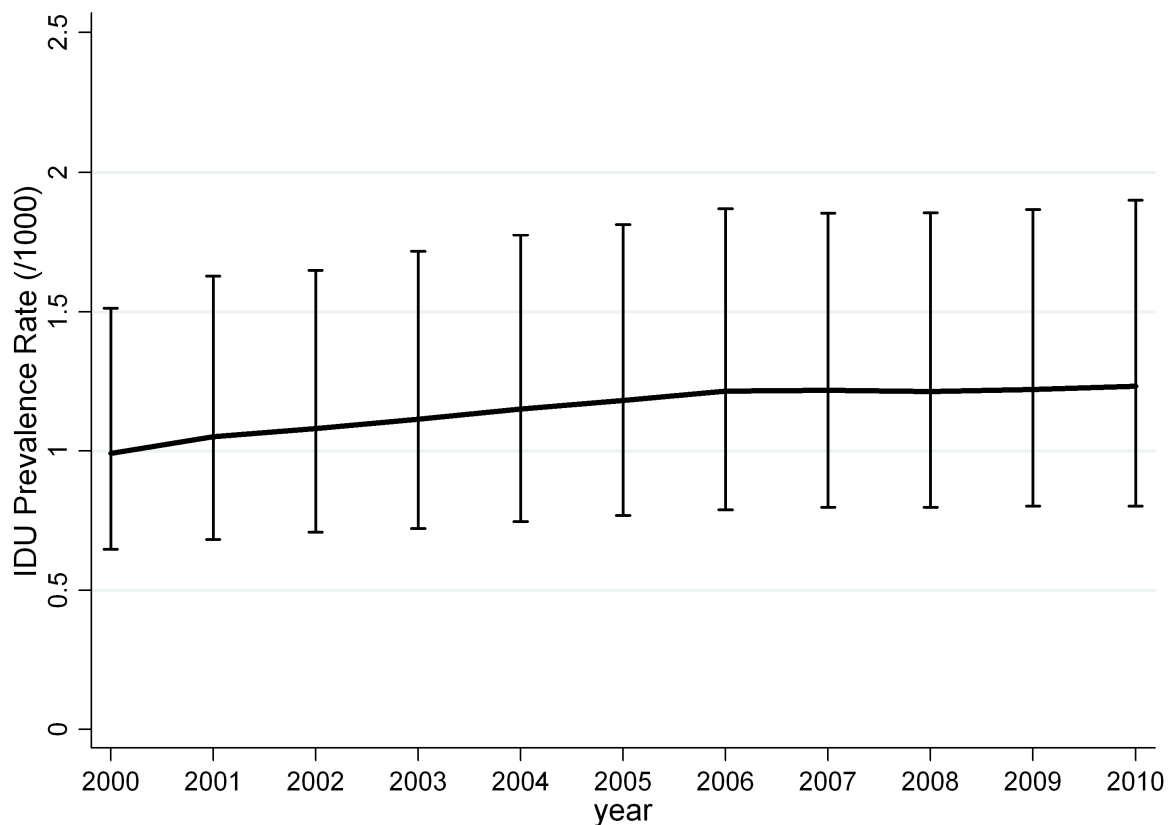
2.1.3. Results and discussion

In 2010, the prevalence rate (per 1000 inhabitants, aged 15-64 years) of ever-IDUs was estimated to be 1.2 (95% CI: 0.78-1.90) and the total number of ever-IDUs in Belgium to be 8,796 (95% CI: 5,717-13,583). The uncertainty in the incidence estimates was large. A sensitivity analysis was carried out, revealing that this uncertainty was primarily due to the uncertainty associated with the estimation of the HIV-prevalence rate among IDUs rather than with the uncertainty resulting from the stochastic mortality model. Time trends of the national prevalence rate of ever-IDUs are graphically presented in Figure 4.3. Partly as a result of the large uncertainty in estimates, no significant time trends were observed. Nevertheless, the results suggest a stabilizing trend in prevalence rate of ever-IDUs from 2006 onwards. The current estimate of 8,796 IDUs in Belgium (95% CI: 5,717-13,583) in 2010 is (borderline not-significantly) smaller than the estimate of 20,000 IDUs (95%CI: 10,300-46,300) from 1995. However, this comparison should be made with caution as a result of methodological differences (age range, (not) accounting for non-AIDS mortality).

As the use of indirect methods inherently relies on empirically non-verifiable (but reasonable) assumptions, the current estimate of problematic drug use will be complemented

with prevalence estimates based on data from the substitution treatment register (see also Chapter 5) and from the mortality register (see also Chapter 6). For now, we (reasonably) assumed that the HIV-prevalence rate among IDUs remained stable the last ten years. However, new and precise HIV-prevalence estimates among IDUs are needed to obtain estimates for future years based on the HIV-multiplier method.

Figure 4.3: Prevalence rate (/1000) and 95% Monte Carlo confidence intervals of ever-Injecting Drugs Users (15-64yrs), 2000-10. 📊



3. Data on PDUs from non-treatment sources

3.1 Injecting Drug Users in contact with syringe exchange in the Flemish region

Data on injecting drug users frequenting the syringe exchange programmes located in Flanders are collected using a structured, voluntary, anonymous questionnaire since 2001 (Windelinckx 2011). Every IDU contacting one of the syringe exchange programmes is asked to fill in a questionnaire, based on the Injecting Risk Questionnaire (IRQ) (Stimson et al. 1998) and additionally containing items on health status, drug use and access to health care. From 2006 onwards, a revised and improved questionnaire is used.

In 2010, a total of 251 IDUs participated. The age of the participants ranged from 18 to 63 years, with an average age of 34.8 years. The majority of the participants were male (76%). Almost 25% of the IDUs live in an unstable environment (homeless, squads, ...). The vast majority of the participants reported non-concurrent poly drug use (on average 4 products). Opiates (57%) were the primary injected drug of choice, followed by stimulant drugs (32%) and drug cocktails (12%). Smoking of freebase cocaine was reported by 41% of the participants. Up to 40% of the participants reported to be initiated into injecting drug use before the age of 20 years and 64% reported to be injected by someone else during first injection. The majority of the participants reported not to have shared syringes (receptive: 79%, distributive: 77%), spoons (65%), water (62%) and filters (68%) during the last month. In total, 15% of the participants reported to have had at least one drug overdose the last year and 15% was never in treatment.

One of the main findings of the survey was the young age at initiation of injecting drug use, with 9% of the participants being even younger than 15 years when injecting the first time. The age of the IDUs frequenting the needle exchange programmes was much higher, indicating that the majority of the IDUs is already (unsafely) injecting for several years before being in contact with risk and harm reduction programmes. The results of the survey apply to IDUs in contact with the syringe exchange programmes in Flanders only. The number of IDUs not in contact with these programmes is believed to be substantial since 60% of the participants to the study indicated to know at least one IDU not in contact with the syringe exchange programmes.

3.2 Street-recruited drug users through snowball sampling in the Walloon Region

In 2010, a study on injecting drug use in the Walloon region was conducted by asbl Eurotox and Modus Vivendi (Sacré et al. 2010). The principal objective of the study is to improve the (drug) health care facilities and its accessibility to injecting drug users, in particular to those subgroups who are less inclined to use these services, being the allochthonous, female and young injecting drug users. The study consisted of two main parts, namely a description of the health care facilities in contact with injecting drug users (organisation, strategies, services, needs,...) and a description of the allochthonous, female and young injecting drugs users (socio-demographic characteristics, patterns of drug use,...).

Information on the health care facilities was obtained through a partly structured and partly semi-open questionnaire send to all addiction services, refuges, social relays and

(emergency units of) general hospitals in the Walloon region in 2010. The majority of the participating health care workers indicated that the (low-threshold) facilities for drug users should be improved. The most common suggestions for improvement are the scaling up of the capacity of the refuge provision and night shelter for drug users and to enhance the involvement of pharmacists in the reduction of drug-related harms (e.g. Stérifix project, see Chapter 7).

An ethnographic approach was used to collect information on the allochthonous, female and young injecting drug users in Liege and Charleroi. In total, 67 current injecting drug users were interviewed, of whom 30 were female, 36 were younger than 30 years and 26 were allochthon. The researchers conclude that allochthonous injecting drug users do not have additional barriers to access health care facilities compared to autochthonous injecting drug users. Female drug users are less inclined to use these services, especially in case they have children to care for. Young drug users and especially minors rarely use health care facilities due to their chaotic life style. Furthermore, they are often not well informed about safe injecting practices.

3.3 Drug use within the party scene

Drug use in nightlife settings within the Flemish Community is biennially investigated through the **Partywise Uitgaansonderzoek** by the VAD, being organised the first time in 2003 (see also Chapter 2). The prevalences of daily substance use can be considered as indications of problematic drug use as regular use of opioids, cocaine or amphetamines. Table 4.1 contains the prevalences of daily substance use by year and substance. The prevalences of daily use of XTC, speed, cocaine and heroin are very low within the party scene. In 2007, these prevalences (except heroine) were slightly higher compared with prevalences of the remaining years. Although regular use of cannabis does not fall within the definition of problematic drug use by the EMCDDA, a declining trend of daily cannabis use was observed. In 2003, the prevalence of daily cannabis use was as high as 20%, declining to 6.8% in 2009 (Rosiers 2010).

Indications regarding injecting drug use and simultaneous polydrug use can be obtained based on the annual survey within the party scene in the French Community ("**Drogues Risquer Moins**", Modus Vivendi, courtesy of Eurotox) (see also Chapter 2). Although polydrug use is not part of the EMCDDA's definition of problematic drug use, concurrent poly drug use is associated with increased risks due to the synergistic effects of the different types of drugs combined.

Table 4.1: Prevalences (percentage) of daily substance use within nightlife settings in Flanders, 2003-2009.

Substance	XTC*	Speed	Cocaine	Heroine	Cannabis*
2003 (N=645)	0.5%	0.8%	0.6%	0%	20%
2005 (N=670)	0.8%	0.6%	0.6%	0.5%	11.6%
2007 (N=775)	1.5%	1.1%	2.1%	0%	12.6%
2009 (N=607)	0%	0.2%	0.3%	0.2%	6.8%

* not part of problematic drug use definition by EMCDDA

Source: Partywise Uitgaansonderzoek, VAD

The survey aims at verifying whether the harm reduction activities apply well to the targeted audience and is therefore not representative for the whole party scene. Nevertheless, time trends as given in Table 4.2 might be cautiously interpreted. The lifetime and last month prevalences of injecting drug use were stable over the years, fluctuating around 3% and 1.5%, as well as the prevalence of simultaneous polydrug use, with more than 10% of the visitors indicating to use at least three different products, alcohol included, during the event.

Table 4.2: Prevalences (percentage) of injecting drug use and polydrug use during event within nightlife settings in Wallonia, 2004-2010.

Year	2004 (N=1354)	2005 (N=1950)	2006 (N=2402)	2007 (N=2618)	2008 (N=3917)	2009 (N=2969)	2010 (N=2111)
Injecting							
lifetime	3%	2.7%	2.7%	3.2%	3.2%	3.5%	4.6%
last month	1.7%	1.8%	1.7%	1.3%	1.1%	1.5%	2.1%
during event	-	-	-	0.6%	0.7%	1.1%	1.2%
Polydrug use*							
2 products**	17.9%	20.6%	18.6%	16.9%	23%	18.7%	17.3%
≥3 products**	14.6%	14%	13.2%	11.5%	12.9%	10.1%	12.7%

* not part of problematic drug use definition by EMCDDA, ** alcohol included

Source : Drogues Risquer Moins, Modus Vivendi

3.4. Problematic drug use among Belgian university and university college students

In 2009, drug use among university and high school students was investigated through the web-based survey 'In hogere sferen 2' (Rosiers et al. 2011). See also Chapter 2 and Annexes for more details on the survey. The results are based on a sample of 3,537 respondents. Prevalences of daily substance use among last year users are summarized by substance and period of use in Table 4.3. The daily use of cannabis was highest during vacation and lowest during exam period. However, still 4% of the students who used cannabis last year declared to daily use cannabis during exam periods. The daily use of amphetamines among last year amphetamine users is higher during the exam period compared to other periods.

Table 4.3: Prevalences (percentage) of daily substance use among university students declaring to have used the substance last year, Ghent – Antwerp, 2009.

Substance	XTC* (N=92)	Amphetamine (N=92)	Cocaine (N=113)	Cannabis* (N=810)
courses	1.1%	1.2%	0.9%	7.2%
exams	1.1%	4.7%	0.9%	4.0%
vacation	1.1%	2.3%	1.8%	9.7%

* not part of problematic drug use definition by EMCDDA

Source: In hogere sferen 2 (Rosiers et al. 2011)

In addition to frequency of substance use, Rosiers et al (2011) also studied problematic drug use based on DSM-IV criteria to assess cannabis dependency (Decorte et al. 2003) and based on the 10-item Drug Abuse Screening Test (DAST-10) for the non-cannabinoid substances (Skinner 2001; de Graaf et al. 2010). Rosiers et al (2011) found that 31% of the last year cannabis users (N=810) expressed at least one symptom of problematic cannabis use and that the probability of expressing these symptoms was positively correlated with frequency of use. For the last year amphetamine, XTC and/or cocaine users (N=139), 42.8% were found to have an increased risk and 14,4% a high risk for problem use whereas only 39.1% of the last year users were identified as limited risk users (Rosiers et al. 2011). Compared with cannabis, the use of the non-cannabinoid substances was less prevalent. However, when non-cannabinoid substances were used, symptoms of problematic drug use were more likely.

3.5 Regular cannabis use among school students

Although regular cannabis use is not part of EMCDDA's definition of problem drug use, regular cannabis use is associated with cognitive deficits including psychosis and poor academic performance. Data on regular cannabis use could be obtained from the school surveys Health Behaviour in School-aged Children survey (HBSC) for the Flemish en French community and 'Vlaams schoolonderzoeksproject naar alcohol en andere drugs' (VLASPAD) (Flanders). A summary of the prevalences of school students indicating to have used cannabis at least 20 times the last month is given in Table 4.4. The prevalence of regular cannabis use is in line with the observations for cannabis use in general, with the prevalence of regular cannabis use increasing as age increases and with higher prevalences for boys compared to girls. More interestingly, when comparing the current prevalences with the ones for previous years, regular cannabis use among school students seems to decrease over time. However, this trend is not confirmed based on the HBSC data for Flanders, for which previously lower prevalences were observed compared to the other data sources.

Table 4.4: Prevalence of regular cannabis use among school students, 2006-2010.

	year	Boys			Girls		
		13-14yrs	15-16yrs	17-18yrs	13-14yrs	15-16yrs	17-18yrs
HBSC (Flanders)	2006	0.8% (N=1319)	2.0% (N=1319)	5.9% (n1204)	0.1% (N=1317)	0.5% (N = 1328)	1.7% (N = 1208)
	2010	0.6% (N = 1241)	1.9% (N = 1285)	6.2% (N = 1216)	0.2% (N = 1221)	0.8% (N = 1312)	1.4% (N = 1216)
HBSC (French community)	2006	0.9% (N=1369)	4.6% (N=1292)	8.4% (N=1027)	0.4% (N=1207)	1.1% (N = 1333)	2.9% (N = 1047)
	2010	0.8% (N = 1069)	3.7% (N =1159)	6.5% (N =806)	0.2% (N = 1113)	1% (N = 1232)	1.8% (N = 980)
VLASPAD (Flanders)	2007	0.4% (N=1258)	2% (N=1271)	14.1% (N=729)	0% (N=896)	0.7% (N = 7272)	1.5% (N = 653)
	2010	0.1% (N=1115)	2.3% (N =1168)	7.4% (N =761)	0% (N=1083)	0.6% (N = 1110)	1.3% (N = 689)



Chapter 5.

Drug-related treatment: treatment demand and treatment availability

Antoine, J. and van Bussel, JCH.

1. Introduction

This chapter describes the drug-related treatments that are available in Belgium. It is divided into two parts. In the first part, the Belgian policy on drug-related treatment based on the joint statement of the inter-ministerial Conference on Drugs is presented. Then a description of the treatments facilities available in the country will be made. A description of projects funded by the federal government is provided to have a global overview of what is undertaken in this domain in Belgium. In the second section of this chapter, the “in treatment” population will be pictured through 4 different data sources. The first source is the 2009-2010 Belgian Treatment Demand Indicator Register (BTDIR) data, reporting new treatment demands mainly from outpatient centres. The second data source is from a general practitioners network in Flanders corresponding to primary care settings (INTEGO). The third source is the minimum psychiatric database filled in psychiatric hospitals or psychiatric units in a general hospital, corresponding to residential treatment centres (MPG-RPM). To close this chapter, results are presented from the substitution treatment register reporting on people in Belgium who are receiving a substitution treatment (methadone or buprenorphine).

2. General description, availability & quality assurance

2.1. Strategy/Policy

In the new Joint statement of the inter-ministerial Conference on Drugs named “A global and integrated drug policy in Belgium” from January 2010 (Conférence Interministérielle Drogues 2010; Interministeriële Conferentie Drugs 2010), certain recommendations are made concerning support strategies for drug-users (www.drugpolicy.be). After affirming the need for a global support strategy, starting from a health approach and integrating other dimensions (welfare, social integration...), the Joint Statement indicates that support for drug-users must be developed and diversified to provide treatment as well as support and aftercare. To achieve this objective, a large choice of facilities is recommended, i.e. facilities specifically dedicated to drug-users or global health care and welfare. The geographic repartition of these settings must also be balanced based on an estimation of the needs. The statement also defines what kind of treatment should be made available: drug-free treatments, withdrawal treatment, substitution treatment, harm reduction, reintegration, and after-care. Complementary, other problems have to be taken into account when treating those patients: double diagnosis, employment, housing, psychosocial problems... Another important point addressed is the consultation and the collaboration between all levels of

collaborators. This must lead to the development of networks offering general and specific treatment approaches. Waiting lists of patients willing to enter centres should be avoided by reducing the lack of field workers and encouraging the training of health care workers. Case Management that includes individualized support for an improved follow-up and a complete approach must be encouraged, particularly in specific groups.

In Belgium, different levels of decision-making provide funding for treatment, including the regional and federal governments. For example, at the federal level, the Federal Public Service for Public Health, Food Chain Safety and Environment provides the financing for a number of therapeutic communities, crisis centres and day centres which were set up in the 1970s and have expanded their capacities in recent years. On the other hand, mental health centres, for example, are financed by the Walloon Region or by the Flemish Community.

Information on organisation of drug treatment and availability and diversification of drug treatment in Belgium for 2010 is available on the Standard Questionnaire 27, Part 1 (SQ27P1_2011_BE_01).

2.2. Treatment systems

2.2.1. Availability and diversification of treatment

In Belgium, there is a wide variety of treatment centres for psychoactive substance-related disorders. The staff members at these centres aim to keep individuals from harming themselves or others by informing them about the effects of and the risks involved in the use of illegal drugs in our society. The main objective of these services is the promotion of quality of life in terms of global health (physical and psychological), as well as in terms of welfare and respect of the autonomy of the drug-user (Vanderplasschen et al. 2002;VAD2011b).

As the problem is very complex, there is no quick and definitive solution available to help drug-users. Treatment is often a long process with different phases for different patients. There is no standard treatment available. During treatment, there are several possible interventions offered by different organisations. Next to specialized or categorical drug centres, informal care and self-care as well as primary care also play an important role in early detecting, caring, and orienting people with a drug problem. An updated list of treatment centres in Belgium is available on the IDA-websites (www.ida-nl.be: *Informatie over Drugs en Alcohol*, and www.ida-fr.be : *Information sur les Drogues et l'Alcool*).

Informal care and self-care. People with a substance-related problem can find help outside the professional care system (their family, friends, neighbours, volunteers...). They can also find a permanent group of experienced people, the possibility of crisis intervention and

weekly meetings with fellow peers. Different self care initiatives exist related to drug addiction such as *SOS nuchterheid*, Narcotics Anonymous Belgium,...

The **street corner social workers** are looking for drug users in their own environment (on the street, in bars, at home,...) and are available for help and advice. They first build a close relationship with drug users, and try to convince them to do something about their problem, and support them while they are making their decision. This is the most low-threshold service available. Vlastrov (Vlaams straathoek overleg) in the Dutch Community and "Coin de rue" in the French Community are the umbrella organisations for street corner social workers.

Primary care is the first, low-threshold, non-specialized access to organized help. The primary care is located close to the population and usually has the first contact with the drugs misusing person. Primary care is useful for detecting a substance related problem, evaluating it and redirecting if more specialized support is needed. In Belgium, primary care is provided by general practitioners, centres for general social work (Centra voor Algemeen Welzijnswerk-CAW in Flanders, Centres d'action sociale globale-CASG in Wallonia), services for domiciliary care, youth advisory centre (JAC in Flanders, Infor-jeunes in Wallonia), and public welfare centres (CPAS-OCMW).

Specialized outpatient care

Medical and Social Care Centres (MSOC: Medisch en Sociaal Opvangcentrum or MASS: Maison d'Accueil Socio-Sanitaire) are low-threshold centres where persons with a substance-related disorder can find social, psychological and health care services. These facilities also try to lower the risk for the neighbourhood in contact with drug-related criminality. The focus group is initially the problematic drug users. Harm-reduction, substitution treatment, and medical and social care are a large part of the daily work. The MSOC's and MASS's also coordinate the needle exchange centres. There are five MSOC in the Dutch Community (Antwerp, Limburg, Oostende, Gent, Vlaams-Brabant) and four MASS in the French Community (Brussels, Charleroi, Liege, Mons)

Day care centres are specialized low-threshold centres that reach a large group of people with drug related problems (from new consumers to known persons with a severe substance related disorder) and their neighbourhood. Support is offered on an individual basis or as part of a group, and on a psychosocial, administrative, or judicial level. Total abstinence is not mandatory but the patients cannot be under the influence during the activities. Substitution treatment (methadone, buprenorphine) is available. In these centres, the emphasis is on the accompaniment during the transition to a more structured day.

In the French Community, several units funded by the “Plan stratégique de Sécurité et de Prévention” or by the regional “Plan de cohésion sociale” receive drug users during the day and sometimes in the evening to provide social, psychological and medical help. These units are generally part of the commune services.

Not all *Centres for mental health care* (CGG: Centra voor Geestelijke Gezondheidszorg or SSM: Service de Santé Mentale) specialize in the treatment of substance-related disorders. But this situation is evolving in Flanders, where each centre now has a specialized unit. The main treatment objective is the healing of mental health including substance use. Total abstinence or at least consumption reduction is the final objective of these services. A wide variety of treatments is available: individual, relational, familial or group therapy. Patients with more complex problems, such as double diagnosis, can find here a specific offer with an interest on continuity.

Residential care

There are low-threshold, non-specialized residential centres where *homeless people* who with a substance-related problem find non-invasive care on voluntary basis. These centres work together with other outpatient centres.

Crisis intervention centres (CIC) and Crisis service in a unit of psychiatric emergency intervention guarantee help in case of crisis, promote a physical detoxification and motivation for other abstinences and they care for further orientation to the best programme. The target group is mainly problematic drug users (See also the pilot-project “Crisis-unit and Case Management”).

Recently, in each province, an emergency intervention crisis service has been established to care for people with substance-related problems, and to build up a case management function. Patients receive an intensive treatment of 5 days (maximum) with the main objective of stabilization. After a meeting with the patient, the case manager can support him and refer him to an outpatient or inpatient service to continue the treatment process.

Psychiatric section of a general hospital. In these settings, various psychiatric disorders are managed, including substance-related disorders. They welcome people after a crisis care, detoxification, and treatment of severe psychiatric complications due to substance use. The corporal follow-up of substance use is the point that receives most attention. Patients are redirected from the emergency service of the same hospital, general practitioners, or other services. A stay in such a section is generally short, and mainly focuses on detoxification,

observation, diagnosis, and motivating of the patient to seek future treatment. No drugs may be consumed during the patient's stay.

Detoxification and treatment service of a psychiatric hospital / detoxification clinic. Most psychiatric hospitals have a special section for the treatment of persons with a substance-related disorder. Such services are traditionally more oriented towards alcohol and medicines but more and more are treating people with a disorder related to illegal substances. With medical and psychiatric personnel taking a personal approach, patients are offered a global package of services such as crisis care, screening, detoxification, treatment, social reintegration, and after-care. Most of the time, it's encouraged to stop taking drugs and it's also a condition during the treatment.

Therapeutic communities are drug-free environments with a strong focus on self-help and peer support, a hierarchical community structure and group therapy sessions. The objective of these long-term programs is to detoxify drug-users and to reintegrate them in the society. The difference with treatment in psychiatric hospitals is that the latter often use drugs/medicine to facilitate detoxification and to reduce craving.

2.2.2. Organisation and quality assurance

Guidelines

The Flemish regional focal point, the Vereniging voor Alcohol en andere Drugsproblemen (VAD) developed an overview of evidence-based guidelines for the treatment of alcohol or drug-related problems. These guidelines are reviewed in the field of methodology, intelligibility and presentation, possibility of objectives, flexibility and the independence of the authors (VAD2011a). This work is part of a research project, funded by the Belgian Science Policy (BELSPO) in 2007, from which a book was published (Autrique et al. 2007) with a list of reviewed guidelines (<http://www.vad.be/evidence-based-werken/richtlijnen.aspx>). New reviewed guidelines published in 2009 and 2010 concern general guidelines (WHO2010;Matthys et al. 2010), as well as more specific ones for cannabis users (Copeland et al. 2009), benzodiazepine users (National Health Service 2009), opiates users (WHO2009;Ministry of Health 2010), double diagnostic problems (Mills et al. 2010) and early detection (Snoek et al. 2010).

The quality assurance treatment description in Belgium is available on the Standard Questionnaire 27, Part 2 (SQ27P2_2011_BE_01).

The Federal Addiction Fund, created in 2006, has an annual budget of €3,000,000 to finance innovative projects related to the prevention and treatment of drug but also alcohol-, tobacco-

and psychoactive medicines-related disorders. These projects have the objective to inform about dangers of drug consumption and dependency or misuse, to reduce the consumption of drugs, especially by young people, to foster comprehension of and respect for the rules governing substance use, and to increase the quality of medical, psychological, and social care. Table 5.1 describes the drug treatment projects funded in 2010 in Belgium.

Five on-going pilot-projects related to drug treatment are also funded by the federal government.

Between June 2009 and December 2010, a study was conducted in the outpatient centre De Kiem in Gent. The aim of the study was to compare the **Community Reinforcement Approach (CRA) + vouchers treatment method** to the standard treatment method for **cocaine users**. Drug users were paid to abstain from using drugs, with a bonus system in which they can earn vouchers. This voucher system is part of a global cognitive behaviour treatment consisting in individual conversations, exercises on attitude and social skills, relationship therapy, encouraging discussions and relapse prevention. Participants can up earn up to €1265 in a six-month period if they can prove their abstinence, by means of a saliva test. If they can't, the participants receive a ticket worth €2,50. In the ambulant centre De Kiem, 18 drug-users were tested with this new treatment and 16 with the old treatment. The results show that the number of days of cocaine use in the CRA group decreased compared to the normal group (3.7 vs. 6.2 days after 3 months and 2.3 vs. 6.1 days after 6 months). In addition, the number of completely abstinent persons was higher in the CRA group (50% vs. 25%). Six months after the beginning of the treatment, the choice of abstinence was 3 times higher in the CRA + vouchers group. On the other hand, the use of social products such as alcohol and cannabis is higher in the CRA + voucher group. Encouraged by these good results, the authors of the study recommend developing this kind of treatment for cocaine users (Vanderplasschen et al. 2011b)

Table 5.1: List of projects funded by the Federal Addiction Fund in 2010.

Institution	Type of project	Target group	Description
CAD Limburg Hasselt	Prevention Withdrawal	Cannabis users	To spread information and provide an online support programme to reduce or stop cannabis use with a professional help. (www.cannabis.be)
CGG Kempen Turnhout	Harm reduction		To reduce the drug-related nuisances in a very poor area and improve the global status of drug users through the CRA (Community reinforcement Approach) method.
De Sleutel Gent	Prevention		To intensify in quantity and quality the prevention, early detection and support.
De Kiem Gent	Prevention Health care	Under judicial constraint	To provide an ambulatory follow-up and consultations for drug-users sent by justice in the context of judicial alternative sanction.
D.U.N.E. Brussels	Prevention Health care	Injecting drug users	To provide a better health care in a needle exchange centre for the most insecure people group through a monitoring, street work and nurse-related care in the street.
Entraide SIDA Namur	Prevention Health care	Injecting drug users	To create a medical and nurse team in a needle exchange centre to carry out the first health care for injecting drug-users, allow HIV or HCV screening and provide support
Free Clinic Antwerp	Prevention	Hepatitis C drug-users	To support drug-users in treatment for hepatitis C
Kompas Kortrijk	Prevention	Minors	To provide a support at home for minors and their family in a crisis situation consisting in an intensive follow-up at home during 6 weeks to stabilize the state, search for an orientation and evaluate the family environment.
CHU BRUGMANN Brussels	Prevention	Adolescents	To evaluate, to assist and to support drug-addicted adolescents based on a multidimensional family approach.
PopovGGZ Drongen	Health care		To optimize care for intellectually limited and drug addicted people.
MSOC Oostende	Prevention	Pregnant women / Parents	To develop an outreached, integrated and proactive support for drug addicted parents via Assertive Community Treatment.

Table 5.1 continued

Institution	Type of project	Target group	Description
Psychiatrisch centrum OLV Kortrijk	Prevention	Young psychotic Drug-users	To provide a psychiatric caring at home for young (16-35y) psychotic drug-users
VAD Brussels	Prevention		To develop and implement a screening instrument ASSIST and short time interventions for drug problems in primary care
Centre Alfa Liège	Prevention	Young people	To set up a phone line to provide information and orientation to young drug users.
THAIS Liège	Prevention	Parents	To support addicted parents to lower the risk of children consumption and neglected children
KATARSIS Genk	Prevention	Parents	To assist and learn the parenthood to drug addicted people in treatment

Source: Federal Addiction Fund, 2010

In Belgium, the Cannabis clinic (Brugmann Hospital) has been part, with four other European countries (France, Germany, Nederland and Switzerland), of the **International cannabis need of treatment (INCANT)** project since 2003 (Jouanne et al. 2010; Rigter et al. 2010). INCANT is a randomized controlled trial that compares MDFT (Multidimensional Family Therapy) with treatment as usual. Its objective is double: to validate a therapeutic method in the field of substance-related disorders in adolescence and to develop means of evaluation of psychotherapies. MDFT is a family-based and developmentally oriented outpatient treatment for adolescent substance use disorders and associated problems. It has been the focus of empirical development and refinement since 1985. MDFT is an integrative set of interventions, tested with success in different doses and treatment delivery settings. In MDFT, substance use disorders are seen as part of a potentially deleterious lifestyle often including other problem behaviors. Therefore, in MDFT the therapist targets as many life domains and problem behaviors as possible. An exclusive focus on substance use would not achieve lasting benefit.

Because of these multiple facets, MDFT involves a broad array of interventions. Many of these are not unique to MDFT, but the particular combination, sequence and focus of interventions make MDFT special among contemporary family-based treatments for adolescent substance use disorders (www.incant.eu).

The project **Intensive treatment of patient with double diagnosis** was launched in 2002 in two double diagnosis units (Psychiatrisch Centrum of Sleidinge and Intercommunale de Soins spécialisées de Liège). The objective of the project is to study the feasibility of intensive treatment units for patients with a substance-related disorder and psychotic disorders. Results show that an intensive and integrated treatment of young adults presenting a double diagnosis provides positive results compared to the classic treatment on psychic functioning, quality of life and the general functioning in short or long term. Another important finding is that the therapeutic effect after one year of standard treatment has decreased compared to the integrated treatment. Tools have also been established for the evaluation of outpatient care, before or after the stay in hospital. (Sabbe et al. 2008)

Crisis units and case management. Emergency departments play an important role in offering first aid to persons with substance use disorders. These facilities can also inform patients, motivate them to seek treatment, and refer them to specialized treatment centres. The national pilot project for the crisis and case management of patients with substance use disorders is subsidized by the Federal Public Service Health, Food Chain, and Environment. Since 2002, nine centers in Belgium devote four crisis beds (six in Brussels and Antwerp) to

the treatment of substance related disorders, with a maximum stay of five days. Each centre treats at least 300 patients annually and at least half of them has to be in a drug-related crisis. These eight facilities are: EPSI (AZ Sint Jan, Bruges), EPSI (AZ Stuivenberg, Antwerp), UPSIE (UZ Ghent), EPSI (UZ Leuven), TEPSI (Ziekenhuis Oost-Limburg, Genk), Centre Hospitalier Régional de la Citadelle (Liège), Centre Hospitalier Régional de Namur, Centre Hospitalier Universitaire Brugmann (Brussels) and Centre Hospitalier Universitaire Ambroise Paré (Mons). After the acute somatic situation of the patient in the observation unit has been checked, this project plans an intensive short term (5 days maximum) treatment where the crisis situation due to substance problems can be analysed to start with the healing process. The case manager, after consultation with the patient, has to refer him to other ambulatory or residential care settings. The objective of the case manager is to guarantee the continuity of care of the patient and to draw up and monitor a care trajectory. (Bruffaerts et al. 2010).

For several years, the city of Liege demands a pilot-project on the **medically assisted treatment with diacetylmorphine**. 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 (called TADAM) gathering some hospitals in Liege was created, the building where the delivery should take place was chosen and a research unit from the University of Liege is currently working on the project. The inclusion of patients started in January 2010. At present 10 people between the ages of 40 and 53 have been selected to be part of the test group (receiving heroin) and 15 people are in the control group (receiving Methadone). The treatment phase with diacetylmorphine started in January 2011.

The polydrug use problematic is tackled in the **POLYMEH project** started in December 2009. The objective of the project is to map the prevalence of polydrug use and the description of polydrug users, to explore the extent and type of psychiatric disorders among these people. Then the aim is to compare characteristics and psychiatric profile of polydrug users with persons who only use one drug. More information on this project is available on the BELSPO-website.

3. Access to treatment

3.1. Characteristics of treated clients (BTDIR data included)

3.1.1. The BTDIR registration

Description of the registration system for 2009/2010 data

In the **French Community**, the Belgian Treatment Demand Indicator Register (BTDIR) data is collected in volunteer inpatient, outpatient and low-threshold centres. Three main types of centres are involved: centres specializing in illegal substance misuse treatment that have a convention with the National Institute for Health and Disability Insurance (NIHDI), centres for mental health care that have a drug addiction agreement with the Public health administration of the Walloon region, and ambulatory treatment centres in the Walloon region with a facultative drug subvention from the Walloon government. The Observatoire socio-épidémiologique Alcool-Drogues en Communauté française (Eurotox asbl), the Focal point of the French Community, merges all data from the Walloon region. In 2009 and 2010, there were 29 Walloon treatment centres participating in the BTDIR collection.

In the **Brussels-Capital Region**, data was collected in 2009 in 12 units of ambulatory centres, 7 residential units, and 1 Low-threshold agency. Concertation Toxicomanies Bruxelles - Overleg Druggebruik Brussel (CTB/ODB), the regional Focal point of the Brussels-Capital Region, collected these data in 2009. In 2010, due to fundamental reorganisation of the regional focal point, the data collection was not available when this chapter was written.

Registration systems in the **Flemish Community** have been collecting data for many years. In 2009, data were collected by 5 low-threshold agencies, 14 residential treatment centres specializing in illegal substance misuse treatment that have a convention with the national institute for invalidity and health insurance and 7 ambulatory treatment centres participate in BTDIR. Each of these centres is associated with the Vlaamse Vereniging Behandelingscentra Verslaafdenzorg (VVBV). For 2010, these data were not yet ready for analysis. All 20 centres for mental health care of the Flemish Community collected BTDIR data in 2009 and 2010.

For these BTDIR data, double counting cannot be avoided. This kind of control is only done partially at centre level or group of centres level. Hospitals are not part of this registration. These data have been submitted to the EMCDDA through the following Standard Tables : Data 2010 on access to treatment (ST24_2011_BE_01), BTDIR data 2009 from low-threshold agencies (ST_TDI_2010_BE_01), BTDIR data 2009 from inpatient centres (ST_TDI_2010_BE_02), BTDIR data 2009 from outpatient centres (ST_TDI_2010_BE_03), BTDIR data 2010 from outpatient centres (ST_TDI_2011_BE_01), BTDIR data 2010 from

inpatient centres (ST_TDI_2011_BE_02) and BTDIR data 2010 from low-threshold agencies (ST_TDI_2011_BE_03).

The new BTDIR protocol from 2011

The BTDIR was officially approved by the inter-ministerial conference on Public health in 2006 (Conférence interministérielle Santé publique 2006; Interministeriële Conferentie Volksgezondheid 2006). A new BTDIR protocol was adopted in 2010 (van Bussel 2010a; van Bussel 2010b). This protocol became operational on January 1st 2011 for centres offering treatment for persons with a substance-related disorder, and willing to register the BTDIR data. A pilot-project in hospitals collecting data for the BTDIR started in August 2011. From 2012, the data collection will be more centralized, harmonized and double counting can be avoided.

Description of patients starting treatment in 2009 (national level)

The total number of patients registered in 2009 through the BTDIR was 9300. Table 5.2 shows the number of patients in treatment by main substance and by gender. The unknown gender records were not indicated. A large majority of patients (78.3%) was registered in outpatient centres, 13.1% in inpatient centres and 8.6% in low-threshold agencies.

The main substances were opiates (in 37.3% of the treatment demands) and cannabis (27.5%). The other substances were cocaine (14.1%), stimulants such as amphetamines (10.2%), hypnotics and sedatives (3.7%) and unknown or other substances (7.2%).

Figure 5.1 represent the age category of patients in treatment by primary drug. Patients in treatment for hypnotics are the oldest: 41.4% of them are aged 40 years or older. On the opposite end of the spectrum, patients in treatment for cannabis are the youngest, with 76.0% of them being under the age of 30. The percentage of new patients under the age of 30 who are being treated for a stimulant-, cocaine- or opiate-related disorder, is 58.6%, 48.8%, and 40.6%, respectively.

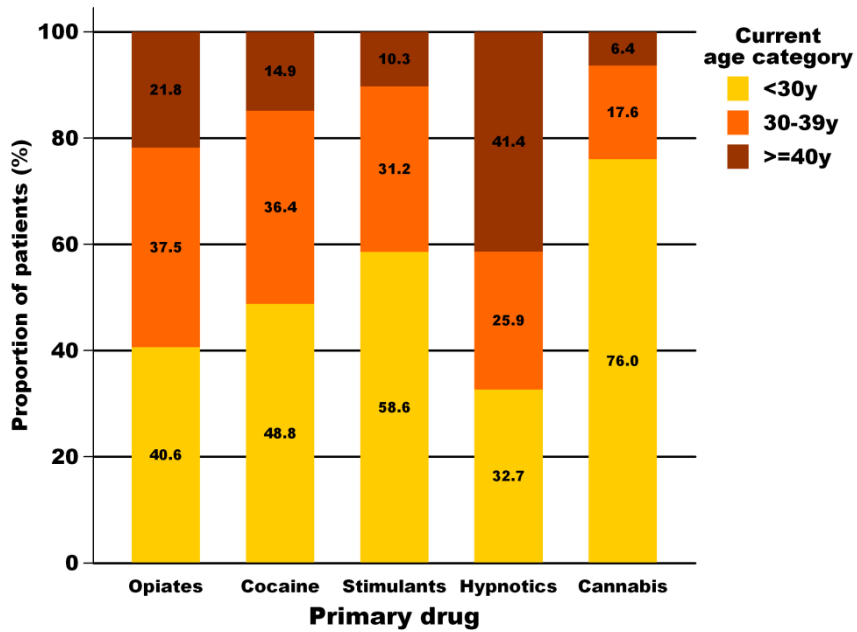
The gender distribution of patients by primary drug is presented in Figure 5.2. Patients entering treatment for the misuse of hypnotics are the group with the greatest percentage of women (36.3%), followed by patient in treatment for stimulants (29.9%). The percentages of women among patients in treatment for opiates, cocaine or cannabis are 18.4%, 20.7%, and 15.4%, respectively.

Table 5.2: Number and percentage of persons starting treatment in Belgium, by main substance and gender (2009).

Main substance	Male		Female		Total	
	N	%	N	%	N	%
Opiates (total)	2802	38.2	634	33.2	3467	37.3
Heroin	2491	34.0	536	28.1	3055	32.9
Methadone	247	3.4	72	3.8	322	3.5
Other opiates	64	0.9	26	1.4	90	1.0
Cocaine (total)	1033	14.1	269	14.1	1308	14.1
Cocaine	1002	13.7	264	13.8	1272	13.7
Crack	31	0.4	5	0.3	36	0.4
Stimulants (total)	663	9.0	283	14.8	946	10.2
Amphetamines	588	8.0	250	13.1	838	9.0
MDMA & other derivates	60	0.8	23	1.2	83	0.9
Other stimulants	15	0.2	10	0.5	25	0.3
Hypnotics and Sedatives (total)	215	2.9	122	6.4	340	3.7
Barbiturates	4	0.1	8	0.4	12	0.1
Benzodiazepines	135	1.8	73	3.8	210	2.3
Other hypnotics & sedatives	76	1.0	41	2.2	118	1.3
Hallucinogens (total)	4	0.1	1	0.1	5	0.1
LSD	3	0.0	0	0.0	3	0.0
Other hallucinogens	1	0.0	1	0.1	2	0.0
Volatile inhalants	5	0.1	2	0.1	7	0.1
Cannabis	2151	29.3	393	20.6	2557	27.5
Other substances	68	0.9	32	1.7	100	1.1
Not known/Missing	390	5.3	175	9.2	570	6.1
Total	7331	100.0	1911	100.0	9300	100.0

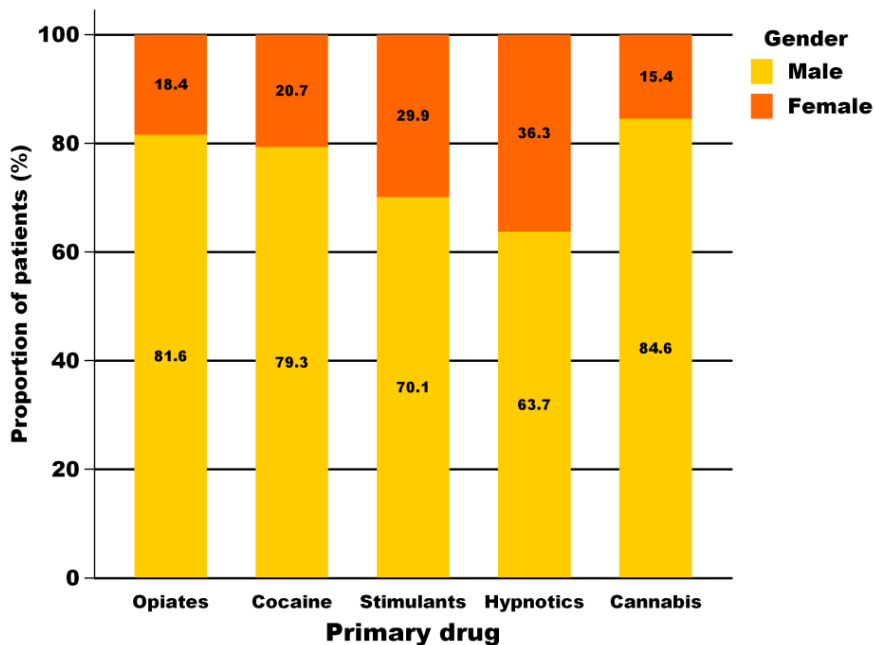
Source: BTDIR, 2009.

Figure 5.1: Relative proportion (%) of persons starting treatment in Belgium, by main substance and age category (2009). 📊



Source: BTDIR, 2009.

Figure 5.2: Relative proportion (%) of persons starting treatment in Belgium, by main substance and gender (2009). 📊

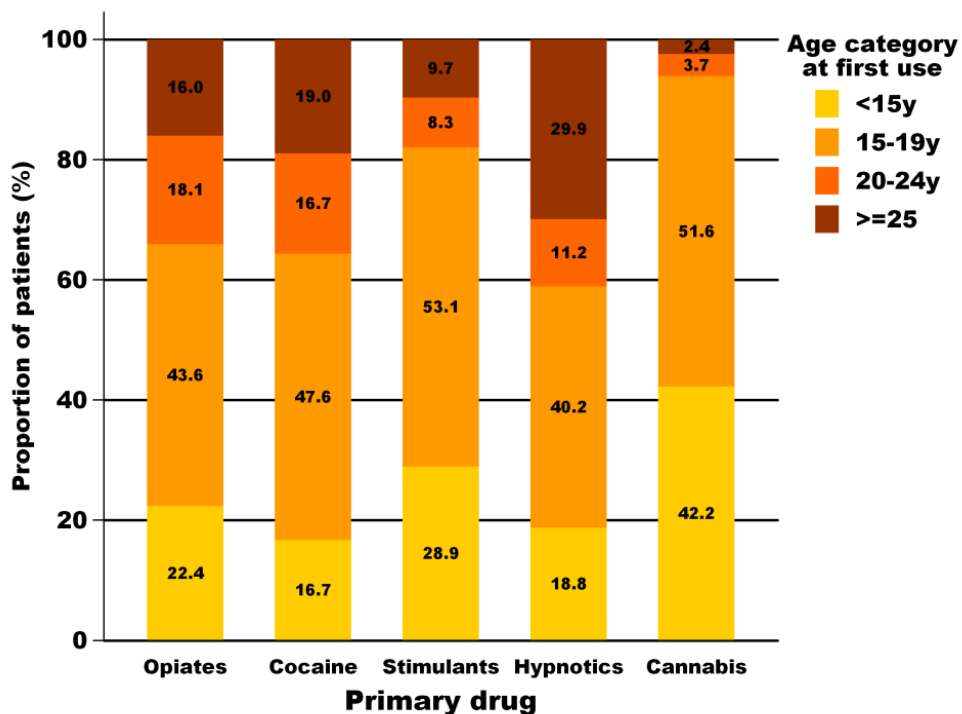


Source: BTDIR, 2009.

Figure 5.3 describes the proportion of the age category at first use by substance type. Cannabis and stimulants are the substances used for the first time at the earliest age. The proportion of patients who used the substance for the first time before the age of 20 is 93.8% for cannabis, and 82.0% for stimulants. The age of first use is higher for opiates, cocaine, and hypnotics users. In these cases, the proportion of patients having consumed the substance for the first time before the age of 20 is 66.0%, 64.3%, and 59.0%, respectively.

The injecting behaviour of patients is important to highlight the risk behaviour of drug users. Among patients in treatment, 24.4% of men and 21.7% of women have already injected substances during their life (currently doing or previously) and 9.4% of men and 7.0% of women are currently injecting substances (at least once during last month).

Figure 5.3: Relative proportion (%) of persons starting treatment in Belgium, by main substance and age category at first use (2009). 📊



Source: BTDIR, 2009.


Description of persons starting treatment in 2010, by treatment facilities

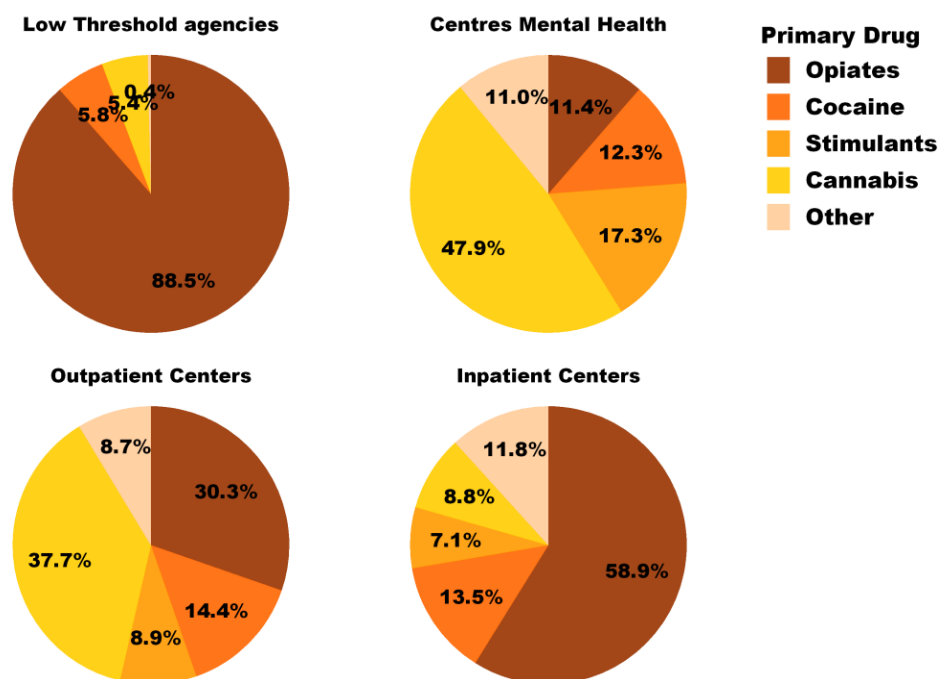
For the 2010 BTDIR data, due to partial national data, the discussion will focus on data by type of treatment facility, namely inpatient centres (all centres in the Walloon region + De Sleutel centres in Flanders), outpatient centres (all centres in the Walloon region + De

Sleutel centres in Flanders), low-threshold agencies (MASS's in the Walloon region) and Centres for mental health care (CGG's in Flanders).

In terms of number of patients registered in 2010 in these treatment facilities, there are 275 patients in low-threshold agencies, 2381 in centres for mental health care, 2167 in outpatients centres and 533 in inpatient centres.

The percentage of primary drugs leading a patient to a treatment facility is presented in Figure 5.4. Differences are important between treatment facilities. Low Threshold agencies and Inpatient centres mainly treat patients with an opiates-related disorder (88.5% and 58.9% of the new treatments, respectively). Centres for mental health care and outpatient centres, mainly treat patients with a cannabis-related disorder (47.9% and 37.7% respectively). Percentages of patients with a cocaine-related disorder vary, between 5.8% in Low Threshold agencies to 13.5% in Inpatient centres.

Figure 5.4: Relative proportion (%) of persons starting treatment, by main substance in different treatment facilities (2010). 

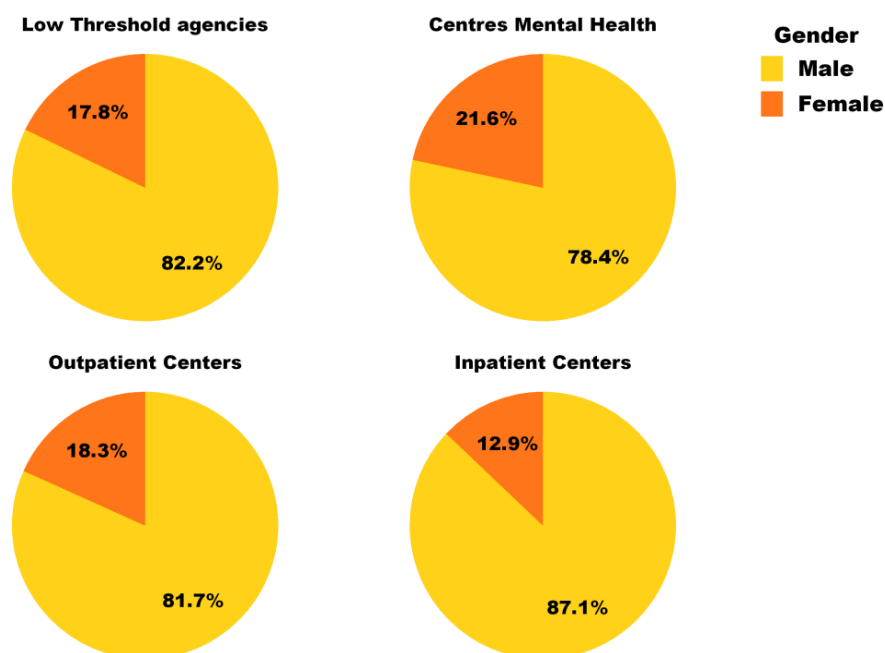


Source: BTDIR, 2010.

Figure 5.5. describes the gender repartition between the different types of centre. Low-threshold agencies and outpatient centres welcome more or less the same percentage of women (17.8% and 18.3%, respectively). In centres for mental health care, the percentage is


higher, with more than 1 patient over 5 being a woman (21.6%) and in inpatient centres, this percentage is lower (12.9%).

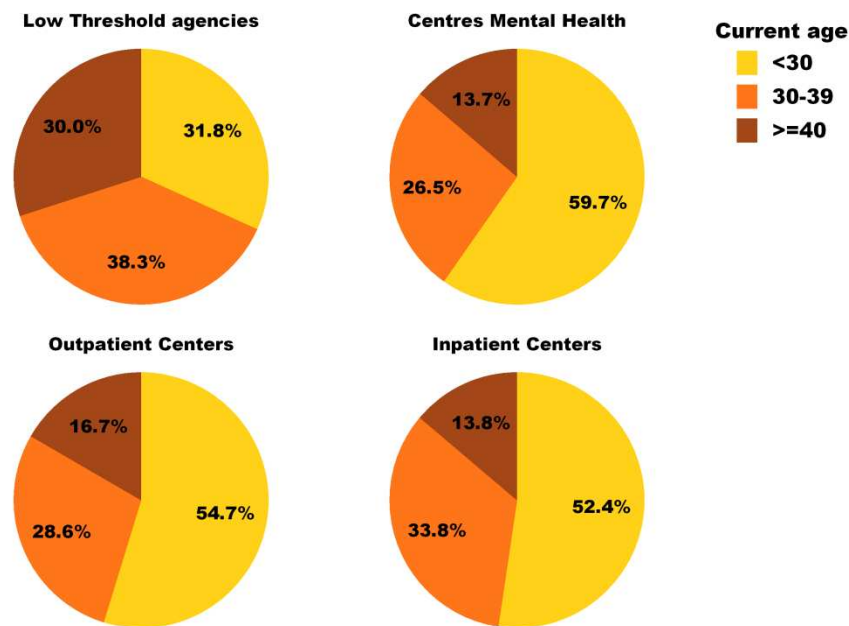
Figure 5.5: Relative proportion (%) of persons starting treatment in Belgium, by gender in different treatment facilities (2010). 📊



Source: BTDIR, 2010.

The relative proportion of patients by age category registered in the different treatment facilities, is presented in Figure 5.6. The youngest patient population was observed in the Flemish centres for mental health care: about 59.7% of the patients were aged under 30. In the outpatient and inpatient centres, the age distribution was largely the same. The youngest patients, those aged under 30, counted for 54.7% and 52.4% of the total population in the outpatient and inpatient centres, respectively. Low-threshold agencies welcome older patients: the proportion of patients aged 40 years or older is 30.0%.

Figure 5.6: Relative proportion (%) of patients starting treatment in Belgium, by age category in different treatment facilities (2010). 




Source: BTDIR, 2010.

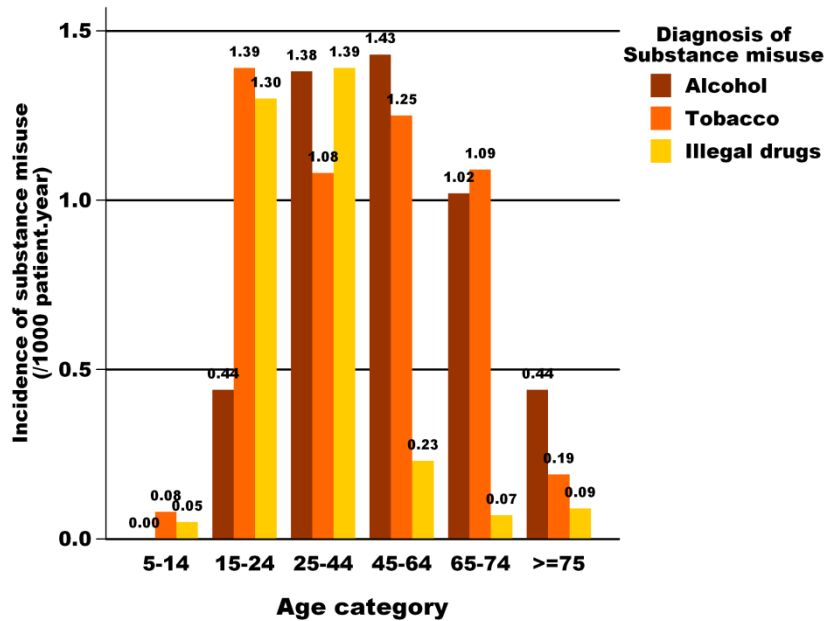
3.1.2. Patients entering primary care

Since 1994, an integrated computerised network (called INTEGO, www.intego.be), hosted by the Academisch Centrum voor Huisartsgeneeskunde (ACHG) of the K.U.Leuven collects information about diagnoses made by a group of general practitioners (92 in 2009) (Bartholomeeusen et al. 2002). This network covers around 2% of the Flemish population and is found to be representative for the Flemish population. The diagnoses (according to the International Classification of Primary Care, ICPC) made by these practitioners as well as patient characteristics such as age and gender are reported in the database. Among these diagnosis, chronic alcohol misuse (code P15), tobacco misuse (code P17), and illegal drug misuse (code P19) are considered here to assess the proportion of clients going to their general practitioner with a substance misuse problem. As for illegal drug misuse, no differentiation by substance is available in the INTEGO registration. Further, data provided by the network are expressed as incidence for 1000 patient year, standardized for the Flemish population of 2008.

Figure 5.7 shows the repartition of diagnosis per age category. The incidence of diagnosis for illegal drug misuse is highest for persons from 15 to 44 years old (1.30 per 1000 for 15-24y and 1.39 per 1000 for 25-44y). Except for these two age categories, incidence is lower than 0.25 per 1000. Incidence of alcohol misuse is the highest for 25-44y (1.38 per 1000),


45-64y (1.43 per 1000) and 65-74y (1.02 per 1000) and drops under 0.5 per 1000 for other age categories. Tobacco misuse remains over 1.0 per 1000 for age categories ranging from age 15 to age 74. Before 15 years old and after 75 years old, incidence drops under 0.20 per 1000.

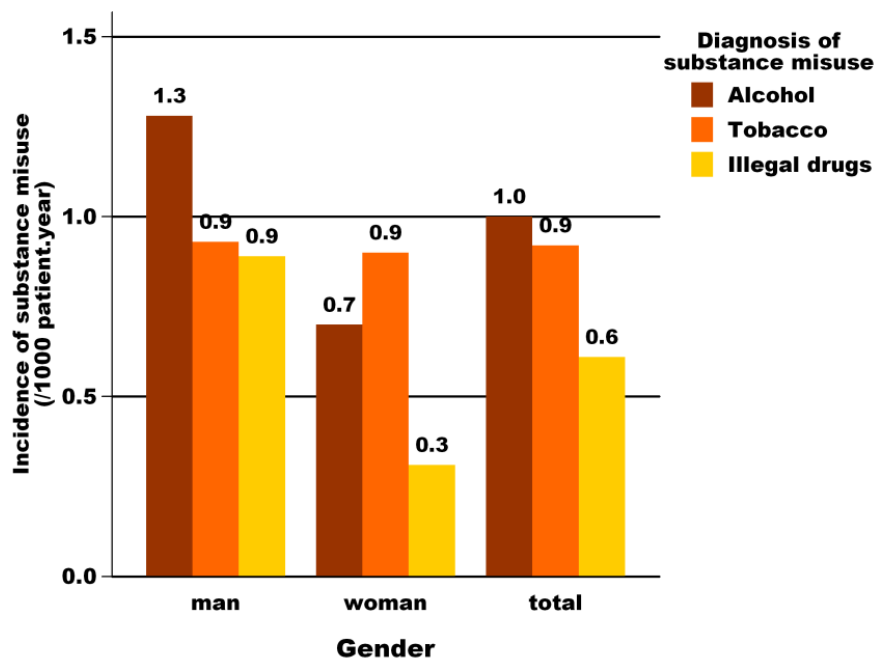
Figure 5.7: Incidence (%) of substance misuse diagnosis by Flemish general practitioners, by age category (2006-2008). 



Source: Intego.be, 2008

Figure 5.8 indicates the incidence of substance misuse diagnosis by gender during the period 2006-2008. An incidence of 0.61 person per 1000 is diagnosed each year for illegal drug misuse. The incidence is lower for women (0.31 per 1000) than for men (0.89 per 1000). The incidence of illegal drug misuse diagnosis is 40% lower than alcohol misuse and 33% lower than tobacco misuse.

Figure 5.8: Incidence (‰) of substance misuse diagnosis by Flemish general practitioners, by gender (2006-2008). 



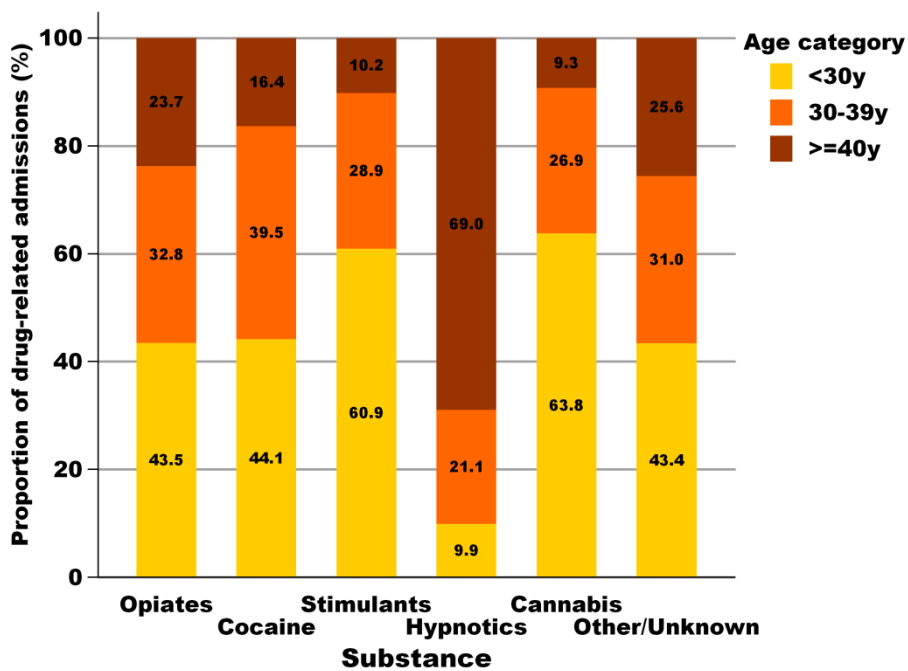
Source: Intego.be, 2008

3.1.3. Patients in psychiatric hospital services

The Minimum Psychiatric Data (MPD) is a registration system by the Belgian Federal Public Service, Health, Food Chain Safety, and Environment (HFDPSE DG1, Data management), collecting data of every psychiatric inpatient admission. This registration was made compulsory for all psychiatric hospitals or psychiatric unit in a general hospital in 1996, and for psychiatric nursing homes in 1998. Diagnostic data are collected based on Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), shortly after patient's admission. It is explicitly requested to complete all DSM-IV axes, allowing the possibility to mention up to three disorders per axis. In addition, it is requested to indicate the main diagnosis causing the admission. The unit of registration is admission and not patient so doubles counts cannot be excluded. The total number of admissions registered in the system evolved from 87,326 in 2000 to 96,494 in 2008. Of the 4,533 (4.70%) admissions registered in 2008, the main diagnosis was a substance related disorder (DSM IV codes: 304.00; 304.20; 304.30; 304.40; 304.50; 304.60; 304.80; 304.90; 305.20; 305.30; 305.50; 305.60; 305.70; 305.90) (Gorissen, 2011). The most prevalent main diagnosis was polysubstance dependence (40.1%), followed by opioid (19.7%), cannabis (14.54%), cocaine (12.7%), amphetamine (7.3%), other or unknown substance (4.7%), hallucinogen (0.5%), and inhalant (0.2%) related disorder (either dependence or abuse).

Figure 5.9 shows the proportion of all substance-related admissions by substance and by age category in 2008. These results are concordant with the data from BTDIR concerning the age distribution between substance categories. On the other hand, the population hospitalized is in general older than the population in the BTDIR (that covers mainly outpatient centres).

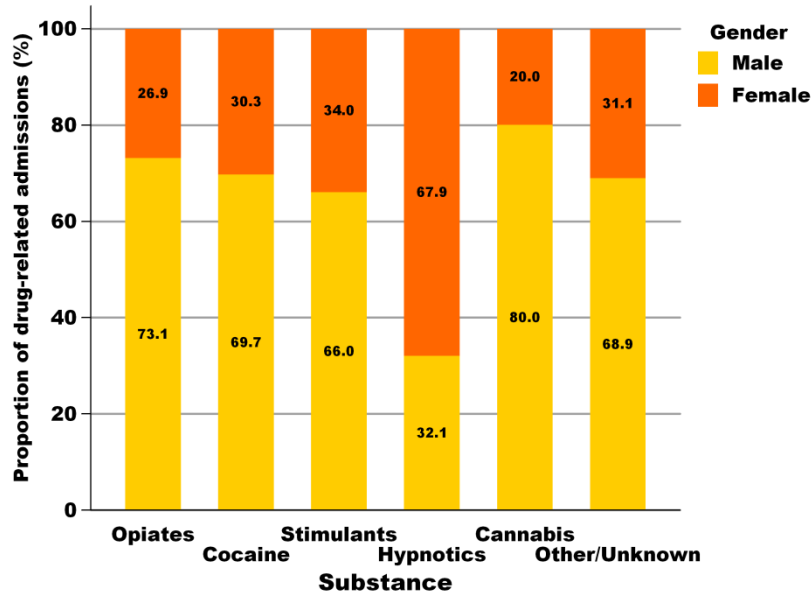
Figure 5.9: Relative proportion (%) of substance-related admissions by age category and substance in Belgian psychiatric hospital services (2008) 📊



Source: MPD (FPSHFDSE DG1, 2011)

Figure 5.10 presents the proportion of substance-related admissions by gender and substance. Compared with the BTDIR data, there is a big difference in the proportion of women. Where the proportion of women is around 20% for Opiates and Cocaine in BTDIR data, this proportion is around 30%. There is also a high proportion of women entering an hospital for a hypnotics-related disorder (67.9%) where this proportion was only 36.3% in the BTDIR.

Figure 5.10: Relative proportion (%) of substance-related admissions by gender and substance in Belgian psychiatric hospital services (2008). 📊

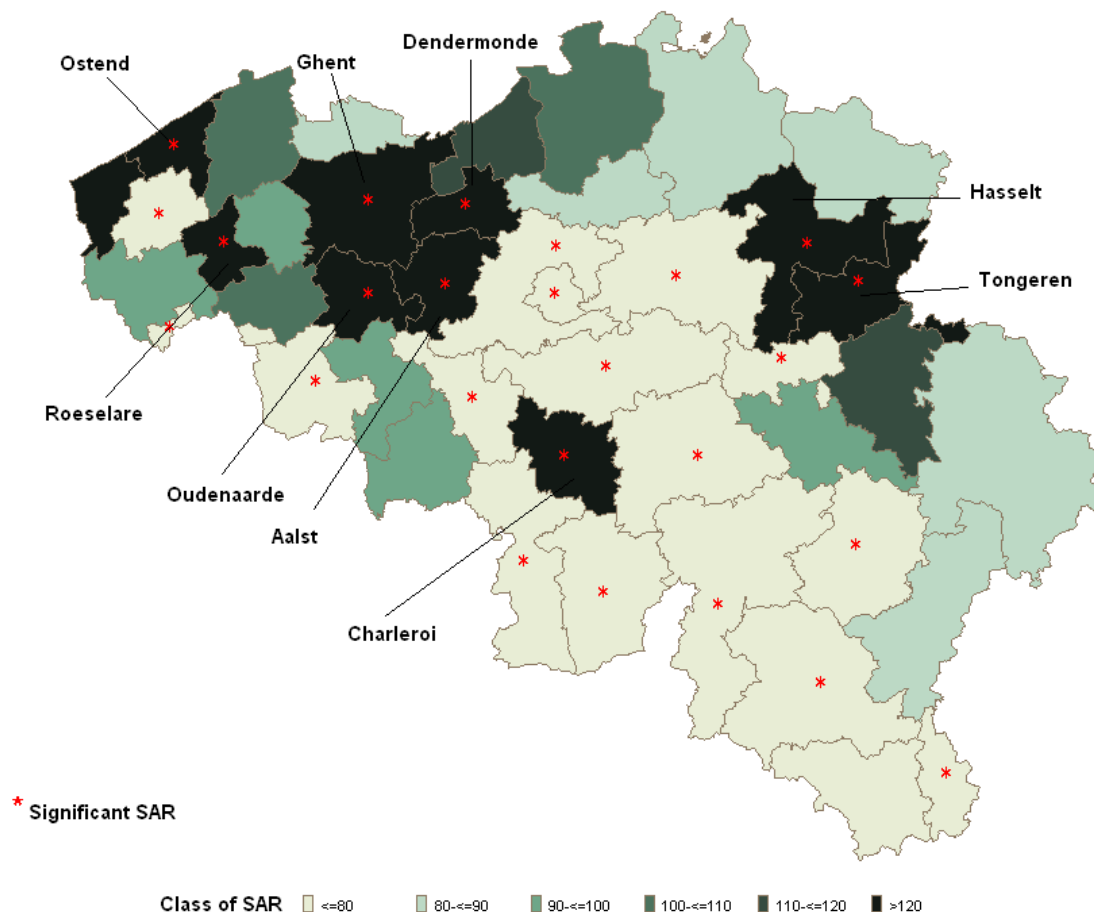


Source: MPD (FPSHFDSE DG1, 2011)

In their report, Windey and Gorissen (2011) visualised for each Belgian district the difference between the number of substance-related admissions registered in the MPD and the number of substance-related admissions expected for these districts, using the Standardised Admission Ratio. Figure 5.11 displays geographically the admissions with Opioid (DSM-IV 304.00), Cocaine (304.20), Cannabis (304.30) and Polysubstance (304.80) as the main reason of treatment. In the districts of Ostend, Roeselare, Ghent, Aalst, Oudenaarde, Dendermonde, Hasselt, Tongeren and Charleroi, more inhabitants than expected were treated for substance dependence, in 2008.

In Belgium, substance-related admissions (both in- and outpatient) are also registered in general hospitals and collected in the Minimum Clinical Data register (MCD). This registration of the Belgian Federal Public Service, Health, Food Chain Safety, and Environment (DG1, Data management), uses the International Classification of Diseases - Version 9 - Clinical Modification, (ICD-9-CM). No data were available at the time this chapter was in writing. A detailed description of the drug-related admissions based on the MCD is envisaged for next year's annual report.

Figure 5.11: Difference (expressed as SAR) between substance-related admissions registered in MPD and substance-related admissions expected, by Belgian district (2008).



Source: Windey and Gorissen (2011)

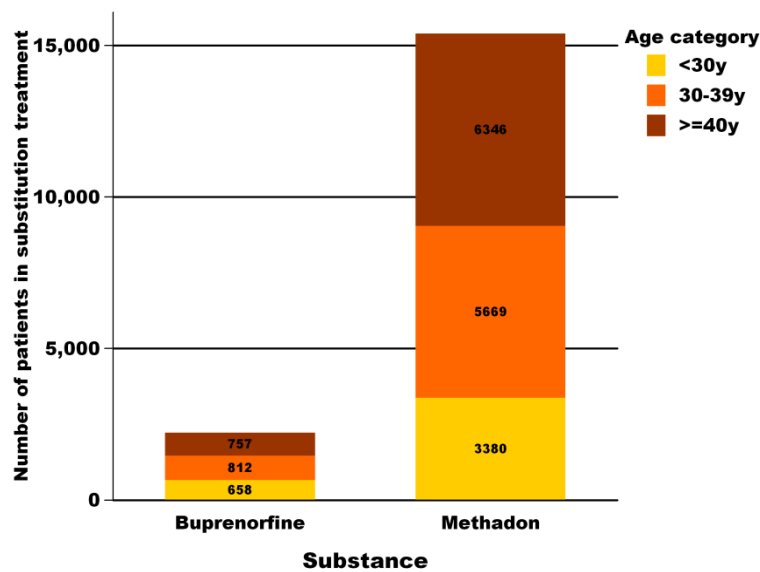
3.1.4. Patients with a substitution treatment

Since April 2009, prescriptions for methadone and buprenorphine are registered in the Pharmanet-system of the National Health Insurance Institution (NIHDI). Before 2009, this National Registration of Substitution Treatment was hosted by the Belgian Institute for Pharmaco-epidemiology (IFEB /IPhEB). The objective of this registration is to avoid multiple prescriptions and allow warnings among concerned practitioners as requested by the Royal Decree of March 19th 2004. This database contains information from public pharmacies, hospitals pharmacies and specialized centres. Substitution treatments provided in prisons are not included in this database. There is also a lack of information regarding non-residents

and people without health insurance. Recently, the Directorate General Inspection of the Federal Agency for Medicines and Health Products (FAMHP) was appointed to develop a real-time monitoring system that could serve both epidemiological and administrative objectives.

Figure 5.11 represents the number of patients undergoing a substitution treatment in 2010, by age category and by substance. Of the 15,395 persons in treatment for methadone, 22.0% were younger than 30, 36.8% were between the ages of 30 and 39, and 41.2% were over the age of 40. Among those in treatment with buprenorphine (n=2,227), 29.6% were under the age of 30, 36.5% were between the ages of 30 and 39, and 33.9% were over the age of 40.

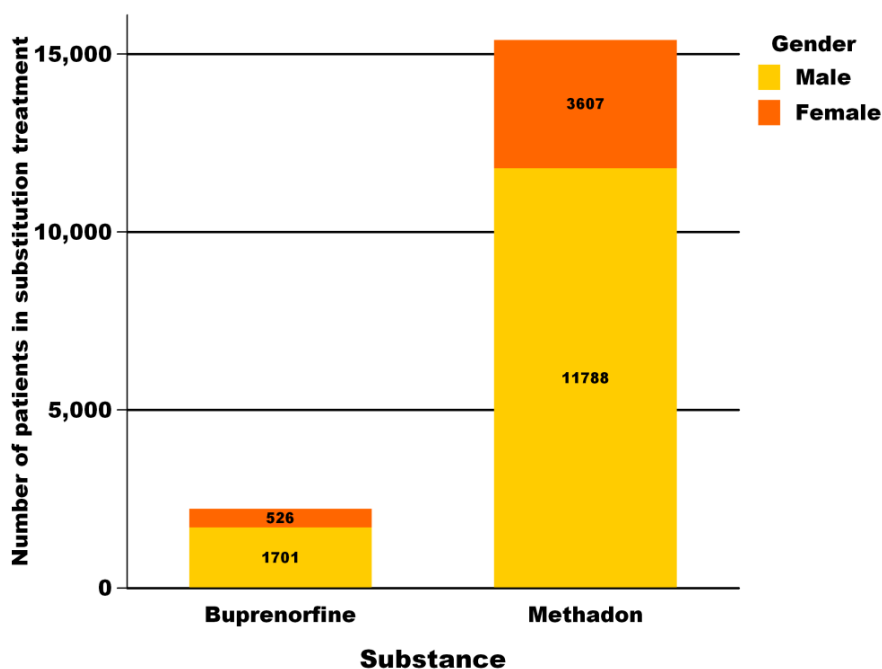
Figure 5.12: Number of patients in substitution treatment in Belgium, by substance and age category (2010). 📊



Source: Pharmanet, 2010

In Figure 5.12 the proportion of women in substitution treatment is relatively the same for both substances: 23.6% for buprenorphine and 23.4% for methadone.

Figure 5.13: Number of patients in substitution treatment in Belgium, by substances and gender (2010). 📊




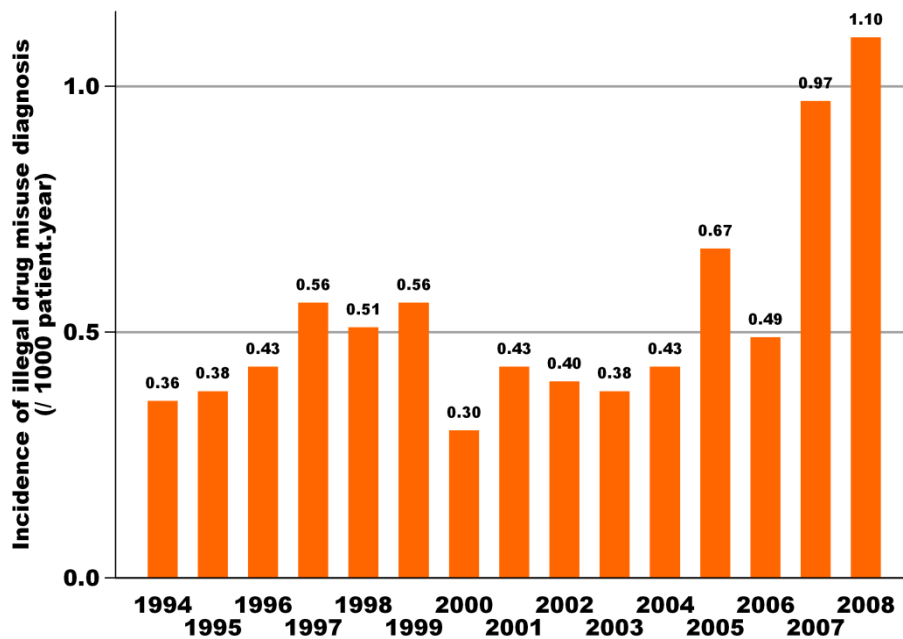
Source: Pharmanet, 2010

3.2. Trends treated population and treatment provision (incl. numbers)

3.2.1. Patients entering primary care

Figure 5.13 indicates the incidence of illegal substance-related diagnoses for the years 1994 - 2008. Between 1994 and 2006 the incidence varies around 0.5 per 1000 (from 0.30 per 1000 in 2000 to 0.67 per 1000 in 2005) and the last two years, incidence reached 1.0 per 1000 (0.97 per 1000 in 2007 and 1.10 per 1000 in 2008). As mentioned earlier, no differentiation by substance is available for the INTEGO registration.

Figure 5.14: Incidence (%) of illegal substance misuse diagnosis by Flemish general practitioners between 1994 and 2008 

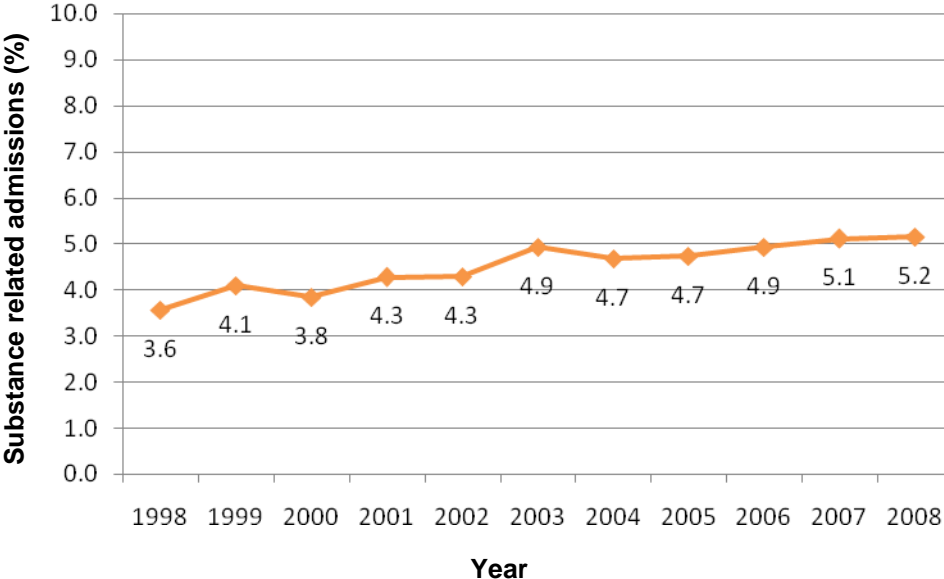


Source: Intego.be, 2008

3.2.2. Hospitalized patients

The proportion of admissions with a substance related disorder (DSM IV codes: 304.00; 304.20; 304.30; 304.40; 304.50; 304.60; 304.80; 304.90; 305.20; 305.30; 305.50; 305.60; 305.70; 305.90) as main diagnosis increased slightly from 1998 (3.6%) to 2008 (5.2%) (Gorissen, 2011). This increase is relatively small and constant over years (Figure 5.15). An increase was found for opioid dependence, cocaine dependence, cocaine abuse and cannabis dependence as main diagnosis (Table 5.3). Marginal or substantial decreases were found for admissions with the other substance related disorders, except for cannabis abuse related admissions, which remained fairly stable between 1998 and 2008.

Figure 5.15: Relative proportion (%) of substance-related admissions (main diagnosis) in Belgian psychiatric hospitals (2000-2008) 



Source: MPD (FPSHFDSE DG1, 2011)

Table 5.3: Admissions (percentage) with an illegal substance related disorder as main diagnosis in Belgian psychiatric hospital services (1998-2008).

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
	%	%	%	%	%	%	%	%	%	%	%
Total (N)	2912	3395	3182	3601	3591	4213	4075	4260	4500	4655	4533
Opioid											
dependence (304.00)	12.7	14.8	15.8	17.5	17.3	16.5	15.9	14.5	17.5	16.8	18.0
abuse (305.50)	4.3	3.3	3.0	3.1	3.2	2.4	2.2	2.8	2.4	2.0	1.7
Cocaine											
dependence (304.20)	3.9	5.3	5.3	6.5	6.5	8.4	7.6	6.5	8.8	8.3	9.8
abuse (305.60)	1.8	2.4	2.0	2.1	2.7	2.5	2.9	3.1	3.4	3.2	3.0
Cannabis											
dependence (304.30)	5.0	4.0	5.5	6.0	6.6	7.4	9.3	9.5	8.4	9.0	9.9
abuse (305.20)	4.4	3.2	5.0	5.1	4.4	5.1	5.5	5.9	5.5	5.8	4.7
Amphetamine											
dependence (304.40)	6.2	5.4	2.8	2.9	3.8	3.9	3.8	4.1	4.4	4.8	4.8
abuse (305.70)	3.9	3.7	2.5	2.7	3.1	2.4	2.8	2.6	2.3	2.6	2.6
Hallucinogen											
dependence (304.50)	0.8	1.0	0.4	0.9	0.5	0.3	0.2	0.2	0.5	0.2	0.3
abuse (305.30)	0.7	0.3	0.3	0.3	0.2	0.1	0.2	0.3	0.1	0.1	0.2
Inhalants											
dependence (304.60)	0.8	0.5	0.4	0.5	0.3	0.2	0.3	0.3	0.5	0.1	0.2
Polysubstance											
dependence (304.80)	47.9	46.9	46.1	44.5	43.3	43.9	42.5	44.1	40.1	41.2	40.1
Other (or unknown) substance											
dependence (304.90)	3.3	4.1	4.4	2.9	3.7	2.9	2.6	2.3	2.3	2.5	2.5
abuse (305.90)	4.3	5.2	6.4	5.1	4.2	4.0	4.2	3.6	3.7	3.6	2.3

Source: MPD (FPSHFDSE DG1, 2011)



Chapter 6.

Health correlates and consequences

Bollaerts, K. and van Bussel, JCH.

1. Introduction

In this chapter, the health consequences of illicit drug use in Belgium are described. Regarding drug-related infectious diseases, data from the Sentinel laboratory network (ST9), national registers (HIV/AIDS and tuberculosis register) and from diagnostic testing in drug services (ST9) are summarized. Behavioural data were collected by Spuitenruil Vlaanderen (Windelinckx, 2010) and Modus Vivendi (*Observatoire socio-épidémiologique alcool-drogues*, Eurotox). Data from the National Poison Centre were used to provide information on drug-related emergencies. In addition, Psychiatric co-morbidity was described based on the Minimum Psychiatric Data (MPD) and based on the EuropASI, used as part of the intake interview at treatment centres from De Sleutel. Finally, information on drug-induced deaths was obtained using the 2000-2009 General Mortality Registers (ICD-10, Selection B) for the Flemish and Brussels Capital region.

2. Drug-related infectious diseases

2.1. HIV/AIDS and viral hepatitis

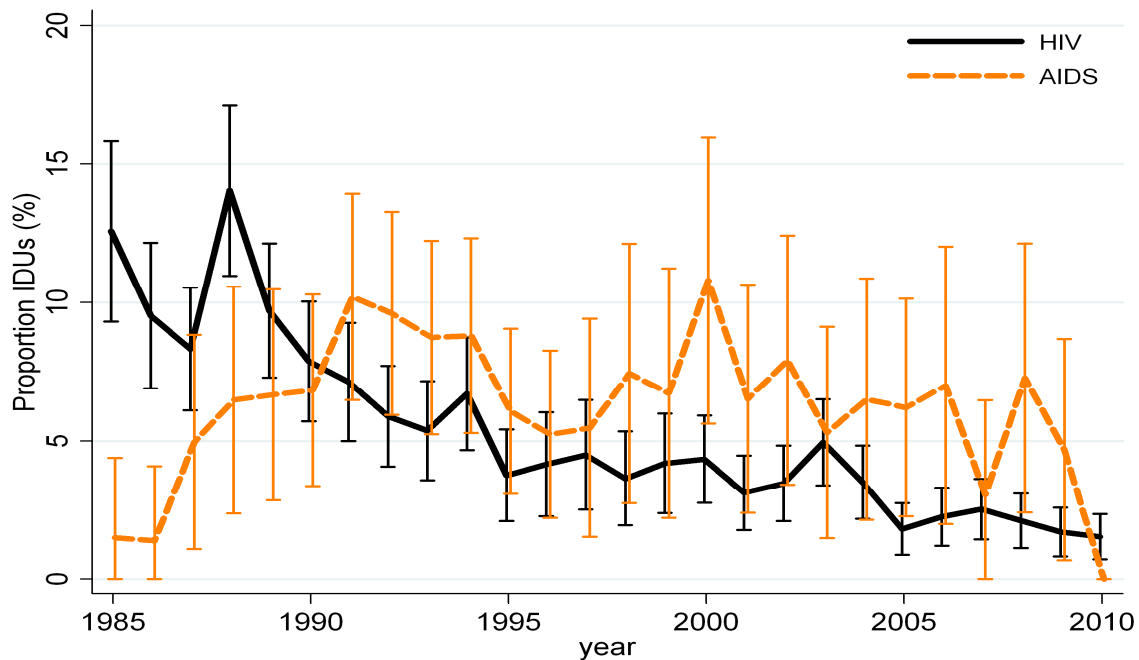
2.1.1. National AIDS/HIV register

The national AIDS/HIV register, hosted by the Scientific Institute of Public Health, Brussels contains the AIDS- and HIV notifications since 1984-1985 (Sasse and Defraye 2009). For every confirmed seropositive case, additional information on age, sex, nationality, residence, sexual orientation, probable mode of HIV transmission is collected at time of HIV diagnosis. For the reported AIDS cases, a follow-up study is conducted each year to collect data on last consultation and possible death. The AIDS/HIV register is deemed exhaustive.

In 2010, 13 persons newly diagnosed with HIV, reported intravenous drug use as the probable mode of HIV transmission, yielding a percentage of 1.5% (95% CI:0.71%-2.3%) of the persons newly diagnosed with HIV being probably attributable to injecting drug use. As a result of reporting delay, no new AIDS diagnoses related to injecting drug use were reported for 2010, so far. The percentage of IDUs among persons newly diagnosed with HIV were much lower compared to the beginning of the HIV epidemic in the mid eighties as can be seen from Figure 6.1. No clear time trends were observed regarding the proportion of IDUs among the newly diagnosed AIDS cases. However, with exception of the onset of the HIV-epidemic, the proportion of IDUs among AIDS-cases was found to be systematically (although not significantly) higher than the proportion of IDUs among the HIV-cases, indicating that IDUs are more rapidly developing AIDS compared to non-IDUs. It is

hypothesized that this is due to the higher hepatitis co-infection rate among IDUs compared to non-IDUs and/or due to differences in treatment compliance.

Figure 6.1: Proportion (%) of ever-Injecting Drug Users (IDUs) among HIV- and AIDS-cases by incidence year, Belgium, 1985-2010. 📊



Source: National HIV/AIDS register, WIV-ISP, Brussels.

2.1.2. HIV diagnostic testing

The prevalence rate of HIV-seropositivity among ever-IDUs at treatment and other diagnostic settings, as collected through Standard Table 9, was obtained based on serological data in the Flemish region and on mainly self-reported data in the Walloon region. More precisely, for the Walloon region, the HIV-diagnosis is self-reported for 75% of the patients and based on medical files otherwise. In 2010, the HIV prevalence rate in the Walloon region was estimated to be 6% (N = 83), with the data being collected through a network of voluntary low-threshold services (n=4), inpatient (n= 7) and outpatient (n=17) drug treatment centres in the Walloon region. For the Flemish region, the HIV prevalence rate in 2010 was estimated to be 3.4% (N = 29) and 5.3% (N =282) based on test results of blood screening collected through De Sleutel (an institution of several ambulatory and residential treatment centres located throughout Flanders) and through Free Clinic (an outpatient clinic located in Antwerp city). An overview of the prevalence rates for the period 2005-2010 is provided in Table 6.1, showing moderately fluctuating prevalence rates without clear time trends.

Table 6.1: Prevalence rate (%) of HIV-seropositivity among ever-IDUs at treatment and other diagnostic settings, 2005-2010.

	Flemish region		Walloon Region
	Free Clinic	De Sleutel	Network of organisations*
2005	7.1% (n = 340)	2.7%(N = 37)	4.4% (N = 90)
2006	5.7% (N = 336)	2.9% (N = 68)	4.4%(N = 45)
2007	6.0% (N=408)	3.7%(N = 54)	6.0% (N = 116)
2008	6.4% (N = 329)	3.3% (N = 60)	3.6% (N = 139)
2009	5.1% (N = 334)	0% (N = 47)	5.1% (N = 118)
2010	5.3% (N = 282)	3.4% (N = 29)	6% (N = 83)

* prevalence rates based on self-reporting

Source: ST9P2_2006-2011_BE

2.1.3. The Sentinel Laboratory Network (SLN) and the National Hepatitis Register (NHR)

The Sentinel Laboratory Network (SLN), coordinated by the Scientific Institute of Public Health (WIV-ISP), has collected demographic and laboratory data on 40 infectious diseases since 1983 (Ducoffre et al. 2010). In 2010, 100 laboratories, representing 58% of all Belgian laboratories, participate in the surveillance system on a voluntary basis. The participating private or hospital laboratories are evenly distributed over 33 out of the 43 administrative districts in Belgium. In 2010, 819 acute hepatitis C cases were notified, sustaining the decreasing trend in hepatitis C notifications (Table 6.2). This decrease is likely due to the intensification of the scale and scope of HCV prevention measures. The results for hepatitis B are not reported here because of a potential bias due to changes in laboratory techniques. This potential bias is currently investigated. No clinical information is collected by the In the SLN-laboratories.

Table 6.2: Hepatitis C notifications by the sentinel Laboratory network, Belgium, 2006 – 2010.

Year	2006	2007	2008	2009	2010
Hepatitis C	1152	1032	980	828	819

Source: SLN (WIV-ISP), (ST9P4_2006-10_BE)

To collect additional information on hepatitis transmission routes and to identify the possible drug attributable cases, a funding request has been placed in 2011 by the Scientific Institute of Public Health (WIV-ISP) to the Belgian National Institute for Health and Disability

Insurance (NIHDI) in order to finance a national Hepatitis register (NHR). This funding request is still pending.

2.1.4. Hepatitis diagnostic testing

The hepatitis prevalence rates among ever-IDUs at treatment was obtained analogously to the HIV prevalence rate described above, and was also collected through Standard Table 9. An overview of the hepatitis B and C prevalence rates for 2003-2010 are given in Table 6.3 and Table 6.4, respectively (ST9P2_2003-2011_BE). Regarding Hepatitis B, 2.8% (Free Clinic) and 0% (De Sleutel) of the patients tested in 2010, tested positive for HbsAg, 56.3% (Free Clinic) and 0% (De Sleutel) for antiHBC and 55.2% (Free Clinic) and 20.0% (De Sleutel) for antiHBs. Regarding Hepatitis C, 80% (Free Clinic) and 28.1% (De Sleutel) of the patients tested positive for HCVab in 2010. The patient population of the Free Clinic is known to be a strongly marginalized population, explaining the high prevalence rates. Comparing the results for the 2010 prevalences with previous years, does not reveal significant time trends.

Table 6.3: Prevalence rate of Hepatitis B among ever-IDUs at treatment and other diagnostic settings, Free Clinic – De Sleutel, Flemish Community, 2003-2010.

		2003	2004	2005	2006	2007	2008	2009	2010
Free Clinic									
HBsAg	%	3.9%	3.5%	3.0%	1.5%	2.6%	4.0%	4.2%	2.8%
	N	285	255	330	334	307	328	336	281
antiHBc	%	61.9%	58.3%	58.8%	55.0%	53.5%	57.3%	56.1%	56.3%
	N	281	252	323	329	303	323	330	277
antiHBs	%	53.0%	48.8%	50.5%	-	-	50.2%	51.8%	55.2%
	N	283	252	327	-	-	327	334	279
De Sleutel									
HBsAg	%	3.9%	0%	0%	0%	0%	1.9%	0%	0%
	N	77	89	35	63	45	54	44	29
antiHBc	%	17.2%	16.7%	8.1%	15.8%	25.0%	2.6%	7.1%	0.0%
	N	58	66	37	38	28	38	28	22
antiHBs	%	12.0%	15.9%	10.8%	12.3%	11.1%	18.4%	25.0%	20.0%
	N	75	88	37	57	45	49	40	30

Source: ST9P2_2003-2011_BE

Table 6.4: Prevalence rate of Hepatis C among ever-IDUs at treatment and other diagnostic settings, Free Clinic – De Sleutel, Flemish Community, 2003-2010.

		2003	2004	2005	2006	2007	2008	2009	2010
Free Clinic									
HCVAb	%	79.1%	76.0%	80.7%	78.7%	80.1%	80.9%	80.9%	80.0%
	N	287	258	337	342	311	335	345	295
antiHAV	%	-	-	-	-	6.2%	50.2%	-	48.1%
	N					308	273	-	216
De Sleutel									
HCVab	%	35.0%	37.5%	50.0%	36.2%	34.0%	27.0%	30.4%	28.1%
	N	80	96	38	69	53	63	46	32

Source: ST9P2_2003-2011_BE

2.2. STIs and tuberculosis

2.2.1. Syphilis diagnostic testing

Injecting drug users frequenting the Free Clinic, an outpatient clinic located in Antwerp city, are offered a blood screening on a regular basis. In 2010, 15 out of the 248 patients (6%) tested positive for syphilis (ST9P2_2011_BE_07), which is comparable with the prevalences observed for previous years.

2.2.2. National Tuberculosis register

The Tuberculosis register is hosted by the Belgian Lung and Tuberculosis Association (BELTA), together with the 'Vlaamse Vereniging voor Respiratoire Gezondheidszorg en Tuberculosebestrijding' (VRGT) in the Flemish region and the 'Fonds des Affections Respiratoires' (FARES) in the Walloon region. The notification of tuberculosis cases is compulsory in Belgium. In the national register, the notifications of both regions are joined and controlled for duplicates.

Since 1980, the national tuberculosis incidence rate has declined sharply, from 28.0 cases per 100.000 person years in 1980 to 9.6 cases per 100.000 person years in 2007. However, since 2007, this declining trend has flattened at an incidence rate of 10.3 per 100.000 person years in 2010. The highest incidences were observed for Liège (35.8/100.000), Brussels (34.6/100.000) and Antwerp (23.2/100.000). Of the 1115 cases registered in Belgium in 2010, 1.2% were associated with intravenous drug use. However, the registration of the identified risk factors is disputable (Patrick de Smet, personal communication).

2.3. Behavioural data

2.3.1. Risk behaviour in Injecting Drug Users in contact with syringe exchange in the Flemish region

Since 2001, data on injecting drug users who frequent one of the syringe exchange programmes located in Flanders have been collected using a structured, voluntary, anonymous questionnaire (Windelinckx 2011). Every IDU contacting one of the syringe exchange programmes is asked to fill in a questionnaire, part of which is based on the Injecting Risk Questionnaire (IRQ) (Stimson et al. 1998). An overview of the responses related to the IRQ is given in Table 6.5. The majority of the participants reported not having shared syringes (receptive: 78%, distributive: 80%), spoons (receptive: 65%), water (receptive: 63%) and filters (receptive: 68%) during the last four weeks.

Table 6.5: Responses to the Injecting Risk Questionnaire (IRQ), Spuitenruil Vlaanderen, 2010.

During the last 4 weeks, how often have you ...	N	0	1	>2	Don't know
shared injecting equipment?	251	67%	10%	15%	8%
given or lent used needle/syringes to a sexual partner?	179	73%	16%	12%	0%
given or lent used needle/syringes to someone else?	252	80%	9%	7%	5%
injected with needles/syringes that had already been used by a sexual partner?	187	77%	12%	11%	1%
injected with needles/syringes that had already been used by someone else?	252	78%	11%	6%	3%
filled your syringe from one that already been used by someone else (frontloading/backloading) ?	252	84%	10%	3%	2%
drawn up from a container or spoon into which someone else had put a used syringe	252	65%	14%	17%	4%
used a filter into which someone else had put a used syringe	252	68%	12%	17%	3%
used the same water or bleach as someone else for flushing out?	251	63%	14%	20%	3%
used old syringes that had been kept in the same container as someone else's old syringes?	251	69%	10%	14%	7%
During the last 4 weeks, with how many different people have you shared injecting equipment?	250	65%	22%	9%	4%

Source: Spuitenruil Vlaanderen (Windelinckx 2011)

The percentage of participants who claim that they did not share needles/syringes is lower compared with previous years. As such, the researchers (Windelinckx 2011) conclude that the harm reduction campaigns of previous years, which focused on not sharing needles/syringes, were successful. However, drug users are less aware of the risk associated with sharing paraphernalia, probably explaining the very high Hepatitis C prevalence rates among IDUs. Future harm reduction campaigns will focus more on this type of risk behaviour.

2.3.2. Risk behaviour in Injecting Drug Users recruited at the street in the Walloon Region

Data on risk behaviour among Injecting Drug Users in the French community is collected using “snowball operations” (Boule de Neige), which has been organised by Modus Vivendi since 1993. The primary objective of these snowball operations is peer prevention targetting hard-to-reach subpopulations. To this end, volunteering injecting drug users (jobistes) are trained (15-hour training) and paid to disseminate information on AIDS and hepatitis prevention and other harm reduction information among their peers.

The information on risk behaviour collected from surveys administered during these snowball operations, is summarized in Table 6.6 for the years 2001-2010. However, these results are not deemed to be representative for the street Injecting Drug Users in the French community, as the results are not corrected for their dependence on the social network of the ‘jobistes’. Nevertheless, the results indicate that injecting risk behaviour remains common among the recruited sample, with the last-six month prevalences of receptive needle/syringe sharing varying from 31.1% to 42.4% during the period 2001-2010. Some drug users even reported having used needles/syringes found on the street during the last-six months. Although the data do not allow conclusions on the extent and frequency of the risk behaviours, they clearly indicate that extreme injecting risk behaviours are not ruled out, explaining the relatively high rates of HIV and very high rates of Hepatitis C infection among IDUs.

Table 6.6: Injecting Risk behaviour among street-recruited Injecting Drug Users, Modus Vivendi (Boule de Neige), French Community, 2001-2008.

Year	2001	2002	2003	2004	2005	2006	2007	2008
Sample size	481	371	284	451	405	135	236	228
During the last 6 months, did you ...								
injected with needles/syringes that had already been used by someone else?	32.4%	31.5%	31.7%	28.8%	30.4%	30.4%	42.4%	31.1%
injected with needles/syringes found at the street?	2.5%	6.2%	5.6%	3.1%	7.4%	6.7%	5.9%	5.7%
use injecting equipment already used by someone else?	42%	46.6%	48.2%	43.2%	50.9%	47.4%	53.8%	56.6%
given or lent used needles/syringes to someone else?	35.6%	33.7%	35.6%	34.8%	32.1%	32.6%	38.6%	35.1%
given or lent used injecting equipment to someone else?	43.2%	33.7%	41.5%	37.5%	37%	31.1%	25.8%	26.3%

Source: Eurotox, L'usage de drogues en Communauté française, 2010.

2.3.3. Risk behaviour in Injecting Drug Users in prison

This issue is discussed in Chapter 11, Special Issue on Drug-related Health Policies and Services in Prison.

3. Other drug-related health correlates and consequences

3.1. Non-fatal overdoses and drug-related emergencies

Since 1963, the Belgian national Poison Centre has received more than 50.000 telephone enquiries each year related to acute or suspected poisoning by the general public and health professionals. In 2010, 337 telephone enquiries were related to drug intoxications (Mostin, personal communication). For 63% of the enquiries (N= 213), only one substance was involved, of which the majority was related to cannabis and their derivatives (N=32) and to ethanol-based products (N=24), which is comparable with previous years.

Table 6.7: Number of telephone enquiries received by the Belgian national Poison Centre, Belgium, 2009-2010.

	2009	2010
Total	53,272	51,152
Illegal substance related inquiries	299	337
Multiple substances	97	124
One substance, of which	202	213
Cannabis	34	32
ethanol based products	27	24
inhalents/ solvent-type substances	12	21
GHB/GBL	14	20
Cocaine	24	18
heroin / opiates	15	17
Amphetamine	16	13
XTC	4	9
new synthetic drugs	0	7
volatile nitrites/poppers	11	6
synthetic cannabinoids	0	0
other / unknown*	45	46

Source: NPC 2011

3.2. Other topics of interest

3.2.1. Psychiatric co-morbidity

Minimum Psychiatric Data

The Minimum Psychiatric Data (MPD) is a registration system by the Belgian Federal Public Service, Health, Food Chain Safety, and Environment, collecting data at every psychiatric inpatient admission. Diagnostic data are collected based on Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), shortly after patient's admission. It is explicitly requested to complete all DSM-IV axes, allowing the possibility to mention up to three disorders for axis I and III and up to two disorders for axis II. In addition, it is explicitly requested to indicate the main diagnosis causing the admission. This registration was made compulsory for all psychiatric hospitals in 1996 and for psychiatric nursing homes in 1998. The unit of registration is admission and not patient.

In 2008, 1.4% (n=1245) of all admissions in psychiatric hospital services, were diagnosed as having primarily a substance induced disorder (DSM-IV code 292), a decrease compared to 1998 (n= 1853, 2.3%) (Table 6.8). The most prevalent sub diagnosis was substance induced

Table 6.8: Admissions (percentage) with an illegal substance induced disorder as main diagnosis in Belgian psychiatric hospital services (1998-2008).

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
	%	%	%	%	%	%	%	%	%	%	%
Total (N)	1853	1649	1646	1567	1566	1460	1384	1428	1381	1427	1245
Substance withdrawal (292.0)	5.9	5.9	4.8	5.3	5.3	6.3	4.7	5.2	6.6	7.4	7.6
Substance induced psychotic disorder + delusions (292.11)	5.1	8.3	6.8	8.4	8.9	10.5	9.7	8.5	8.8	8.2	11.0
Substance psychotic disorder + hallucinations (292.12)	3.6	4.7	3.6	3.6	3.8	3.1	5.5	4.3	5.4	5.5	3.9
Substance intoxication delirium (292.81)	3.1	2.9	2.1	2.6	2.6	2.9	3.9	3.5	3.2	2.7	2.9
Substance induced persisting dementia (292.82)	0.3	0.4	0.4	0.4	0.7	0.6	0.4	0.5	0.7	0.4	0.4
Substance induced persisting amnesic disorders (292.83)	0.2	0.2	0.7	0.4	0.4	0.5	0.8	0.5	0.3	0.8	0.5
Substance induced mood disorders (292.84)	1.9	1.6	1.2	1.6	1.5	0.5	1.3	1.2	0.9	1.1	1.4
Substance induced (anxiety) disorders (292.89)	78.0	74.5	78.5	75.3	73.5	73.6	72.5	73.7	72.1	71.8	70.0
Substance -related disorders NOS (292.9)	1.9	1.5	2.0	2.4	3.4	1.8	1.2	2.6	2.0	2.0	2.4

Source: MPD (FPSHFDSE DG1, 2011)

anxiety disorder (70.0%), followed by substance induced psychotic disorder + delusions (11.0%), substance withdrawal (7.6%), substance induced psychotic disorder + hallucinations (3.9%), substance intoxication delirium (2.9%), substance-related disorder NOS (2.4%), substance induced mood disorders (1.4%), substance induced persisting amnesic disorders (0.5%), and substance induced persisting dementia (0.4%).

Among all psychiatric admissions within 2008 for which a substance related disorder was reported, the most frequently diagnosed psychiatric co-morbidities were personality disorders (41%), substance-related disorders due to other illicit drugs (27.3%), psychotic disorders (17.4%) and alcohol-related disorders (7.8%). An overview of the psychiatric co-morbidity by substance is given in Table 6.8. Personality disorders are less common among psychiatric admissions for which an amphetamine-related disorder was reported, compared to the admissions involving disorders related to substances other than amphetamine. Psychotic disorders (44.4%) and impulse control disorders (4.6%) were most prevalent when a cannabis-related disorder was diagnosed whereas mood (30.9%), adjustment (12.4%) and anxiety (5.8%) disorders were most prevalent when a sedative-, hypnotic- or anxiolytic-related disorder was diagnosed. Polydrug dependence was common, especially when opioid- (47.9%), cocaine- (33%) and amphetamine-related disorders (27.3%) were reported,

Table 6.9: Psychiatric co-morbidity (percentage) among psychiatric hospital admissions by substance-related disorder, Belgium, 2008.

Substance	Amphetamine	Cannabis	Cocaine	Opioids	Sedatives	Poly-substances
Number of admissions	728	1758	740	1588	2075	2253
Mood disorders	12.4%	13.9%	15.9%	9.3%	30.9%	12.4%
Anxiety disorders	0.5%	2.7%	1.5%	1.9%	5.8%	2.8%
Cognitive disorders	0.3%	0.2%	0.3%	0.6%	1.8%	0.6%
Adjustment disorders	4.1%	6.7%	6.6%	3.5%	12.4%	4.1%
Somatoform disorders	0.5%	0.1%	0.5%	0.8%	1.7%	0.8%
Impulse control disorders	2.1%	4.6%	2.4%	0.8%	1.6%	2%
Psychotic disorders	12.6%	44.4%	9.1%	9.2%	5.6%	17.4%
Personality disorders	30.6%	36.5%	40.5%	39.8%	42%	49.2%
other drugs related	27.3%	14.6%	33%	47.9%	7.4%	2.7%
alcohol related disorders	6.5%	8.1%	14.1%	7.8%	11.7%	2.3%
nicotine related disorders	0%	1.3%	0.8%	0.9%	0.4%	0.1%

Source: MPD (FPSHFDSE DG1, 2011)

and was less common in case of cannabis- (14.6%) and sedatives-related disorders (7.4%). Additional alcohol dependence was most common in case of cocaine- (14.1%) and sedative-related disorders (11.7%).

Psychiatric comorbidity in Drug Users entering treatment in the Flemish region

De Sleutel is an institution consisting of several ambulatory and residential treatment centres located throughout Flanders. As part of the intake interview, the European Addiction Severity Index (EuropASI), is administered to all patients entering treatment in one of the treatment centres of De Sleutel (Raes et al. 2004; Raes and Lombaert 2004).

Based on the data collected through the EuropASI, the prevalence of comorbidity between drug use disorders and other mental illnesses (double diagnosis) is estimated by cross-classifying patients as mild (severity scores 0-3), moderate (severity scores 4-5) and severe (severity scores 6-9) on the life areas 'alcohol and drug use' and 'psychiatric status'. Patients were then classified as 'moderate double diagnosis' when they had moderate problems in both the substance misuse and the psychiatric domain, or when they had severe problems in one domain combined with moderate problems in the other domain. Patients were classified as 'severe double diagnosis' when they had severe problems in both the substance misuse and psychiatric domains.

Table 6.9 summarizes the prevalence of the psychiatric co-morbidity for the years 2006-2010. For 2010, half the patients entering treatment (53.9%) were classified as double diagnosis patients, with 12.7% classified as suffering from severe double diagnosis. These prevalences are comparable with previous years and confirm that psychiatric co-morbidity is common among illegal substance users.

Table 6.10: Prevalence of psychiatric co-morbidity of patients entering treatment (De Sleutel), Flanders, 2006-2010.

	2006	2007	2008	2009	2010
Sample size	631	639	651	814	581
Double diagnosis (%)					
moderate	37.9%	40.8%	32.9%	37.0%	41.1%
severe	13.9%	12.1%	16.7%	13.6%	12.7%
total	51.8%	52.9%	49.6%	50.6%	53.8%

Source: De Sleutel : Lombaert, personal communication

Polydrug use and mental health among drug users who have a demand for treatment (POLYMEH)

The POLYMEH project is carried out by a research consortium of the department of orthopedagogics of the University of Ghent, the department of adolescent psychiatry of the University of Antwerp and the department of political science of the Free University of Brussels. The primary research objectives of this project are the estimation of the prevalence and the characteristics of polydrug use in the population of drug users in treatment in Belgium, the estimation of the prevalence of co-morbid psychiatric disorders (DSM Axis I and II-disorders) in this population and the comparison of the psychiatric profile of polydrug users with this of problem drug users using one single drug.

The main conclusion of the researchers was that poly drug use, although being an ill-defined concept, was rather the rule than the exception. Given that the overall majority of the illicit drug users are poly drug users, the researchers question the meaningfulness of the concept 'primary substance of misuse', both in the context of epidemiological research (e.g. TDI-registration by EMCDDA) and clinical practice.

Cannabis use and mental health

Based on a study of 766 patients (ranging in age from 16 to 65 years) diagnosed with *schizophrenia* or *bipolar disorder* at either the outpatient or the inpatient unit of a psychiatric centre in Flanders, De Hert and colleagues found that cannabis use is associated with a lower age at onset for both schizophrenia and bipolar disorder (De Hert et al. 2010). The authors cautiously interpret their results as being in line with the hypothesis that cannabis use may unmask a pre-existing genetic liability that is partly shared between patients with schizophrenic and bipolar disorder, being both disorders in which psychotic symptoms are common. Indeed, The Genetic Risk and Outcome in Psychosis (GROUP) investigators showed that genetic risk for *psychotic disorder* may be expressed in part as differential sensitivity to the psychotomimetic effect of cannabis (GROUP investigators 2011). Van Winkel showed that genetic variation in AKT1 might explain this differential sensitivity (2011).

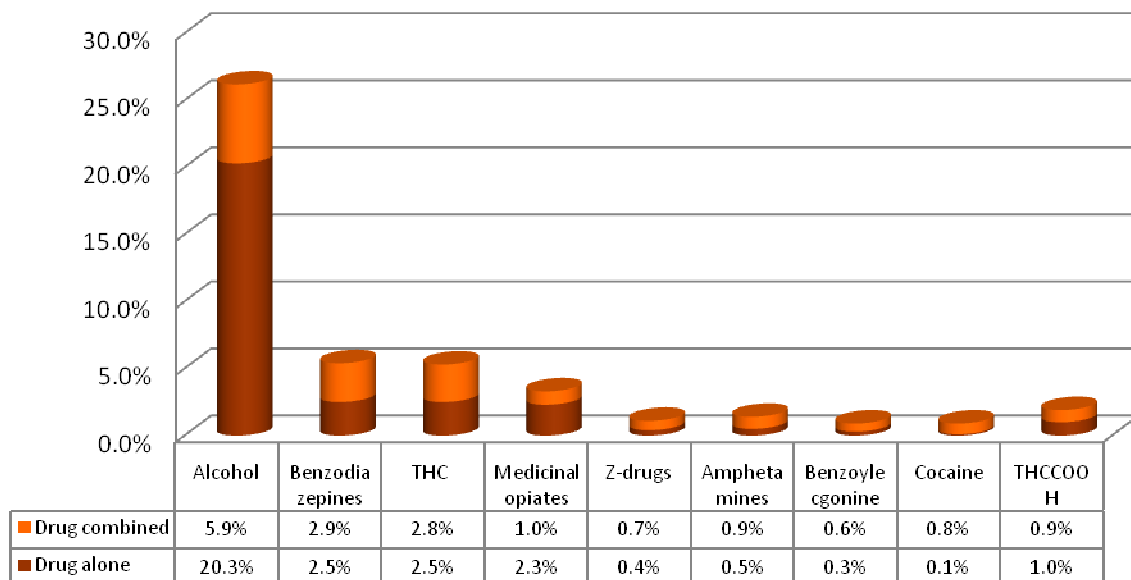
A world-wide psychiatric epidemiological study on the effect of early cannabis use (< 17yrs) on later onset of *depression spells* was recently conducted (de Graaf et al. 2010). In total, 50,718 respondents from 17 countries including Belgium, participated to the general population survey on mental health. For Belgium the 2000 data of the European Study of the Epidemiology of Mental Disorders (ESEMeD) was included (Alonso et al. 2002). A modest but statistically significant robust sex- and age-adjusted association between early cannabis

use and later onset of depression spells was found. However, this association disappeared after statistical adjustment for early norm violations.

3.2.2. Road traffic accidents

Between January 2008 and May 2010, 1078 injured drivers admitted to the emergency departments of Ghent University Hospital, Regional Hospital of Namur, University Hospital Sart Tilman (Liège), Leuven University Hospital and Brussels University Hospital, were included in an injured drivers study, as part of the European project DRUID (Driving Under the Influence of Drugs alcohol and medicines). Blood samples of the injured drivers were tested on 32 illicit and medicinal analytes. Thirty-five percent were drivers of personal cars or vans, 38% were bicycle drivers. Thirty-seven percent of drivers were found positive for one or more (il)licit substances. The highest prevalence was found for alcohol only (20.3%). 5.5% of the sampled subjects were positive for medicinal drugs only: benzodiazepines (2.5%) and medicinal opiates (2.3%) being the most common drugs detected. 4.9% of patients had used an illicit drug only with the highest prevalence for THC (2.5%). The most common combinations found were benzodiazepines + alcohol (1.9%) and THC + alcohol (1.5%) (Van der Linden et al. 2011a).

Figure 6.2: Prevalence (%) of substance use among injured drivers, DRUID Belgium (2008-2010). 📊



Source: DRUID 2011 (Van der Linden et al. 2011a).

4. Drug-related deaths and mortality of drug users

In Belgium, national data on **drug-induced deaths** are available from the General Mortality Register (GMR). Since 1991, the FPS Economy – Directorate-general Statistics and Economic Information, centralises the data from the death certificates coded by the competent administrations of the Flemish (for both the Flemish and the Brussels-Capital Region) and French (Walloon Region) Communities according to the International Classification of Diseases, Injuries and Causes of Death (ICD). The 9th edition (ICD-9) was used until 1997. From 1998 onwards, the 10th edition (ICD-10) was used. The mortality information is registered on the basis of residency (*de jure* information) as opposed to the region where the death occurred (*de facto* information). Data on drug-induced deaths among non-residents are not available.

Recent national data are missing as a result of delays at the level of the French-speaking community. However, substantial progress has been made during the last years and the national mortality data are expected to be available shortly. For now, recent data are only available for the Flemish and Brussels Capital region and were obtained from their respective administrations.

Cases of drug-induced deaths were extracted from the 2000-2008/2009 mortality databases using the EMCDDA “Selection B” case definition (EMCDDA2009). According to this definition, cases are selected when the underlying cause of death was drugs psychoses, drug dependence, nondependent drug abuse, accidental poisoning, intentional poisoning and poisoning with undetermined intent due to opiates, cocaine, amphetamines and derivatives, cannabis and hallucinogens.

The number of drug-induced deaths by year and region are summarized Table 6.10. In 2008, 78 drug-induced deaths were observed in the Flemish region, which is the highest number observed since 2000. The standardised (European Standard Population) drug-induced mortality rates per 1000.000 inhabitants are shown in Figure 6.3, indicating that the mortality rates are generally higher in the Brussels Capital Region compared to the Flemish Region. These differences (although being not significant, except in 2007) are explained by differences in urbanisation degree, with the Brussels Capital Region being the more urbanized. For the Flemish region, a recent increasing trend was observed, which is significant when comparing 2006 with 2008. On the other hand, a recent (however not significant) decreasing trend was observed for the Brussels Capital Region (see also ST5_2011_BE_01 and ST6_2011_BE_01).

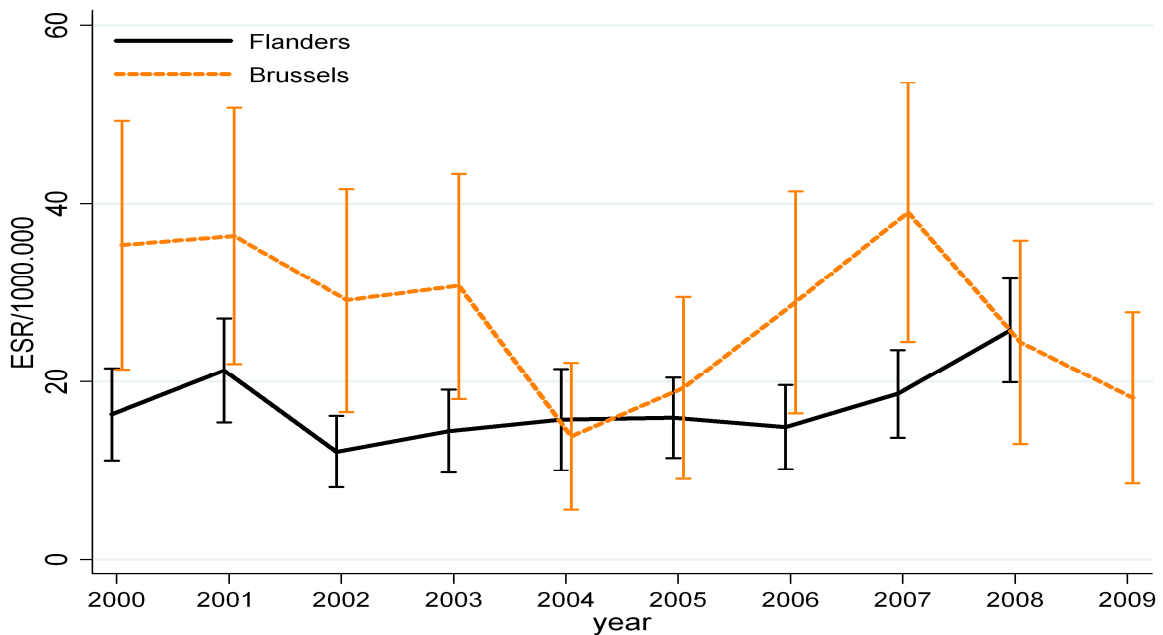
Table 6.11: Number of drug-induced deaths (15-64yrs) based on the General Mortality Registers (Selection B) for the Flemish and Brussels Capital region, 2000-2008/2009.

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Flanders	43	55	38	42	32	51	40	58	78	
Brussels	25	25	22	23	12	14	24	28	19	14

Sources: Vlaams Agentschap Zorg en Gezondheid (Flanders), Observatoire de la Santé et du Social de Bruxelles-Capitale (Brussels)

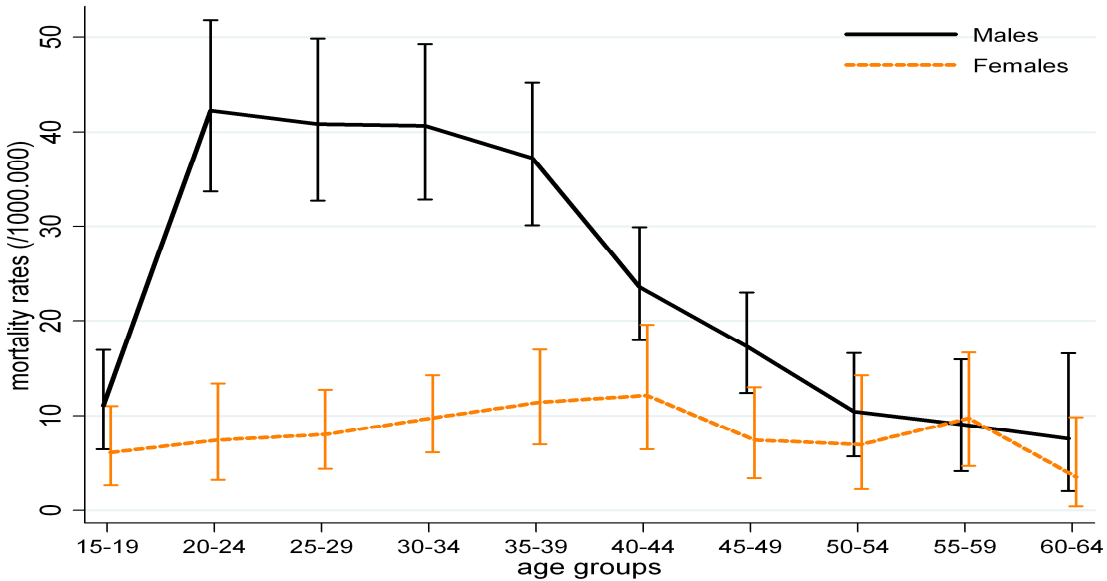
The age- and sex-specific crude drug-induced mortality rates are given in Figure 6.4. The drug-induced mortality rate is significantly higher among males than among females for the age range 20 to 40 years. Especially, young males between the ages of 20 and 24 are at increased risk of directly dying from drug use.

Figure 6.3: Standardized drug-induced mortality rates (15-64yrs) and 95% confidence intervals by year and region, Flemish and Brussels capital region, 2000-2008/2009. 📅



Sources: Vlaams Agentschap Zorg en Gezondheid (Flanders), Observatoire de la Santé et du Social de Bruxelles-Capitale (Brussels)

Figure 6.4: Age- and sex-specific crude drug-induced mortality rates (per 1000.000 person years), Flemish and Brussels capital region, 2000-2008/2009. 📊



Sources: Vlaams Agentschap Zorg en Gezondheid (Flanders), Observatoire de la Santé et du Social de Bruxelles-Capitale (Brussels)



Chapter 7.

Responses to health correlates and consequences

Bollaerts, K., Van der Linden, T. and van Bussel, JCH.



1. Introduction

Within this chapter, the recent preventive and health care responses to health correlates and consequences associated with the use of illegal psychoactive substances in Belgium are described. In particular, the organisation of crisis care for drug users is described as well as the results of its evaluation (ECCAM-project). In addition, a description of the Belgian Early Warning System on Drugs (BEWSD) is presented, including an overview of the warnings sent in 2010. Finally, the syringe exchange programmes and the implementation of oral fluid drug testing are discussed.

2. Prevention of drug-related emergencies and reduction of drug-related deaths

2.1. Emergencies

In Belgium, crisis care for drug users who find themselves in a crisis, a state of acute psycho-emotional disequilibrium, is available from three sources. First, there is the national pilot project for the crisis and case management of patients with joint substance use and mental health crisis launched in October 2002 (FPS Health, Food Chain Safety and Environment). In 9 centres in the proximity of the emergency departments of general hospitals, crisis beds are offered with a maximum stay of five days. These centres are geographically dispersed over Belgium (Antwerp, Brussels, Ghent, Genk, Leuven, Brugge, Liège, Namur and La Louvière). In each centre, a minimum of 300 patients are treated per year and special attention is given to continuing health care. Second, crisis intervention in specialising drug treatment centres exist in Belgium since 1980. The so-called Crisis Intervention Centres (CICs) conventioned by NIHDI aim to offer immediate short-term help to persons in crisis (detoxification), as well as encouraging and supporting them to seek continued treatment (motivation, orientation). In 2010, an average capacity of 77 patients per day was available at the 8 CICs geographically dispersed over Belgium (Koen Deraedt, NIHDI, personal communication). Finally, more than 20 psychiatric hospitals and psychiatric units in general hospitals offer crisis interventions to drug users as well.

Recently, the research project 'Evaluation of Crisis and Case Management' (ECCAM) was carried out by a research consortium of the department psychiatry of the Catholic University of Leuven, the department of orthopedagogics of Ghent University and the department vaccinology of the University of Antwerp (Bruffaerts et al. 2010). The primary research

objectives of this project were to describe the services that are involved in crisis- and case management, to describe the characteristics of the patient population and to carry out a health economic analysis, based on which recommendations for optimising crisis and case management for substance abusers were formulated.

The patients within crisis care were mostly males, having the Belgian nationality. An overview of the characteristics of the patients within crisis care at the crisis intervention centres within specialized drug treatment centres (CICs) and at the emergency departments of the general hospitals (FOD pilot project) are summarized in Table 7.1. Both types of crisis care can be considered early-intervention programmes, with the average age being 26 and 38 years, respectively, which is much lower compared to the average age of 48 years of patients in treatment demand. Furthermore, the two types of crisis care are complementary in the sense that drug abusing patients were more often treated in the CICs while alcohol-misusing patients were more often treated in the crisis centres in emergency departments of the general hospitals (Bruffaerts et al. 2010).

Table 7.1: Characteristics of patients in crisis care at Crisis Intervention Centres (CICs) within specialized drug treatment centres and at emergency departments of general hospitals (FOD pilot project).

		CICs	FOD pilot project
Time period		2006-2008	September-November 2009
Geographical coverage		Flanders (5 treatment centra)	Belgium (9 crisis centra)
Admissions (#)		2578	927
Males (%)		83%	64%
Average age		26 years	38 years
Belgians (%)		93%	91%
Primary drug (%)	opiates	50%	11%
	cocaine and/or tranquilizers	22%	11%
	amphetamines and/or stimulantia	14%	8%
	cannabis	11%	11%
	alcohol	4%	50%
Primary diagnosis (%)	substance abuse	58%	-
	suicide attempts, thoughts, plans	19%	-
	psychotic symptoms	8%	-
	depressive symptoms	8%	-

Source: ECCAM

Based on a qualitative analysis, the researchers of the ECCAM-project concluded that the current implementation of case management of substance abuse patients within Belgium is very heterogeneous, especially with respect to outreaching, advocacy and direct service provisioning. The researchers proposed to systematically implement crisis care methods (assessment, intervention, planning, after care) and to scale up the capacity of the crisis care units.

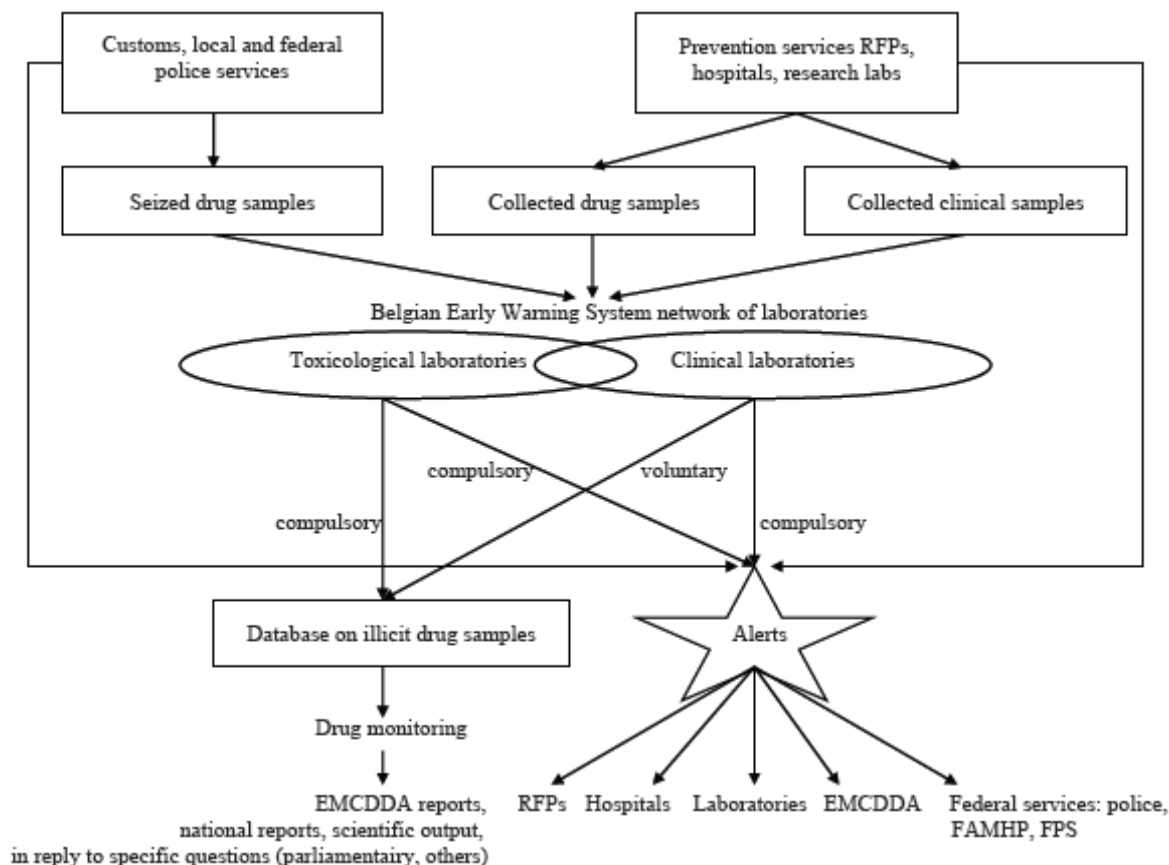
2.2 Drug related deaths

2.2.1. Belgian Early Warning System on Drugs

The Belgian Early Warning System on Drugs (BEWSD), coordinated by the WIV-ISP, is a partner of the European EWS network authorized by the EMCDDA, and has existed since 2002. A total of 20 laboratories (clinical and/or toxicological), geographically dispersed over Belgium (11 in Flanders, 5 in the Walloon region, and 4 in Brussels) participated in the BEWSD since 2002, 14 of which reported toxicological results. The toxicological laboratories analyse the illicit drugs samples, which are either seizures or samples collected by prevention services or hospitals. The clinical laboratories analyse blood or urine samples, typically sent by hospitals. When new psychoactive substances are for the first time in Belgium detected or when unusually high concentrations or high risk combinations are observed, the laboratories inform the WIV-ISP as promptly as possible. The WIV-ISP then consults the regional focal points *L'observatoire socio-épidémiologique alcool-drogues* (Eurotox, French Community) and the *Vereniging voor alcohol- en andere drugsproblemen* (VAD, Flemish Community) to harmonize and compile all available information before sending an alert message. This message contains information on drug composition, route of administration and if available, trafficking and adverse health risks of the newly detected drugs. The alert messages are sent to a national network including federal police services, the Federal Agency for Medicines and Health Products (FAMHP), the drug department of the Federal Public Service "Health, Food Chain Safety and Environment" (FPS), laboratories and hospitals, and the 4 regional focal points (Eurotox, VAD, Concertation Toxicomanies Bruxelles-Overleg Druggebruik Brussel - CTB-ODB, and Social-Psychologisch Centrum - SPZ), and to the EMCDDA. Treatment and prevention services are informed through the regional focal points. Warnings originating from other countries of the European EWS network are also distributed through the BEWSD network. This (inter)national exchange of information allows appropriate actions to be taken in order to prevent users from the (extra) risks these new or hazardous drugs may cause and to end drug crime. A schematic overview of the BEWSD is given in Figure 7.1. In addition to distributing alerts, a database is build

containing the results of all samples analysed by the toxicological laboratories participating to the BEWSD. The BEWSD-database is presented in Chapter 10.

Figure 7.1: Schematic overview of the Belgian Early Warning System on Drugs (BEWSD).



Source: Belgian Early Warning System on Drugs

In 2010, 51 messages were issued by the WIV-ISP, of which six were related to new substances or high concentrations detected by the Belgian laboratories. There was one warning on high-dosage MDMA capsules, and five warnings on new substances first detected in Belgium: Etaqualone, Fluoromethcathinone, JWH-018, Methedrone, and 4-fluoromethamphetamine.

Next to the warnings sent out by the national focal point, the regional focal points VAD and Eurotox also send information on new and high-risk psychoactive substances to their network. To this end, VAD uses a forum (VAD2011b), while Eurotox sends the information through to their network by e-mail. Table 7.2 and Table 7.3 give an overview of the information sent by the regional focal points VAD and Eurotox as well as the warnings originating from Belgium that were sent by the WIV-ISP. In 2010, a report on the evaluation of the communicational aspects of the BEWSD was published (Gelders et al. 2010). The media reach of a single press release was estimated to be 7% based on a telephone survey

(N=1717). In addition, a content analysis was conducted on all 199 press releases originating from the BEWSD and published in 13 journals from January 2003 until March 2007. The researchers concluded that the press releases were too limited, too technical for the general public and lack stories of human interest (Gelders et al. 2010). The researchers suggested that communication should focus more on specific target groups (i.e. general public, professionals and drug users) and that the way and style of communication (i.e. communication channels, content) should be adjusted according to the intended target group (Gelders et al. 2010).

Table 7.2: Overview of other warnings/information sent by the Belgian Early Warning System on Drugs (BEWSD) in 2010.

Author	Method	Date	Drugs involved	Description
WIV-ISP	Email to network	08/04/2010	Etaqualone	Powder sample collected at a low threshold treatment/harm reduction centre in Antwerp with streetname QUAALUDE
WIV-ISP	Email to network	07/05/2010	Fluoromethcathinone	Three collected samples containing a white-beige powder, bought on the internet, sold under three different names: 'Neo-Dove II', 'Lift-Up', 'Sub-Coca dragon'
VAD	Forum	05/07/2010	Fluormethcathinone, Etaqualone	Two new drugs (Flephedrone and Etaqualone) were analysed in Belgium
WIV-ISP	Email to network	28/07/2010	JWH-018	Seizure at Brussels Airport of two bags, each containing 1g white powder carrying the names 'Bonzai Black Diamond' and 'Bonzai Cyprus'
WIV-ISP	Email to network	05/08/2010	Methedrone	One sample containing 1g white powder collected at a low threshold treatment/harm reduction centre in Ghent. Streetname: ND3. The user bought the sample on the internet (www.biorepublik.com/neodove1_english.html).
VAD	Forum	05/08/2010	JWH-018	JWH-018 was found for the first time in Belgium
WIV-ISP	Email to network	17/11/2010	4-fluoromethamphetamine	Seizure in Antwerp of 2 tablets with following properties: white, round, average weight of 170mg, diameter of 7.1mm, 4.0mm thick, with rolex logo.
VAD	Forum	02/12/2010	Methedrone, fluoromethamphetamine	Methedrone and fluoromethamphetamine were found for the first time in Belgium.

Source: Database BEWSD; VAD EWS forum.

Table 7.3: Overview of warnings/information on the identification of high-risk psychoactive substances sent by the Belgian Early Warning System on Drugs (BEWSD) in 2010.

Author	Method	Date	Psychoactive substances involved	Description
VAD	Forum	08/01/2010	Heroin	Heroin users infected with anthrax in Glasgow, Scotland
Eurotox	Yahoo group	24/02/2010	Cocaine	Ready-made crystal of crack: first registration in the French Community (24 tel helpline)
Eurotox	Email to network	05/03/2010	Heroin	Anthrax-adulterated heroin in Scotland, England and Germany
VAD	Forum	19/03/2010	Mephedrone	Update on the status of mephedrone in Scandinavia and United Kingdom: several deaths possibly related to mephedrone use
Eurotox	Yahoo group	24/03/2010	Taurine and caffeine	Emergence in the Walloon Brabant of a new energy drink ("XK1") rich in Taurine
WIV-ISP	Email to network	05/07/2010	MDMA, highly dosed	Seizure in Antwerp of fifteen capsules with an average weight of 183 mg, containing 98% MDMA
VAD	Forum	08/07/2010	MDMA	Highly dosed MDMA analysed in Belgium
Eurotox	Yahoo group	07/09/2010	Cathinones	"Legal Highs" (cathinones): Several occurrences of various products in Belgium
Eurotox	Yahoo group	18/11/2010	PMA and PMMA	PMA and PMMA: Several occurrences in Holland
VAD	Forum	18/11/2010	PMMA	PMMA was found in XTC-tablets in the Netherlands, so far not found in Belgium

Source: Database BEWSD; VAD EWS forum, Eurotox: personal communication.


3. Prevention and treatment of drug-related infectious diseases

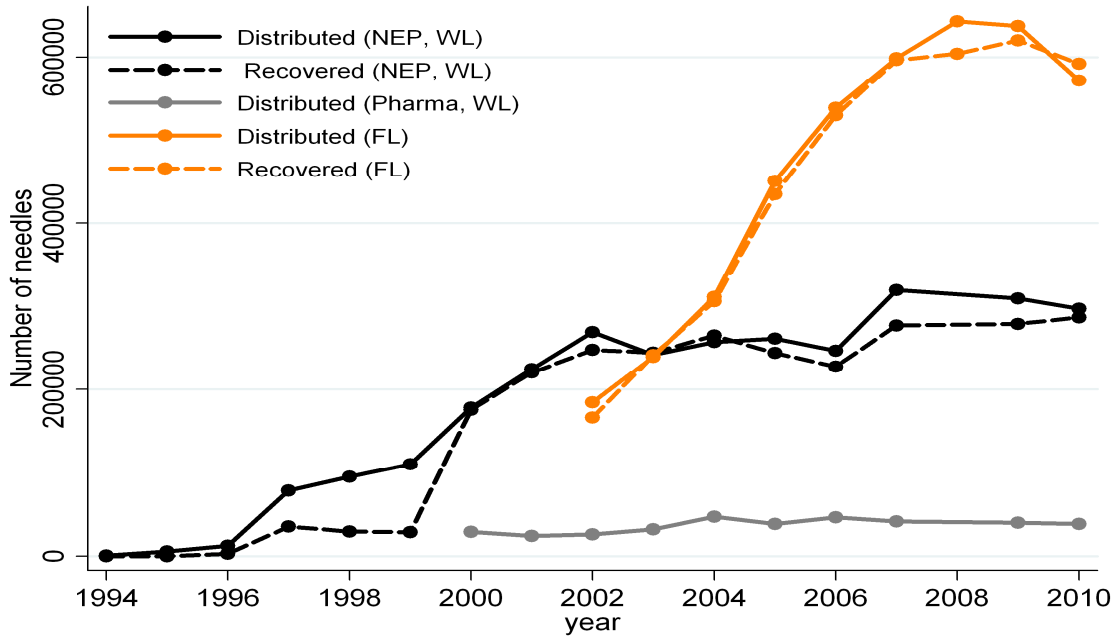
To reduce the spread of infectious diseases and other health risks among injecting drug users, as well as to reduce the risk to the general population by recuperation of used needles, syringe exchange programmes distribute injecting material and additional prevention material (cf. SQ23_2011_BE_02 – 03).

In the Flemish community, the syringe exchange programme, which started in 2001, has been carried out by one regional and five provincial coordinators (one per province in Flanders), working as independents at the Medical and Social Care Centres (MSOCs) for drug users. The provincial coordinator builds networks of health care professionals, and pharmacists, who help him/her to distribute the injecting material, including syringes, filters, ascorbic acid, spoons (Exchange©), alcohol swabs, flasks of injectable sterile water, foil, bicarbonate, and containers to recover syringes.

In the French Community, the needle exchange programme has been coordinated by Modus Vivendi since 1994. In 2008, the organisation of the needle exchange programme was reorganised, resulting in a lack of data for that year. Since 2008, injecting equipment has been offered through 16 official fixed-site and mobile services (with accreditation) located in Brussels, Charleroi, Dinant, Arlon, Namur, Liège and Ciney. On top, more than 10 other services distribute injection equipment. However, the number of syringes distributed within the later services is unknown. Finally, a network of pharmacists participating in the “Stérifix” project distributes “Stérifix” bags at the cost of 0.5 euro, including two syringes, two alcohol swabs, two dry post-injecting swabs, two spoons, two flasks of injectable sterile water and harm reduction information.


In the Flemish Community, 571,825 syringes were distributed in 2010, and 592,123 were returned, resulting in a “recuperation rate” of 103.6% (Windelinckx and Bosschaerts 2011) (see also ST10_2011_BE_01). In the Walloon region, 297,260 syringes were distributed through the 16 official fixed-site and mobile services and 286.866 were returned, resulting in a recuperation rate of 96.5% (Casero et al. 2010) (see also ST10_2011_BE_02). In addition, 38,220 syringes were dispatched to the network of pharmacists participating to the “Stérifix” project in 2010. However, there is no information available on the number of syringes effectively sold through this network. Compared to previous years, the number of distributed needles slightly decreased (Figure 7.2) whereas the recuperation rate increased (Figure 7.3), confirming the importance of the harm reduction programmes in reducing the risks (e.g. needle-stick injury and consequent infection) to the general population.

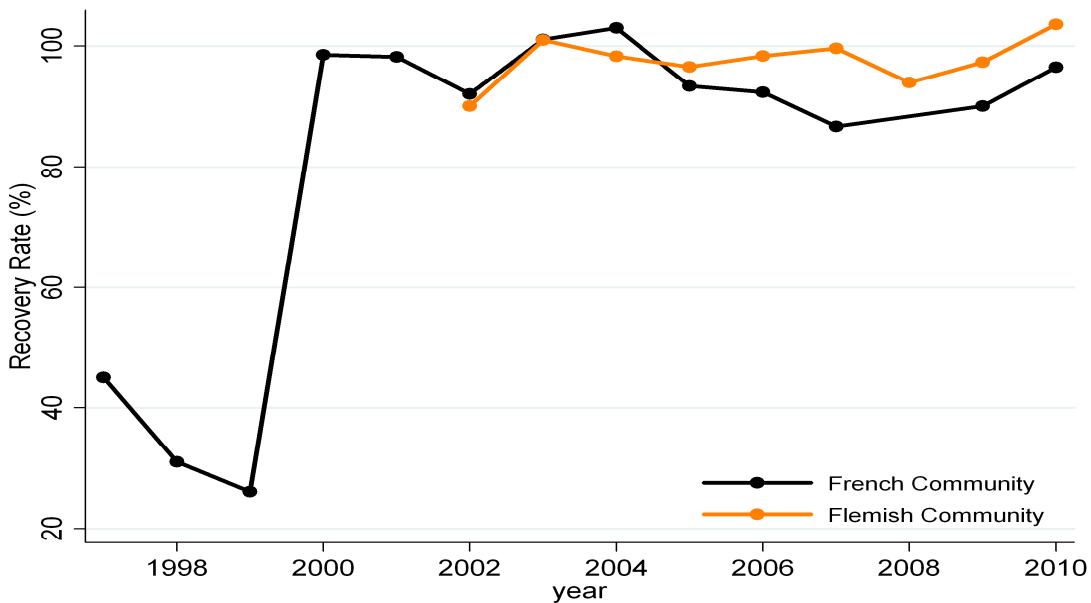
Figure 7.2: Number of syringes distributed and recuperated in the Flemish Community and in the French Community by Needle Exchange Programmes (NEP) and by pharmacists (Stérifix project) , 1994-2010 



[note: the data 2008 for the French Community are lacking as a result of reorganisation].

Source: Casero et al. 2010; Windelinckx and Bosschaerts 2011.

Figure 7.3: Recovery rate of the syringes distributed by Needle Exchange Programmes (NEP) in the Flemish and French Community, 1994-2010. 



[note: the data 2008 for the French Community are lacking as a result of reorganisation].

Source: Casero et al. 2010; Windelinckx and Bosschaerts 2011.

The effectiveness of the syringe exchange programme in Flanders is evaluated yearly by means of the voluntary, anonymous questionnaire, discussed in Chapter 6 (Section 2.3.1.). The results for 2010 indicate that, next to the needle exchange programmes, pharmacists play an important role in distributing injecting material, with 75% of the IDUs in the needle exchange programme also visiting pharmacists to obtain injecting material. Many used needles were properly returned, a fact also supported by the high recuperation rate. However, 7.6% of the IDUs indicate to engage in unsafe disposal of their injecting equipment (e.g. throwing needles unprotected into the garbage or on the street).

4. Responses to other health correlates among drug users

Till September 2010, urine samples were used by the Belgian police (both local and federal police services) to detect drug driving. Since October 1st 2010 onwards, oral fluid drug tests (Securetec® DrugWipe 5®) were used, detecting the presence of marijuana/hashish (THC), cocaine/crack, opiates/heroin/oxycodone/morphine, (meth)amphetamines or ecstasy (Wille et al. 2010) . Simultaneously with the introduction of the oral fluid drug tests, the police controls to detect drug driving offences were scaled up and a national information campaign “gene zever” (Flanders) - “crache test” (Wallonia) was launched. Information was disseminated in three ways: on roadside billboards, information leaflets distributed by the police and on an online questionnaire. While the campaign’s main goal was to inform drivers about the change in testing procedure, and the legal consequences of driving under the influence of drugs, they were also informed about the effects of drugs on driving performances (Belgian Institute for Traffic Safety 2010).

The Responsible Young Drivers have participated in the European project “Ten D by night” (Drugs, Dance, Disco, Dose, Drugs, Danger, Damage, Disability and Death), aiming to develop a European approach in order to reduce the number and seriousness of road accidents that occur during the weekends and can be associated with the consumption of alcohol and psychoactive substances (Berchiolla et al. 2010). Within the framework of this project, semi-structured questionnaires, breath alcohol tests, several drug consumption tests and reaction time measurements using a driving simulator were administered from young drivers aged 16-34 years (Siliquini et al. 2010). Concretely, in 2009, the Responsible Young Drivers organised “Ten D” actions at 12 different recreational settings in Belgium. During these actions, additional informative and awareness-raising material was disseminated.

See also Chapter 3 for other prevention projects, aiming to reduce drug-related health problems among drug users and Chapter 9 for results about the drug driving.



Chapter 8.

Social correlates and social reintegration

Vanderplasschen, W.; De Maeyer, J; Colpaert, K. and Goethals, I.

1. Introduction

Studies and initiatives on social in-/exclusion and drug use in Belgium were searched for using various databases. For retrieving scientific studies, we used the keywords 'drug use', 'addiction', or 'substance abuse' AND 'social inclusion', 'social exclusion', 'social integration', 'housing', 'education', 'training', 'employment', 'homelessness', or 'social networks' AND Belgium in PubMed and Web of Science. In order to identify new projects and initiatives concerning these topics, we searched the EDDRA database of the EMCDDA, the websites of the Belgian (sub)focal points and the project lists of the Department of Health Promotion (Walloon and Brussels region) and the federal 'Addiction Fund', which is intended to launch new initiatives to complement the available treatment offer for drug users.

In general, few specific services are available for promoting the social inclusion of drug users, but they can address the CAW (Centra Algemeen Welzijnswerk/ Centre d'aide Sociale Générale/Centres for general social services) for housing, food and other issues related to basic human rights, the OCMW/CPAS (Openbare Centra voor Maatschappelijk Welzijn/Centre public d'Action Sociale/Public social services) for a minimal income, or adult education for acquiring an additional degree. These services are available for any Belgian citizen, but not specifically targeted at persons with substance use problems.

Specific initiatives for drug users in this context are the so-called social workplaces (De Sleutel), where drug users who are long-term unemployed and who didn't complete lower secondary school can be employed or trained. Also, the 'Opvang Dakloze Druggebruikers' in Antwerp where homeless drugs users can stay overnight is an example of such a specific initiative. Finally, some peer support projects, like the 'Jobist'-project in Brussels (Modus Vivendi), promote social inclusion since they provide a positive identity (i.e. prevention or harm reduction worker) to drug users who are often stigmatized by the society for their drug consumption (Modus Vivendi 2007).

In this chapter, we focus on new initiatives and studies regarding the social in-/exclusion of (specific groups of) drug users and on indicators of the social in-/exclusion derived from the Belgian Health Interview Survey database (BHIS), the Belgian Treatment Demand Indicator Registre (BTDIR) and some specific studies on this topic.

Details about methodology of the studies described can be found in the Annexes.

2. Social exclusion and drug use

2.1. Social exclusion among drug users

2.1.1. Homelessness

Few information is available about homeless drug users in Belgium. In 2010, the number of homeless individuals reached by social services was estimated to be around 20 000 (De Boyser et al. 2010). Among this population, social workers identified a large and growing number of persons with substance use (80%) and other psychiatric disorders (75%).

2.1.2. School drop out

No recent information on drug use and school drop-out is available in Belgium. School drop-outs can be hardly reached with school surveys, and qualitative research (e.g. participant observation) is the most likely method to reach this population. In addition, available school surveys on drug use behaviour among adolescents usually do not report on truancy or other early signs of drop-out.

For some years, the organisations 'Citadelle' and 'Canal J' in Tournai collaborate to reach adolescent drug users in their natural environment (at home, in school, ...) and succeed to contact a substantial number of school drop outs (Lamkaddem and Roelands 2010).

Based on a secondary analysis of initial assessment interviews with drug users entering therapeutic communities in Flanders between 1996 and 2010 (Vanderplasschen et al. 2011a), it appeared that the mean number of completed school years increased significantly during this period (10.7 in 1997 vs. 11.9 years in 2010). Also, the number of persons without a school degree, an indicator of early school drop-out, diminished significantly from 52.6 in 1997 to 22.0% in 2010.

2.1.3. Social networks

Initiatives for the establishment of social networks among drug users in the community are still in its infancy. Although such projects have been set up for persons with 'mental health problems' in general, and are consequently accessible for drug users, few (or only a specific group of) drug users address these initiatives (e.g. Poco Loco, Ghent). In some big cities like Brussels, several organizations (e.g. Dune asbl, MASS Bruxelles, Dagcentrum De Sleutel) offer low threshold services for drug users to drop in and have a chat or drink some coffee or soup. It can be expected that the number of outreach projects, drop-in services and other low threshold initiatives for persons with mental health problems (including drug abuse) will

further increase in the near future, given the current reform and further deinstitutionalization in mental health care. This reform is commonly referred to with the specific section of the hospital law (art. 107) that stipulates the objectives and conditions of this reorganization.

On the other hand, many treatment services try to involve the family and social network of the client during residential treatment, e.g. in therapeutic communities (Broekaert 2006). Some services collaborate intensively with the parents/family of drug users like the 'Incant'-project at the Brugmann Hospital in Brussels, an evidence-based intervention for adolescent drug (cannabis) users and their families based on the Multi-Dimensional Family Therapy-approach (MDFT) (Rigter et al. 2010) (see also chapter 5, section 2.2.1. for a more detailed description of MDFT).

Some organizations (e.g. De Kiem, Drughulp Kempen) have applied the Community Reinforcement Approach (CRA) to reconnect drug users with persons and activities in their surroundings. The ability to re-establish community life was identified as a major strength in the qualitative evaluation of the CRA+vouchers project in De Kiem (Vanderplasschen et al. 2011b).

Also, data from population surveys provide information about the social embedment of persons who use drugs. For example, the Belgian Health Interview Survey (BHIS) (2008) assesses, among others, individuals' satisfaction with social life and the quality of the social support they receive. The BHIS reveals that last year cannabis users are slightly more likely to participate in social life (73.0% vs. 70.1% among non-drug users) (Table 8.1). Satisfaction about their social contacts was higher among persons who did not use any illicit substance during the past year (94.4%), but this number was almost as high among persons who used cannabis (90.1%) (Table 8.1).

The quality of social support of cannabis users and persons who didn't use illicit drugs during the past year was comparable (Table 8.2). Due to the limited number of last year users of cocaine, amphetamine/XTC and opioids, the results for these subgroups are not presented here.

Table 8.1: Participation in and satisfaction with social life in last year cannabis users and persons who did not use drugs in the past year (15-64y), by gender (Belgium, 2008).

Last year user of **	Gender	Participating in associative life			Satisfying social contacts		
		%*	95% CI	N	%*	95% CI	N
Cannabis	M	77.0	70.2 – 83.7	213	89.9	85.0 – 94.8	212
	F	64.5	49.7 – 79.2	106	90.5	79.3 – 100.0	106
	Total	73.0	66.2 – 79.8	319	90.1	85.2 – 95.0	318
No use of an illicit drug in the last year	M	72.8	70.5 – 75.1	2387	94.4	93.4– 95.5	2386
	F	67.6	65.2 – 70.0	2682	94.4	93.3– 95.6	2678
	Total	70.1	68.2 – 72.0	5069	94.4	93.6 – 95.3	5064

*weighted percentages, ** the data for last year users of amphetamines/XTC, cocaine and opioids are excluded from the table because of limited sample size

Source: BHIS, 2008.

Table 8.2: Self-reported social support quality of last year cannabis users and persons who did not use drugs in the past year (15-64y), by gender (Belgium, 2008).

Last year user of **	Gender	Social support quality						
		Limited		Average		Strong		
		%*	95% CI	%*	95% CI	%*	95% CI	N
Cannabis	M	16.0	9.8 – 22.3	47.5	38.1 – 57.0	36.4	27.0 – 45.9	213
	F	14.9	4.6 – 25.2	53.0	38.1 – 68.9	32.1	17.8 – 46.5	105
	Total	15.7	9.8 – 21.5	49.3	40.8 – 57.7	35.1	26.6 – 43.5	318
No use of an illicit drug in the last year	M	13.1	11.4 – 14.7	49.9	47.2 – 52.5	37.1	34.5 – 39.7	2385
	F	13.8	12.2 – 15.4	50.4	47.9 – 53.0	35.8	33.3 – 38.3	2680
	Total	13.4	12.2 – 14.7	50.2	48.2 – 52.1	36.4	34.4 – 38.4	5065

*weighted percentages, ** the data for last year users of amphetamines/XTC, cocaine and opioids are excluded from the table because of limited sample size

Source: BHIS, 2008.

2.1.4. Social exclusion among drug users in demand for treatment

Social exclusion is a phenomenon often associated with continued problem drug use (Buchanan 2004). Several mutually reinforcing processes are at work (e.g., school drop-out, family problems, unemployment, financial problems, mental health problems, ...), which contribute to the marginalisation and social exclusion of drug abusers. Treatment services may intervene at various stages in this vicious process. Consequently, the degree of social exclusion among drug users in demand for treatment will differ between various types of treatment modalities, e.g., early intervention initiatives, detox centres, methadone maintenance treatment or needle exchange programs.

Based on the Belgian Treatment Demand Indicator data of 2009, some indicators of social exclusion can be studied. More than one third (33.2%) of all persons entering treatment in 2009 had no school degree or only a degree of primary education (Table 8.3). The proportion of persons without school degree is considerably higher among persons between 45 and 54 years (45.0%) and those over 55 years old (52.6%) (Table 8.5), and among persons with cannabis as main problem substance (41.3%) (Table 8.4). One in two treatment demands concern persons who are unemployed (55.1%), and 2 in 3 persons over 35 years old are unemployed when they address a treatment agency (Table 8.5). Cocaine abusers are most likely to be employed at treatment entry (56.6%), while opiate abusers are least likely to be employed when they enter treatment (36.6%). No gender differences in unemployment rates were observed among persons entering treatment.

About 15.4% of all treatment demands concern persons who are living in unstable circumstances (changing situations) and one third lived alone (with one or more children) at treatment entry. In particular opiate abusers (40.5%) and persons over 35 years old (>51.0%) were most likely to live alone (Table 8.4). Only small gender differences were observed, with 35.9% of the women and 32.7% of all men living alone.

A recent qualitative study using focus groups with drug users in and out of treatment identified important aspects of social inclusion according to drug users' own experiences (De Maeyer et al. 2009). A supportive social network is regarded as crucial to re-integrate into mainstream society. Participation in the community is further deemed important, but may be hindered by years of isolation, trauma and stigmatisation. Safety is a theme that was mentioned in almost all focus groups, and almost all participants stressed the importance of having meaningful daily activities. Finally, most respondents commented that work is one of the best ways to integrate in society, but several problems may complicate this.

Table 8.3: Indicators of social exclusion among drug users in demand for treatment, by status and gender (Belgium, 2009).

Exclusion criteria	Group	%	95% CI	N*
Living alone or Living alone with child	All	33.4	32.3-34.5	7033
	Men	32.8	31.5-34.0	5542
	Women	35.9	33.5-38.4	1476
Living in an unstable accommodation	All	20.0	18.9-21.1	5538
	Men	20.5	19.4-21.8	4493
	Women	17.2	15.0-19.7	1033
Unemployed	All	45.5	44.0-46.9	4691
	Men	45.1	43.5-46.7	3790
	Women	46.4	43.1-49.8	877
No degree or Primary education	All	33.2	32.2-34.3	7501
	Men	34.1	32.9-35.3	5985
	Women	29.4	27.1-31.8	1503

*Total BTDIR population

Source: BTDIR, 2009

Table 8.4: Indicators of social exclusion among drug users in demand for treatment, by status and first substance used (Belgium, 2009).

Exclusion criteria	Group	% excluded	95% CI	N*
Living alone or Living alone with child	All	33.3	31.8-34.7	4066
	Opioids	40.5	38.1-42.9	1649
	Cocaine	34.7	31.0-38.6	631
	Stimulants	32.8	28.6-37.3	469
	Cannabis	22.3	19.9-24.9	1138
Living in an unstable accommodation	All	15.4	14.3-16.5	4272
	Opioids	22.9	20.9-24.9	1715
	Cocaine	11.2	8.9-13.8	679
	Stimulants	11.5	8.7-14.7	463
	Cannabis	4.6	3.5-6.0	1170
Unemployed	All	55.1	53.2-56.9	2837
	Opioids	63.4	60.6-66.1	1219
	Cocaine	43.3	39.1-47.7	533
	Stimulants	51.9	46.3-57.4	322
	Cannabis	47.6	43.5-51.6	612
No degree or Primary education	All	34.7	33.3-36.1	4513
	Opioids	34.9	32.8-37.2	1835
	Cocaine	26.3	23.1-29.7	710
	Stimulants	27.9	23.9-32.0	492
	Cannabis	41.3	38.5-44.1	1255

*Total BTDIR population

Source: BTDIR, Belgium, 2009

Table 8.5: Indicators of social exclusion among drug users in demand for treatment, by status and age category (Belgium, 2009).

Exclusion criteria	Group	% excluded	95% CI	N*
Living alone or Living alone with child	All	33.3	31.8-34.7	4066
	<15	0.0	0.0-0.0	21
	15-24	13.0	11.2-15.0	1276
	25-34	36.8	34.5-39.1	1730
	35-44	51.5	48.0-55.0	796
	45-54	56.0	49.1-62.8	216
	55+	75.0	53.3-90.2	24
Living in an unstable accommodation	All	15.4	14.3-16.5	4272
	<15	0.0	0.0-0.0	21
	15-24	9.7	8.1-11.4	1335
	25-34	15.3	13.7-17.1	1758
	35-44	20.3	17.6-23.1	858
	45-54	15.4	10.9-20.7	228
	55+	13.0	2.8-33.6	23
Unemployed	All	55.1	53.2-56.9	2837
	<15	0.0	0.0-0.0	2
	15-24	55.3	51.7-58.9	743
	25-34	49.8	47.1-52.5	1348
	35-44	64.2	60.3-68.1	601
	45-54	63.0	54.0-71.4	127
	55+	83.3	51.6-97.9	12
No degree or Primary education	All	34.7	33.3-36.1	4513
	<15	92.0	74.0-99.0	25
	15-24	39.0	36.5-41.6	1431
	25-34	26.7	24.8-28.8	1904
	35-44	40.3	37.1-43.5	919
	45-54	45.0	38.1-52.0	209
	55+	52.6	28.9-75.6	19

* Total BTDIR population

Source: BHIS, 2009

2.1.5. Social status among people deceased by using drugs

Information on drug-related deaths in Belgium is extremely scarce and rather outdated (cf. EMCDDA country overview), although some new data are available for Flanders and Brussels. Given the scarcity of data, it may not surprise that no research is available on the social status of persons who deceased by using drugs.

2.2. Drug use among socially excluded groups

Several recent studies have focused on drug use among socially excluded groups, such as youngsters in vulnerable situations, sex workers, prisoners (cf. chapter 9), and individuals with intellectual disabilities.

The JOP-monitor (Youth research in Flanders and Brussels) assessed the association between social vulnerability and substance use among a sample of 2513 youngsters (age 12-15) in secondary schools in Brussels (Cardoen et al. 2011). Social vulnerability was operationalized as having low self-esteem, negative (future) perspectives and feelings of insecurity. The study showed that indicators of social vulnerability only had a minimal impact on regular use of cannabis. The only variables significantly associated with higher frequency of cannabis use were the observation of nuisance in the neighbourhood and staying down one or more classes. The authors concluded that social vulnerability rather affects drug initiation, but not the frequency of drug use (Cardoen et al. 2011).

As no information is available on the prevalence of drug use and drug-related health problems among sex workers in Belgium, a national study was set up on sex work and drug use, coordinated by professor Decorte (Ghent University, Institute for Social Drug Research). This study aimed at assessing the nature and extent of legal and illegal drug use among female sex workers based on a survey. In addition, qualitative in-depth interviews and focus groups with sex workers were used to identify emerging problems, specific (health care) needs and barriers to health care and treatment services.

In total, 543 women participated in the study which was conducted in five Belgian cities (Antwerp, Brussels, Charleroi, Gent and Liège). The mean age of the respondents was 35.7 years, and the women usually started with sex work at the age of 25.6 (Decorte et al. 2011). Alcohol and benzodiazepines are the most frequently used substances: 13.0% of the sex workers used alcohol daily and 26.0% used benzodiazepines on a daily basis. Older women and women with a longer career in the sex work industry were more likely to use benzodiazepines. One quarter of the respondents used cannabis during the last month, 16.7% used cocaine, 7.2% heroin, 3.8% amphetamines, 3.4% crack and 1.7% xtc. Based on the Severity of Dependence Scale (SDS) that was used by the researchers, 30.0% of the respondents experienced dependence of one or more substances: 15.9% was classified as dependent on alcohol, in particular sex workers in bars and girls involved in street prostitution. The authors further identified 13.6% of the respondents who were dependent on benzodiazepines, 10.2% on cocaine, 7.5% on cannabis and 6.7% on heroin (Decorte et al. 2011). The dependence rates reported in this study are high in comparison with the last

month consumption rates, which raises questions concerning the reliability and validity of the instrument used. The authors conclude that substance use and misuse is substantially higher among sex workers than in the general population, and that the highest prevalence of substance misuse was found among street sex workers. Most participants in this study only began using drugs after they had started sex work.

Poly drug use is very common among sex workers, since 32.2% of them used multiple substances during one day in the last month. Alcohol and cannabis (33.0%) are most frequently combined, but also alcohol and cocaine (28.0%) and alcohol and benzodiazepines (16.0%). According to the respondents alcohol and cocaine are combined to keep on working, while benzodiazepines are taken to get asleep after using cocaine (Decorte et al. 2011). Almost 42.4% of the sex workers use at least one substance at work and half of them (48.6%) state this makes their work easier. Almost one in five sex workers (18.5%) often have unprotected sex when they have used alcohol or drugs. This is in particular the case for cocaine (33.0%) and heroin users (76.0%).

In a study by the organization Espace P in Liège, Namur and Charleroi among sex workers who have been vaccinated for Hepatitis B between 1998 and 2008 (n=1786), the number of illicit drug users was estimated at 17.5% (Casero et al. 2010). This percentage is likely to be an underestimation, given the high proportion of non-response to this question (over one third). 35% of the respondents used alcohol daily, of whom 12% misused alcohol. The findings of this study are in line with the recent study by Decorte and colleagues (2011), but illustrate the difficulty to collect reliable data among this hidden and vulnerable population.

A new emerging target population among drug users appear to be persons with intellectual disabilities or low cognitive capacities. In 2010, a research project was started at the Ghent University College (coordinated by professor Stijn Vandeveldde) on the screening and assessment of substance use problems in persons with intellectual disabilities. Given the increased inclusion of persons with disabilities in our communities and growing problems reported by practitioners concerning the assessment and treatment of individuals with limited cognitive abilities, this study was set up to develop an adapted screening and assessment tool and to estimate the prevalence of drug problems among persons with disabilities. Based on a pilot study among professionals, it appears that substance use in this population mostly concerns alcohol problems (71%) and that it is often associated with mood changes and other psychiatric disorders (Neyrinck et al. 2011).

Finally, data from the Belgian Health Interview Survey (2008) reveal that drug use among populations at risk of social exclusion (as indicated by educational achievement, employment status or being on welfare benefits) is higher than among the general population. For

example, last year consumption of cannabis is higher among unemployed persons (9.1 vs. 5.1%) (Table 8.6, Table 8.9, Table 8.10), as well among male as among female unemployed persons. Also, young unemployed persons (<35 years) are more likely to use cannabis than their older peers (Table 8.9). People who are unemployed due to sickness or disability have similar drug consumption rates as the general population, although the number of amphetamine/XTC and opiate users in this category is relatively high (Table 8.7). Among respondents with no degree or only a degree of primary education (Table 8.8), low drug use rates were reported in the BHIS compared with the general population. Due to the small sample size, the data are not presented by age category.

Table 8.6: Last year prevalence of drug consumption in unemployed people (15-64y), by gender and type of drugs (Belgium, 2008).

Type of drug	Gender								
	%**	95%CI	N	%**	95%CI	N	%**	95%CI	N
Cannabis	13.2	7.5 - 19.0	197	5.7	1.0 - 10.4	228	9.1	5.3 – 12.9	425
Cocaine	2.1	0.0 – 4.2	193	2.5	0.0 – 5.3	223	2.3	0.6 – 4.1	416
Amphetamines/XTC	3.6	0.23– 7.0	193	0.9	0.0 – 2.2	223	2.1	0.4 – 3.8	416
Opioids	0.9	0.0 – 2.0	193	0.6	0.0 – 1.7	223	0.7	0.0 – 1.5	416

*Unemployment **not** due to specific cause (e.g. being student, being disabled,...) ; ** Weighted percentage

Source: BHIS, 2008

Table 8.7: Last year prevalence of drug consumption in sick/disabled people (15-64y), by gender and type of drugs (Belgium, 2008).

Type of drug	Gender								
	%**	95%CI	N	%**	95%CI	N	%**	95%CI	N
Cannabis	6.6	1.3 – 11.9	98	5.5	0.0 – 14.8	112	6.0	0.5 – 11.5	210
Cocaine	1.1	0.0 – 3.2	98	0.0	/	109	0.5	0.0 – 1.5	207
Amphetamines/XTC	2.2	0.0 – 5.6	98	1.4	0.0 – 4.1	109	1.8	0.0 – 4.3	207
Opioids	2.9	0.0 – 6.4	98	1.8	0.0 – 4.6	109	2.3	0.0 – 4.9	207

*People being unemployed due to sickness/disability; ** Weighted percentage

Source: BHIS, 2008

Table 8.8: Last year prevalence of drug consumption in low educated people* (15-64y), by gender and type of drugs (Belgium, 2008).

Type of drug	Gender						Total		
	Male			Female			%**	95%CI	N
	%**	95%CI	N	%**	95%CI	N	%**	95%CI	N
Cannabis	3.8	0.6– 6.9	173	3.3	0.0 – 9.1	184	3.5	0.1 – 6.9	357
Cocaine	1.7	0.0 – 4.0	164	0.0	/	181	0.7	0.0 – 1.8	345
Amphetamines/XTC	0.2	0.0 – 0.7	164	0.0	/	181	0.1	0.0 – 0.3	345
Opioids	0.0	/	164	0.0	/	181	0.0	/	345

* no degree or primary education; ** weighted percentage

Source: BHIS, 2008

Table 8.9: Last year prevalence of drug consumption in the general population (15-64y), by gender and type of drugs (Belgium, 2008).

Type of drug	Gender						Total		
	Male			Female			%*	95%CI	N
	%*	95%CI	N	%*	95%CI	N	%*	95%CI	N
Cannabis	7.2	5.9 – 8.4	2667	3.2	2.3– 4.1	2869	5.1	4.3– 6.0	5536
Cocaine	1.3	0.7 – 1.8	2644	0.5	0.2 – 0.8	2839	0.9	0.6 – 1.2	5483
Amphetamines/XTC	1.4	0.8– 2.0	2644	0.4	0.2– 0.7	2838	0.9	0.6 – 1.3	5482
Opioids	0.2	0.1– 0.4	2644	0.1	0.0 – 0.3	2838	0.2	0.1– 0.3	5482

* Weighted percentage

Source: BHIS, 2008

Table 8.10: Last year prevalence of drug consumption in unemployed people, by age category and type of drugs (Belgium, 2008).

Type of drug	Age category															Total		
	15-24			25-34			35-44			45-54			55-64			%**	95%CI	N
Cannabis	18.2	6.7 – 29.8	69	20.2	9.1 – 31.4	108	5.9	0.3 – 11.5	72	0.0	/	77	1.6	0.0 - 4.2	99	9.1	5.3 – 12.9	425
Cocaine	5.7	0.0 – 12.0	68	3.7	0.0 – 7.7	106	3.4	0.0 – 10.2	74	0.0	/	76	0.0	/	92	2.3	0.5 – 4.1	416
Amphetamines/XTC	5.6	0.0 – 13.0	68	4.2	0.0 – 9.1	106	1.6	0.0 – 4.9	74	0.0	/	76	0.0	/	92	2.1	0.4 – 3.8	416
Opioids	2.9	0.0 – 6.6	68	1.2	0.0 – 3.6	106	0.0	/	74	0.0	/	76	0.0	/	92	0.7	0.0 – 1.5	416

* Unemployment **not** due to specific cause (e.g. being student, being disabled,...); ** weighted percentage

Source: BHIS, 2008

3. Social reintegration

To our knowledge, few information on the reintegration of drug users is available from longitudinal and/or follow-up studies in Belgium. Only two recent studies have focused on indicators of social integration from a longitudinal perspective. One among a community sample (Decorte and Muys 2010) and one among a cohort of opiate dependent individuals who started methadone treatment between 1997 and 2002 (De Maeyer et al. 2011b).

Based on a baseline study in 1996-1997, Decorte interviewed 111 regular cocaine users, who had not been in treatment nor been arrested for drug issues (Decorte and Muys 2010). In 2008-09, 12 years after the original study, 56 respondents (i.e., 50.5% of the original sample) were re-interviewed. Findings from this follow-up on housing, education and employment are reported below.

The study by De Maeyer and colleagues (2011) was set up as a cross-sectional study of the current QoL of a cohort of opiate-dependent individuals who started outpatient methadone treatment between 1997 and 2002 in the region of Ghent (Belgium). In total, 159 subjects participated in this non-randomized study. Forty-one participants (25.8%) were no longer in methadone treatment by the time of the interview, while almost three-quarters of the sample (74.2%) was currently still on methadone treatment. The mean duration of methadone treatment was 7.6 years ($SD = 4.4$). A high proportion of the sample (86.5%) followed at least two methadone treatment episodes.

3.1. Housing

The study of cocaine users showed that 12 years later, most subjects were in a serious relationship and lived together with a partner. Sixty percent of these persons had children (Decorte and Muys 2010).

The longitudinal study of opiate dependent persons in methadone treatment demonstrated that the largest group of subjects had never been married (69.8%) and lived alone (40.3%). Still, 45.3% of the participants had an intimate relationship.

3.2. Education, training

The follow-up study by Decorte and Muys (2010) revealed that one third of their sample had a university or further education degree. The treatment sample by De Maeyer and colleagues included less educated persons, since 56.6% did not complete any form of secondary education.

3.3. Employment

At the time of the 2008 interview, more than 60% of the sample of cocaine users was employed (full or part time), mostly as skilled laborers or office workers. Of the persons who started methadone treatment between 1997 and 2002 (De Maeyer et al. 2011b), about one quarter of the participants (26.4%) currently had a paid job. Still, 59.7% of the sample had a structured daily activity. Regression analyses on this study sample demonstrated that having structured daily activities and employment were the main, significant determinants of (specific domains of) a good quality of life (De Maeyer et al. 2011a).



Chapter 9.

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

Deprez, N. and Van Malderen, S.

1. Introduction

In this chapter, results from different sources are combined to get an overview of the drug-related crime and the judicial process for these crimes in Belgium.

Data on drug law offences are provided data from the federal police and the surveys from the Jeugdonderzoeksplatform, carried out in Flanders (JOP monitor 1, JOP-monitor 2) and the Dutch schools in Brussels (JOP-monitor Brussel). These surveys collect data on the percentage of youth selling drugs.

For drug driving, police data are used as well. It is important to note that in October 2010, the Belgian police services changed their screening method for drug use in the driving population. This change will be described, as well as the screening results provided by the Federal Highway Police. Blood sample results from drivers under influence are provided by one of the analysing labs. Furthermore, some other studies about drug use among the driving population were carried out in Belgium (TEND and Driving Under the Influence of Drugs, alcohol and medicines (DRUID)). Their main results can also be found in this chapter. Preventive measures for drug-related crime and the alternatives for prison are described based on some specific studies, evaluating the project 'Proefzorg' (Test Care: Treatment instead of prosecution) and 'De Drugbehandelingskamer' (Ghent Drug Treatment Court).

Judicial consequences of drug law offences are available from the several judicial services. Data on the number of drug-related cases entering and leaving the first line court system is provided by the statistical service of the Public Prosecutor. For the cases closed at the public prosecutor's office, an overview is given of the closing decisions of the drug-related cases. The number of new drug law offence cases entering the Court of Appeal, is provided by the Permanent Office for Statistics and Work load measurement. Finally, the number of convictions and suspensions for drug law offences are gathered by the Service of Criminal Policy based on data coming from all courts in Belgium. These data are only available up until 2004.

Information about drug use in prisons is provided based on the prison survey "Drug use in Belgian prisons: Monitoring of health risks". This survey is organised biennially in all Belgian prisons, since 2006. Next to that a recent PhD-study by Vandam (Ghent University, 2010) focused specifically on the relation between detention and drug use among a small sample of prisoners.

2. Drug-related crime

Four types of drug-related crime were defined by the EMCDDA (2007) namely (1) psychopharmacological crimes: crimes committed under the influence of a psychoactive substance, as a result of its acute or chronic use; (2) economic-compulsive crimes: crimes committed in order to obtain money (or drugs) to support drug use; (3) systemic crimes: crimes committed within the functioning of illicit drug markets, as part of the business of drug supply, distribution and use; (4) drug law offences: crimes committed in violation of drug (and other related) legislations (EMCDDA2007). The last one will be described in section 2.1. The other three will be addressed in section 2.2.

2.1. Drug law offences

2.1.1. Police data

On a yearly basis, the federal police publishes criminality statistics based on the local and federal police reports describing one or more criminal offences (see Table 9.1) (Federale Politie - CGOP / Beleidsgegevens 2011). In 2010, a total of 1,028,454 criminal offences were reported, of which 40,725 were drug law offences (use, possession, dealing, trafficking, or production of drugs), yielding a rate of 4.0%.

Table 9. 1: Drug-related law offences in relation to the total number of law offences, Belgium, 2006-2010.

Offences	Year				
	2006	2007	2008	2009	2010*
Total (N)	1,007,284	1,016,337	1,022,235	1,045,518	1,028,454
Drug-related (n)	40,412	44,545	46 123	47,671	40,725*
Drug-related (%)	4.0	4.4	4.5	4.6	4.0

*Since 2010, individual drug use was only counted as drug possession, before this was often counted both as use and possession; results from 2010 might be incomplete

Source: CGOP/B (Federale Politie - CGOP / Beleidsgegevens 2011).

Table 9.2 shows the number of drug law offences as main offence by type of drugs (ST11_2011_BE_01). This means for example that one person possessing and dealing drugs (both at the same time) is only counted for the dealing of the drugs. Nevertheless, all

drug types present in the main offence are included. Each year, the majority of the offences were cannabis related, with the percentage increasing from 63.9% (95% CI: 63.4% – 64.4%) in 2006 to 70.9% (95% CI: 70.4% – 71.4%) in 2009. This trend in cannabis-related offences is (partially) due to the increase in discovered cannabis plantations (see also Chapter 10). The number of XTC related offences declined from 5.4% (95% CI: 5.2% - 5.6%) in 2006 to 1.6% (95%CI: 1.5% - 1.7%) in 2010. The offences related to other drugs fluctuated over the years, ranging from 7.8% to 10.2% for heroin- from 8.9% to 10.1% for cocaine/crack-, from 6.7% to 8.1% for amphetamine- and from 2.5% to 3.5% for other drug related offences.

Table 9.2: Drug-related offences as main offence, by type of drug, Belgium, 2006-2010.

Drug type	Year									
	2006		2007		2008		2009		2010	
	n	%	n	%	n	%	n	%	N	%
Cannabis	22,640	63.9	25,044	65.2	26,348	65.3	27,344	70.9	25,711	70.4
(Meth)amphetamine	2,862	8.1	2,800	7.3	3,275	8.1	2,580	6.7	2,830	7.8
XTC	1,921	5.4	1,796	4.7	1,607	4.0	798	2.1	593	1.6
Heroin	3,301	9.3	3,897	10.2	3,706	9.2	2,997	7.8	3,145	8.6
Cocaine/crack	3,569	10.1	3,683	9.6	4,042	10.0	3,879	10.1	3,234	8.9
Other	1,165	3.3	1,166	3.0	1,392	3.4	963	2.5	991	2.7
Total	35,458	100	38,386	100	40,370	100	38,561	100	36,504	100

Source: Federal police: ST11_2011_BE_01 / ST11_2008_BE_01

2.1.2. Self-reported criminality

The dark number of undetected and unreported crime limits the usefulness of the judicial data. To complement the judicial data and to get a better estimation of the criminal activities among youngsters, the data from the JOP-monitor 1 (2005) and 2 (2008) in Flanders and the JOP-monitor Brussel (2010) in Brussels can be used. The latter one however differs from the first two in methodology (class survey in Brussels versus postal survey in Flanders) and age of the target population. In 2005, 3.1% of the youngsters in Flanders aged 14 to 25 reported to have sold drugs in the past year. In 2008, depending on the age group, this percentage was 2.1% (14-25yrs) and 1.8% (12-30 yrs), which is in line with the finding that criminality is an age-related phenomenon, peaking around the ages of 18 to 21 (Op de Beeck and Cops 2010). Comparing 2005 with 2008, there was a decreasing trend, although not significant.

In 2010, the percentage of Dutch-speaking adolescents in Brussels reporting to have sold drugs was 6.1% (Table 9.3). Although a comparison with the results for Flanders is difficult due to aforementioned differences in methodology and target population, the results indicate

higher drug-related criminality in Brussels. This observation is in line with the finding that the prevalence of drug use is higher in the Brussels Capital region compared to Flanders (see Chapter 2).

Table 9.3: Percentage of youth reporting to have sold drugs the past year, Flanders and Brussels, 2005-2010.

Study	Coverage	Year	Age group	Sample Size	Percentage (%)
JOP-monitor 1	Flanders	2005-2006	14-25 y	2,097	3.1
JOP-monitor 2	Flanders	2008	12-30 y	3,650	1.8
			14-25 y	2,378	2.3
JOP-monitor Brussel	Brussels, Dutch- speaking	2010	12-18 y	2,273	6.1

Sources: JOP-monitor 2 (Op de Beeck and Cops 2010); JOP-monitor Brussel (Cops and Op de Beeck 2011).

2.2. Other drug-related crime

2.2.1. Drug-related crime

In Belgium, there is no specific database on 'other drug-related crime', being defined as psychopharmacological crimes, economic-compulsive crimes or systemic crimes (EMCDDA2007). In 2008, the DRUGCRIM project (Definition and measurement of drug-related crime) was carried out by a research consortium of the University of Ghent and University of Liège (De Ruyver et al. 2008a). The objectives of the project were firstly, to develop a working method allowing regular measurement of the nature and scope of drug-related crime in Belgium and secondly, to describe the then drug-related crime using policy reports. A summary of the latter is given in the previous national report (Lamkaddem and Roelands 2010). The proposed working method requires the introduction of some variables (e.g. 'Was the person under influence when committing the crime?') in the local and/or national police databases. To the author's knowledge, no new data on drug-related crime are available (yet).

2.2.2. Drug driving, police data

Specific road controls for drug use in the driving population are carried out by the Federal Highway Police as well as by local police services. The procedure for these road controls changed since October 1st, 2010. The original psycho-motor test battery and observation of external characteristics are replaced by a visual assessment. The indication of at least three symptoms out of at least 2 categories, is considered to indicate recent drug use and a screening test is performed. The new screenings test consists of a oral fluid test, replacing the urine test used before. If this test is positive or if the person refuses, a blood sample is taken and analysed by a specialized laboratory (Wegwijs in het Belgisch verkeersreglement, 2011). The oral fluid test used is the Securetec® Drugwipe-5(+), which has also been subject to an evaluation (Wille et al. 2010). The test detects the presence of (1) marijuana/hashish (THC), (2) cocaine/crack, (3) opiates, (4) amphetamines/methamphetamines/ecstasy. The main advantages of oral fluid are the simplicity and noninvasiveness of sample collection, which can be easily observed, making adulteration more difficult. Infection risk is lower than for blood, and oral fluid may better reflect recent drug use. Drug detection in oral fluid is based on drug diffusion from blood and/or contamination of the oral cavity with substance reflecting an actual drug influence, while urine provides a wider window for drug detection and is not correlated with blood levels (Toennes et al. 2005; Bosker and Huestis 2009).

Table 9.4 and Table 9.5 show the results from the controls done by the Federal Highway Police, in the framework of the Road Safety Action Plan (Ricour, personal communication, 2011). The timing of these controls is based on a schedule of 'control hours': about 51% of the controls should take place during the weekend, and about 50% of the controls should take place during the night and early morning.

Table 9.4 shows the results of the urine screenings test for drug use in traffic done by the Federal Highway Police. In 2009 fewer screenings tests were done, compared to the years before. Probably, police services temporarily saved their actions for the pending change in screening method (that was approved later than expected, in 2010). During this more selective screening period in 2009, the percentage of positive screenings tests was higher. Results for 2010 are divided over 2 tables, because of the change in screening method between in October 2010. In the first 9 months of 2010, the number of urine screenings was again rather limited compared to the number of screenings in 2006-2008; but the percentage of positive tests was comparable to 2008. In the last three months of 2010, since the introduction of the oral fluid screenings test and the launch of the campaign 'Gene zever – Crache test' (see also Chapter 7), 316 drug screenings tests were done. The percentage of positive oral fluid screenings (23.7%) was however low in comparison to the percentage of

positive urine screenings before. This might be (partially) due the screening procedure: the limited correlation between the signs and symptoms of drug use and actual drug use (Blencowe et al. 2010), and the limited sensitivity of the oral fluid screening for the presence of cannabis (Wille et al. 2010). However, it is also possible that screenings were done less selectively in the framework of the campaign 'Gene zever – Crache test'. Continued monitoring might allow more substantiated conclusions. Information on the drug screenings tests done by local police services is collected by the department of the General National Database, more specially the CGOP/B, but is at this moment not complete enough to be reported here.

Table 9.4: Drug controls by the Federal Highway Police, urine screening, Belgium, 2006-2010.

	Year				
	2006	2007	2008	2009	2010*
Number of controls	599	683	814	344	258
Screenings tests					
N	250	326	328	118	108
% positive	68.4	61.3	64.9	86.4	68.5
refusals	2	15	2	2	1
Blood tests	171	200	213	102	74

*Jan – Sept 2010; **The number of controls refers to the number of times a person is subject to the control procedure 'drugs in traffic'

Source: Ricour, personal communication, 2011.

Table 9.5: Drug controls by the Federal Highway Police, oral fluid screening, Belgium, 2010.

	2010*
Number of controls	N/A**
Screenings tests	
N	316
% positive	23.7
refusals	1
Blood tests	75

*Oct. - Dec 2010; **The number of controls is not registered anymore since the introduction of the oral fluid screenings Oct. 1st 2010.;

Source: Ricour, personal communication, 2011.

Table 9.6: Substances detected in blood sample test after positive urine screening, 2010, NICC.

Substances detected in blood	N	%
Amphetamines	104	9.9
Amphetamines + cannabis	45	4.3
Amphetamines + cannabis + cocaine	6	0.6
Amphetamines + cocaine	8	0.8
Amphetamines + opiates	1	0.1
Cannabis	573	54.5
Cannabis + cocaine	46	4.4
Cannabis + cocaine + opiates	1	0.1
Cannabis + opiates	1	0.1
Cocaine	62	5.9
Cocaine + opiates	5	0.5
Opiates	17	1.6
Below legal cut-off value	182	17.3
Total blood tests	1,051	100

Amphetamines: Amphetamine, MDMA, MDEA, MBDB

Source: NICC, personal communication, 2011.

Since the results of the oral fluid tests are only marked as positive for any substance or negative; information on the specific substances found in driving-under-influence-cases are only available when blood samples were taken. The National Institute for Criminology and Criminalistics (NICC) analyses the majority of these samples. The results of the blood samples are given separately for the period January-September 2010 (when screening was conducted on urine) and the period October-December 2010 (when on-site oral fluid tests were used) in Table 9.6 and Table 9.7.

The false positive rate was smaller for the oral fluid on site test (10.4%) compared to urine screening (17.3%) , as expected by the fact that oral fluid is superior to urine in correlating with serum analytical data (Toennes et al. 2005).

Caution should be made when comparing both data sets, due to the fact of different screening methods for which no common reference blood samples were obtained.

Table 9.7: Substances detected in blood sample test after positive oral fluid screening, 2010, NICC.

Substances detected in blood	N*	%
Amphetamine	49	10.6
Amphetamine + cannabis	20	4.3
Amphetamine + cannabis + cocaine	5	1.1
Amphetamine + cannabis + cocaine + opiates	0	0.0
Amphetamine + cannabis + opiates	0	0.0
Amphetamine + cocaine	8	1.7
Amphetamine + cocaine + opiates	0	0.0
Amphetamine + opiates	1	0.2
Cannabis	223	48.2
Cannabis + cocaine	27	5.8
Cannabis + cocaine + opiates	0	0.0
Cannabis + opiates	1	0.2
Cocaine	63	13.6
Cocaine + opiates	8	1.7
Opiates	10	2.2
Below legal cut-off value	48	10.4
Total blood tests	463	100

* October-December 2010.

Amphetamines: Amphetamine, MDMA, MDEA, MBDB

Source: NICC, personal communication, 2011.

2.2.3. Drug driving, other research

Several Belgian research groups participate in European studies about drug use in drivers. In the 'TEN D by night' study, the driving performance after use of psychoactive substances is investigated in several countries, among which also Belgium (Siliquini et al. 2010) For a description of this study, see Chapter 7 (section 4.3) and the methodology table in the Annexes. In this study, 5% of the participants from Belgium/The Netherlands (N=851), recruited at night life setting declared to have driven under the influence of drugs in the last month.

Furthermore, the Belgian research branch of the Driving under the influence of Drugs, Alcohol and Medicines (DRUID) project was conducted in 2010 by the Toxicology Laboratory of the University of Ghent. A proficiency testing scheme was set up for the DRUID research project, both for blood and oral fluid analyses. Pil et al. (2010) describes the results of the four rounds of proficiency testing in which oral fluid was analysed by eleven laboratories. These rounds were organised between March 2008 and September 2009. The first part of the prevalence study was a road-side survey. After police control actions, volunteers were

asked to participate in an interview and to provide a blood and oral fluid sample (N=2,949). The biological test results showed that 0.5% of the drivers had used cannabis (alone or in combination). Cocaine was detected in 0.4% of the samples, illicit opiates in 0.2%. Cannabis use was detected more often in drivers aged 18-24y than in the older age categories (Van der Linden et al. 2011b). The part of the DRUID study focussing on injured drivers, is discussed in chapter 6.

3. Prevention of drug-related crime

3.1. Drug-related crime

Within the DRUGCRIM project (see also this chapter, Section 2.2) recommendations were formulated to prevent drug-related criminality, among which the optimisation of referral to treatment and the implementation of case management for drug offenders (De Ruyver et al. 2008a). Projects offering treatment to drug offenders as an alternative to custody are described in Section 4.1.

3.2. Drug driving

Please refer to chapter 7.

4. Interventions in the criminal justice system system

4.1. Alternatives to prison

Within the Federal Drug Note 2001, it was already stated that alternatives to custody should be stimulated for drug users. Nowadays, several projects referring drug users from judicial services to treatment facilities exist in Belgium, among which the projects 'Proefzorg' and 'Drugbehandelingskamer' (DBK). These projects were evaluated and are described below.

In 2005, the pilot project 'Proefzorg' was introduced in Ghent (De Sleutel 2006). This 'referral-to-treatment' project is implemented at prosecutor's level and includes two possible trajectories: a short one (only one appointment at a treatment centre) and a longer one (three consultations in a treatment centre, and a follow-up of six months maximum). Whether a person is referred to the short or longer trajectory, depends on the severity of the problems and the living situation of the person. After the successful completion of the treatment

programme, the judicial case will be closed without consequences. If treatment was not successful, the person will be sued by the correctional court (Serlippens and Dangreau 2008). In the research projects 'Do's and don'ts in a comprehensive and integrated drug policy' ('DODONBEL') and 'Essential and supplementary preconditions in the interaction of justice and drug treatment services' ('JUSTHULP') the 'Proefzorg' project was defined as an example of good practice and it served as an example to develop similar projects in other judicial areas (De Ruyver et al. 2008b; De Ruyver et al. 2009).

In 2008, the pilot project 'Drugbehandelingskamer' (DBK) was launched in Ghent as well. This project can be considered as an extension of the 'Proefzorg' project and is situated at sentencing level. The prosecutor magistrate decides whether a person is referred to Proefzorg or DBK, depending on the committed crime and any previously failed Proefzorg trajectory. After a referral to the DBK by the prosecutor magistrate, the judge can still decide not to start the project for the referred person (because of absence of the accused at the hearing, refusal of the accused, decision that the case is not suited for the DBK,...). If the treatment programme is started, the drug user is closely followed at court level through monthly hearings (De Ruyver et al. 2008b; De Keulenaer and Thomaes 2010; De Ruyver et al. 2010).

Based on a quantitative evaluation of 280 cases referred to DBK between May 2008 and December 2009, De Keulenaer & Thomaes (2010) evaluated the project positively. Of the 280 cases, 148 (52.9%) started treatment. At the time of the project evaluation, 91 persons finished treatment and 57 persons were still in treatment. Of the 91 cases that finished treatment, compliance with the conditions was unknown for 14 cases. For the remaining 77 cases, 41 (53.2%) were closed positively. The commitment to the treatment programme resulted in less severe sentences at court.

Based on a qualitative evaluation, De Ruyver et al (2010) showed that the involved actors are generally positive about the project. Nevertheless, the authors conclude that there is still room for improvement, like the guarantee of a follow-up, and a clear description of the competencies of all actors.

4.2. Other interventions in the criminal justice system

A general overview of the number of cases entering the prosecution system of first line courts is given in Table 9.8 based on the data from the College of the Procurator General (College van procureurs-generaal: Statistisch analisten 2011). In the last 5 years, 4.6% to 5.7% of the cases entering this prosecution system were related to drugs or doping. The closing decisions for the drug/doping-related cases are shown in Table 9.9. Most of the cases leave the prosecution without consequence (varying between 54.6% and 57.8% in the

years 2006 – 2010). The second most used closing is to 'hand over the case' (varying between 14.2% and 18.3% from 2006 until 2010), joinder (varying from 12.0% to 12.9%) comes at the third place. The current data do not allow making a more detailed subdivision of the drug-related cases (e.g. 'possession of cannabis', 'dealing of narcotics', etc.), as not all prosecutor's offices are using these subdivisions systematically (Van Dael, personal communication).

Table 9.8: Drug/doping related cases entering the prosecution system of first line court, Belgium, 2006-2010.

	Year				
	2006	2007	2008	2009	2010
Total (N)	741,436	703,341	712,329	724,422	729,354
Drug/doping related (n)	33,874	39,058	40,843	40,695	37,835
% drug/doping-related	4.6	5.6	5.7	5.6	5.2

* both new and reopened cases

Source: College of the Procurator General (College van procureurs-generaal: Statistisch analisten 2011).

Table 9.9: Closing decision for drug/doping related cases at prosecution system of first line court, Belgium, 2006-2010.

	Year									
	2006		2007		2008		2009		2010	
	N	%	n	%	N	%	n	%	N	%
Without										
consequence	19,674	57.7	22,136	57.8	21,539	54.6	22,679	56.9	21,392	57.3
Handed over	5,058	14.8	5,983	15.6	7,217	18.3	5,877	14.7	5,303	14.2
Joinder	4,412	12.9	4,869	12.7	5,097	12.9	4,950	12.4	4,478	12.0
Out-of-court										
settlement	763	2.2	891	2.3	932	2.4	1,356	3.4	1,115	3.0
Mediation completed	97	0.3	116	0.3	114	0.3	113	0.3	123	0.3
Immediate summons	1,767	5.2	1,930	5.0	2,102	5.3	2,322	5.8	2,289	6.1
Pre-trial chamber	2,346	6.9	2,358	6.2	2,427	6.2	2,591	6.5	2,634	7.1
Total	34,117	100	38,283	100	39,428	100	39,888	100	37,334	100

Source : College of the Procurator General (College van procureurs-generaal: Statistisch analisten 2011)

Since 2008, data at the level of the Court of Appeal are provided in the 'Annual Statistics of the courts' by the Permanent Office for Statistics and Work load Measurement. It should be

mentioned that the data can be subject to small changes after the yearly publication (f.e. the classification of the cases can be reconsidered). However, based on the reports, data show that each year about 3.3% of the new correctional cases entering the Court of Appeal are related to drug crime (Federale Overheidsdienst Justitie.Vast Bureau Statistiek en Werklastmeting 2009;2010;2011).

The Service for Criminal Policy collects the information about the final judgements in all courts in Belgium. The data are only available until 2004. Table 9.10 shows the number of drug/medication-related sentences and suspensions in relation to the total numbers of registered sentences and suspensions. From 2000 until 2004, 2.2% to 2.4% of the sentences were related to drugs/medication. When looking at the suspensions in 2000 - 2004, 9.1% to 12.9% were related to drug/medication.

Table 9.10: Drug/medication-related sentences and suspensions , Belgium, 2000 – 2004.

	Year				
	2000	2001	2002	2003	2004
Sentences					
All (N)	171,576	181,695	181,799	190,932	166,417
Drug/medication-related (n)	3,998	3,918	4,087	4,330	3,928
% drug/medication-related	2.3	2.2	2.3	2.3	2.4
Suspension					
All (N)	8,527	10,274	10,725	8,148	5,722
Drug/medication-related (n)	1,103	1,081	974	787	635
% drug/medication-related	12.9	10.5	9.1	9.7	11.1

Source: Service for Criminal Policy (Dienst voor het Strafrechterlijk beleid 2011)

5. Drug use and problem drug use in prisons

5.1. Sources of drug monitoring in Belgian prisons

Drug testing does not serve as data source to monitor drug use in prisons. First of all, Belgian legislation, with an exception in traffic legislation and doping legislation (cf. 9.2.2, Drug driving), does not allow for mandatory drug testing. Consequently, mandatory drug tests imposed by prison authorities are inexistent in the Belgian prison system. Secondly, drug testing is only possible on medical grounds with the consent of the patient (Law concerning the rights of the patient, 2002) but this voluntary drug testing is not organised or gathered systematically nor is it representative for the prison population.

To enable a systematical and representative data collection on drug use in prison a survey “Drug use in Belgian prisons: Monitoring of health risks” is organised in all Belgian prisons. Next to that a recent PhD-study by Vandam (Ghent University, 2010) focused specifically on the relation between detention and drug use among a small sample of prisoners (n=91). Both studies are described below.

5.2. Survey “Drug use in Belgian prisons: Monitoring of health risks”

The instrument used in the research “Drug use in Belgian prisons: Monitoring of health risks” is based on the self-report questionnaire, for prisoners to examine drug use and related health risks, developed by De Maere, Hariga, Bartholeyns & Vanderveken (De Maere et al. 2000).

Since 2006 this standardised self-report questionnaire is used on a 2-yearly basis in all Belgian prisons and serves as the information source to monitor drug use (illicit drugs, alcohol and misuse of medicines) and risk behaviours in the prison population (Todts et al. 2007; Todts et al. 2009). It is used as a tool for policy making. It is the Prison Health Care Service of the Directorate-general of Penitentiary Institutions of the Federal Department of Justice that is responsible for this information gathering and manages the organisation of the survey (cf. chapter 11, Selected Issues, for organisation of health and drug policy in prison). Data on drug use in Belgian prisons presented in this annual report stems from the third and latest edition of the monitoring organised in 2010 (Van Malderen et al. 2011). For this edition, the questionnaire was improved in order to gain more in-depth information in the patterns of use during detention by including additional questions. A representative sample of 1,251 prisoners was obtained (i.e. 10% of the prison population). For more information, about the methodology, please refer to the methodology table in the annexes.

With this third edition of 2010 comparisons are made and conclusions are formulated over the period 2006-2010 (Van Malderen et al. 2011). The main results on the epidemiological side and risk behaviour are presented here. Results on health responses are discussed in chapter 11.

5.2.1. Prevalences and patterns of use

Life time prevalence of illicit drug use, defined as both drug use prior and during imprisonment, is reported for 60% to 66% of the prisoners. As in the general population (EMCDDA 2010a) cannabis remains the illicit drugs most frequently reported in prison population with a life time prevalence rate varying from 52.3% to 58.3% over the period 2006-2010. Rates from 39% to 43% for cocaine demonstrate that it is repeatedly the most

frequently reported product after cannabis over the same period (see also ST12_2011_BE_01).

Life-time prevalence of alcohol use during the current imprisonment shows a stable rate varying from 21% up to 22% over the period 2006-2010. Last month prevalence of alcohol use during the current imprisonment defined as 'one to multiple times and daily use' varies from 7% up to 9%. Daily use varies from 0.4% up to 1% in prison population.

Life time prevalence of illicit drug use during the current imprisonment varies from 30% up to 34% over the period 2006-2010. In 2010, mainly sentenced prisoners report drug use while in prison (see Table 9.11).


Table 9.11: Sentences and suspensions of drug-related cases, Belgium, 2000 – 2004.

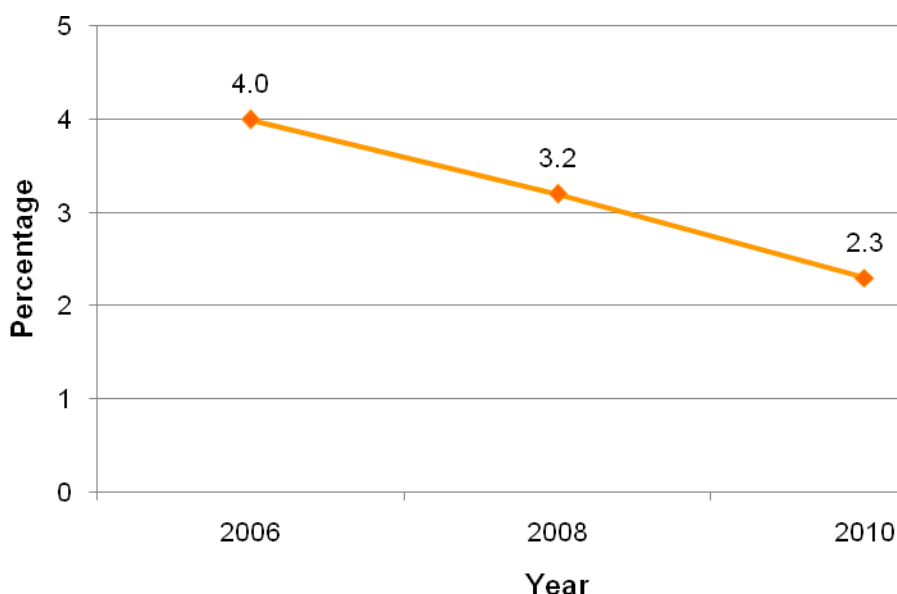
			Legal status				Total
			Remand	Sentenced	Mentally-ill	Others	
Drug use imprisonment	No	N	120	143	50	20	333
	% within Legal status		68,2%	33,0%	47,2%	64,5%	44,6%
	Yes	N	56	290	56	11	413
	% within Legal status		31,8%	67,0%	52,8%	35,5%	55,4%
Total	N		176	433	106	31	746
	% within Legal status		100,0%	100,0%	100,0%	100,0%	100,0%

Source: Van Malderen et al (in press) Drug use in Belgian prisons: Monitoring of health risks 2010. Brussels: Federal Department of Justice.

In 2006 and in 2010 drug injecting during the last month before imprisonment is reported by respectively 8% and 7% in prison population. This last month prevalence is defined as drug injecting going from '(almost) daily use to once or several times' during the last month before the current imprisonment. Daily use varies from 4% to 5% and 3% to 4% in prison population declaring to have injected any drug once or several times during the last month.

Life time prevalence of injecting drug use in prison population (both drug use prior and during imprisonment) varies from 15% to 18% over the period 2006-2010. However, injecting drug use in prison decreases over the period (see Figure 9.1). In 2010, 2% declares to inject any drug in prison, while in 2008 this figure is 3% and 4% in 2006. In comparison with last month prevalence before imprisonment, it seems that drug injecting tends to be lower while in prison.

Figure 9.1: Injecting drug use within prison 2006-2010. 



Source: Van Malderen et al (in press) Drug use in Belgian prisons: Monitoring of health risks 2010. Brussels: Federal Department of Justice.

Cannabis is the most frequently reported drug used in prison with a rate between 27% and 32%. Heroin as most frequently used illicit drug in prison after cannabis is a recurrent observation over the years with a rate from 12% up to 13%. A similar rate is observed for the use of benzodiazepines without prescription and is classified as the third product most frequently used in prison over the years 2006-2010.

Since heroin use seems widespread in prison, respondents were asked, for the first time in the latest survey of 2010, about their mode of administration of heroin during detention. Most drug users in prison declare to inhale the heroin vapour (14%) in contrast to 2% of the prison population stating to inject it. In the case of initiation in the use of new substances during imprisonment, heroin is firstly reported in prison population (6%).

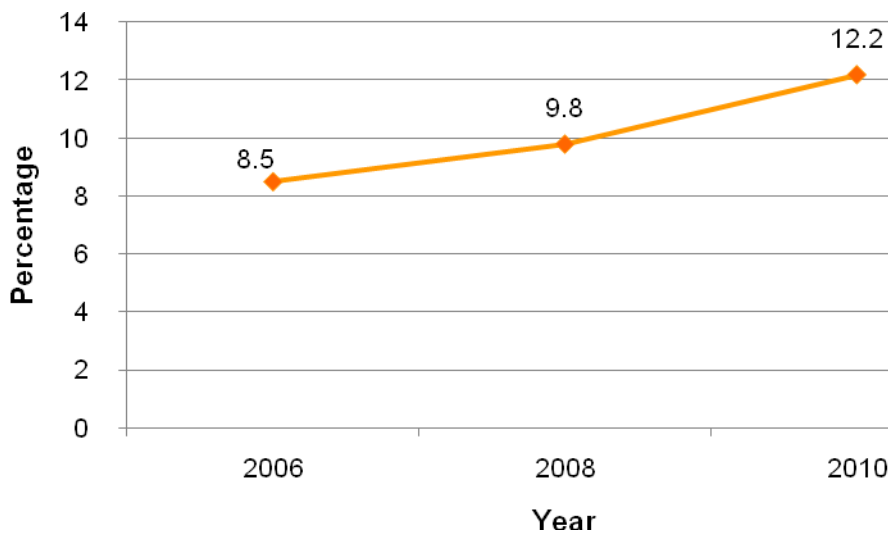
To gain more insight into the profile of the drug users, prisoners declaring to use drugs during their detention were, also for the first time in 2010, questioned about their frequency of use in prison. It seems that an important part can be categorised as regular users. 11.8% of the prison population declares to use drugs from multiple times a month to weekly and daily use. When the definition of regular use is defined in a more broadly sense, even more than 20% can be defined as frequent users: from once a month to multiple times a month, weekly and daily use.

5.2.3. Risk behaviours

Risk behaviour in prison such as tattooing and body piercing, unprotected sexual activities, intravenous drug use and the use and sharing of needles and other paraphernalia is examined in order to monitor the risk of transmission of blood borne infections such as HIV, hepatitis B and C.


In prison such risk behaviour is clearly present. With a rate from 9% in 2006, 10% in 2008 up to 12% in 2010 for tattooing and an increase from 1% to 4% in 2010 for body piercing these practices are still increasing (Figure 9.2, Figure 9.3).

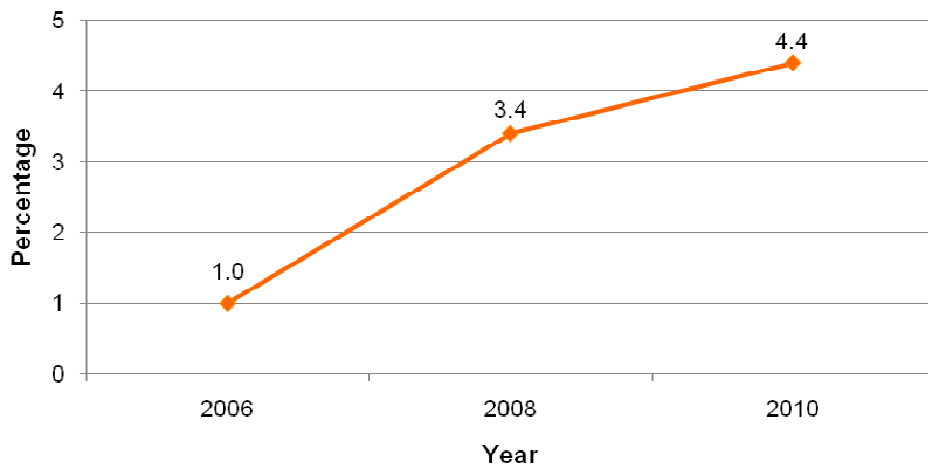
Figure 9.2: Tattooing within prison 2006-2010 



Source: Van Malderen et al (in press) Drug use in Belgian prisons: Monitoring of health risks 2010. Brussels: Federal Department of Justice.

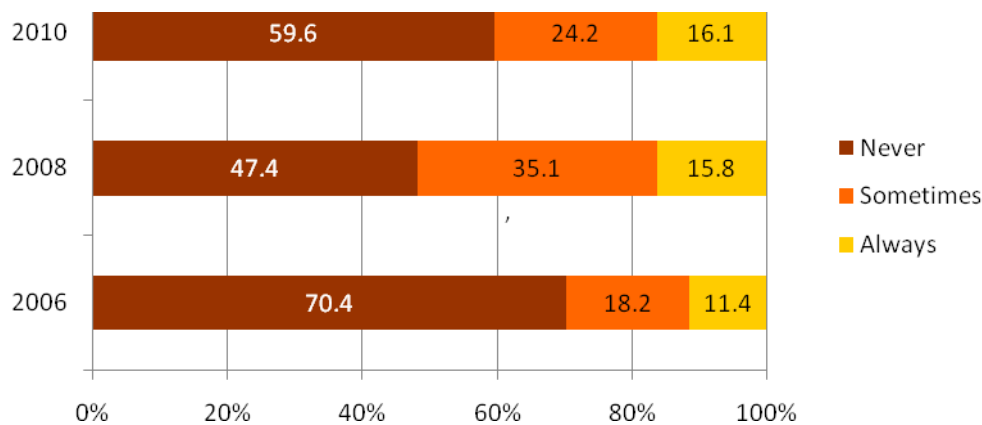
A rate varying from 70% in 2006, 47% in 2008 and 60% in 2010 of prisoners who are sexually active in prison (conjugal visits excluded) but never use a condom demonstrates a clear risk (Figure 9.4). At the same time, it has to be mentioned that free condoms are not yet made available in a low threshold and anonymous manner. In the latest Action Plan 2011 on Drug policy in Belgian Prisons the implementation of a condom distribution method in Belgian prisons is included (cf. chapter 11).

Figure 9.3: Body piercing within prison 2006-2010 



Source: Van Malderen et al (in press) Drug use in Belgian prisons: Monitoring of health risks 2010. Brussels: Federal Department of Justice

Figure 9.4: Sexual activities in prison without condom 2006-2010.



Source: Van Malderen et al (in press) Drug use in Belgian prisons: Monitoring of health risks 2010. Brussels: Federal Department of Justice.

In 2010 it is for the first time examined whether not using a condom is related to tattooing and getting body pierced in prison. Analysis shows no relation between these different types of risk behaviours and assumes that these behaviours need to be addressed differently and with attention for different target groups.

Sharing needles and other paraphernalia occurs in prison with rates ranging between 17% and 35% in injecting drug users within prison. Cleaning of this paraphernalia in prison is

reported by 32% up to 76% of these drug users who inject during detention. Over the same period of 2006-2010, boiling water is mostly used.

Sharing of a toothbrush and a razor is also examined over the period 2006-2010 and is reported by 4% up to 5% of the prison population.

5.2.4. Information related to the illegal drug market in prison

With the survey, the demand side of the drug phenomenon is monitored. No information is collected on the supply side. However, some self-report data is gathered on issues relating to the drug market in prison.

Prisoners are asked whether they experienced problems during their current detention as a consequence of drug use of others or as a result of the illegal drug market in prison.

Where an increase was observed in 2008 with 29% of the prison population affirming having such problems against 22% of the prison population in 2006, a figure of 22% for 2010 shows it has stabilized. Problems mostly reported are theft (16%-26%), being forced to use drugs (22%-33%) and physical threat (18%-25%). Table 9.12 illustrates the nature of the different problems reported.

The nature and frequency of the problems experienced are comparable over the period 2006-2010, with the exception of the 'other problems' reported. These 'other problems', for the first time specified in the data-analysis of 2008, could be categorised as drug nuisance: from smell nuisance (smell of smoking cannabis) to vandalism, respondents report *'fights'*, *'disturbing behaviour'*, *'being loud'*, *'communal problems'*, *'fear for relapse'*, *'asking to deal drugs'*, *'asking to use drugs'*, and a *'negative atmosphere'*. In 2010 these 'other problems' are rarely reported (2.9%). An explanation can be found in the additional answering categories, included for the first time in 2010: 'physically attacked', 'sexually threatened', and 'sexually attacked'. However, these categories do not completely correspond with the nature of the 'other problems' reported in 2008 but it is possible that some of these problems reported are related to one of the additional categories.

Table 9.12: Problems experienced as a result of drug use and drug market in prison 2006-2010.

Nature of the problem	2006 (n=194) %*	2008 (n=315) %*	2010 (n=278) %*
Physically threatened	24.2%	18.1%	24,8%
Physically attacked	<i>not included</i>	<i>not included</i>	11,5%
Robbed	22.2%	16.2%	25,5%
Pressured to give up money or goods	16.0%	11.1%	16,5%
Pressured to give up drugs			9,7%
Pressured to use drugs (but refused)	13.4%	20.3%	12,9%
Pressured to use drugs (and gave in)	8.3%	12.4%	11,2%
Forced to give up my medication	10.8%	4.8%	15,5%
Sexually threatened	<i>not included</i>	<i>Not included</i>	2,5%
Sexually attacked	<i>not included</i>	<i>Not included</i>	2,5%
Other problems	35.6%	52.1%	2.9%

*Total exceeds 100%: multiple answering categories included in the questionnaire

Source: Van Malderen et al (in press) Drug use in Belgian prisons: Monitoring of health risks 2010. Brussels: Federal Department of Justice.

In 2010 it is for the first time examined by what means prisoners obtain their drugs in prison. The Table 9.13 shows that drugs are often obtained through the trade with goods, (25%), cigarettes for example, but the category 'others' is mostly reported (40%) by prisoners declaring to use drugs while in prison.

Table 9.13: Means to obtain drugs in prison 2010

Means to obtain drugs	Frequency (N)*	Valid percentage (%)
By sexual services	5	0.7%
By goods	173	24.8%
By cleaning prison cell of drug dealer	3	0.4%
By cooperating at the drug distribution	42	6.0%
Other	280	40.1%

*Total N= 698

Source: Van Malderen et al (in press) Drug use in Belgian prisons: Monitoring of health risks 2010. Brussels: Federal Department of Justice.

Payment with money, cash or by bank transfer is especially reported here, and buying goods of the canteen list in prison for the one who is selling drugs. Only once 'paying of custodial staff by friends outside' is reported.

5.3. Other research

The PhD-study by Vandam (Ghent University, 2010) focused specifically on the relation between detention and drug use among a small sample of prisoners (n=91) who were about to be released (i.e. last three months before release). 60% of this sample used illegal substances during the last three months of their detention. Cannabis (56%) is the most frequently used substance, followed by heroin (18%), amphetamines (16%), cocaine (3%) and XTC (3%) (Vandam et al. 2010). Also, prescribed psychoactive medication (56%) is frequently used during detention, and 24% stated to have used psychoactive medication without prescription. Only 15% of these prison releases used alcohol during the last 3 months of detention, and none of them did so on a daily basis. The majority of prisoners who used illegal substances before they were imprisoned (79%) also did so during the last three months of their detention, although the frequency was considerably lower and only 26% used daily.

6. Responses to drug-related health issues in prisons

Please refer to the Selected Issue.

7. Reintegration of drug users after release from prison

Since the beginning of 2011 every prison situated in the Dutch speaking part of Belgium has a “Central Intake Unit for drug using prisoners”, called “CAP”. The implementation of such units in prisons situated in the French speaking part of Belgium is foreseen for the beginning of 2012.

The objective of this Central Intake Unit is to facilitate a referral to treatment services in the community intended for prisoners within their prospect of release. One team of external drug workers is running this “CAP”. The prisons situated in the Dutch speaking part of Belgium are pragmatically divided into several (geographical) clusters in order to link each drug worker to one prison cluster. The external drug worker comes into prison to see prisoners with a demand for treatment. On the basis of an assessment of the prisoner’s need, information and advice is given concerning the existing treatment possibilities extra muros, and a referral to health care and treatment services outside is realised.

Since prison health care and drug policy is a competence of the Minister of Justice (cf. Selected Issues), this Central Intake Unit is financed by the Federal Department of Justice. Nonetheless, the drug workers of the “CAP” are working from a health care perspective and do not formulate advice concerning risk taxation or recidivism.

The advantage of such a team is that an efficient referral can be prepared by one specialised person and through-care can be realised for prisoners upon release. Moreover, this team consists of a fixed team of external drug workers who have contact with and insight into the different drug treatment providers in the region.

A decorative horizontal bar in a vibrant orange color. It features a jagged, stepped right edge. Above the bar, a yellow hexagon and a dark red hexagon are partially visible. Below the bar, a yellow hexagon and a light orange hexagon are also partially visible.

Chapter 10.

Drug markets

Deprez, N. and Van der Linden, T

1. Introduction

Information to estimate the drug market in Belgium comes from several different sources: questionnaires among youth or users, police reports, lab results etc.

First of all, information about the perceived drug availability in secondary school pupils is reported by the *Leerlingenbevraging* from the *Vereniging voor Alcohol- en andere Drugproblemen* (VAD-LLB), the pupils questionnaire from *De Sleutel*, the Flemish part of the Health Behaviour in School-aged Children research (HBSC), and the Flemish part of the European School Survey Project on Alcohol and Other Drugs (VLASPAD). The second wave of the Jeugdonderzoekplatform (JOP-monitor 2) reports on the percentage of youngsters in Flanders that have been offered drugs during the past year.

Information on the drug seizures and illicit laboratories are provided by the General Directorate of Judicial Police, Direction of crime against persons (DGJ-DJP), drug programme, based on the General National Database (GND). This GND gathers all police reports from Belgium (federal and local police services). Information on drug origin and trafficking is reported by the federal police as well.

The reported information on precursors comes from the Precursor Unit from the Federal Agency for Medicines and Health product (FAMPH) of Belgium.

For the estimation on drug prices, data from 2 sources are discussed in this chapter: Observatoire socio-epidemiologique alcool-drogues (Eurotox asbl, the Regional Focal Point in Walloon Region) and data from the DGJ-DJP.

For the parts on purity and composition of illicit drugs in Belgium in 2010 the Database of the Belgian Early Warning System on Drugs (BEWSD) was used.

The database of the BEWSD includes all notifications of new and high-risk psychoactive substances identified in Belgium. The reporting of the analysis results to the BEWSD is regulated by 2 Royal Decrees (Federale Overheidsdienst Volksgezondheid 2003; Federale Overheidsdienst Volksgezondheid 2006). These Royal Decrees make the reporting of analytical results to the BEWSD mandatory for the toxicological laboratories in Belgium, except for cannabis. The reporting of analytical results by clinical laboratories is only mandatory for new substances (see also chapter 7). Based on the information that is included in the BEWSD, it is not possible anymore to make a distinction between large seizures at customs level, or small seizures at users' level. The data are therefore not separated.

Through the Belgian Early Warning System on Drugs 10 labs reported on toxicological data,. For the toxicological analyses, data on 3857 records resembling 1847 drug samples were

gathered. 1822 samples were seized, 23 were collected samples and for 2 the origin was unknown. For approximately 75% purity levels were reported. For the calculation of purities/potencies and composition of illicit drugs only seized samples were taken into account.

Throughout the chapter, several other relevant studies done by Belgian researchers are included as well.

2. Availability and supply

2.1. Perceived availability of drugs, access to drugs

Through the VAD-LLB, HBSC Flanders, VLASPAD and pupils questionnaire of De Sleutel, information is collected regarding the perceived availability of illicit drugs ('would you be able to get drugs') among youngsters. When comparing the results, it should be taken into account that the exact formulation of the questions and the response categories are not the same for the different questionnaires. Next to the percentage of pupils reporting to be able to get drugs, we provide for each study the percentage of pupils answering 'I don't know', as we consider them here as valid answers (and not as missing values). For a further overview on the comparison of the HBSC Flanders, VLASPAD and VAD-LLB, please refer to Lambrecht et al. (2011).

To conclude this section we will look at the JOP-monitor 2, that collects information about the percentage of youngsters being offered drugs.

The **VAD-LLB** collects information on perceived availability for cannabis and other drugs (not specified) as reported by secondary school pupils, for the school years 2007/08 – 2009/10 (Kinable2009;2010b;2011). In 2009/10, 39.4% of the pupils thought they would get cannabis whereas this percentage was 27.2% for other illicit drugs. For the respective questions, 18.2% and 23.9% said they did not know. Boys reported significantly higher availability of cannabis (boys: 45.3%; girls: 33.4%) and of other illicit drugs (boys: 32.3%; girls: 22.0%) than girls. The older the pupils, the higher the reported availability (cannabis: 12-14y: 17.7%; 15-16y: 47.2%; 17-18y: 64.4%; other drugs: 12-14y: 12.7%; 15-16y: 31.5%; 17-18y: 44.2%) (Kinable 2011). The results are stable over the years (Kinable2009;2010b;2011).

The 2010 wave of the Flemish **HBSC**, showed a perceived availability of 27.6% for cannabis and 18.8% for other drugs (not specified). The difference with the VAD-LLB is probably due to a difference in question formulation ('would you be able to get cannabis' (VAD) versus

'would you be able to get cannabis *easily*' (HBSC)). The fact that more pupils from the HBSC replied they did not know whether they could get cannabis (30.0%) or other drugs (35.5%), compared to the VAD-LLB, is most likely also related to the question formulation.

The trends for gender and age in the HBSC were comparable to those reported in the VAD-LLB: a higher perceived availability among boys than girls (boys cannabis: 34.1%, boys other drugs: 22.5%, girls cannabis: 21.2%, girls other drugs: 15.2%); and in older pupils compared to younger ones (cannabis 13-14y: 9.9%, 15-16y: 28.7%, 17-18y: 44.5%; other drugs: 13-14y: 8.5%, 15-16y: 20.7%, 17-18y: 27.3%). In the 2006 wave of the HBSC in Flanders, the response categories were different from those in 2010. In 2006, 27.0% of the pupils said they would get cannabis 'without any problem'. For XTC and cocaine, this was 14.7% and 11.0% respectively (Hublet, personal communication).

The pupils survey of **De Sleutel** asks how *difficult* it would be to obtain drugs if one wanted to, and specifies the question for perceived availability for more different types of drugs. We limit the description here to a selection of those drugs. In the 2009 wave, 29.2% of the pupils of fulltime secondary education said it would be 'rather easy' or 'very easy' to get cannabis. For XTC, amphetamine, cocaine and heroin, these percentages were respectively 14.2% and 14.7%, 15.0%, and 10.3%. For cannabis, 19.7% did not know whether it was possible to get it, for XTC, amphetamine, cocaine and heroin, this was 26.7%, 27.8%, 26.8% and 28.6% respectively.

Again, it were the older pupils who reported a higher perceived availability: for cannabis (1st/2nd year: 6.1%, 3rd/4th year: 23.1%, 5th/6th year: 52.8%), amphetamine (1st/2nd year: 4.0%, 3rd/4th year: 13.2%, 5th/6th year: 24.2%), XTC (1st/2nd year: 3.7%, 3rd/4th year: 12.1%, 5th/6th year: 24.1%), cocaine (1st/2nd year: 4.5%, 3rd/4th year: 13.3%, 5th/6th year: 24.6%) and heroin (1st/2nd year: 3.6%, 3rd/4th year: 10.5%, 5th/6th year: 15.2%). Comparison with the previous wave (2005) is only possible for the 3rd to 6th year of secondary education. Overall, between 2005 and 2009, the perceived availability of (illicit) drugs decreased among the pupils in 3rd/4th year, while it remained stable for the 5th/6th year students (Lombaert, personal communication).

In the **VLASPAD** survey, the focus of the question was also on how *difficult* it would be to get several drugs. For cannabis, 31.1% of the pupils said it would be very or rather easy to get it. For other illicit drugs, this was: 13.1% for XTC, 16.9% for amphetamine and 14.5% for cocaine. For cannabis, 14.0% did not know how difficult it would be, for XTC, amphetamine, and cocaine, this was 17.3%, 16.6% and 16.2% respectively.

In general, the above mentioned gender and age trends were also confirmed in the VLASPAD (although the gender difference was not significant for cocaine). The 2010 wave

of the VLASPAD also included a question about the perceived availability of ADHD medication (without medical prescription): 17.8% of the pupils reported it would be (very or rather) easy to obtain it (19.6% of the boys and 15.9% of the girls); 17.1% said they did not know. Also for this substance, age plays a role in the perceived availability. It ranges from 5.2% in the youngest group (≤ 12 year olds) to 31.0% in the oldest group (≥ 18 year olds) (Lambrecht, personal communication).

Within the **JOP-monitor 2** (2008), information was collected on the percentage of Flemish youngsters aged 12-30 being offered drugs during the past year (Op de Beeck and Cops 2010). Results show that in 2008, significant more males (33.5%) were being offered drugs in the past year than females (20.6%) (see also Table 10.1). Furthermore, there is a significant age effect with the percentage of people reporting being offered drugs, being the highest amongst youngsters aged 18-21 years (Op de Beeck and Cops 2010).

Table 10.1: Percentage of youngster being offered drugs in the past year, Flanders, 2008.

	Gender		Age (y)					Total
	M	F	12-13	14-17	18-21	22-25	26-30	
N	1,644	2,064	453	877	770	670	852	3,596
Being offered drugs in the past year (%)	33.5	20.6	2.4	23.9	39.8	33.0	24.0	28.8

Source: JOP-monitor 2 (Op de Beeck and Cops 2010)

2.2. Drugs origin: national production versus imported

2.2.1. Police data

The federal police provided information on the origin and destination of international 'large-quantity seizures' of drugs in Belgium (more than 0.5kg, 100 tablets or 0.5l). The cannabis seizures were mainly originating from The Netherlands and Belgium, whereas the cannabis resin seizures were mostly originating from Morocco. Heroin was mostly imported from Turkey and cocaine from South-America, mainly Colombia. Amphetamine and XTC were mostly produced in Belgium, or imported from The Netherlands (Domnicent, personal communication).

2.2.2. Other research

One of the goals of the GEOCAN research project ('Study of part of locally cultivated cannabis on Belgian market of the drug'), was to develop a method to identify the origin of the cannabis based on genetic fingerprinting and the chemical compounds present in the

cannabis. The researchers were able to identify the geographical origin of 75% of the cannabis samples. As the research was mainly based on Belgian and Dutch cannabis, further research including samples originating from other countries is needed (Charlier et al. 2010b).

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

2.3.1. Police data

Information about the trafficking patterns for drugs in Belgium is also provided by the Belgian federal police. During the past 4 years, more and more cannabis plantations were found in Belgium (see also Table 10.6), of which the production is often meant for export to The Netherlands. This could be a consequence of the more severe prosecution of cannabis-related organised crime in The Netherlands. Furthermore, Belgium is a trafficking country for cannabis resin. Belgium is also a meeting point for heroin traffickers rather than a heroin trafficking country. Seizures of more than 50 kg of heroin are rare in Belgium, but heroin traffickers meet in Belgium to stay out of the attention of the law enforcement in the countries where they are trafficking heroin.

In addition, Belgium is known to be a transit country for cocaine with the Brussels airport and the port of Antwerp being used as a gateway to traffic the cocaine from South-America or Africa to Europe. Finally, each year, some illicit amphetamine and/or XTC laboratories are dismantled in Belgium (see also Table 10.5). There is a strong link between the Dutch and Belgian synthetic drug production with the same persons being often involved in the synthetic drug market in both countries (Dommicent, personal communication).

2.3.2. Other research

A recent overview of the research and police data on cannabis cultivation in Belgium and The Netherlands (Decorte 2010), pointed to the fact that the small-scale home growers constitute an important segment of the Belgian cannabis market. These small-scale home growers are more and more working in a professional way. However, they are not necessarily profit-oriented. Reasons for this increase in small-scale growing of cannabis could be the dissatisfaction with the cannabis products sold in the Dutch coffee shops (Decorte 2010).

3. Seizures

3.1. Quantities and numbers of seizures of all illicit drugs

The numbers of drug seizures based on the GND, are provided in Table 10.2 for the years 2006-2010. For all years, the majority of the drug seizures contained cannabis (herbs, plants or resin). This percentage of cannabis related seizures gradually increased from 67.9% (95%CI: 67.4% - 68.4%) in 2006 to 72.8% (95%CI: 72.4% - 73.2%) in 2009. This increasing trend stabilized in 2010 with 72.3% of the seizures being cannabis related (95%CI: 71.8% - 72.7%). This time trend is in line with the increasing number of cannabis related drug offences (see Chapter 9, Section 2.1).

When looking at the types of the seized cannabis, different time trends were observed. While there has been a more or less steadily decrease in the percentage of cannabis resin seizures from 2006 (16.2%; 95%CI: 15.8% - 16.6%) until 2010 (13.3%; 95%CI: 13.0% - 13.6%), the percentages of herbal cannabis (2006: 51.5%; 95%CI: 51.0% - 52.0%; 2010: 56.4%; 95%CI: 55.9% - 56.9%) increased quiet steadily. The increase for cannabis plants (2006: 0.2%; 95%CI: 0.2% - 0.2%; 2010: 2.6%; 95%CI: 2.4% - 2.8%) is partly due to an increase in data quality of the GND (between 2006 and 2007) (Dommicent, personal communication), but is also related to the increasing number of cannabis plantations being discovered (see also Table 10.6). Another remarkable trend is the declining percentage of XTC-like substances in seizures. From 2006 to 2010, the percentage seizures containing XTC, decreased from 5.9% (95%CI: 5.7% - 6.1%) to 1.7% (95%CI: 1.6% - 1.8%). For heroin, cocaine, amphetamines and LSD, no clear time trends were observed.

During the past 5 years, the quantity of the drug seizures fluctuated strongly for all substances (see Table 10.3), due to the occurrence of exceptionally large seizures.

Table 10.2: Number of drug seizures by substance, Belgium, 2006-2010.

Drug type	Year									
	2006		2007		2008		2009		2010	
	n	%	n	%	n	%	n	%	N	%
Cannabis										
Resin	5,546	16.2	5,870	16.0	4,921	15.3	6,206	15.5	5,048	13.3
Herbal	17,668	51.5	19,196	52.4	16,831	52.3	22,274	55.5	21,485	56.4
Plants*	73	0.2	466	1.3	666	2.1	732	1.8	979	2.6
(All)	(23287)	(67.9)	(25532)	(69.6)	(22418)	(69.7)	(29212)	(72.8)	(27512)	(72.3)
Heroin	2,341	6.8	2,850	7.8	2,307	7.2	3,054	7.6	3,433	9.0
Cocaine	3,708	10.8	3,656	10.0	3,345	10.4	4,021	10.1	3,448	9.1
Amphetamine	2,933	8.6	2,767	7.6	2,646	8.2	2,944	7.3	2,912	7.6
Meth- amphetamine	.	.	.	.	.	.	.	.	64	0.2
XTC-type	2,009	5.9	1,798	4.9	1,412	4.4	921	2.3	650	1.7
LSD	1	0.0	1	0.0	.	.	.	.	59	0.2
Total	34,279	100	36,604	100	32,128	100	40,152	100	38,078	100

* The cannabis plant seizures are underreported in the GND, especially for 2006. See Table 10.6 for a more accurate estimate of the cannabis plantations discovered since 2007

Source: Federal police: ST13_2009_BE_01; ST13_2011_BE_01.

Table 10.3: Total quantities of seized drugs by substance, Belgium, 2006 – 2010.

Drug type	Year				
	2006	2007	2008	2009	2010
Cannabis resin (kg)	8,054.8	58,544.8	1,529.3	18,659.7	3,153.0
Herbal cannabis (kg)	4,563.2	12,731.7	4,890.7	4,486.2	5,207.7
Cannabis plants (units)*	110,368.0	148,251.0	177,190.0	272,714.0	312,528.0
Heroin (kg)	154.1	548.5	62.9	274.8	386.0
Cocaine (kg)	3,946.0	2,469.8	3,851.5	4,605.0	6,844.0
Amphetamine (kg)	118.8	483.1	410.7	49.1	362.4
Methamphetamine (kg)	.	.	.	.	38.8
XTC-type substances (tablets)	482,904.0	541,245.0	162,821.0	31,025.0	32,954.0
LSD (units)	120.0	1.0	.	.	3,924.0

* Change in methodology: since 2008 the capacity of cannabis plantations is reported instead of the actual seizure and the reporting of plantations is done directly to the DGJ-DJP instead of through the GND. The data from 2006 and 2007 is are less reliable.

Source: Federal police: ST13_2009_BE_01; ST13_2011_BE_01.

Exemplary, in 2007, there were two major seizures of cannabis resin (42,920 kg and 11,000 kg) and one major seizure of herbal cannabis (8,460 kg). In 2009, there were two major seizures of cannabis resin (8,000 kg and 7,020 kg) as well. For the other years, no exceptionally large seizures were reported. The increase in seized quantities of the cannabis

plants is partly due to a change in methodology. Since 2008, the capacity of plantations is reported instead of the actual seizure. This way, the effect of invasion time (before or after harvest) is minimized.

3.2. Quantities and numbers of precursor chemicals used in the manufacture of illicit drugs

Data on the precursors found are collected and reported by the Precursor unit from the Federal Agency for Medicines and Health Products (FAMHP) (Mergan 2011). An overview of the precursor seizures is given in Table 10.4. In 2010, 5000 liters of 1-phenyl-2-propanon (BMK), which can be used in the synthesis of amphetamines, was found in a bulk container originating from Vietnam and destined for Germany. Precursors seized in illicit laboratories included hydrochloric acid and sulphuric acid, methanol, formamide formic acid and sodium hydroxide. Finally, the exportation of 150 kg of ephedrine was intercepted (Mergan 2011).

Table 10.4: Precursors found in Belgium, 2010.

Substance	Purity	Amount	Location of detection
1-phenyl-2-propanon (BMK)		5,000 l	Bulk container
1-phenyl-2-propanon (BMK)		50 l	Belgian lab
Hydrochloric acid	32%	75 l	Belgian lab
Hydrochloric acid	36%	941 l	Belgian lab
Sulphuric acid	51%	75 l	Belgian lab
Sulphuric acid	96%	25 l	Belgian lab
Methanol		70 l	Belgian lab
Formamide		650 l	Belgian lab
Formic Acid		300 l	Belgian lab
Sodium hydroxide		987 kg	Belgian lab

Source: FAMHP (Mergan 2011)

3.3. Number of illicit laboratories and other production sites dismantled; and precise type of illicit drugs manufactured there

3.3.1. Police data

Each year, a number of illicit laboratories producing amphetamine and XTC were dismantled in Belgium. However, the numbers fluctuated over the years (Table 10.5). In 2010, the Belgian police reported the detection of 3 amphetamine- and 2 GHB-laboratories in Belgium (Dommicent, personal communication).

Table 10.5: Number and type of labs dismantled by Belgian police services, 2006 - 2010.

Lab type	Year				
	2006	2007	2008	2009	2010
Labs for synthetic drugs					
XTC	1		1		
Amphetamines		3	3	1	4**
GHB			1*		2
LSD		1		1	
XTC + amphetamine	1				
Unknown/unspecified combinations		4			
Other					
Creation of tablets			1		
Total	2	8	6	2	6

*possibly also methamphetamine was produced here

**one of them situated in The Netherlands

Source: Dommicent, personal communication.

Table 10.6: Number of cannabis plantations discovered, by plantation size, Belgium, 2007-2010.

Plantation size*	Year							
	2007		2008		2009		2010	
	n	%**	n	%**	n	%**	n	%**
Micro	66	16.8	136	21.1	138	18.7	211	21.8
Mini	130	33.1	219	33.9	227	30.8	312	32.2
Small	62	15.8	125	19.3	161	21.8	165	17.0
Middle sized	40	10.2	58	9.0	73	9.9	94	9.7
Big	44	11.2	63	9.8	67	9.1	104	10.7
Industrial	51	13.0	45	7.0	71	9.6	82	8.5
Total with info on size	393	100	646	100	737	100	968	100
No info***	73		20		1		11	
Total	466		666		738		979	

* Micro: 2-5 plants; Mini: 6-49 plants; Small: 50-249 plants; Middle sized: 250-499 plants; Big: 500-999 plants, Industrial: >1000 plants; ** Percentage based on total number of plantations with known size; *** including cannabis cutting sites and other plantations with unknown size.

Since 2008, the capacity of cannabis plantations is reported instead of the actual seizure; and the plantations are reported directly to the DGJ-DJP instead of through the GND. For 2007, the corrections on capacity of plantations could be done for only a part of the plantations.

Source: Dommicent, personal communication

There has been an increase in cannabis plantations discovered during the past 4 years: from 466 to 979 (Table 10.6) (Dommicent, personal communication). Although such a finding might reflect the focus from police services, it is likely that more plantations are started. As

mentioned before (section 2.3.1), this production is often meant for export to the Netherlands. However, the data also show that 16.8% (2007) to 21.8% (2010) of the discovered plantations are 'micro' plantations, counting 2 to 5 plants. A commentary on this phenomenon of small-case home growers, by Decorte (2010), is summarized in section 2.3.2.

3.3.2. Other research

In December 2009, the YILCAN project ('Determination of the yield of an illegal indoor cannabis plantation') was launched, aiming to estimate the profit of illicit indoor cannabis plantations (Belgian Science Policy 2011). Results showed that the yield of cannabis plantations depends on the plant density, the plant variety and light intensity (Vanhove et al. 2011). The profit for the cannabis grower is at least €4 per gram of cannabis (Van Damme P. and De Ruyver 2011).

4. Price/purity

4.1. Price of illicit drugs at retail level

Table 10.7:: Drug prices in euro at street level, Belgium, 2006-2010.

Drug type	Year														
	2006			2007			2008			2009			2010		
	Mean	min	max	mean	min	max	mean	min	max	Mean	min	max	mean	min	max
Cannabis resin per gram															
Eurotox, French Community	.	.	.	6.80	1.50	20.00	8.70	0.60	16.00	8.23	1.50	20.00	7.74	2.00	20.00
Federal Police, French Community	6.99	2.00	18.66	6.28	2.00	12.00	7.90	3.00	15.00	7.47	4.00	12.00	6.95	3.00	15.00
Federal Police, Flemish Community	6.34	3.00	10.00	6.77	3.00	11.00	6.80	3.00	12.00	6.45	5.00	10.00	7.45	5.00	10.00
Cannabis herbs per gram															
Eurotox, French Community	.	.	.	6.30	2.00	15.00	9.20	1.00	20.00	8.10	3.00	15.00	8.28	3.00	20.00
Federal Police, French Community	5.33	0.72	12.50	5.97	2.00	12.50	8.11	3.00	25.00	6.91	3.33	12.00	8.20	5.00	12.50
Federal Police, Flemish Community	5.43	0.66	13.33	5.96	3.00	12.00	5.87	2.63	10.00	7.39	3.00	12.50	6.41	2.80	10.00
Heroin unspecified per gram															
Federal Police, French Community	23.47	6.66	40.00	23.25	10.00	50.00	23.94	5.00	50.00	24.39	10.00	50.00	24.19	8.00	50.00
Federal Police, Flemish Community	28.74	7.24	60.00	26.70	10.00	60.00	25.22	12.00	40.00	22.67	10.00	40.00	23.82	9.00	62.50
Heroin brown per gram															
Eurotox, French Community	.	.	.	33.20	10.00	75.00	24.60	10.00	52.00	26.38	10.00	50.00	23.36	8.00	70.00
Heroin white per gram															
Eurotox, French Community	.	.	.	31.4.	15.00	70.00	24.20	20.00	30.00	33.88	12.00	80.00	.	.	.
Cocaine per gram															
Eurotox, French Community	.	.	.	48.40	20.00	75.00	49.90	25.00	81.00	52.95	25.00	120.00	49.70	20.00	100.00
Federal Police, French Community	49.83	20.00	75.00	47.50	20.00	100.00	47.82	5.00	87.00	52.80	10.00	100.00	52.16	30.00	100.00
Federal Police, Flemish Community	46.25	30.00	60.00	48.96	30.00	60.00	50.75	30.00	70.00	48.92	15.00	70.00	49.14	30.00	100.00
Crack per gram															
Eurotox, French Community	.	.	.	30.90	5.00	60.00	45.00	5.00	70.00	55.00	40.00	60.00	.	.	.

Table 10.7 continued

Drug type	Year														
	2006			2007			2008			2009			2010		
	Mean	min	max	mean	min	max	mean	min	max	mean	min	max	mean	min	max
Amphetamine per gram															
Eurotox, French Community	.	.	.	10.90	5.00	30.00	9.50	3.00	20.00	11.57	2.00	40.00	9.58	2.00	40.00
Federal Police, French Community	8.63	4.00	20.00	10.50	6.00	15.00	6.55	1.50	10.00	10.91	2.80	25.00	9.06	2.50	10.00
Federal Police, Flemish Community	8.44	3.00	15.00	10.55	3.00	25.00	8.68	3.50	20.00	8.06	5.00	12.00	8.37	2.50	15.00
XTC per tablet															
Eurotox, French Community	.	.	.	6.20	1.00	20.00	6.10	2.00	20.00	6.24	1.00	25.00	4.70	1.00	15.00
Federal Police, French Community	3.66	0.20	10.00	3.63	1.00	6.00	4.05	1.14	10.00	4.14	1.20	10.00	5.15	2.00	10.00
Federal Police, Flemish Community	2.97	0.83	7.50	4.40	1.00	10.00	3.18	1.80	5.00	3.45	1.00	8.00	3.42	1.00	10.00
LSD per dose															
Eurotox, French Community	.	.	.	8.90	5.00	15.00	10.50	4.00	30.00	9.46	1.00	25.00	9.60	5.00	30.00
Federal Police, French Community	.	.	.	7.50	5.00	10.00	8.25	6.50	10.00	.	.	.	.	.	.
Federal Police, Flemish Community	6.50	2.00	10.00	9.17	7.00	10.00	.	.	.	10.00	10.00	10.00	12.00	12.00	12.00

* French Community data from federal police include Brussels

Source: Federal police: Dommicent, personal communication (related Standard Table: ST16_2008_BE_03; ST16_2011_BE_01);

Eurotox: ST16_2008_BE_02; ST16_2009_BE_02; ST16_2010_BE_02; ST16_2011_BE_02

Information on street prices for drugs is collected by both police services and Eurotox. All local and federal police reports reaching the National Drug Service from the federal police are screened for information on drug prices. This information is obtained during interrogation of the suspect dealers and users. In addition, Eurotox collects information on street prices within the French Community by questioning drug users frequenting needle exchange programmes or in contact with outreach workers.

An overview of the reported mean, minimum and maximum prices by drug type and by region and data provider is given in Table 10.7. The average price for 1 gram of cannabis resin varied in 2010 from 6.95 to 7.74 euros, depending on the region and source of information. For herbal cannabis, the mean reported price in Flanders was 6.41 euros, while in the French Community and Brussels, it was 8.20 (reported by federal police) to 8.28 euros (Eurotox). For heroin, mean reported prices are 23.36 to 24.19 euros depending on region and reporting instance (brown heroin and unspecified heroin). For cocaine, the mean price per gram is about 50 euros (49.14 to 52.16 euros). Amphetamine is sold at a mean price of 8.37 to 9.58 euros per gram. An XTC-tablets cost in 2010, 3.42 to 5.15 euros. One LSD-unit cost about 9.60 to 12.00 euros.

4.2. Purity/potency of illicit drugs

For this part the results of analyses performed on substances seized by police services and customs, and reported through the Belgian Early Warning System on Drugs were used. It concerns both seizures at user's level as well as seizures from large drug traffics. An overview of the distribution of the substance concentrations over the period 2002-2010 is shown in Figure 10.1.

This year mean, minimum and maximum **amphetamine** concentrations are respectively: 31.6, 0.3 and 74.4 %. After a decrease started in 2007, with in 2008 the lowest value, the mean amphetamine concentration is approximately at the level of 2006. The maximum concentration is similar to the values of previous years, disregarding a decrease in 2008.

The mean Δ^9 -tetrahydrocannabinol (THC) concentration in **herbal cannabis** stayed equal (11.1%). Maximum THC concentration showed an increase in the period 2007-2009, while the 2010 value (22.3%) decreased again to the level of 2002 and 2006. The minimum concentration in 2010 was 0.5%. The 2010 data for **cannabis resin** are similar to the values of 2009, mean, minimum and maximum concentration being 11.8, 29.0 and 0.3% respectively. The mean THC concentrations are quite stable since 2006, while the maximum concentrations are increasing, but are still lower than the outlier values in 2003 and 2004.

The 2010 distribution of concentration of **cocaine** (mean: 55.0, minimum: 0.2 and maximum: 96.3%) is similar to previous years.

Except for an increase in 2004 and 2006, mean **heroin** concentrations are stable, with in 2010 a value of 21.2% . Maximum concentrations seem to be dropping with the lowest value in 2010 (55.5%).

After a small decrease since 2008, mean **3,4-Methylenedioxymethamphetamine (MDMA)** concentration has increased to 92.3 mg/tablet in 2010. Also the maximum value of 198.2 mg/tablet is much higher than previous years. Although analysis is done on less samples this year (29 versus 48 and 141 mg/tablet in 2009 en 2008 respectively), 5 high values varying between 175.5 and 198.17 were reported in 2010. This increase is not caused by higher purity values, but can be attributed to higher weights of the tablets (+/- 340 mg). Minimum concentration in 2010 is 5.0 mg/tablet.


4.3. Composition of illicit drugs and drug tablets

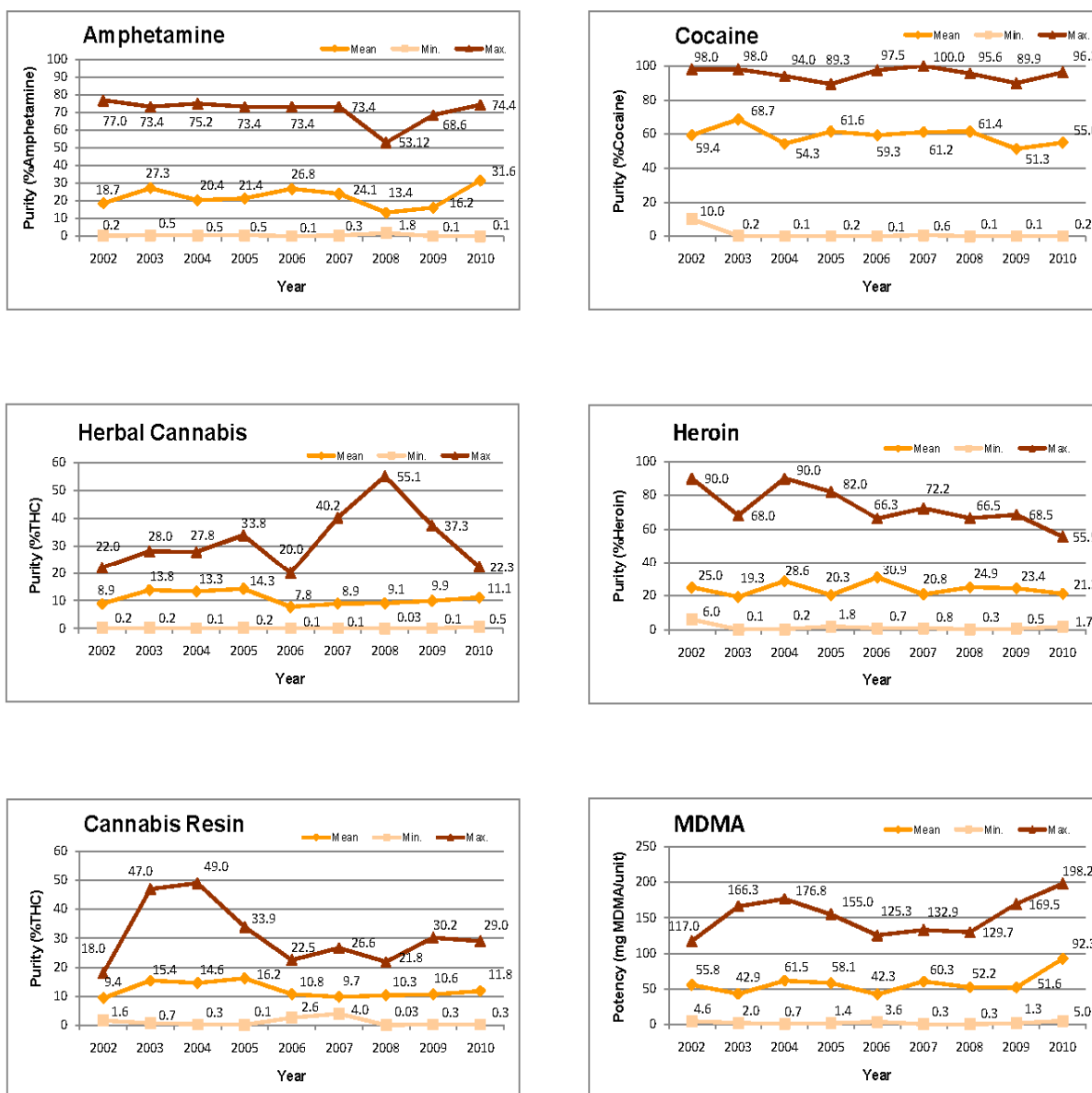
4.3.1. Tablets

The database from the Belgian Early Warning System on Drugs (BEWSD) contains information on the composition of seized drug tablets, of which a summary (years 2007-2010) is given in Figure 10.2 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 by sample and not by total amount of tablets.

In 2010 tablets containing MDMA-like substances counted for approximately one fourth of the tablets. This percentage is declining since 2008 (69.4) over 33.5% in 2009 to 26.6% in 2010. The category 'miscellaneous' containing only substances that are not included in the 1971 UN Convention on Psychotropic Substances Schedules I and II are counted, raised to 66.4% in 2010, which is comparable to the 2009 value (56.2%). This category counted for 31.7 and 28.8% in 2007 and 2008, respectively.

The content of the 'miscellaneous' category is specified a little more in Figure 10.3. The following 4 categories were chosen: 1-(3-chlorophenyl)piperazine (mCPP) alone (mCPP as the only reported substance); mCPP in combination (these combinations might include medicines or other psychoactive substances, but also non-active ingredients); other psychoactive ingredients or medicines (e.g. caffeine, benzodiazepines); only non-active ingredients (comprising vitamins, glucose etc). The category 'no drugs found' was left out of this calculation (in 2007, 2008 2009 and 2010 respectively 6, 9, 19 and 6 cases).

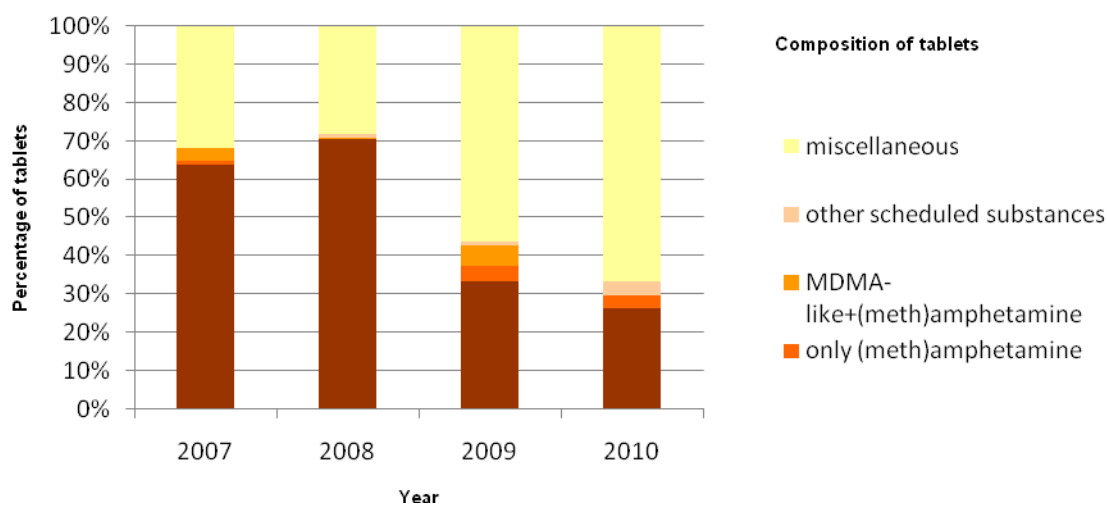
Figure 10.1: Substance concentration in seized samples, Belgium, 2002-2010. 



Source: Database of the Belgian Early Warning System on Drugs, ST14_2011_BE_01.

In 2010 the proportion of samples that include (meth)amphetamine stayed stable.

In the category ‘other scheduled substances’, the combination 4-bromo-2,5-dimethoxyphenethylamine (2-CB) + amphetamine was observed twice; 2,5-dimethoxy-4-bromoamphetamine (DOB), THC and the combination 1-benzylpiperazine (BZP) + 1-(3-trifluoromethylphenyl)-piperazine (TFMPP) each occurred once.

Figure 10.2: Distribution of tablets by drug composition. 📊

¹ Scheduled drugs refer to substances controlled under the 1971 UN Convention on Psychotropic Substances Schedules I and II and under European legislation (Council Decisions).

² 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).

³ 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).

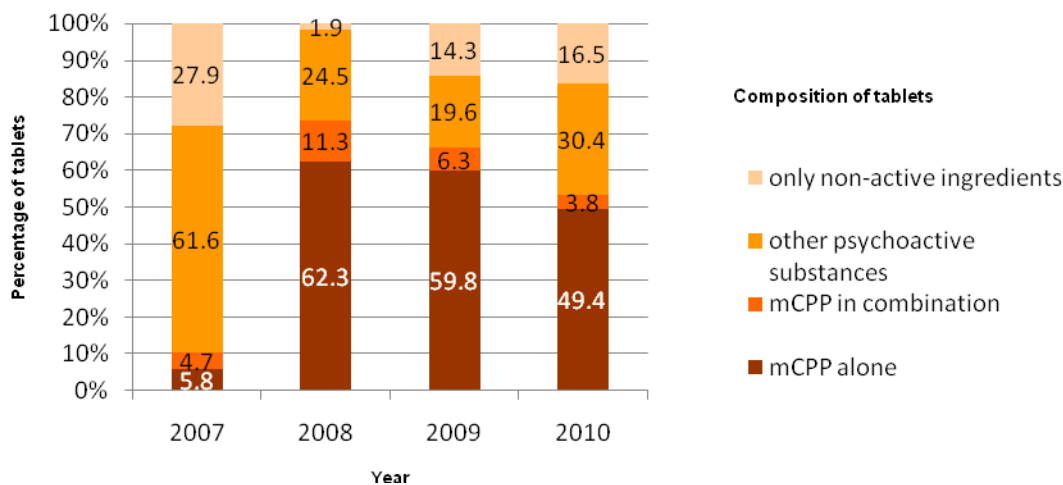
⁴ The category 'MDMA-like substances and (meth)amphetamine (as the only scheduled substances)' refers to tablets containing only MDMA-like substances and amphetamine and/or methamphetamine, together with or without non-scheduled substances (e.g. mCPP, caffeine).

⁵ 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).

⁶ 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).

Source: Database of the Belgian Early Warning System on Drugs, ST15_2011_BE_01.

Figure 10.3: Description of tablets category ‘miscellaneous’. 



Source: Database of the Belgian Early Warning System on Drugs, ST15_2011_BE_01.

While the ‘miscellaneous’ category contained mostly other psychoactive substances (including medicines) in 2007 (61.6%) and mCPP being the most reported compound (alone or in combination) in 2008 and 2009 (73.6 and 66.1% respectively), in 2010 these groups are representing respectively 30.4% and 53.2%. The group ‘other psychoactive substances’ counts 24 observations and consist of benzodiazepines or Z-drugs in 9 cases; antipsychotics in 2 cases (one in presence of caffeine); caffeine as the only reported substance in 3 cases and one case each for cocaine (+benzoylecgonine), fluormetamphetamine, tramadol and methadone. The group ‘only non-active ingredients’ counts 13 observations including ampiciline, lactose, scopolamine and tamoxifen each reported once, while sucrose, methandienone and sildenafil citrate are observed respectively 2, 3 and 4 times.

Table 10.8 shows the substances that were reported in combination with MDMA-like substances and / or methamphetamine for data of 2010. It can be concluded that for the tablets in which any other substance was reported, it was most likely caffeine or mCPP. While in 2007 the part of MDMA-tablets without cutting agents counted for 75.0%, this percentage raised to 97.1% in 2010.

Table 10.8: Reported combinations and cutting agents in MDMA-like and (meth)amphetamine containing tablets, seized in the context of the Belgian Early Warning System on Drugs, 2010

Other reported substances	MDMA-like substances (as the only scheduled ¹ substances) ²	(Meth)Amphetamine (as the only scheduled ¹ substances) ³
Alone	33	1
Caffeine		1
mCPP	1	
mCPP + metoclopramide+caffeine		1
mCPP + domperidone		1
Total	34	4

¹ Scheduled drugs refer to substances controlled under the 1971 UN Convention on Psychotropic Substances Schedules I and II and under European legislation (Council Decisions).

² 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).

³ 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).

Source: Database of the Belgian Early Warning System on Drugs, ST15_2011_BE_01.

4.3.2. Other product types

Information on the composition of seized drug samples with product type other than tablets is reported in this paragraph for the year 2010. Leaving out the tablet data, the database of the BEWSD contains 682 cannabis, 345 cocaine, 157 heroin, 172 amphetamine and 13 MDMA samples. The distribution of these samples by product type is given in Table 10.9.

Amphetamine was mostly found in powder form (78.5%). The category 'others' contained spoons, liquids, hardmass-powder mix, plants and pieces. In 73.8% of the amphetamine samples, caffeine was found as adulterant in 73.8% of the amphetamine samples. The precursor benzylmethylketon (BMK) and the impurity Di-(β -phenylisopropyl)amine (DPIA) due to amphetamine production through the Leuckart route were observed in 6.4% and 3.5% of the amphetamine samples, respectively.

The product type resin occurred in 69% of the **cannabis** cases. The category 'others' (2.0%) included joints, powder and pieces. In 1 powder sample the adulterant caffeine was found. The non-psychoactive cannabinoid 'cannabidiol' was found 189 times, the psychoactive cannabinoid 'cannabinol' 172 times. In 21 cases the presence of 11-*nor*-9-Carboxy-THC (THCCOOH) was reported.

Table 10.9: Distribution of samples by product type and drug group, Belgium, 2010.

Product type	Percentage (%) within samples				
	Amphetamine	Cannabis	Cocaine	Heroin	MDMA
Hard mass- powder mix			1.5		7.7
Herbs		15.4			
Liquids			1.5		7.7
Paste	12.2				
Pieces/hard mass				3.8	
Plants		13.6			
Powder	78.5		91.0	89.2	84.6
Resin		68.9			
Rest/traces (powder)	4.1		2.9	2.6	
Other	5.2	2.0	3.2	4.5	
Total (n)	172	682	345	157	13

Source: Database of the Belgian Early Warning System on Drugs, ST15_2011_BE_01.

Ninety-one percent of the **cocaine** samples were powders. The category 'other' included cases of pieces/hard mass, spoons, 'herbs', 'paste', 'gel', 'syringe', 'banknote' and 'plant material in teabag'. Data regarding adulterants and cutting agents and impurities found in cocaine samples, show that levamisole and phenacetine are the most used adulterants found in 61.7 and 31.3% of the cases. The impurity benzoylecgonine was found in 12 cases.

The most frequently found product type in **heroin** samples was powder (89.2%). The 4.5% 'other' product types contained spoons, hard mass-powder mix, aluminium foil and syringe.

One sample contained next to heroin also amphetamine as scheduled drug.

Caffeine and paracetamol were the most found adulterants (155 and 143 observations respectively). For the category impurity, noscapine, monoacetylmorphine and papaverine were found in respectively 94.9, 94.3 and 82.8% of the regarded heroin samples.

MDMA was most found in powder form (84.6%). The one sample with product type 'liquid' contained also the adulterant caffeine.

In 6 cases toxicological analysis revealed the presence of both cocaine and heroin.

Regarding new substances - being new narcotic or psychotropic drugs that are not scheduled under the 1961 United Nations Single Convention on Narcotic Drugs or under the 1971 United Nations Convention on Psychotropic Substances – scarce information is found on purity. New psychoactive substances are not often seized due to their not illegal character, and not all labs perform analyses on new drugs due to lack of reference material or expertise in this domain. An overview of new substances first reported in Belgium in 2010 is given in Chapter 7.

5. Other research

5.1. Alternative sampling methods

5.1.1. Rapid (Risk Analysis Project for the Identification of illegal Drugs)

In the Flemish, and with extension the Belgian drug field, information about the purity and the composition of street drugs is very scarce. Therefore VAD took the initiative to develop a new pilot project for the identification and monitoring of illegal drugs. The Rapid project was planned to run in six outpatient treatment centres, working with severe drug users. The idea was to analyse only those drugs that were harmful because of a (potential) dangerous composition, noticed by one of the drug users. The results of the programme were brought back to the user during a feedback moment and were stored in a database for monitoring purposes. Presumably a majority of analysis would lead to an early warning.

Although all the essential elements of the project (guidelines, partners, laboratories, ...) were set, the project was never launched because of budgetary reasons (Schrooten, personal communication)

In the French Community, a similar project already exists conducted by Modus Fiesta. Consumers have the possibility to let their products be tested. While in 2010 no analyses were performed within this project due to budgetary reasons, in 2011 the project could be restarted.

5.1.2. Waste water analysis

Projects conducted by University of Antwerp

The University of Antwerp recently conducted several studies on wastewater analysis. Sewage epidemiology assumes that human consumption and the resulting excretion of illicit drugs leads to the collection of these substances and/or their metabolites in the sewage system. More details on the methodology of sewage epidemiology can be found in the Annexes (van Nuijs et al. 2011a).

In 2007-2008 the project COWAT (Cocaine in Water) collected samples from the 41 largest WWTPs in Belgium. Samples, representative for a complete day, have been taken on a Wednesday and on a Sunday during summer- and winter time. The highest calculated cocaine consumption was observed in the WWTPs of Antwerp-South, Deurne, Brussels-Nord and Charleroi. All these WWTP regions receive wastewater from highly urbanized regions. But high cocaine consumption was also observed in smaller towns such as Genk and Arlon which was rather surprising and needs further investigations. A statistical higher consumption of cocaine during weekends (Sunday) compared with weekdays (Wednesday) was observed. From the local results, an extrapolation to the whole of Belgium was made

based on assumptions on drug dose and average daily use by a user and they found a prevalence cocaine users of 0.80% which was in agreement with the available estimation (0.9%) (van Nuijs et al. 2009a;van Nuijs et al. 2009b;van Nuijs et al. 2009c).

In a follow-up study conducted in 2009, an extensive sampling campaign was organised in the WWTP Brussels-Nord. Daily composite samples were collected for 2 consecutive months and for the 4 season times. These samples were analysed for all types of drugs and metabolites. Cocaine and heroin were found to be the two most used substances. Amphetamine and ecstasy showed lower use and methamphetamine consumption was negligible. A significant higher cocaine, amphetamine and ecstasy use was observed for the period Friday-Sunday compared with Monday-Thursday suggesting a recreational consumption pattern. For heroin and methadone no significant daily variations could be found (van Nuijs et al. 2011b;2011c).

Together with other European research groups active within this field, a collaboration was started to bring the sewage epidemiology approach in a transnational context. The decision was taken to collect daily composite influent wastewater samples for 7 consecutive days at the same time in 19 locations in 11 countries in Europe (i.e. Belgium, Croatia, Czech Republic, Finland, France, Italy, Norway, Spain, Sweden, The Netherlands and United Kingdom) in March 2011. These samples were analysed for cocaine and its metabolite, amphetamine, ecstasy and the heroin metabolite. The normalisation for the number of inhabitants will allow to compare consumption of illicit drugs in Europe. Treatment of the results is ongoing and results will be available in the winter 2011-2012.

The researchers conclude that these studies present solid evidence that sewage epidemiology is a promising approach to gain knowledge about the consumption of illicit drugs, complementary to the conventional socio-epidemiology. The relatively low-costs, short time frame of obtaining results and the high objectivity are the biggest advantages of sewage epidemiology and show that it can have its place in future research on trends and patterns in illicit drug consumption.

The project GEOAMP

The GEOAMP study was conducted within a collaboration of the Ghent University and the University of Liège. (Charlier et al. 2010a) and aimed to determine whether the analysis of the waste production in wastewater could locate a possible clandestine laboratory near the discharge point. The following substances were searched in the waste water from water treatment plants in the North (Antwerp and Hasselt) and South (Oupeye) of Belgium: amphetamine, MDA, MDMA, N-acetylamphetamine, N-formyl-MDA en N-acetyl-MDA. The analytical methods used were similar to those used in the COWAT project.

The researchers identified amphetamine and MDMA in the samples, in both the North and South regions. As for precursors, only N-acetylamphetamine, has been found in the samples. The study concluded that the results were evidence of a synthetic drug consumption but not of production since no precursors were found. No link could be made between the presence of synthetic precursors in wastewater and production of drugs.

However the result could be used to assess the use of amphetamine and MDMA in a geographic area drained by the water treatment plants where the samples were analysed. Based on the water stations already examined, there are 2344 kilograms of amphetamine and 61.9 kilograms of MDMA used annually in Belgium. In two of the three water treatment plants, high drug concentrations were found in the COWAT-project, meaning these GEOAMP data are probably an overestimation.

5.1.3. Other toxicological developments

At the NICC several studies on development of new sampling methods for post-mortem analyses are being performed. In 2010, a study was published in the Journal of Analytical toxicology on the quantification of methadone and its metabolite 2-ethylidene-1,5-dimethyl-3,3-diphenylpyrrolidine (EDDP) in larvae of *Lucilia sericata* (Diptera: Calliphoridae) (Gosselin et al. 2010). The validation and actual sample analysis showed that the method is sensitive, rugged, precise, accurate, and well-suited for routine analysis of methadone and EDDP in a single larva obtained from forensic cases.

5.2. Development of new analysing procedures

To be able to analyse scheduled drugs, labs need to keep their analysing methods as efficient as possible. Labs invest in new improved methods: shorter analysing time, easier sample preparation, multiple-compound analysing, improved quantification,...

Following Belgian studies on the development of new methods for determination of drugs have been published in 2010

- Determination of gamma-hydroxybutyric acid in dried blood spots using a simple GC-MS method with direct "on spot" derivatisation (Ingels et al. 2010)
- Analysis of amphetamines and metabolites in urine with ultra performance liquid chromatography tandem mass spectrometry (Ramirez Fernandez et al. 2010).
- Evaluation of the identification power of RPLC analyses in the screening for drug compounds (Dumarey et al. 2010).



Part B

Selected Issues



Chapter 11.

Drug-related health policies and services in prison

Van Malderen, S.



1. Introduction

In this chapter the organisation of the Belgian prison system and its prison population is discussed. The prison health policy in general and the drug-related health policy and existing services are explained with attention for the competent authorities involved. The complex Belgian state structure has its repercussions on the organisation of these services and explains the differences in services between prisons and on regional level.

Without passing over or wanting to neglect this state structure, but based on pragmatic reasons, reference is made to Flemish prisons and French prisons. In this chapter Flemish prisons can be considered as prisons situated in the Dutch speaking part of Belgium (Flanders). French prisons can be considered here as situated in the French speaking part of Belgium (Walloon part) including the prisons in Brussels Capital Region.

2. Prison systems and prison population: contextual information

2.1. The Penitentiary institutions

The Belgian prison system falls under the competence of the Directorate-general of Penitentiary Institutions, as one of the four Directorate-generals of the Federal Department of Justice.

This Directorate-general is responsible for the execution of penalties and measures of deprivation of freedom within 31 prisons. These prisons are under the control of the national prison administration or head office but are regionally divided: 15 prisons are situated in Flanders, 14 in the Walloon part, and two in Brussels (Brussels Capital Region).

Next to these prison institutions, three closed federal centres for minors and one institution of the “Commission for the protection of the society “are under direct control of the Directorate-general of Penitentiary Institutions. While the latter is meant as penitentiary institution for the mentally-ill offenders, the three closed federal centres are intended for minors who have committed an ‘as a crime defined act’ (juvenile offenders). The transfer to these closed federal centres only takes place under certain conditions and when the community centres (centres under the control of the Flemish government or Walloon Region) have reached their capacity.

Finally, this listing of Belgian prisons is not complete without referring to the prison in Tilburg. Tilburg is situated in the neighbouring country the Netherlands. Since the end of 2009, the Belgian prison administration has a three year rental contract to use the Tilburg prison capacity in order to solve, in the short-run, the problem of overcrowding in the Belgian prisons. This prison is not situated on Belgian territory, nonetheless, it has to be regarded as a Belgian penitentiary institution since the Belgian (penitentiary) legislation is binding in this institution (Directorate-general of Penitentiary Institutions 2011a).

2.2. Prison population

2.2.1. Sources used

To discuss the characteristics of the prison population the SPACE I Survey 2009 (Aebi and Delgrande 2011) is consulted. On the one hand, this information is completed with available statistics of the Directorate-general of Penitentiary Institutions on the prison population on a given day. On the other hand, reference is made to data gathered for the two-yearly prison self-report survey “Drug use in Belgian prisons: Monitoring of health risks” (cf. Chapter 9). With this survey, self-reported data is collected but also statistics are retrieved for a specific set of variables from the database of the Directorate-general in order to compare characteristics of the survey sample with those in general prison population. With the latest and third edition of this study in 2010 data is presented over the period 2006-2010 (Van Malderen et.al. in press). However, data of the survey presented in this chapter only relates to the retrieved statistics and does not include the self-reported data.

When discussing these three different sources one has to take into account that prison population is defined differently. In the Space survey and in the data concerning prison population on a given day provided by the Directorate-general, prison population is broadly defined and also includes persons with a penal status who are not detained in a penitentiary institution (for example persons under electronic surveillance). Moreover juvenile offenders as well as adult offenders are included. Data of the two-yearly survey in prison, however, only refer to adult offenders detained in a penitentiary institution. This definition in restricted sense is explained by the scope and objective of this survey as the monitoring of drug use within prison walls, and oriented at adult offenders (from the legal age of 18 years). Therefore, these data coming from different sources cannot be simply considered as comparable but rather as supplementary sources.

2.2.2. Total number of prisoners

The Belgian prison population increased with 19.7% between 2000 and 2009 and this increase continues over the period 2009-2011 (Aebi and Delgrande 2011, p. 39). Where on the first of September 2009 the total number of prisoners is 10,901 (Aebi and Delgrande 2011, p. 39), the total number of prisoners on the first of September two years later, in 2011, is 11,913 (Directorate-general of Penitentiary Institutions 2011b). Belgium is not an exception and is confronted with the problem of prison overcrowding (Aebi and Delgrande 2011, p. 38). Especially the category of sentenced prisoners and prisoners on remand is increasing (Maes et al. 2011)).

2.2.3. Legal status

The prison population is divided into remand and sentenced prisoners, mentally ill prisoners and others, the latter defined as persons held for administrative reasons. Over the period 2006-2010, the majority of the population is sentenced (53-54%), more than one in three is on remand (35%-38%), 10% is categorised mentally ill (9%-10%) and less than 1% is held for administrative reasons (Todts et al, 2007; Todts et al, 2009; Van Malderen et al, in press). It is the objective to separately detain prisoners based on their legal status. Due to overcrowding prisoners are sometimes put together regardless their legal status. For the mentally-ill, one penitentiary institution is exclusively intended for their imprisonment and some institutions have separate sections to enable specialised care. The on going construction of two forensic psychiatric centres aims to divert the mentally-ill from prison to appropriate mental health services (cf. infra). Drug-addicted offenders are not detained in separate institutions. Drug free programs for example, are organised in prison where also non-addicted prisoners are detained.

2.2.4. Gender

The percentage of women in Belgian prisons remains stable with 4% both in 2009 (Aebi and Delgrande 2011, p. 53) and 2011 (Directorate-general of Penitentiary Institutions 2011a) on the first of September. Women are held in separate sections of certain penitentiary institutions.

2.2.5. Age

The age of criminal responsibility in Belgium is 18 years. However, from the age of 14 years the Juvenile Court may, under certain conditions and for rehabilitation purposes, consider placement in a closed centre of the community (revised Youth Protection Law of 1965). When these centres have reached their capacity, minors can be transferred temporarily to one of the three closed federal centres under the control of the Directorate-general of Penitentiary Institutions of the Federal Department of Justice (cf. supra).

The Juvenile Court is the competent authority for dealing with 'as crime defined acts' committed by persons aged under 18 years. In some cases, however and under certain conditions the Juvenile Court can refer the case to the Criminal Court when a minor of 16 years or older is involved. For the detention of these minors a specialized closed centre, under the competence of the Directorate-general of Penitentiary Institutions, was established in 2009 (Royal Decree of 12 November 2009). It is the Regional Government who is responsible for offering youth services such as learning and leisure services.

On the first of September, less than 1% of the prisoners were youth offenders (Aebi and Delgrande 2011). More recent data on the first of September 2011 show a similar observation with 0.5% of the prisoners held in one of the three closed federal centres (Directorate-general 2011).

Over the period 2006-2010 more than half of the prison population are young adults, aged between 21 and 35 years (52%-53%). The other part of the population consist of prisoners older than 36 years old (41%-43%) and 5% to 6% is under the age of 21 (Van Malderen et.al; in press).

2.2.6. Detention history

The bigger part of the prison population has already been in prison (65%-67%) but also one in three can be categorized as first offender (33%-35%).

2.2.7. Drug offenders and drug-addicted offenders

Based on the Space statistics (2011) 36.3% are sentenced for drug offences. This is a higher percentage compared to the latest data of the statistics of the Directorate-general showing that 31.3% of all the prison population is detained for drug offences (regardless their legal status).

Space statistics for Belgium point to double counting since the main offence rule is not well defined in Belgium (Aebi and Delgrande 2011, p. 66). Consequently, this double counting also occurs with the latest data of the Directorate-general and cannot explain this higher percentage. Moreover, Space only includes sentenced prisoners, expecting not a higher, but

lower percentage compared to the latest data of the Directorate-general, since the latter involves all categories of legal status. Compared to the self-reported data however, these figures show again a different result with 37.9% declaring to be in prison due to a drug offence (Van Malderen et al, in press). This item is examined by asking prisoners whether they are in prison for 'drug possession', 'drug trade', 'for other reasons' or 'for other reasons and drugs'. Prisoners could give multiple answers. However, one would expect a result more in line with the 31.3 % of the Directorate-general since the same population is involved (all categories of legal status included) and also here double counting occurs.

Nevertheless, taking into account the different data sources, one can observe that more than one in three is detained due to a drug offence. A distinction has to be made, however, between a drug offender and a drug using or drug-addicted offender. It is found repeatedly in 2008 and 2010, that the nature of the offence is not a predictable factor for drug use during imprisonment (Van Malderen et.al, in press). Both drug offenders and non-drug offenders take drugs while in prison and vice versa.

2.2.8. Health and social status

Information on the health and social status of Belgian prisoners is not systematically and structurally collected. Every prisoner has a medical, electronic file but the data these files generate cannot simply be retrieved in order to be used as a monitoring tool. Therefore the implementation of a new computer program and the development of one database is announced for the end of 2011 to enable a systematic data-collection suited for research analysis.

3. Organisation of prison health policies and service delivery

The following information is based on legislative sources and circulars, self-reported data of the survey "Drug use in Belgian prisons: Monitoring of health risks" and expert opinion. Reference is made to additional sources when used.

3.1. Prison health

3.1.1. Organisation and legal framework

In Belgium, prison health care is a competence of the Minister of Justice. The Prison Health Care Service, on central level, as part of the Directorate-general of Penitentiary Institutions, is responsible for the organisation, funding and delivery of care and drug-related health services to prisoners. The Prison Health Care Service is the service provider for the

'improvement, determination, preservation and improvement of physical and mental health' (art. 87,1^o, law of principals 2005). In each Belgian prison a single Service for Health Care is installed executing the health policy formulated by the central Service for Health Care in Prisons.

In Belgian prisons, there is a clear division between providing health care to prisoners (health perspective) and providing medical and psychosocial advice as part of security measures and probation (security perspective). Prisoners' health is central to the Service for Health Care in Prisons and care providers are bound by professional secrecy. The Psychosocial Service in Prisons is responsible for securing society, aiming at recidivism prevention.

The basic principles of health care in prison are legally embedded within the law of principals concerning the prison system and the legal position of prisoners of 2005. With this law the legal position of prisoners is regulated. Formerly, prison life and prisoners' rights were based on a system of favours, guidelines and circulars coming from the executive power. However, this law of principals is not yet fully implemented. Royal Decrees have to be issued for the coming into force of several articles. In 2010 the articles concerning health care in prison are not yet implemented. Until this time the General Regulations of the Penitentiary Institutions of 1965, coming from the executive power, are still in effect.

Next to the Federal Government, the Regional Governments are also involved in health policy in prisons, being competent for ambulatory health care and preventive health care. The Regional Governments define these competencies differently, as preventive health care, ranging from needle exchange, vaccination programs to suicide prevention. The complex Belgian state structure with different governments and a fragmented division of competencies has also its repercussions on the organisation of services in the Belgian prison system. It explains the differences in services between prisons and the regions.

3.1.2. Implementation of the principle of care in prisons

The principles of equivalence, continuity and specificity of care are laid down in articles on prison health care (art. 88 and art. 89, law of principals 2005). Equivalence of care is translated into prisoners' right to a visit from a freely chosen physician in the community for the provision of medical advice. The provision of treatment by this physician in the prison setting is only possible on reasonable grounds and upon agreement by the head of the Prison Health Care Service. Reference is also made to the situation where specialised treatment is needed. Transferring a prisoner to a specialized prison, hospital or health care institution is possible when specialized treatment cannot be provided in prison. In Belgian prisons such transfers occur on a daily basis.

Within the Belgian prison system basic medical services exist but no hospital facilities that meet hospital standards. Two penitentiary institutions have a section functioning as outpatients' clinic executing hospital assignments to a limited extent. For example aftercare, small interventions such as eye operations, dermatologic interventions or arthroscopic surgery are offered. Other surgical interventions are not executed since quality of care cannot be achieved. Nevertheless, special care for certain target groups, such as drug addicts (cf. *infra*) and the mentally ill, is inadequate. In 2008 the Minister of Justice has announced the construction of two Psychiatric Forensic Centres to divert the mentally-ill from prison to appropriate mental health services. In 2011 the construction of these two forensic psychiatric centres is still in development.

3.1.3. General level of health and social staff resources

Health staff working in the prison system is under the control of the Prison Health Care Service of the prison administration. This staff is employed as civil servants or as self-employed persons. The bulk of the prison staff is custodial staff (78.1%). Medical and paramedical staff counts for 2.2% and 4.3% are responsible for the assessment and the psychologists (Aebi and Delgrande 2011, p. 102). Attention has to be paid to the fact that this 4.3% cannot be counted as health care staff. The staff responsible for the assessment and the psychologists in these statistics is considered as staff of the Psychosocial Service in Prisons operating from the perspective of protecting society and assessing the risk of recidivism.

3.2. Drug-related health policies targeting prisoners

3.2.1. Legal framework and regulations

The principles of the Belgian drug policy are laid down in the Federal Drug Policy Note of 2001 and reconfirmed in 2010 with the Communal Declaration (cf. Chapter 1). The drug policy in prisons is based upon this extra muros policy and consists of the pillars prevention, reduction of harm, treatment and enforcement.

Naturally, Belgian drug law is applicable in prisons but also specific circulars of the executive and the judiciary are important sources translating legislation into practice. Basic documents for drug policy in prisons are the Ministerial Circular n°1785 concerning drugs in prisons of 2006, the Ministerial Circular n° 1806 of 6 February 2009 concerning the consultation with the public prosecutor in case of infractions on the drug law in prisons and the Circular n° COL 1/2009 prosecution policy concerning infractions on the drug legislation at the entrance

and within the prisons (Van Malderen 2011). See also Van Malderen (2011) for in-depth information and discussion on drugs in prisons from a legislative perspective.

It is the Director-general of the Directorate-general of Penitentiary Institutions and the Head of the Prison Health Care Service who are responsible for the execution of drug policy in Belgian prisons. To this end the Central Steering Group Drugs of the prison administration presents an Action Plan to the Minister of Justice. This Steering Group, composed of representatives of the different policy sectors and policy levels (Federal and Regional) is responsible for the implementation of the policy by approving the Action Plans. For the actual implementation, coordination and putting into practice of the proposed initiatives, two Regional Coordinators of Drug Policy in Prisons are assigned to the Prison Health Care Service on central level.

The objective is an evidence-based drug policy in prison by installing practices 'that work'. Since 2009 the implementation of it started through the attribution of a budget assigned to install specifically defined projects. These projects are presented in the yearly Action Plans.

The Action Plan 2010 'Drug Policy in Belgian Prisons' was approved on 23 February 2010 and presents for each policy pillar different initiatives. The Action Plan is structured as initiatives covering all Belgian prisons and initiatives only applicable for the Flemish prisons or the French prisons.

By discussing the provision of drug-related health services in prison (cf. *infra*), reference is made to these initiatives in the Action Plan.

3.2.2. Drug expertise in prison: Import and in-reach model

In Belgian prisons services for drug users are delivered both by experts that are part of the prison health teams and by external providers. Cooperation with external drug service providers exists in drug free programs and to prepare community drug treatment upon release (cf. *infra*).

Prison health teams are also supported by personnel who are experts in a specific drug-related field, such as physicians that function as reference for the opiate substitution treatment.

4. Provision of drug-related health services in prison

The following information is based on legislative sources, circulars and Action Plans, self-reported data of the survey “Drug use in Belgian prisons: Monitoring of health risks” and expert opinion. Reference is made to additional sources when used.

4.1. Prevention, treatment, rehabilitation, harm reduction

4.1.1. Medical consultation and screening- and the assessment of drug-use upon entry into custody

The law of principals of 2005 and the Royal Decree of 8 April 2011 foresees in a medical consultation within 24 hours upon entry into custody. As a standard procedure an medical intake is executed with attention for drug use and psychopathological disorders. This information is not collected in a way that it can be generated or simply retrieved in order to use as a monitoring tool. The implementation of the new computer program for medical files and the development of one database as announced for the end of 2011 will make a change (cf. supra).

An instrument for the screening and assessment of drug use and psychopathological disorders in prisons is developed but not in use (Soyez et al. 2007). In 2010 a follow-up research project is started to refine the instrument and to define preconditions to enable its implementation.

4.1.2. Drug prevention and harm reduction information

The two-yearly monitoring of drug use and health risks in prisons clearly demonstrates that risk behaviour in Belgian prison population is not negligible (cf. chapter 9). In collaboration with the non-profit organisation Modus Vivendi and financed by the Federal Department of Justice, a booklet on drug-related health problems and risk behaviour in prison is made by and for prisoners. It is available since 2009 in French prisons. Since 2011 it is also available in Flemish prisons.

In 2011 a new information campaign oriented at prisoners on hepatitis C oriented at prisoners has been launched in Belgian prisons.

Flyers, brochures, and posters to inform prisoners on the effect of different drugs, are made available in every prison.

A peer support project is repeatedly run in several French speaking prisons. It is installed once a year by a non-profit organization and financed by the French Community.

Prison staff is informed on risk behaviour, drug use, drug policy, effects of different drugs and drug users' behaviour by offering training (cf. infra).

4.1.3. Drug-related treatment, rehabilitation and harm reduction

Low-intensity cognitive-behavioural interventions

In 2010 preparations are made to develop and install 'Short Duration Group Therapy for drug users' in a pilot prison. This cognitive-behavioural program is based on the Transtheoretical Model of change of Prochaska and DiClemente and on the experience of the British prison system with cognitive-behavioural therapy for drug using offenders.

Opiate Substitution Therapy (OST)

Used medications for opiate substitution therapy in Belgian prisons are methadone and buprenorphine. Detoxification as well as maintenance programs are available in prison. A technical protocol as a strict procedure on OST is used as a quality assurance of service. In the penitentiary institutions for remand prisoners, addiction specialists are assigned as reference.

Pressure from the prisoner's environment is experienced as an obstacle for detoxification, as well as a lack of health care staff and former prosecution of prison physicians in cases of overdose where methadone is involved.

On 23 February 2010, 3% of the total prison population receives OST, 82.9% is treated with methadone, 17% with buprenorphine.

On 13 of April 2011 again 3% of the total prison population receives OST. Methadone is used for 80% of those treated with OST and buprenorphine is prescribed in 20% of the cases.

Therapeutic community (TC)

The preparation of a first TC in the Belgian prison system is included in the Action Plan of 2010. Location was found for this TC near the prison of Ruiselede. However, the Nimby-effect has lead to a disapproval of this location.

Drug free programs

Drug free wings in the Belgian prisons know a history of failures, caused by lack of expertise and lack of means. In 2009 a new project started in the Bruges prison and is still successful. One drug-free section is open for maximum 20 prisoners. Standardised procedures for screening, intake of prisoners and voluntary drug testing (as one of the conditions for admission) are developed as well as clearly defined in- and exclusion criteria. Next to relapse

therapy, services aimed at the development of prisoner's social and administrative skills and activities at daily living in order to increase personal functioning are offered.

In the open prison of Ruiselede, with its full employment regime and drug testing, most of the capacity (more or less 50 prisoners) is used to treat sentenced prisoners for who drug addiction has lead to their offending. A high intensity, cognitive behavioural programme of 8 months is offered as final step in the rehabilitation process. After the program, care is continued in this prison setting by offering a follow-up programme of relapse prevention and social skill training. Finally, release is prepared in Ruiselede.

Research of the Prison health Care Service over the period 1995-2005 shows that participants are significantly less likely to be re-arrested (31% vs. 51%) and are arrested less (0.95 vs. 1.7 times for research period). Moreover, the period before a new arrest occurs is longer in participants than non-participants (550 days vs. 389 days). Participants are also more often re-arrested for violating release conditions than committing a criminal offence.

Infectious diseases

Access to provider initiated voluntary testing of hepatitis and HIV in prison is available to prisoners. According to self-reported data over the period 2006-2010, one in three of the prison population has made use of this service. Self reported hepatitis B and C and HIV status as a result of these testing, shows that 2% up to 4% is carrier of HIV. For Hepatitis, being carrier of the C type is most reported with a rate varying from 11% up to 14%. Hepatitis B is reported by 3% to 5%. Rates for carriers of Hepatitis B and C ranging from 0.3% to 3% in prisoners who have been tested in prison (Van Malderen et.al, in press).

Needle and syringe program

Needle and syringe programs are not available in Belgian prisons and are not provided by the responsible regional governments. In 2010, 2% declares to inject any drug in prison, while in 2008 this figure was 3% and 4% in 2006 (Van Malderen et.al, in press). Taking into account a rather low and decreasing percentage of prisoners who inject in prison, needle and syringe programs are not defined as a priority. Bleach is available as household item but not distributed by the Health Care Service.

Provision of condoms

In 2009 a special package containing a condom and lubricant was developed. These packages are available free of charge at the Health Care Service in each prison. However, in practice, these are neither used, nor efficiently distributed and in 2010 most prisoners report not knowing about the availability of these condoms (Van Malderen et.al, in press).

Therefore, the availability and low threshold accessibility to condoms by implementing a condom distribution method in Belgian prisons is included in the latest Action Plan 2011 on Drug policy in Belgian Prisons.

Diagnosis and treatment of injecting-related infections

The diagnosis and treatment of HIV, hepatitis B and C is possible in Belgian prisons. Antiretroviral treatment is offered for HIV and interferon therapy for hepatitis B and C. Moreover, cooperation with Aids resource centres exists.

Social services for drug users in prison

Organisations and services financed by the regional governments are present in prisons. This staff, not employed by the prison authorities, represents social services in the community. For example educational courses are organised inside prison and housing and employment in preparation of release is organised. These services are not specially oriented at drug users. Specific programs for drug users in order to strengthen the different life domains as a protective factor to avoid relapse or problematic drug use are not institutionalised but fragmented. In some prisons such services do exist but the type of service and service providers differ. The Flemish Government has implemented the Strategic Plan for providing services to prisoners including vocational training, education and cultural activities. Consequently, in every prison situated in Flanders, a team is present providing these services. The government of the Walloon region supports local prison projects varying according to local needs.

Preparation of release and continuity of care

Referrals to specialised drug treatment providers in the community are prepared by the Central Intake unit and financed by the Federal Department of Justice. Since the spring of 2011 these units are installed in every prison in the Dutch speaking part of Belgium. One team of community drug workers is composed assessing prisoners who have a need for community treatment upon release. These drug workers have knowledge of the diverse existing drug treatment and procedures in order to inform the prisoner of the possibilities and to prepare a referral. Bound by professional secrecy they act on basis of the prisoners need and are present in prison on a fixed moment. Prisoners can apply for a consultation on one's own initiative or following a referral of services intramuros or extramuros. The implementation of Central Intake Units in French prisons is currently prepared.

4.2. Drug testing

In the absence of a legal ground, mandatory drug testing is not possible in the Belgian prison system. With the exception of drugs in traffic and the use of doping in sports drug testing is only possible with the consent of the patient. Moreover, drug testing is considered as a physical examination affecting one's physical integrity. Patient's consent is necessary in accordance with the law concerning the rights of the patient of 2002 (with exception of criminal investigation and prosecution by law).

However, mandatory or voluntary drug testing cannot be applied as an isolated measure but has to make part of a global approach of the drug problem in prison.

5. Service quality

5.1. Practical guidelines and standards of drug-related health services for prisoners

In general, specific guidelines and procedures are implemented for different treatments and acts that have to be performed in the broad range of health care. The technical protocol for opiate substitution therapy can be mentioned but also standardised procedures are in place for the treatment of hepatitis B and C and for post exposure prophylaxis. New drug projects, as the 'Short Duration Group Therapy for drug users', are structured by clear implementation guidelines and manuals are in development.

Implementing the instrument for screening- and assessment of drug use and psychopathological disorders in prisons (cf. supra) should advance quality of care upon entry. At this moment however, health staff in prison is lacking and generally delays the implementation of drug-related health services in prisons.

5.2 Training (of prison staff in drug PR, HR)

As part of the basic training for all new staff members of the Directorate general Penitentiary Institutions, a course on drugs in prison and drug policy is organized. The multidimensional character of the drug phenomenon is explained in order to sensibilise and break down mistaken ideas about drug use(rs) by providing balanced information. Participants are informed about the latest data on drug use in prison and related health risks collected by the two yearly monitoring in Belgian prisons (cf. Chapter 9, 9.5), as well as on-going and coming initiatives as stipulated in the yearly Action Plan on Drug Policy in Prisons.

Next to this basic training, tailored training packages on specific drug-related issues are offered to meet prisons need. The quality of these trainings is assured by the Prison Health Care service.

6. Discussion, methodological limitations and information gaps

Drug policy in Belgian prisons is gradually put into practice but still drug-related health services are inadequate in terms of availability, taken into account the principle of equivalence, continuity and specificity of care.

Offering care starts with a good screening and assessment of prisoners need. The developed instrument for screening- and assessment of drug use and psychopathological disorders in prisons is essential in identifying those needs and referring prisoners to the most suitable treatment programme. However, the potential of these screenings and assessments can only be maximized when health staff can actually refer to treatment and prepare a treatment plan. Health staff teams in prisons are understaffed to provide, next to the basic, daily medical care, drug-related services. Every year, more than ten thousand prisoners are coming in and out of prisons. The prison system is to a great extent confronted with drug users, posing challenges and opportunities to offer services and treatment for individual but even more for societal ends in preventing re-offending.



Chapter 12.

Drug users with children (addicted parents and children related issues)

Asueta-Lorente, J-F.



1. Introduction

In this chapter, national studies and reviews are first consulted to assess prevalence, characteristics and health-related risks in relation to drug users with children. The legal framework as well as policies specifically addressing drug users with children are then described. Projects targeting drug using parents are presented, from 2007 up to now, with a specification of the target group, objectives and goals as well as the funding (see also Chapter 3, for more information on some of the projects focussing on drug using parents and their children). Finally, national guidelines for drug treatment addressing parents, pregnant women and their children are presented.

2. Size of the problem

2.1. Prevalence and characteristics of drug using pregnant women and parents

In Belgium, an epidemiologic survey built upon a questionnaire sent to the maternity services in 1994 listed 108 births from drug using women. However, only for Brussels capital region, an evaluation based on an estimation by the federal police of the drugs users (8000-15000), taking into account their age (between 18 to 45 years old) and the fertility rate lead to a number of 100 to 200 births a year (Verduyckt 1995). This important discrepancy supports the idea that the population of drug using parents/pregnant women constitute a rather “discrete” population making its assessment difficult.

In 2008 in the French Community, *l’Observatoire de l’Enfance, de la Jeunesse et de l’Aide à la Jeunesse* (OEJAJ, Infancy, Youth and Youth Help Observatory) conducted a study on the characteristics of the population entering the *Services d’Accueil Spécialisé de la Petite Enfance* (SASPE, Specialized early childhood services). When looking at children (0 to 12 years old) for whom a placement procedure had been asked by the *Service d’Aide à la Jeunesse* (SAJ, Youth Help Service) between the first of February and the 31st of July, it can be seen that in 14% of the cases the placement request was motivated by the addiction of one of the parents (OEJAJ2009).

In the residential programme *De Kiem*, a specific project, namely *De Tipi*, started in 1996 is dedicated to provide housing and care to drug-addicted mothers and their children. Table 12.1 shows the amount of specific registrations in *De Tipi* (number and proportion) since its beginning (Sleiman 2005). Over the years, 8.7% of the requests made at *De Kiem* address housing of drug-addicted mothers.

Table 12.1: Number and proportion of treatment demands in the therapeutic community and in *De Tipi*, 1996-2009.

Number of treatment demands	Year													
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Residential programme (total n)	182	207	208	195	208	200	241	216	174	228	226	267	301	254
Therapeutic community (n)	171	187	193	173	191	181	215	197	158	215	209	237	275	236
De Tipi (n)	11	20	15	22	17	19	26	19	16	13	17	30	26	18
Proportion of De Tipi (%)	6.0	9.7	7.2	11.3	8.2	9.5	10.8	8.8	9.2	5.7	7.5	11.2	8.6	7.1

Source: Calle, personal communication

The team of *Parentalité-Addiction* in Brussels is specialised in the care of the future parents and families confronted with problems related to drug use. The objectives are to support the intra-family links by proposing alternatives to meet the needs of the family and to offer a preventive support (Lamkaddem and Roelands 2009). In 2008, 20 pregnancies were followed by *Parentalité-Addiction*, and 18 in 2009.

The Belgian Treatment Demand Indicator Registre (BTDIR) registration for the year 2009 can be used to get information on drug-using parents living with their children at the moment of the treatment demand –no data is available on drug-using parents not living with their children at that time. It appears that on 8130 treatment demands, 855 (10.5%) were made by parents living with their children. More precisely, 2.3 % (n=188) of the demands were made by a parent living alone with his child and 8.2 % (n= 667) of the demands came from a parent living with his partner and his child. Among the 1663 women in treatment, 7.6% (n=127) were women living alone with their children and 10.4% (n=173) were women living with a partner and a child; among the 6467 men in treatment, 0.9% (n=61) were men living alone with their children and 7.6% (n=494) were men living with a partner and a child (Antoine, personal communication).

Figure 12.1: Proportion of treatment demands made by parents living with their child, by living situation and gender. 📊



Source: Antoine, personal communication.

2.2. Physical, mental and other risks/harm among drug using pregnant women / parents and their children

A review on drug addiction and motherhood (Van Woensel and Beyra-Vanneste 2000) stated that all psycho-active drugs can alter the hypothalamic-pituitary axis causing adverse effects on the reproductive system as well in men as in women: decreased libido, sexual dysfunction and decreased fertility. More specifically for women, an alteration of their menstrual cycles or amenorrhea is observed, due to the drugs consumption but also to their lifestyle and nutritional status. The decreased fertility also leads these women not to care for the necessary contraceptive measures.

Cannabis tends to diminish the thirst- and hunger sensation, possibly leading to maternal malnutrition and dehydration that can be passed on to the foetus. Similarly, as this molecule inhibits the production of oxytocin and prolactin, it may interfere with lactation. No teratogenic effect has been proven for taking cannabis but it is often smoked with tobacco for which the negative effects on pregnancy are well documented. It seems that cannabis consumption has no effect on birth-weight nor mortality during the first two years of life but affects gestation duration among heavy consumers (> 6 times a week). Although some authors report a slight delay in the behaviour development during the first

month of life, maybe due to an increase in plasma norepinephrine, there is no evidence of an effect of the consumed cannabis during pregnancy on the child behaviour.

Cocaine has a vasoconstrictive action that causes tachycardia and hypertension. This property can induce a miscarriage during the first trimester of pregnancy and placental abruption in the third quarter, the half-hour after ingestion of cocaine. In addition to these known effects, decreased gestational age, retarded foetal growth and reduced head circumference were also described. No teratogenic effect nor increased mortality during the first two years of life has been demonstrated but some authors reported an increased incidence of sudden death in infants as well as behavioural disorders during the perinatal period.

Opiates use is linked to lower birth weight, head circumference and foetal growth and pre-term delivery of the child from opiates-addicted mothers. Moreover, the consumption of heroin is responsible for withdrawal symptoms, negative for the foetus.

The use of ecstasy is related to a higher incidence of cardiovascular and musculoskeletal malformations in newborns.

Table 12.2: Strength of the harm evidence related to substances use around pregnancy.

Substance	Congenital disorders	Pregnancy problems	Foetal growth	Neo-natal problem
Cannabis	-	+/-	+/-	+/-
Opiates	-	+/-	+	+
Cocaine	+/-	+/-	+	+/-

« + » : Documented effect ; « - » : No effect ; « +/- » : No consensus

Source: Maternité et toxicomanie: état des connaissances (Van Woensel and Beyra-Vanneste 2000).

Often related to the consumption of drugs, infectious diseases cannot be neglected. The active hepatitis B (HBsAg and HBeAg +) will be transmitted in about 90% of cases. Hepatitis C has a vertical transmission of about 11% for HCV-RNA positive patients and almost zero (<1%) for patients not carrying the HCV-RNA (PCR-). There is no evidence about virus transmission through breast milk but it is often not recommended when the mother is a carrier of HCV-RNA. Vertical transmission of AIDS can take place at three moments of pregnancy: in utero, during childbirth and breastfeeding. The anti-viral treatment and elective caesarean section are recommended to decrease perpartale transmission.

One of the main neo-natal problems is the withdrawal syndrome among children exposed to opiates during pregnancy: it is characterized by signs of hyper irritability of the central

nervous system, gastrointestinal dysfunction, impaired breathing and symptoms of the autonomous form such as yawning, sneezing, mottling and fever (Claeys 2011).

Risk factors are linked with the addiction of parents, as it interferes with the educational situation: those parents are described as having a changing mood and a chaotic lifestyle, leading to unsecure environment, unhealthy or unadapted food, bad hygiene and limited medical follow-up of the child. Addicted parents are more prone to experience judicial problems that can lead to the placement of the child, not living with his parents being a factor of less good development. Drug-addicted mothers have a limited social network, suffer from psychological and emotional problems and are more rigid, less responsive; they use physical punishment more often, discuss less and make more often negative comments about their children behaviour. In families involved in drug addiction, the organisation of the family can imply co-dependency of one of the parents and parentification. There is also an increased risk that children of addicted parents will show the parents' same destructive behaviour (Vanderplasschen et al. 2009).

3. Policy and legal framework

Chapter 1 should be consulted for general information on policies and laws related to drugs.

3.1. Policies addressing drug using parents / pregnant women and their children

The Belgian Federal Drug Policy Note does not specifically target drug using parents and their children (Service Public Fédéral Santé Publique 2011). In its joint declaration on a global and integrated policy on drugs, the Interministerial Conference on Drugs indeed stressed that drug using parents are a target group that needs specific attention because they are at that time not reached and/or because no specific strategy has been developed for them (Conférence Interministérielle Drogues 2010) . This latter point was also previously stressed in an evaluation report on the *Maisons d'Accueil Socio-Sanitaire* (MASS, Medical Social Care Centres) (Pelc I. et al. 2001), that can be described as low-threshold agencies (Maison d'accueil socio-sanitaire de Bruxelles 2011)).

3.2. Legal frameworks addressing drug using parents / pregnant women and their children

Two introductory remarks have to be mentioned in order to address the legal framework about drug using parents/ pregnant women and their children. First of all, the Belgian law doesn't specifically target drug-addicted parents but the general legal framework about drug

possession applies to them in the sense that Belgian law punishes possession of drugs other than cannabis by imprisonment for between three months and five years, and/or a fine. Specifically, it is stated that the length of imprisonment may be increased to fifteen or even twenty years in the case of drug offences in relation to minors aged less than twelve, this being considered as an aggravating circumstance. In that sense, even recreational use by adults in the presence of minors is prosecuted in the most severe manner (EMCDDA2004). Second, there are no specific measures addressing children of drug-using parents: the addiction of their parent(s) can be a motive to consider those children as endangered and in that sense it is Youth help/protection that will take them in charge (Lefèvre 2004; Association Interrégionale de Guidance et de Santé 2011). These two reasons lead us to develop in this point how Youth help/protection is organised.

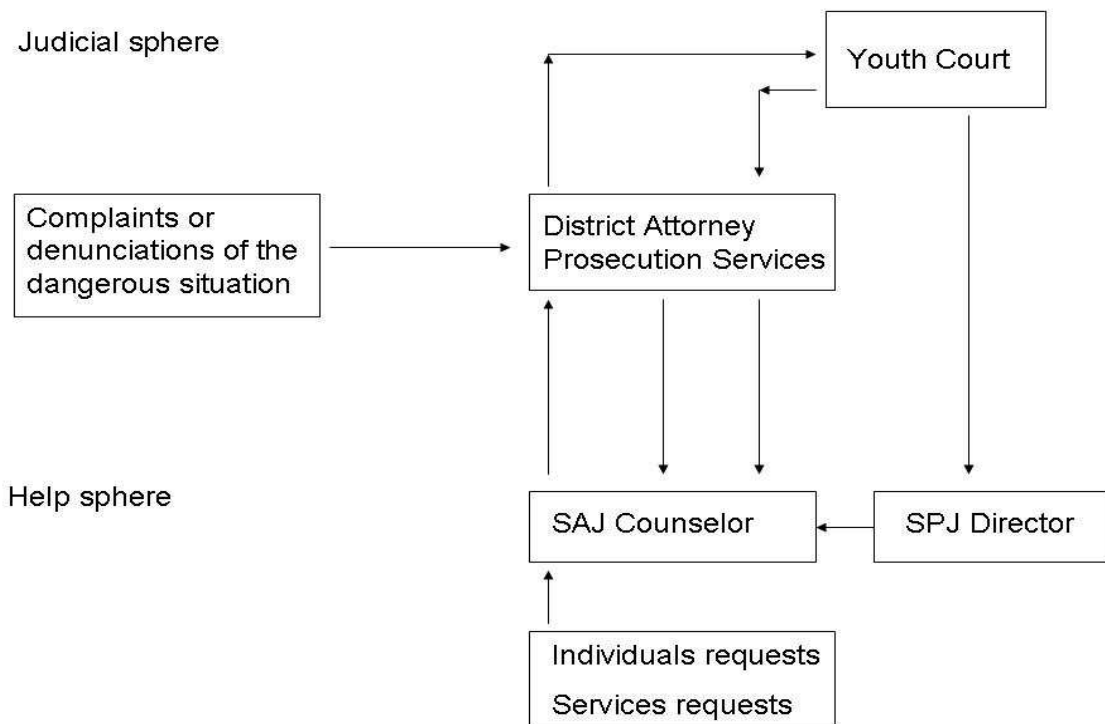
In Belgium each Community organises and is competent for Youth help/protection. For the French Community, reference is made to the Decree of March 4th 1991 and to the Decree of May 19th 2004. In Flanders in 1985, the *Decreet op de Bijzondere jeugdbijstand* (Decree on Specialized Youth Help), the *Gecoördineerde decreten van de Bijzondere Jeugdbijstand* in 1990 (Coordinated Decrees on Specialized Youth Help) and the Decree of March 7th 2008 related to youth assistance constitute the framework of youth help/protection. Those Decrees apply indeed to “*people who have serious difficulties in carrying out parental duties and to children whose health or security are in danger or whose education conditions are compromised by the family*” (Association Interrégionale de Guidance et de Santé 2011).

At the national level, the *laws of May 15th and June 13th 2006* modified again the framework of Youth Protection, based inter alia on the *International Convention on the Rights of the Child* (DGAJ2008; Fédération des Associations de Parents de l'Enseignement Officiel 2008).

Two important characteristics describe specialized Youth Help. First, it has to be complementary and supplementary to other forms of welfare: complementary, because it can help finding or strengthen in a more suitable way the assistance that the society offers to all families, from birth to 18 years old; supplementary because this specialized help should only be provided in cases where those so-called “front line services” could not provide adequate support (Association Interrégionale de Guidance et de Santé 2011). The second and most important characteristic relates to specialized Youth Help organisation: it can either be organised on a voluntary basis (consented help) or either depend from the judicial sphere (constraint help).

In the French Community, the presence of a danger to the child is the first criterion for orientation to the SAJ by the “front line” services. A second criterion is indeed the non compliance of the family. The two criterions lead the SAJ to call for the Youth Court via the *Procureur du Roi* (Prosecutors’ Office) in the perspective of a constraint help (OEJAJ2007). There is thus an important difference between the consented help and the constraint help: this latter is formulated by the judge of Youth Court when children or adolescents are in danger and it is the role of the Director of the *Service de Protection Judiciaire* (SPJ, Judicial Protection Service) to apply the measures decided by the Youth Court. For all those cases where specialized help services have been requested, the child can then be referred to Public Services or to Private, associative ones (Communauté Française 2011).

Figure 12.2: Representation of the different pathways according to the type of specialized help in the French Community.



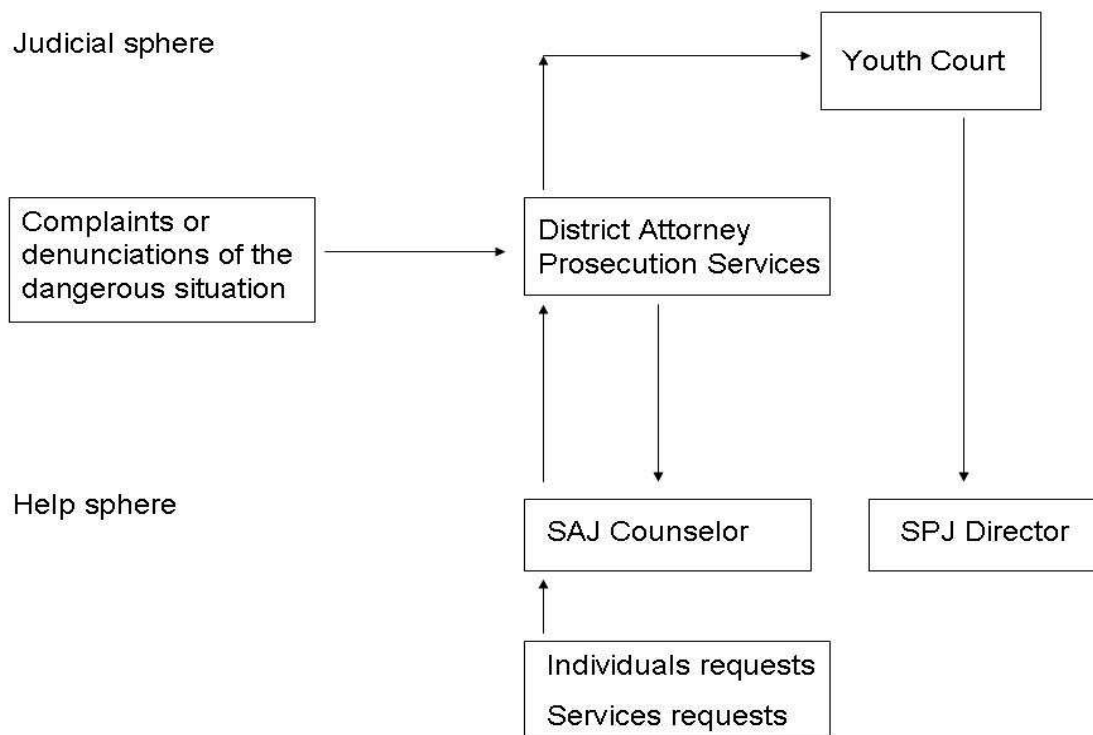
The situation in Flanders is almost similar to the one in the French Community: the *Bijzondere Jeugdbijstand* (Specialized Youth Help) is based on voluntary, consented help and on a constraint, judicial one (Lefèvre 2004). In each district, there is a *Comité voor Bijzondere Jeugdzorg* (CBJ, Committee for Specialized Youth Care): its main task is to organise consented help for children and adolescents and their parents in problematic

educational situations (Ondersteuningsstructuur Bijzondere Jeugdzorg 2011). If the CBJ cannot find a solution, then the file goes to the *Bemiddelingscommissie* (Mediation Commission) (Jongeren Welzijn 2011). The task of the *Bemiddelingscommissie* is to act as a buffer: the objective is to make consented help possible and to avoid a judicial intervention for minors. If no solution is found, then the *Bemiddelingscommissie* has three options: first, mediation succeeds and the voluntary help is again directed to the CBJ; second, mediation fails but a judicial intervention is not seen as necessary; third, mediation fails and the case is transmitted to the Youth Court through the prosecution services. The Youth Court is the judicial part of the *Bijzondere Jeugdbijstand*: it is competent in the case of problematic educational situations when no voluntary help is possible and can furthermore take actions against the parents. It is important to notice that the prosecution services can submit a case to the Youth Court if it is estimated that compulsory educational measures have to be taken and if it can be proved that no immediate voluntary help is possible when at the same time the minor is endangered: these are provisional measures in cases of extreme urgency. (Lefèvre 2004).

In the case of Brussels, until the 1st of October 2009, Youth Help took the form of a hybrid system where Communities decrees (decrees of the French Community and the Flemish Community) and federal law (law of April 8, 1965) coexisted (Lefèvre 2004). The problem being constraint help since Communities decrees in Brussels cannot apply to individuals but only to institutions that may be considered as belonging to one of the Communities. Through the adoption of the *Ordonnance du 29 avril 2004* by the *Common Community Commission* (COCOM) and its application since the 1st of October 2009, Youth Help was reorganised on the territory of Brussels Capital (Van Keirsblick 2009), targeting young people aged less than 18 years old whose health or security are endangered (Lefèvre 2004). One of the major changes is that, for constraint help, the prosecution services cannot anymore refer directly to Youth Court: negotiated, consented help has first to be tried. Another difference relates to the Director of the SPJ: once his intervention is requested, he cannot refer back to the SAJ if an agreement on voluntary, consented help is then found (Lefèvre 2004).

For the German-speaking Community, the *Jugendhilfedekret* (Decree on Youth Help) of the 20th of March 1995 –revised by the *Dekret über Jugendhilfe und zur Umsetzung von Jugendschutzmassnahmen* (Decree on Youth Help and on the implementation of youth protection measures)- organises Youth Help. The same general framework prevails, as in the French and Dutch Communities: there is on one hand, the voluntary, consented help managed by the *Jugendhilfedienst* (JHD, Youth Help Services) and on the other hand, the constraint one, ruled by the Youth Court Services (Landschaftsverband Rheinland 2005).

Figure 12.3: Representation of the different pathways according to the type of specialized help in the Brussels Capital Region.



Source: L'aide à la jeunesse à Bruxelles (Lefèvre & Mondelaers, 2004)

The judicial measures that can be taken against parents by the Youth Court in the case of constraint help are the control of child allowance -someone receives it and make sure that it is used for the specific needs of the child-, the forfeiture of parental authority and court sentences related to a child offence when this one is linked to a lack of control or education by the parents (Service Public Fédéral Belge 2010).

In the French Community for example, in the case of forfeiture of parental authority, a tutor will be designated by the Youth Court, usually on the recommendation of the *Conseiller de l'Aide à la Jeunesse* (SAJ Counselor). The non-deprived parent has priority to carry out this mission. If no person in the environment of the child can perform this task, a social worker from a tutor service will be in charge of parental authority (DGAJ2008).

As final remark, in all those cases of endangered children, it has to be noticed that the notion of discretionary competence is very important: the field of People Assistance - and thus Youth Protection - is a person-related matter, so that there are no “ready-made” answers; each situation has to be appreciated thoroughly. For example, if a child is placed in a foster

home because his parents are in prison, it will not be automatically decided that they will live with the child at their release. In the perspective of the highest interest of the child, the costs and benefits of living with his parents and breaking the bonds with the foster family have to be estimated.

4. Responses

4.1 Responses addressing drug using parents/pregnant women and their children

In 2006, a budget of 190000 euro was allocated by the National Institute for Health and Disability Insurance (NIHDI) to a specific project focusing on the target group of drug-using parents. This agreement provided dependent mothers or fathers with children following a residential treatment programme, the possibility to stay with the children in a specific, isolated service of the institution where the revalidation takes place, the objective being to not separate the parent(s) from the child(ren) because of the treatment. In that sense, since January 1st 2007, the NIHDI finances two parent-child sections, *de Tipi* in Gavere and *maison Kangourou* in Châtelet (Conférence Interministérielle Drogues 2010). The specific guidance at “*De Tipi*” consists of a weekly gathering of the group. During this gathering it is extensively spoken about topics concerning the evolution of the children, the planning and organisation of the household and the cohabitation of different families. Besides there are, on a regular base, separate trainings concerning specific topics. The Tipi-mentors are regularly present to observe, support and provide individual coaching. The mother makes up a plan regarding the education of her child(ren), this plan being regularly evaluated and adjusted (Sleiman 2005). The *maison Kangourou* project is a combination of care programmes and education for parenthood, in partnership with the Office de la Naissance et de l'Enfance (ONE, Birth and Infancy Office). The child and his mother live in the same place at a pace that matches the one that all women know when they work. While undergoing treatment, children are at nursery or school. In *maison Kangourou*, women are fully responsible for their children on weekdays as on weekend days (Kangourou-Trempline 2011).

The Federal Addiction Fund supports several actions and projects aiming at providing information on risks related to drug use, reducing consumption, providing medical, psychological and social assistance. One of the Federal Addiction Fund priorities is to stimulate support and treatment of vulnerable groups like addicted mothers and their children. The latest projects funded by the Addiction Fund related to drug using

parents/pregnant women and their children, since 2007 up to now, are reported in the Table 12.3.

The evaluation of those project is made in a qualitative way, through steering committees taking place 2 to 3 times a year: the projects proposals provides a schedule and the steering committees evaluates if the schedule is respected (Huard, personal communication).

In addition to those projects related to the Federal Addiction Fund, several other projects or actors targeting drug using parents and pregnant women exist among care services for drug addicts. The Table 12.4 presented hereafter compiles projects/actors not yet presented that relates to drug users with children and/or drug-using pregnant women, using data since 2000: it should be noted that some of those projects do not exist anymore (Walckiers 2001; Sleiman and Sartor 2002; Sleiman 2003; Sleiman 2004; Sleiman 2005; Sleiman and Roelands 2007; Lamkaddem and Roelands 2008; Lamkaddem and Roelands 2009; Lamkaddem and Roelands 2010).

Table 12.3: List of projects addressing drug using parents and/or their children supported by the Federal Addiction Fund (2007-2010).

Institution	Target group	Description	Actions/Goals	Funding period	Funding (in euro)
CAT Preventiehuis Gent	Children of drug using parents	Prevention of addictions, psychic or psychosocial problems	Build a strong parental link. Promote awareness of the problem by the drug using parents. Inform parents and children. Develop the child competencies.	07/2007 - 06/2008	64500
De Kiem	(Ex-)addicted parents	Try to increase the parents' upbringing competencies	Parents' courses. Video-interactive accompaniment. Creation of a parents group.	07/2007 - 06/2008	28112.18
Trempline	Parents in residential setting	(Re-)establish/preserve the link with their children. Develop their educational competencies.	Inform parents. Parents' accompaniment for social or medical appointments. Parents-children activities. Thematic groups. Parents-children communication tools Individual consultations for parents.	07/2007 - 06/2009	75950
Kliniek Sint-Jozef vzw	Youngsters with psychological problems Children/youngsters of addicted parents	Coordinate offer on prevention and care	Promote awareness of health risks related to substances use. Strengthen youngsters' social competencies. Upbringing support for the parents.	07/2007 - 06/2009	91290
MSOC Gent	Addicted parents/pregnant women	Offer a concrete care and an intensive accompaniment	Intervisions with/formations for carers. Create as fast as it is possible a secure upbringing framework for the children.	07/2007 - 12/2011	294025
Katarsis	Parents following therapy in the Katarsis treatment centre for addiction	Support to the parenting role	Individual accompaniment. Work in Life-groups. Organisation of several activities.	01/2009 - 12/2010	60446.72

Table 12.3 continued

Institution	Target group	Description	Actions/Goals	Funding period	Funding (in euro)
Centre Alfa	Children of addicted parents Health professionals	Realisation of a tale explaining drug addiction	Realisation of a tale. Formation of health professionals to the tale use.	01/ 2009 - 12/2010	61000
MSOC Oostende	Drug-addicted parents and their children/youngsters	To offer in a proactive way an integrated and intensive accompaniment	Outreached support/home accompaniment for the (Multi-problems) families.	01/2010 - 12/2011	156590
THAIS	Drug-addicted parents and their children	Support to the parenting role for addicted persons	Propose fun activities to do in family, like week-ends at the countryside. Promote the link between parents and children.	01/2010 – 12/2010	28000
Het Veerhuis – Siddartha (MSOC Vlaams Brabant)	Drug-using parents and their children	Upbringing support to drug using parents and their children in Flemish Brabant and expertise promotion of the low-threshold services to drug using parents and their children in Flanders	Setting up parent groups, implementing the script and roadmap "Pregnancy", and implementing children's books to make the topic debatable in children. Focus on information transfer, training and education in the various Flemish MSOC's, where all the previous gained experience and developed methods are exchanged in order to increase the expertise around the target group and to promote regional cooperation and coordination. (see also Chapter 3)	01/2011 - 12/2011	57780
CSM Assuétudes du CPAS de Charleroi	(Ex-) drug using parents. Children aged 0 to 6 years old in relation with (ex-)using parents	Discussion groups Relay-parents training	Train relay-parents. Promote the expression of difficulties. Promote share of knowledge and experiences. Strengthen, valorize, support the parents' resources and competencies. Promote a positive representation of institutions among substance users.	07/2007 - 12/2009	131287

Source : Huard, personal communication.

Table 12.4: Projects addressing drug using parents/pregnant women and their children (2000-2011).

Institution	Project name	Target group	Project
Kind en gezin	N/A	First childhood	Assistance to parents on healthy living
Office de la Naissance et de l'Enfance	N/A	First childhood	Assistance to parents on healthy living
N/A	N/A	First childhood	Parents training (Elternt raining), German-speaking Community
Centra Geestelijke Gezondheidszorg (CGG)	KOPP-project	Children of drug or alcohol misusing parents with psychological/psychiatric problems	Avoid or decrease psychological/social problems
AVAT	La Brique	Youngsters aged 12-17 of drug using parents	To offer a place of exchange but also a creative space for the expression of emotions.
De Sleutel	Het gat in de haag	Early childhood	Development of the child lifeskills
VAD through MSOC Genk	N/A	Individuals and groups	Development and implementation of models of educational support; educational manuals (see also Chapter 3)
Belgium (European Project)	Vulnerable people: addicted mothers and their young children	Children of addicted parents, parents addicted to drugs, addicted pregnant women	Exchange of information about all the methods used in the various countries for identifying the target groups of the project as early as possible and reaching individuals with assistance in order to prevent problems in the raising of their young children

Table 12.4 continued

Institution	Project name	Target group	Project
N/A	Expert people	Addicted parents and their children	Prevention of problems among the target group through the development of a training model to improve the knowledge and skills of professional counsellors working with addicted parents with children
Free Clinic	Bubbels & Babbels	(ex)-drug dependent parents	To provide all the essential support to the parents regarding the welfare and the basic needs of the child and decrease the harmful effects of drug addiction on children, families and the community
Trempoline	N/A	Personnel of the pre- and postnatal consultations of the Office de la Naissance et de l'Enfance	Organisation of modules of training on "Dependence and parenthood"
Hopital Public Saint Pierre	Alizés	Drug using parents and non-drug using parents	Counseling of the target group by the mean of various activities like information sessions, psycho-motricity activities
MSOC/MASS	Kiddo, PROject,...	(Ex)-drug addicted parents and their children	To get parents aware of the consequences of their addiction for their children; to cooperate with other services to develop a specific help service for drug addicted parents and lead the parents to these initiatives; to inform the clients about the existence of the different available services and encourage them to make use of these services; to improve the skills of other organisations working with drug addicted parents; to integrate educational assistance in the existing framework
Centre ALFA	N/A	Pregnant women or women with a newborn baby	To offer a psycho-medico-social follow up in order to prevent future drugs problems for the children.
VAD	N/A	Future mothers	Development of a leaflet "Drugs en Zwangerschap"
Les Hautes Fagnes	N/A	Mother and child	Residential treatment programme where specific place is available for one mother and her child

Table 12.4 continued

Institution	Project name	Target group	Project
Bruges prison	N/A	Mothers with children up to 2,5 years old; women who are to give birth while in prison	Special unit within the prison for this target group (Walloon prisons provide this kind of service individually)
DrugLijn	N/A	Drug using parents and children of drug using parents	To provide information through the website, i.e. "Drugs and pregnancy", "What to do if your parent(s) use drugs?"
Hopital Public Saint Pierre	Parentalité-Addiction	Parents and the (future) baby	To stabilize the drug consumption (especially of the mother) during pregnancy and the post-partum; To prevent the damages suffered by the baby (e.g., withdrawal syndrome); To improve the early relationship between the baby and his family circle; To reduce neglecting or ill-treatment behaviours; To improve the social insertion of the family; To propose haptonomy techniques
De Sleutel	Weekend parents	Addicted parents and their children	To monitor and to improve weekend visits from addicted parents to their children
De Sleutel	Ouderwinkel	(ex)-drug dependent parents	To provide information about the education of children; to give opportunities to the parents to exchange on their own experiences
Service de Santé Mentale du Centre Public d'Aide Sociale de Charleroi	Parent's house	Parents	To support parenthood in the context of a "priority action zone" (zone suffering from socio-economic lacks) through collaboration with the structure "Espace citoyen de Dampremy"
De Sleutel	Kinship carers	Children	De Sleutel selected and interviewed grandparents who took care of their grandchildren in situations of drug abusing parents

Source: Belgian Annual Report on Drugs, 2001-2009; VAD, 2011.


4.2 Guidelines addressing drug using parents/pregnant women and their children

In 2000, a follow-up of the 1994 conference about consensus on methadone was held. This experts meeting stated a double position about methadone use and pregnancy. First, and importantly, pregnancy does not constitute a contra-indication to methadone use. Second, if pregnancy occurs, it is recommended to not stop methadone treatment but this situation will request specific competencies for caring (Pelc I. et al. 2011). As pregnancy is no contra-indication to methadone use, the following general guidelines resulting from this follow-up conference are of application. As such, the treatment shall begin with a 30 mg/day dosis and specific psychiatric comorbidity will be assessed and treated separately. No prescription of take-away doses will be made during the first six weeks and information to the patient and its relatives on risks related to an accidental methadone use should always be given by the practitioner. It will be noted that a medium or long duration of substitution therapy is necessary for the development of the expected positive evolution and in that sense the practitioners will ensure the strengthening of the patient therapeutic compliance.

Clinical guidelines on Buprenorphine use for the treatment of opiate-addicted drug users have been developed by the non-profit organisation *Vereniging voor Alcohol en andere Drugproblemen* (VAD). Using Medline, the VAD library and manual search using an iterative procedure across references, randomized, double-blind clinical studies, meta-analyses and guidelines were selected through a search based on the two following MeSH terms: buprenorphine and opioid related disorders. Furthermore additional articles were searched for in Addiction abstracts. Books were searched in Drugscope and Toxibase, including studies since 2004, where use of Buprenorphine was applied according to strict guidelines in terms of setting and framing. Specifically, when focusing on drug using parents/pregnant women and/or their children, the guidelines join with the Australian ones. Thus, insofar as current knowledge failed to gather enough information about the safety of treatment, the use of Buprenorphine in pregnant and lactating women is a contra-indication. Pregnant women are proposed to switch to Methadone and are informed of the lack of information about Buprenorphine and safety for the foetus. If, after consideration Buprenorphine is chosen, then an informed consent is signed by the physician and the patient (VAD2005).

In 2001 it was stated that “when in prison, continuation of maintenance treatment is recommended for pregnant women” (Walckiers 2002). In 2004 maintenance was recommended for all prisoners entering the prison while already in treatment, and if they were (probably) not to stay longer than one year. It was nevertheless stressed that “caution

is expected when the patients are pregnant, HIV positive or suffering from hepatitis". Initiation of substitution treatment is then possible (Sleiman 2004).

A decorative graphic at the top of the page features a solid brown horizontal bar. On the right side of this bar, there are two overlapping hexagons: a yellow one on top and a dark red one on the bottom. Below the bar, two more hexagons are visible, one orange and one light orange, appearing to be partially cut off by the bottom edge of the bar.

Part C

Bibliography

AUTHORS AND CONTRIBUTORS

Author information

Antoine Jerome joined the Belgian Monitoring Centre for Drugs and Drug Addiction in January 2011. He has a bioengineer background and developed his knowledge in epidemiology and statistics. He worked for 2 years in the Epidemiology team of the Institute of Public Health on different topics as statistical support. He is the person in charge of the coordination of the Treatment Demand Indicator project.

Asueta-Lorente Juan-Francisco has a master in Psychology. He previously worked in the field of chronic pain as a clinician as well as a researcher. Since February 2011, he works at the SURD team at the WIV-ISP, where he participates in a specific project of the Belgian Science Policy focusing on developing best practice guidelines for the detection, prevention and treatment of substance misuse in children and youngsters (12-18) using the ADAPTE process.

Bollaerts Kaatje graduated as Master in Psychology at the Catholic University Leuven in 2001 and as Master in Applied Statistics at Hasselt University in 2004. She obtained her PhD in Applied Mathematics on statistical models in epidemiology and quantitative risk assessment at Hasselt University in 2009. After obtaining her PhD, she started working at the Belgian Monitoring Centre for Drugs and Drug Addiction (WIV) as statistician-epidemiologist.

Casero Lucia has a Master in Pharmacy. She joined Eurotox in 2007 as a coordinator after graduating with a Master in Public Health (MPH) from the ULB-UCL University. She holds some complementary certificates in Public Health in particular from the University Carlos III in Madrid and from the Tropical Institute of Medicine in Antwerp. Her career includes several years of coordinator and program manager in Non-profit organizations.

Colpaert Kathy is research and teaching assistant at the Department of Orthopedagogics at Ghent University. The topic of her PhD-research is psychopathology and poly substance dependence.

Jelle Crement graduated as Master in Criminological Sciences at Ghent University in 2011. Since August of that same year, he works at the 'Institute for International Research on Criminal Policy' (UGent).

De Maeyer Jessica (PhD) is post-doctoral researcher at the Department of Orthopedagogics at Ghent University. Her research is focused on quality of life and empowerment of drug users.

Prof. dr. Brice De Ruyver is master of law (1978), master of criminology (1978) and doctor in criminology (1986). He is Full Professor at Ghent University attached to the Department of Criminal law and Criminology and Director of the research group 'Institute for International Research on Criminal Policy' (IRCP).

Prof. De Ruyver participates in different international networks and has published on drug policy, organised crime, human trafficking, criminal policy & international policy regarding Justice and Home Affairs. He was and is promoter of several research projects (circa 70), amongst others for the European Commission and several Belgian federal government departments (Science policy, Justice, Interior, Foreign Affairs, Development Cooperation,...). Since April 2000 until March 2008 he was expert adviser to the Prime Minister in relation to security and the police reforms. Since 2002 he is member of the scientific committee of the EMCDDA (Lisbon). Since 2010 he is national drug coordinator.

Deprez Nathalie graduated as Master in Psychology at Ghent University in 2008. She works at the Belgian Monitoring Centre for Drugs and Drug Addiction (WIV-ISP), since October 2008.

Goethals Ilse is research and teaching assistant at the Department of Orthopedagogics at Ghent University. Her PhD-research focuses on change processes in drug-free therapeutic communities.

Laudens Fred studied Psychology and works for VAD since 1999. He is the liaison between VAD, as the Flemish regional focal point, and the IPH.

Delfine Lievens is master of criminology (2008) and master in management of public organizations (2010). She previously worked as scientific researcher at the Department of Accountancy and Corporate Finance and at the Department of Penal law and Criminology (research group IRCP) of Ghent University. Since September 2011 she is a PhD student who

investigates the governmental supervision and management of expenditures regarding the realization and evaluation of drug policy.

Sasse, André, MD, MPH is currently Head of HIV/AIDS/STI Surveillance program at the Scientific Institute of Public Health in Brussels, Belgium. Doctor Sasse first worked as a medical doctor and as an epidemiologist in African and South American countries before going on to study public health, epidemiology and biostatistics at the University of North Carolina at Chapel Hill, USA. He also worked as a public health adviser in former USSR countries.

Schelinga, Carolin works at the Arbeitsgemeinschaft für Suchtvorbeugung und Lebensbewältigung

van Bussel Johan Ma, MSc, completed his PhD in Biomedical Sciences (K.U.Leuven). In August 2009, he joined the Operational Direction Public health and surveillance of the Scientific Institute for Public Health (WIV) and worked as a senior scientist for the European Community Health Indicators Monitoring program (ECHIM). As of May 2010, Johan van Bussel is head of the Substance Use and Related Disorders research program of the WIV and head of Belgian Monitoring Centre for Drugs and Drug Addiction, focal point of the European Information Network on Drugs and Drug Addiction (REITOX) of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

Van der Linden Trudy studied Biomedical Science at the University of Ghent. She previously worked on the Integrated European project DRUID (Driving Under the Influence of Drugs, alcohol and medicines). Since April 2011 she is ad interim coordinator of the Belgian Early Warning System on Drugs.

Van Malderen Sara is Coordinator of Drug Policy in Prisons for the Federal Department of Justice since 2009 where she proposes and advises new initiatives for drug policy in prison. She is responsible for the development, implementation and coordination of drug-related initiatives in prison. In 2004 she received a Master degree in Criminology and in 2005 an advanced Master in European Criminology and Criminal Justice Systems. From 2005 until the end of 2008 she was scientific researcher at the Ghent University for the Institute for International Research on Criminal Policy. Several publications and presentations are to her name as expert in the field on drugs and drug policy. Next to this expertise she also has publications on other criminological phenomena from nuisance, to the exchange of law enforcement information.

Prof. dr. Freya Vander Laenen is bachelor of Social Work (1993), master of Criminology (1996) and doctor in Criminology (2007). She is Professor at Ghent University attached to the Department of Penal law and Criminology and member of the research group 'Institute for International Research on Criminal Policy' (IRCP).

Prof. dr. Vander Laenen participates in different international networks and has published on drug prevention, harm reduction, drug related crime, drug policy and on qualitative methodology in drug research.

Vanderplasschen Wouter (PhD) is lecturer at the Department of Orthopedagogics at Ghent University. He is a senior researcher in the field of addiction treatment and recovery.

Bibliography

List of references

- Aebi, M. F. & Delgrande, N. (2011). Council of Europe Annual Penal Statistics SPACE I: Survey 2009 (Report PC-CP (2011) 03), Council of Europe, Strasbourg, France.
- Association Interrégionale de Guidance et de Santé (2011). Décret relatif à l'aide à la jeunesse [online]. Available: http://www.joconda-aigs.be/Joconda/Valise%20pedagogique/moniteur_belge/4_mars_1991.htm [accessed 17-8-2011].
- Autrique, M., Vanderplasschen, W., Pham, T.H., Broekaert, E., & Sabbe, B. (2007). Evidence-based werken in de verslavingszorg: een stand van zaken - Les pratiques 'evidence based' dans l'aide aux toxicomanes: un état des lieux Academia Press Gent.
- Baeten, I. & Rosiers, J. (2010). Alcohol- en druggebruik in de bijzondere jeugdzorg. Vragen over aanpak en begeleiding anno 2010. Rapport nodenbevraging bijzondere jeugdzorg., VAD, Brussels.
- Bartholomeeusen, S., Buntinx, F., & Heyrman, J. (2002). Ziekten in de huisartspraktijk: Methode en eerste resultaten van het Intego-netwerk. Tijdschrift voor Geneeskunde, **58**, 863-871.
- Bayingana, K., Demarest, S., Gisle, L., Hesse, E., Miermans, P. J., Tafforeau, J. et al. (2006a). Gebruik van Illegale Drugs. In: Gezondheidsenquête door middel van Interview, België, 2004, K. Bayingana et al., eds., pp. 499-541. Afdeling Epidemiologie - Wetenschappelijk Instituut Volksgezondheid, Brussel.
- Bayingana, K., Demarest, S., Gisle, L., Hesse, E., Miermans, P. J., Tafforeau, J. et al. (2006b). Usage de drogues illicites. In: Enquête de santé par interview, Belgique, 2004, K. Bayingana et al., eds., pp. 499-541. Service d'Epidemiologie - Institut Scientifique de Santé Publique, Bruxelles.
- Belgian Institute for Traffic Safety 2010. Persconferentie: Presentatie van de informatiecampagne over nieuwe speekseltesten.
- Belgian Science Policy (2011). Determination of the yield of an illegal indoor cannabis plantation (YILCAN) [online]. Available: <http://www.belspo.be/belspo/fedra/proj.asp?l=en&COD=DR/56> [accessed 22-8-2011].
- Berchiolla, P., Carena, F., Chiado Piat, S., hiers, J., Druart, A., Kedzia, M., Sanchez, L., Siliquini, R., Siliquini, V., Specchia, M. L., Vankov, D., Vanzino, S. B., & Villerusa, A. (2010). Ten D by night project., S&T Soc.Coop., Italy.
- Blencowe, T., Pehrsson, A., and Lillsunde, P., editors (2010). Analytical evaluation of oral fluid screening devices and preceding selection procedures.
- Bosker, W.M. & Huestis, M.A. (2009). Oral fluid testing for drugs of abuse. Clin.Chem., **55**, 1910-1931.
- Broekaert, E. (2006). What future for the Therapeutic Community in the field of addiction? A view from Europe. Addiction, **101**, 1677-1678.
- Bruffaerts, R., Vanderplasschen, W., Van Hal, G., & Demyttenaere, K. (2010). Crisisopvang voor middelengebruikers in België: een formele evaluatie en aanbevelingen voor een duurzaam beleid - De Evaluatie van Crisis en Case Management (ECCAM) - studie

Bibliography

- Buchanan, J.F. (2004). Missing links? Problem drug use and social exclusion. Probation Journal, **51**, 387-397.
- Buziarsist, J., Demarest, S., Gisle, L., Tafforeau, J., Van der Heyden, J., & Van Oyen, H. (2002a). Deel 3 Leefstijl - Gebruik van Illegale Drugs. In: Gezondheidsenquête door middel van Interview, België, 2001, S. Demarest et al., eds., pp. 1035-1078. Afdeling Epidemiologie - Wetenschappelijk Instituut Volksgezondheid, Brussel.
- Buziarsist, J., Demarest, S., Gisle, L., Tafforeau, J., Van der Heyden, J., & Van Oyen, H. (2002b). Livre 3 Style de vie - Usage de drogues illicites. In: Enquête de Santé par Interview, Belgique, 2001, L. Gisle et al., eds., pp. 1035-1078. Service d'Epidemiologie - Institut Scientifique de Santé Publique, Bruxelles.
- Cardoen, D., Berten, H., & Vettenburg, N. (2011). Alcohol- en softdrugsgebruik in Brussel. In: Jong in Brussel. Bevindingen uit de JOP-monitor Brussel., N. Vettenburg, M. Elchardus, & J. Put, eds., pp. 349-382. Acco, Leuven.
- Casero, L., Hogge, M., Rwubusisi, M., Bastin, P., Dal, M., & Van Huyck, C. (2010). L'usage de drogues en Communauté française. Rapport Communauté française 2010., Eurotox asbl, Brussels.
- Casero, L., Rwubusisi, M., Pozza, M., Vanhuyck, C., Dal, M., & Bastin, P. (2008). Elaboration d'un cadastre des actions de prévention des assuétudes et de réduction des risques liés à l'usage de drogues subsidiées par les pouvoirs publics en Communauté française., Eurotox,
- Charlier, C., Verstraete, A., Dewulf, J., Maebe, K., Pirson, L., Van Puyenbroeck, L., Isalberti, C., Collart, A., Theunis, L., & Decock, L. (2010a). Trace detection of synthetic drugs production in waste waters (GEOAMP)
- Charlier, C., De Ruyver, B., Verstraete, A., De Backer, B., Maebe, K., Legrand, S.-A., Colman, C., & Theunis, L. (2010b). Study of part of locally cultivated cannabis on Belgian market of the drug (GEOCAN).
- Claessens, J. & Defillet, T. (2010). Screenen met de ASSIST in de eerstelijnszorgsector VAD Brussel.
- Claessens, J. & Raskin, K. (2010). Vroeginterventie via groepswerking met jonge druggebruikers., VAD, Brussels.
- Claeys, N. (2011). Genderspecifieke hulpverlening aan drugsverslaafde vrouwen. Verslaving.Tijdschrift over verslavingsproblematiek, **1**, 73-82.
- College van procureurs-generaal: Statistisch analisten (2011). Jaarstatistiek van het Openbaar Ministerie. Opsporing en vervolging van strafzaken door de parketten van de rechtbanken van eerste aanleg. [online]. Available: http://www.just.fgov.be/statistique_parquets/start/n/home.html [accessed 30-7-2011].
- Communauté Française (2011). Les Services de l'Aide à la Jeunesse en Communauté Française [online]. Available: <http://www.arianet.irisnet.be/legislat/aidej.htm> [accessed 11-8-2011].
- Communauté française de Belgique (2011). Evaluation des dispositifs de al politique de santé en Communauté française., Perspectif Consulting, Efficiencies,
- Conférence Interministérielle Drogues (25-1-2010). Une politique globale et intégrée en matière de drogues pour la Belgique.
- Conférence interministérielle Santé publique. Drogues 13.2. - Enregistrement des demandes de traitement via le Treatment Demand Indicator. Enregistrement des demandes de traitement via l'opérationnalisation du Treatment Demand Indicator Européen. 2006/22273, 22932-22934. 3-5-2006.

- Copeland, J., Frewen, A., & Elkins, K. Management of cannabis use disorder and related issues. A clinician's guide. 1-128. 2009. Sydney, National Cannabis Prevention and Information Centre, University of New South Wales.
- Cops, D. & Op de Beeck, H. (2011). Dader- en slachtofferschap onder Brusselse scholieren. In: Jong in Brussel. Bevindingen uit de JOP-monitor Brussel, N. Vettenburg, M. Elchardus, & J. Put, eds., pp. 297-328. Acco, Leuven.
- De Boyser, K., Linchet, S., Van Dijck, L., Casman, M. T., Dierckx, D., & Vranken, J. (2010). Onderzoek naar de OCMW-hulpverlening van dak- en thuislozen., POD Maatschappelijke integratie, Brussel.
- de Graaf, R., Radovanovic, M., van Laar, M., Fairman, B., Degenhardt, L., Aguilar-Gaxiola, S. et al. (2010). Early cannabis use and estimated risk of later onset of depression spells: Epidemiologic evidence from the population-based World Health Organization World Mental Health Survey Initiative. Am.J.Epidemiol., **172**, 149-159.
- De Hert, M., Wampers, M., Jendricko, T., Franic, T., Vidovic, D., De Vriendt, N. et al. (2010). Effects of cannabis use on age at onset in schizophrenia and bipolar disorder. Schizophrenia Research, **126**, 270-276.
- De Keulenaer, S. & Thomaes, S. (2010). Kwantitatieve evaluatie van het pilootproject 'Drugbehandelingskamer' aan de Rechtbank van Eerste Aanleg te Gent.
- De Maere, W., Hariga, F., Bartoleyns, F., & Vanderveken, M. (2000). Gezondheid en druggebruik in het penitentiair milieu. Ontwikkeling van een epidemiologisch onderzoeksinstrument., Federale diensten voor Wetenschappelijke, Technische en Culturele Aangelegenheden, Brussel.
- De Maeyer, J., Vanderplasschen, W., & Broekaert, E. (2009). Exploratory study on drug user's perspectives on quality of life: more than health-related quality of life? Social Indicators Research, **90**, 107-126.
- De Maeyer, J., Vanderplasschen, W., Lammertyn, J., van Nieuwenhuizen, C., & Broekaert, E. (2011a). Exploratory study of domain-specific determinants of opiate-dependant individuals' quality of life. European addiction research, **17**, 198-210.
- De Maeyer, J., Vanderplasschen, W., Lammertyn, J., van Nieuwenhuizen, C., Sabbe, B., & Broekaert, E. (2011b). Current quality of life and its determinants among opiate-dependent individuals five years after starting methadone treatment. Qual Life Res, **20**, 139-150.
- De Ruyver, B., Lemaitre, A., Born, M., Colman, C., Pirenne, C., & Vandam, L. (2008a). Definition and measurement of drug-related crime.
- De Ruyver, B., Lemaitre, A., Born, M., Ponsaers, P., Pauwels, L., Vander Laenen, F., Vanderplasschen, W., Van Malderen, S., Chapeau, M., Vindevogel, S., Cammaert, F., Moës, A., Devue, A., & Vandam, L. (2008b). Do's and don'ts in a comprehensive and integrated drug policy.
- De Ruyver, B., Lemaitre, A., Schoenaers, F., Ponsaers, P., Pauwels, L., Vander Laenen, F. et al. (2009). Essential and supplementary preconditions for the interaction of justice and drug treatment services
- De Ruyver, B., Pelc, I., De Graeve, D., Bucquoye, A., Cornelis, L., & Nicaise, P. (2007). Drug Policy in figures II: a study into the actors involved, government expenditure and target groups reached. Academia Press Gent.
- De Ruyver, B., Vander Laenen, F., Vanderplasschen, W., Colman, C., & Broekaert, E. (2010). De Drugbehandelingskamer. Kwalitatieve evaluatie van het pilootproject 'Drugbehandelingskamer'.

Bibliography

- De Sleutel (2006). Project Proefzorg Gent in samenwerking met De Sleutel een succes. [online]. [accessed 17-8-2011].
- Decorte, T. (2010). The case for small-scale domestic cannabis cultivation. International Journal of Drug Policy, **21**, 271-275.
- Decorte, T., Mortelmans, D., & Tieberghien, J. (2009). Haalbaarheid van een repetitieve prevalentiestudie onder de algemene bevolking : eindrapport Academia Press Ghent.
- Decorte, T. & Muys, M. (2010). Tipping the balance: a longitudinal study of perceived 'pleasures' and 'pains' of cocaine use (1997 - 2009). In: Pleasure, pain and profit: European perspectives on drugs., T. Decorte & A. Fontaine, eds., pp. 35-54. Pabst, Wolfgang Science, Lengerich.
- Decorte, T., Muys, M., & Slock, S. (2003). Cannabis in Vlaanderen: patronen van cannabisgebruik bij ervaren gebruikers. Acco Leuven.
- Decorte, T., Stoffels, I., Leuridan, E., Van Damme P., & Van Hal, G. (2011). Middelengebruik onder sekswerkers in België: een kwantitatieve en kwalitatieve studie in vijf sectoren van de seksindustrie., Academia Press, Gent.
- Defillet, T. & Claessens, J. (2010). Handleiding ASSIST voor de eerstelijnsgezondheidszorg VAD Brussel.
- Degenhardt, L., Hall, W., & Warner-Smith, M. (2006). Using cohort studies to estimate mortality among injecting drug users that is not attributable to AIDS. Sex Transm.Infect., **82 Suppl 3**, iii56-iii63.
- Derluyn, I., Vanderplasschen, W., Alexandre, S., Stoffels, I., Scheirs, V., Vindevogel, S., Decorte, T., Franssen, A., Kaminski, D., Cartuyvels, Y., Broekaert, E., & . (2010). Treatment trajectories of drug users from ethnic minority groups., Belgian Science Policy, Brussels.
- Dienst voor het Strafrechterlijk beleid (2011). Dienst voor het Strafrechterlijk beleid. Statistiek. [online]. [accessed 22-8-2011].
- Direction Générale de l'Aide à la Jeunesse (2008). Aide à la jeunesse: question de parents [online]. Available: http://www.aidealajeunesse.cfwb.be/fileadmin/sites/ajss/upload/ajss_super_editor/professionnel/documents/publications/AJ_questions_parents_2008.pdf [accessed 8-8-2011].
- Directorate-general of Penitentiary Institutions (2011a). Activity report 2010.
- Directorate-general of Penitentiary Institutions, a. m. (2011b). Prison population on 01.09.2011
- Ducoffre, G., Quoilin, S., & Wuillaume, F. (2010). Surveillance of influenza A and respiratory syncytial virus (RSV) by the Belgian sentinel laboratory networks. Arch Public Health, **68**, 83-84.
- Dumarey, M., Vander, H.Y., & Rutan, S.C. (2010). Evaluation of the identification power of RPLC analyses in the screening for drug compounds. Anal.Chem., **82**, 6056-6065.
- European Monitoring Centre for Drugs and Drug Addiction (2004). Policy and law: European Legal Database on Drugs [online]. Available: <http://www.emcdda.europa.eu/html.cfm/index5174EN.html#> [accessed 7-7-2011].
- European Monitoring Centre for Drugs and Drug Addiction (2007). Drugs and crime - a complex relationship. EMCDDA Lisbon.
- European Monitoring Centre for Drugs and Drug Addiction (2009). Standard Protocol version 3.2 for the EU Member States to collect data and report figures for the Key indicator drug-related deaths., EMCDDA, Lisbon.

- European Monitoring Centre for Drugs and Drug Addiction. 2010 Annual report on the state of the drugs problem in Europe. 2010a. Lisbon, EMCDDA.
- European Monitoring Centre for Drugs and Drug Addiction (2010b). Selected Issue 2010: problem amphetamine and methamphetamine use in Europe., Publications office of the European Union, Luxembourg.
- European Monitoring Centre for Drugs and Drug Addiction (2011). Report on the risk assessment of mephedrone in the framework of the Council Decision on new psychoactive substances, EMCDDA, Lisbon.
- Evenepoel, T. (2011). Jaarverslag van de druglijn, 2010., VAD, Brussels.
- Favresse, D. & De Smet, P. (2008). Tabac, alcool, drogues et multimédias chez les jeunes en Communauté française de Belgique. Résultats de l'enquête HBSC 2006., Service d'Information Promotion Education Santé (SIPES), ESP-ULB, Brussels.
- Federal Public Service Health, Food Chain Safety and environment (2011). General Drug Policy Cell [online]. Available: <http://www.beldonor.be/eportal/Myhealth/risksanddiseases/Healthrisks/drugpolicy> [accessed 29-8-2010].
- Federale Overheidsdienst Justitie.Vast Bureau Statistiek en Werklastmeting (2009). De jaarlijkse statistieken van de hoven en rechtbanken. Gegevens 2008. Correctionele griffies van de Hoven van Beroep.
- Federale Overheidsdienst Justitie.Vast Bureau Statistiek en Werklastmeting (2010). De jaarlijkse statistieken van de hoven en de rechtbanken. Gegevens 2009. Hoven van Beroep, Correctionele griffies.
- Federale Overheidsdienst Justitie.Vast Bureau Statistiek en Werklastmeting (2011). De jaarlijkse statistieken van de hoven en de rechtbanken. Gegevens 2010. Hoven van Beroep, Correctionele griffies.
- Federale Politie - CGOP / Beleidsgegevens (2011). Politiecriminaliteitsstatistieken, België, 2000-2010. [online]. Available: http://www.polfedfedpol.be/crim/crim_statistieken/2010_trim4/pdf/nationaal/rapport_2010_trim4_nat_Belgie_nl.pdf [accessed 4-8-2011].
- Fédération des Associations de Parents de l'Enseignement Officiel (2008). Quelle aide pour nos enfants?
- Flemish Agency for Care and Health (2011). Evaluation Health objective Tobacco, Alcohol, Drugs. [online]. Available: <http://www.zorg-en-gezondheid.be/Cijfers/Gezond-leven-en-milieu/Tabak-alcohol-drugs/Evaluatie-gezondheidsdoelstelling-tabak,-alcohol,-drugs> [accessed 29-8-2010].
- Flemish agency for Care and Health (2011). Vereniging voor Alcohol- en andere Drugproblemen. [online]. Available: <http://www.zorg-en-gezondheid.be/Zorgaanbod/Preventieve-gezondheidszorg/Partnerorganisaties/Vereniging-voor-Alcohol--en-andere-Drugproblemen/> [accessed 29-8-2010].
- Gelders, D., Patesson, R., Vandoninck, S., Steinberg, P., Van Malderen, S., Nicaise, P. et al. (2010). Gevraagd: betere informatie van de overheid over dreigende ontwikkelingen in het aanbod van drugs. Verslaving.Tijdschrift over verslavingsproblematiek., **6**, 18-31.
- Gelders, D., Patesson, R., Vandoninck, S., Steinberg, P., Van Malderen, S., Nicaise, P., and et al. (2008). Warning of dangerous drugs: analysis of the early warning system in Belgium. [online].

Bibliography

- Gelders, D. & Vander Laenen, F. (2007). 'Mr. Police Officer, I thought cannabis was legal'; Introducing new policy regarding cannabis in Belgium: a story of good intentions and Babel. Drugs: Education, Pr, **14**, 103-116.
- Ghapro vzw. (2011). Jaarrapport 2010., Ghapro vzw., Antwerpen.
- Gisle, L. (2010a). Het gebruik van illegale drugs. In: Gezondheidsenquête België, 2008. Rapport II - Leefstijl en Preventie, L. Gisle et al., eds., pp. 307-384. Operationele Directie Volksgezondheid en surveillance - Wetenschappelijk Instituut Volksgezondheid, Brussel.
- Gisle, L. (2010b). L'usage des drogues illicites. In: Enquête de santé, 2008. Rapport II - Style de Vie et Prévention, L. Gisle et al., eds., pp. 307-384. Direction Opérationnelle Santé publique et surveillance. Institut Scientifique de Santé Publique, Bruxelles.
- Godin, I., Decant, P., De Smet, P., Favresse, D., & Moreau, N. (2011). EMCDDA ST2 Health behaviour in School-Aged Children 2010. Lifetime, last 12 months and last 30 days prevalence tables., Universié libre de Bruxelles, Service d'Information Promotion Education Santé, Brussels.
- Gorissen, JP (2011) Opvolging prevalentie psychiatrische ziektebeelden in de medische opnames van PZ en PAAZ: 1998-2008, [online]. Available: http://www.health.belgium.be/filestore/19070119/Ziektebeelden_NL%20.htm [accessed 14-2-2012].
- Gosselin, M., Ramirez Fernandez, M.M., Wille, S.M., Samyn, N., De, B.G., & Bourel, B. (2010). Quantification of methadone and its metabolite 2-ethylidene-1,5-dimethyl-3,3-diphenylpyrrolidine in third instar larvae of *Lucilia sericata* (Diptera: Calliphoridae) using liquid chromatography-tandem mass spectrometry. J.Anal.Toxicol., **34**, 374-380.
- GROUP investigators (2011). Evidence that familial liability for psychosis is expressed as differential sensitivity to cannabis: an analysis of patient-sibling and sibling-control pairs. Arch.Gen.Psychiatry, **68**, 138-147.
- Infor-drogues (2011). Rapport annuel d'activités Infor-drogues, 2010
- Ingels, A.S., Lambert, W.E., & Stove, C.P. (2010). Determination of gamma-hydroxybutyric acid in dried blood spots using a simple GC-MS method with direct "on spot" derivatization. Anal Bioanal Chem, **398**, 2173-2182.
- Interministeriële Conferentie Drugs (25-1-2010). Een globaal en geïntegreerd drugsbeleid voor België.
- Interministeriële Conferentie Volksgezondheid. Drugs 13.2. - Registratie van de behandelingsaanvragen via de Treatment Demand Indicator. Registratie van de behandelingsaanvragen via de operationalisatie van de Europese Treatment Demand Indicator. 2006/22273, 22932-22934. 3-5-2006.
- Jongeren Welzijn (2011). Wat is POS of een problematische opvoedingssituatie? [online]. Available: http://wvg.vlaanderen.be/jongerenwelzijn/wegwijzer/ALGEMEEN/A4_wat_is_pos.htm [accessed 24-8-2011].
- Jouanne, C., Phan, O., & Corcos, M. (2010). Comparaison de l'efficacité de la MultiDimensional Family Therapy (MDFT) versus la Treatment As Usual Explicitité (TAUE) dans le traitement de l'abus et de la dépendance au cannabis chez l'adolescent: présentation du protocole INCANT. Annales Médico-Psychologiques, **168**, 487-494.
- Kangourou-Trempline (2011). Kangourou à Châtelet: Communauté thérapeutique enfants admis [online]. Available: <http://www.labiso.be/?page=VisualiserContenuOuvrage&Id=359> [accessed 4-8-2011].

- Kinable, H. (2009). VAD-leerlingenbevraging in het kader van een drugbeleid op school : synthesesrapport schooljaar 2007-2008.
- Kinable, H. (2010a). VAD-leerlingenbevraging in het kader van een drugbeleid op school : synthesesrapport schooljaar 2008-2009 VAD Brussel.
- Kinable, H. (2010b). VAD-leerlingenbevraging in het kader van een drugbeleid op school : synthesesrapport schooljaar 2008-2009 VAD Brussel.
- Kinable, H. (2011). VAD-leerlingenbevraging in het kader van een drugbeleid op school : synthesesrapport schooljaar 2009-2010., VAD, Brussels.
- Lambrecht, P. & Andries, C. (2011). EMCDDA ST 2 Het Vlaamse Schoolonderzoeksproject naar alcohol en andere drugs - VLASPAD 2010., VUB, Brussel.
- Lambrecht, P., Hublet, A., & Kinable, H. (2011). Vergelijking van Vlaamse schoolsurveys over middelengebruik. Rapportering over de realisaties van het samenwerkingsprotocol. Brussel.
- Lamkaddem, B. and Roelands, M., editors (2008). Belgian National Report on Drugs 2007. New developments, trends and in-depth information on selected issues, Scientific Institute of Public Health, Brussels.
- Lamkaddem, B. and Roelands, M., editors (2009). Belgian National Report on Drugs 2008. New developments, trends and in-depth information on selected issues, Scientific Institute of Public Health, Brussels.
- Lamkaddem, B. and Roelands, M., editors (2010). Belgian National Report on Drugs 2009. New developments, trends and in-depth information on selected issues., WIV-ISP, Brussels.
- Lamkaddem, B. and Roelands, M., editors (2011). Belgian National Report on Drugs 2010. New developments, trends and in-depth information on selected issues., Scientific Institute of Public Health, Brussels.
- Landschaftsverband Rheinland, Landesjugendamt Amt für Verwaltung und erzieherische Hilfen, editors (2005). Ambulante Jeugdzorg - Overzicht van de wettelijke regelingen,
- Lefèvre, S. (2004). L'aide à la jeunesse en Communauté française. Bruxelles sous la loupe, 2, 9-40.
- Lombaert, G. (2010). Middelengebruik bij 12 tot 18-jarige scholieren in Brugge, De Sleutel, Gent.
- Maes, E., Mine, B., De Man, C., & Van Brakel, R. (2011). Naar elektronisch toezicht in het kader van de voorlopige hechtenis? Waarom de invoering ervan, vanuit het oogpunt van een vermindering van de gevangenispopulatie, misschien toch niet meteen de meest aangewezen strategie is. Fatik, 129,
- Maes, L. & Vereecken, C. (2006). Resultaten HBSC 2006 - Middelengebruik, Universiteit Gent, Gent.
- Maes, L. & Vereecken, C. (2011). Jongeren en Gezondheid 2010. EMCDDA ST2, Universiteit Gent: Vakgroep Maatschappelijke Gezondheidskunde , Gent.
- Maison d'accueil socio-sanitaire de Bruxelles (2011). Maison d'accueil socio-sanitaire de Bruxelles [online]. Available: http://www.mass-bxl.be/a_qui_fr.php [accessed 3-8-2011].
- Matthys, F., Möbius, D., Stes, S., Joostens, P., Tremmery, S., Vermassen, A., and Sabbe, B. (2010). Good Clinical Practice in de herkenning en behandeling van ADHD bij (jong)volwassenen met verslavingsproblemen : Richtlijnen voor de klinische praktijk [online]. Available: <http://www.vad.be/media/458694/richtlijnen%20adhdverslaving.pdf>

Bibliography

- Mergan, D. (2011). Renseignements annuels sur les substances fréquemment utilisées dans la fabrication illicite de stupéfiants et de substances psychotropes. Chiffres année 2010. Belgique.
- Mills, K.L., Deady, M., Proudfoot, H., Sannibale, C., Teesson, M., Mattick, R. et al. (2010). Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings Sydney.
- Ministry of Health (2010). New Zealand Clinical Guidelines for the Use of Buprenorphine (with or without Naloxone) in the Treatment of Opioid Dependence. [online]. Available: [http://www.moh.govt.nz/moh.nsf/pagesmh/10447/\\$File/nz-guidelines-buprenorphine-2010.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/10447/$File/nz-guidelines-buprenorphine-2010.pdf) [accessed 14-9-2011].
- Modus Vivendi. La fonction de jobiste en réduction des risques liés à l'usage des drogues. Analyse et recommandations sur une facette originale de la prévention participative. 2007. Brussels, Modus Vivendi.
- Modus Vivendi asbl (2010). Rapport d'activités à la Commission Communautaire Française de la Région de Bruxelles Capitale. 2010.
- Modus Vivendi asbl. (2011). Rapport d'activités 2010. Communauté française de Belgique.
- Muys, M. (2009). Substance use among migrants: the case of iranians in Belgium. VUBPRESS Brussels.
- National Health Service (2009). Benzodiazepine and z-drug withdrawal - Management [online]. Available: http://www.cks.nhs.uk/benzodiazepine_and_z_drug_withdrawal [accessed 14-9-2011].
- Neyrinck, S., Vandeveld, S., Vandewalle, J., Soye, V., Vanderplasschen, W., Broekaert, E. et al. (2011). An exploration of substance use and abuse in people with ID. Journal of applied Research in Intellectual Disabilities., **23**, 524.
- Observatoire de l'Enfance, d. l. J. e. d. l. à. l. J. (2007). Etude sur l'articulation entre les services de première ligne et les services de l'aide à la jeunesse
- Observatoire de l'Enfance, d. l. J. e. d. l. à. l. J. (2009). Etude sur les demandes et les prises en charge dans les services d'accueil spécialisé de la petite enfance (SASPE)
- Ondersteuningsstructuur Bijzondere Jeugdzorg (2011). Comites voor Bijzondere Jeugdzorg [online]. Available: http://www.steunpuntjeugdhulp.be/download_file.php?filepath=/home/osbj/www/sites/osbj/files/File/restyling%20inhoud/Comit%c3%a9%20BJZ.pdf [accessed 24-8-2011].
- Op de Beeck, H. & Cops, D. (2010). Jongeren en delinquentie. In: Jongeren in cijfers en letters. bevindingen uit de JOP-monitor 2., N. Vettenburg, J. Siongers, & J. Deklerck, eds., pp. 283-310. Acco, Leuven.
- Pelc I., De Ruyver, B., Casselman, J., Noirfalise, A., Macquet, C., Bosman, G., Bullens, F., From, L., Meuwissen, K., Nicaise, P., Vander Laenen, F., & Warland, O. (2001). Evaluation des maisons d'accueil socio-sanitaire pour usagers de drogues
- Pelc I., Hooft, P., Noirfalise, A., Vander Stichele, R., Willems, J., & Fischler, B. (2011). Suivi de la conférence méthadone de 1994: évaluation des recommandations formulées en 1994 et propositions complémentaires
- Pil, K., Esposito, F.M., & Verstraete, A. (2010). External quality assessment of multi-analyte chromatographic methods in oral fluid. Clin.Chim.Acta, **411**, 1041-1045.
- Plasschaert, S., Ameye, L., De Clercq, T., Walckiers, D., Sartor, F., Micalessi, I., Jossels, G., Todts, S., Goubau, P., Plum, J., Vranckx, R., & Van Oyen, H. (2005). Study on HCV, HBV and HIV

- seroprevalence in a sample of drug users in contact with treatment centres or in prisons in Belgium, 2004-2005, Scientific Institute of Public Health - Unit of Epidemiology, Brussels.
- Raes, V. & Lombaert, G. (2004). EuropASI: A standard in De Sleutel, Belgium. Journal of substance abuse
- Raes, V., Lombaert, G., & Keymeulen, R. (2004). De Nederlandse vertaling van de handleiding voor training en afname van Europasi vraaggesprekken, aangepast voor België-Vlaanderen. Versie 2004., De Sleutel, Gent.
- Ramirez Fernandez, M.M., Wille, S.M., di, F., V, Gosselin, M., & Samyn, N. (2010). Analysis of amphetamines and metabolites in urine with ultra performance liquid chromatography tandem mass spectrometry. J.Chromatogr.B Analyt.Technol.Biomed.Life Sci., **878**, 1616-1622.
- Rigter, H., Pelc, I., Tossmann, H.P., Phan, O., Grichting, E., Hendriks, V.M. et al. (2010). INCANT: a transnational randomized trial of multidimensional family therapy versus treatment as usual for adolescents with cannabis use disorder. BMC Psychiatry, **10**,
- Rombouts, D. (2011). Jaarverslag bubbels en babbels., Bubbels en babbels, Antwerpen.
- Rosiers, J. (2010). Partywise. Kwantitatief luik uitgaansonderzoek 2009 [online]. Available: http://www.vad.be/media/474471/pw_trendonderzoek_09.pdf
- Rosiers, J. (2011). Ginger. Preventie van alcohol- en andere drugsproblemen. Rapport 2010. Monitoring van activiteiten., VAD, Brussels.
- Rosiers, J., Hublet, A., Van Damme, J., Maes, L., & Van Hal, G.r. (2011). In hogere sferen? Volume 2. Een onderzoek naar het middelengebruik bij Vlaamse studenten. Universiteit Antwerpen Antwerp.
- Sabbe, B., Malone, M., Van Ham, S., & De Wilde, B. (2008). Onderzoek naar de effectiviteit van de residentieel geïntegreerde behandeling voor patiënten met een dubbeldiagnose
- Sacré, C., Daumas, C., & Hogge, M. (2010). Usagers de drogues par injection en Région wallonne
- Sartor, F., Walckiers, D., Sasse, A., & Bils, L. (2001). Estimate of the prevalence of injecting drug use in Belgium. Archives of Public Health, **59**, 63-75.
- Sasse, A. & Defraye, A. (2009). HIV infections and STI co-infections in men who have sex with men in Belgium: sustained increase in HIV diagnoses. Euro.Surveill, **14**,
- Serlippens, A. & Dangreau, J. Over druggebruikers die criminaliteit plegen en criminelen die drugs gebruiken. Orde van de Dag. 44[27], 32. 2008.
- Service public de Wallonie (2008). Décret relatif au plan de cohésion sociale dans les villes et communes de Wallonie.
- Service Public Fédéral Belge (2010). Tribunal de la jeunesse [online]. Available: http://www.belgium.be/fr/justice/organisation/tribunaux/tribunal_de_premiere_instance/tribunal_de_la_jeunesse/ [accessed 21-10-2011].
- Service Public Fédéral Santé Publique, Sécurité de la Chaîne Alimentaire et Environnement (2011). Note politique du Gouvernement Fédéral relative à la problématique de la drogue [online]. Available: http://www.emcdda.europa.eu/attachements.cfm/att_35439_FR_Belgium%20Policy%20Note%202001-%20French.pdf [accessed 5-7-2011].

Bibliography

- Siliquini, R., Chiado Piat, S., Alonso, F., Druart, A., Kedzia, M., Mollica, A. et al. (2010). A European study on alcohol and drug use among young drivers: the TEND by Night study design and methodology. BMC Public Health, **10**, 205.
- Skinner, H. A. (2001). Assessment of substance abuse: drug abuse screening test (DAST). In: Encyclopedia of Drugs, Alcohol & Addictive Behavior., R. Carson-DeWitt, ed., pp. 147-178. Macmillan Reference USA, New York.
- Sleiman, S., editors (2003). Belgian National Report on Drugs 2003., D/2003/2505/40th ed. Scientific Institute of Public Health, Brussels.
- Sleiman, S., editors (2004). Belgian national report on drugs 2004.
- Sleiman, S., editors (2005). Belgian national report on drugs 2005.
- Sleiman, S. and Roelands, M., editors (2007). Belgian National Report on Drugs 2006. New developments, trends and in-depth information on selected issues. Scientific Institute of Public Health, Brussels.
- Sleiman, S. and Sartor, F., editors (2002). Belgian National Report on Drugs, 2002., D/2002/2505/41th ed. Scientific Institute of Public Health, Brussels.
- Snoek, A., Wits, E., van de Mheen, D., and Wilbers, G. (2010). Vroegsignalering : Richtlijn. Vroegsignalering Middelenmisbruik of -afhankelijkheid bij jongeren [online]. Available: http://www.ggznederland.nl/verslavingszorg/publicaties-resultaten-scoren-pagina/rs_vroegsignalering.pdf
- Soyez, V., De Wilde, J., Vandevelde, S., Broekaert, E., Vander Beken, T., Guillaume, R., Dumortier, E., & Caels, Y. (2007). Druggebruik en psychopathologie in gevangenis. Een exploratieve studie tot methodiekontwikkeling., Programmatorische Federale Overheidsdienst Wetenschapsbeleid., Gent.
- Stimson, G.V., Jones, S., Chalmers, C., & Sullivan, D. (1998). A short questionnaire (IRQ) to assess injecting risk behaviour. Addiction, **93**, 337-347.
- The Gallup Organisation. (2011). Flash Eurobarometer N° 330. Youth attitudes on drugs. Analytical Report, The Gallup Organisation, Hungary.
- Tieberghien, J. & Decorte, T. Geen dak boven je hoofd? Over dakloze jongeren en middelengebruik. Tijdschrift voor Verslaving 7[4]. 2011.
- Todts, S., Glibert, P., Van Malderen, S., Van Huyck, C., Saliez, V., & Hogge, M. (2009). Drug use in Belgian prisons: monitoring of drug related health risks 2008, Federal Department of Justice, Brussels.
- Todts, S., Hariga, F., Pozza, M., eclercq, D., libert, P., & alessi, M. I. (2007). Drug use in Belgian prisons: monitoring of drug related health risks 2006., Modus Vivendi, Brussels.
- Toennes, S.W., Kauert, G.F., Steinmeyer, S., & Moeller, M.R. (2005). Driving under the influence of drugs -- evaluation of analytical data of drugs in oral fluid, serum and urine, and correlation with impairment symptoms. Forensic Sci.Int., **152**, 149-155.
- van Bussel, J. C. H. (2010a). De registratie van de Treatment Demand Indicator in België Brussels: WIV-ISP.
- van Bussel, J. C. H. (2010b). L'enregistrement du Treatment Demand Indicator en Belgique Bruxelles: WIV-ISP.
- Van Damme P. & De Ruyver, B. (2011). Determination of the yield of an illegal indoor cannabis plantation (YILCAN). Summary

- Van der Heyden, J., Gisle, L., Demarest, S., Drieskens, S., Hesse, E., & Tafforeau, J. (2010). Gezondheidsenquête België, 2008. Rapport I - Gezondheidstoestand, Operationele Directie Volksgezondheid en Surveillance, Wetenschappelijk Instituut Volksgezondheid, Brussels.
- Van der Linden, T., Legrand, S.-A., Isalberti, C., & Verstraete, A. (2011a). Prevalence of psychoactive substances in injured drivers. Country report Belgium
- Van der Linden, T., Legrand, S.-A., Silverans, P., & Verstraete, A. (2011b). Prevalence of drugs in the general driving population. Country report Belgium.
- Van Hal, G., Rosiers, J., Bernaert, I., & Hoeck, S. (2007). IN HOGERE SFEREN? Een onderzoek naar het middelengebruik bij Antwerpse studenten, Universiteit Antwerpen, Antwerpen.
- Van Keirsblick, B. (2009). L'ordonnance relative à l'aide à la jeunesse à Bruxelles entre en vigueur
- Van Malderen, S. (2011). Drugs en gevangenis. In: Wet en Duiding. Drugwetgeving 2011., J. Dangreau, ed., pp. 138-165. Lancier, Gent.
- Van Malderen, S., Pauwels, L., Walthoff-Born, C., Glibert, P., & Todts, S. Drug use in Belgian prisons: monitoring of drug related health risks 2010. Brussels: Federal Departement of Justice . 2011.
- van Nuijs, A., Castiglioni, S., Tarcomnicu, I., Postigo, C., de Alda, M.L., Neels, H. et al. (2011a). Illicit drug consumption estimations derived from wastewater analysis: A critical review. Science of the Total Environment, **409**, 3564-3577.
- van Nuijs, A., Mougel, J.F., Tarcomnicu, I., Bervoets, L., Blust, R., Jorens, P.G. et al. (2011b). A one year investigation of the occurrence of illicit drugs in wastewater from Brussels, Belgium. Journal of Environment Monitoring, **13**, 1008-1016.
- van Nuijs, A., Mougel, J.F., Tarcomnicu, I., Bervoets, L., Blust, R., Jorens, P.G. et al. (2011c). Sewage epidemiology--a real-time approach to estimate the consumption of illicit drugs in Brussels, Belgium. Environment International, **37**, 612-621.
- van Nuijs, A., Pecceu, B., Theunis, L., Dubois, N., Charlier, C., Jorens, P.G. et al. (2009a). Can cocaine use be evaluated through analysis of wastewater? A nation-wide approach conducted in Belgium. Addiction, **104**, 734-741.
- van Nuijs, A., Pecceu, B., Theunis, L., Dubois, N., Charlier, C., Jorens, P.G. et al. (2009b). Cocaine and metabolites in waste and surface water across Belgium. Environmental Pollution, **157**, 123-129.
- van Nuijs, A., Pecceu, B., Theunis, L., Dubois, N., Charlier, C., Jorens, P.G. et al. (2009c). Spatial and temporal variations in the occurrence of cocaine and benzoyllecgonine in waste- and surface water from Belgium and removal during wastewater treatment. Water Research, **43**, 1341-1349.
- van Winkel, R. (2011). Family-based analysis of genetic variation underlying psychosis-inducing effects of cannabis: sibling analysis and proband follow-up. Arch.Gen.Psychiatry, **68**, 148-157.
- Van Woensel, G. & Beyra-Vanneste, A.L. (2000). Maternité et toxicomanie : état des connaissances. Revue de la Médecine Générale, **171**, 124-134.
- Vandam, L., De Ruyver, B., & Vander Beken, T. (2010). De invloed van de detentie op het gebruik van legale en illegale drugs. In: Actualia strafrecht en criminologie 2010., L. Pauwels & G. Vermeulen, eds., pp. 265-286. Maklu, Antwerpen.
- Vander Laenen, F., De Ruyver, B., Christiaens, J., & Lievens, D. (2011). Drugs in figures III (in press).
- Vanderplasschen, W., Autrique, M., and De Wilde, J., editors (2009). Kinderen en adolescenten: problemen en risicosituaties: gezin, Bohn Stafleu Van Loghum, Houten.

Bibliography

- Vanderplasschen, W., De Bourdeaudhuij, I., & Van Oost, P. (2002). Co-Ordination and Continuity of Care in Substance Abuse Treatment. European addiction research, **8**, 10-21.
- Vanderplasschen, W., De Maeyer, J., Goethals, I., & Broekaert, E. Evolution of poly drug use among TC-residents in Belgium between 1997 and 2010. 2011a.
- Vanderplasschen, W., Goossens, K., Vandeveld, D., Thienpont, J., Hauglustaine, V., & Littera, L. (2011b). De CRA+vouchers methodiek : is het belonen van abstinentie bij cocaïnegebruikers effectief? Orthopedagogische Reeks Gent 1-69.
- Vanhove, W., Van Damme, P., & Meert, N. (2011). Factors determining yield and quality of illicit indoor cannabis (*Cannabis* spp.) production. Forensic Sci.Int., **212**, 158-163.
- Verduyck, J. C. (1995). Parentaliteit et toxicomanie [online]. Available: <http://users.swing.be/carrefour.naissance/Articles/sc/Parentalitetoxicomanie.htm> [accessed 5-7-2011].
- Vereniging voor Alcohol- en andere Drugproblemen v.z.w. (2005). Buprenorfine: aanbevelingen voor het gebruik van buprenorfine - hoog gedoseerd - in de behandeling van opiaatafhankelijkheid, Vereniging voor alcohol- en andere drugsproblemen,
- Vereniging voor Alcohol- en andere Drugproblemen v.z.w. (2011a). Evidence-based richtlijnen (hulpverlening) [online]. Available: <http://www.vad.be/evidence-based-werken/richtlijnen.aspx> [accessed 14-9-2011a].
- Vereniging voor Alcohol- en andere Drugproblemen v.z.w. (2011b). Wegwijs in de drughulpverlening [online].
- Vérgaiginsky, C., editors (2011). Assu-études. Une enquête menée auprès des acteurs de l'enseignement secondaire de la Région Bruxelles-Capitale. Centre local de promotion de la santé de Bruxelles.
- Vlaams Agentschap Zorg en Gezondheid (2006). Available: <http://www.zorg-en-gezondheid.be/Beleid/Gezondheidsdoelstellingen/Gezondheidsdoelstelling-tabak,-alcohol-en-drugs/> [accessed 15-7-2011].
- Walckiers, D., editors (2001). Belgian National Report on Drugs 2001, IPH/EPI Reports Nr 2002-001th ed. Scientific Institute of Public Health - Unit of Epidemiology, Brussels.
- Walckiers, D., editors (2002). Belgian National Report on Drugs 2001., D/2002/2505/001th ed. Scientific Institute of Public Health, Brussels.
- Wegwijs in het Belgisch verkeersreglement (2011). Speekseltesten tegen drugs in verkeer vanaf 1 oktober 2010. [online]. Available: <http://www.wegcode.be/actueel/recente-wijzigingen/1617-speekseltesten> [accessed 16-8-2011].
- Wille, S.M.R., Samyn, N., Ramirez-Fernandez, M.D.M., & De Boeck, G. (2010). Evaluation of on-site oral fluid screening using Drugwipe-5+, RapidSTAT and Drug Test 5000 for the detection of drugs of abuse in drivers. Forensic Science International, **198**, 2-6.
- Windelinckx, T. (2011). Evaluatie Onderzoek Spuitenruil Vlaanderen 2010., Free Clinic, Antwerp.
- Windelinckx, T. & Bosschaerts, W. (2011). Project Spuitenruil Vlaanderen. Werkjaar 2010. Eindrapport Spuitenruil Vlaanderen., Free Clinic, Antwerp.
- Windey, F. & Gorissen, JP. (2011). Minimale Psychiatrische Gegevens 2008 in beeld, [online]. Available: www.health.belgium.be/filestore/.../mpg_2008_in_beeld%20NL.pdf [accessed 14-2-2012].
- World Health Organisation 1986. Ottawa Charter for Health promotion.

World Health Organisation, editors (2009). Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence, Genova.

World Health Organisation (2010). mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: Mental Health Gap Action Programme (mhGAP). [online]. Available: http://whqlibdoc.who.int/publications/2010/9789241548069_eng.pdf [accessed 14-9-2011].

Alphabetic list of relevant databases available on internet

Belgian Health Interview Survey (BHIS) interactive analysis module

<http://www.iph.fgov.be/epidemie/hisia/index.htm>

Belgian Senate

<http://www.senat.be>

Federal Research Actions (FEDRA)

http://www.belspo.be/belspo/fedra/pres_fr.stm

Ginger

<http://www.vadginger.be/>

IDA-web

<http://www.ida-fr.be/accueil>

<http://www.ida-nl.be/>

Moniteur Belge, Belgisch Staatsblad.

http://www.just.fgov.be/index_fr.htm

National Institute of statistics

<http://www.statbel.fgov.be>

Alphabetic list of relevant internet addresses

Arbeitsgemeinschaft für Suchtvorbeugung und Lebensbewältigung (ASL)

<http://www.asl-eupen.be/>

Belgian Early Warning System on Drugs

<http://ewsd.wiv-isp.be>

Belgian Government

<http://www.fgov.be>

Belgian Health Interview Survey

<http://www.iph.fgov.be/epidemiologie/epien/index4.htm>

Belgian Information Network on Drugs and Drug Addiction

<http://workspaces.wiv-isp.be/BINDDA/default.aspx>

Belgian Monitoring Centre for Drugs and Drug Addiction

<http://workspaces.wiv-isp.be/BMCDDA/default.aspx>

Belgian Science Policy Office

<http://www.belspo.be>

Brussels region

<http://www.bruxelles.irisnet.be/>

College of procurator general

http://www.just.fgov.be/statistique_parquets/start/n/home.html

Concertation Toxicomanies Bruxelles - Overleg Druggebruik Brussel (CTB-ODB)

<http://www.ctb-odb.be/>

De Druglijn

<http://www.druglijn.be/>

De Sleutel

<http://www.desleutel.be>

Driving under the Influence of Drugs, Alcohol and Medicines (DRUID)

<http://www.druid-project.eu/>

European Institutions

<http://www.europa.eu.int>

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

<http://www.emcdda.europa.eu/index.cfm>

European School Survey Project on Alcohol and Other Drugs (ESPAD)

<http://www.espad.org>

EUROTOX

<http://www.eurotox.org/>

Federal Police

Bibliography

<http://www.polfed-fedpol.be/>

Federal Public Service Health, Food Chain safety and environment

http://www.health.fgov.be/CSH_HGR/index.html

Federal Public Service Home Affairs

<http://www.ibz.fgov.be>

Federal Public Service Justice

<http://www.just.fgov.be>

Fedito Bruxelloise et Wallonne

<http://www.fedito.be>

Fédération Wallonie-Bruxelles

<http://www.cfwb.be>

Free Clinic

<http://www.free-clinic.be/>

Health Behaviour in School-Aged Children (HBSC)

<http://www.hbsc.org/>

Infor Drogues

<http://www.infor-drogues.be>

International Cannabis Need of Treatment Project (INCANT)

<http://www.incant.eu>

Modus Vivendi

<http://www.modusvivendi-be.org>

National Institute for Health and Disability Insurance (NIHDI)

<http://www.riziv.fgov.be>

<http://www.inami.fgov.be>

Permanent office statistics and work load measurement

<http://www.vbsw->

[bpsm.be/index.php?option=com_content&view=section&id=5&Itemid=27&lang=nl](http://www.vbsw-bpsm.be/index.php?option=com_content&view=section&id=5&Itemid=27&lang=nl)

Poison Centre

<http://www.poisoncentre.be/>

Prospective Jeunesse

<http://www.prospective-jeunesse.be>

Scientific Institute of Public Health (WIV-ISP)

<http://www.wiv-isp.be>

Service for Criminal Policy

<http://www.dsb-spc.be/>

Sozial-Psychologisches Zentrum (SPZ)

<http://www.spz.be>

University Hasselt

<http://www.luc.ac.be/mpg/fr/Default.htm>

University Libre de Bruxelles

<http://www.ulb.ac.be>

University of Liège

<http://www.ulg.ac.be>

University of Antwerpen

<http://www.ua.ac.be/>

University of Ghent

<http://www.UGent.be>

University of Leuven

<http://www.kuleuven.ac.be>

University of Louvain-la-Neuve

<http://www.uclouvain.be>

Vereniging voor Alcohol en andere drugproblemen (VAD)

<http://www.vad.be/>

Vlaamse overheid

<http://www.vlaanderen.be>

Vlaamse schoolonderzoeksproject naar alcohol en andere drugs (VLASPAD)

<http://www.vlaspad.be/vlaspad/vlaspad.php>

Vlaamse vereniging voor respiratoire gezondheidszorg en tuberculosebestrijding vzw (VRGT)

<http://www.vrgt.be/>

Vrije Universiteit Brussel

<http://www.vub.ac.be/english/index.php>

Zorg en Gezondheid

<http://www.zorg-en-gezondheid.be/>

List of Standard Tables and Standard Questionnaires submitted in 2011*

ST/SQ	Title	Submitted by	Data provider	BAR chapter(s)**
ST2_2011_BE_01	School Surveys, Flemish Community, 2010.	VAD	VAD-LLB	2
ST5_2011_BE_01	Acute/direct related Deaths, Belgium, 2005.	BMCDDA	General mortality Registre	6
ST6_2011_BE_01	Evolution of Acute/direct related Deaths, Belgium, 2004-2005.	BMCDDA	General mortality Registre	6
ST7/8_2011_BE_01	Problem Drug Use, Belgium, 2010.	BMCDDA	ADIS/HIV register and ST9	4
ST9_2011_BE_01	Serology prevalence of DRID: methods, French Community, 2010.	Eurotox	Treatment centres	6
ST9_2011_BE_02	Serology prevalence of DRID: methods, Flemish Community, 2010.	VAD	De Sleutel	6
ST9_2011_BE_03	Serology prevalence of DRID: methods, Antwerp, 2010.	VAD	Free Clinic	6
ST9P2_2011_BE_01	Serology prevalence of DRID: HIV self-reported, French Community, 2010.	Eurotox	Treatment centres	6
ST9P2_2011_BE_02	Serology prevalence of DRID: HIV Ab, Flemish Community, 2010.	VAD	De Sleutel	6
ST9P2_2011_BE_03	Serology prevalence of DRID: anti HBs, Flemish Community, 2010.	VAD	De Sleutel	6
ST9P2_2011_BE_04	Serology prevalence of DRID: anti HBc, Flemish Community, 2010.	VAD	De Sleutel	6
ST9P2_2011_BE_05	Serology prevalence of DRID: HBsAg, Flemish Community, 2010.	VAD	De Sleutel	6
ST9P2_2011_BE_06	Serology prevalence of DRID: HCV Ab, Flemish Community, 2010.	VAD	De Sleutel	6
ST9P2_2011_BE_07	Serology prevalence of DRID: HIV Ab, Antwerp, 2010.	VAD	Free Clinic	6
ST9P2_2011_BE_08	Serology prevalence of DRID: HBsAg, Antwerp, 2010.	VAD	Free Clinic	6
ST9P2_2011_BE_09	Serology prevalence of DRID: HCV Ab, Antwerp, 2010.	VAD	Free Clinic	6
ST9P2_2011_BE_10	Serology prevalence of DRID: anti HAV, Antwerp, 2010.	VAD	Free Clinic	6
ST9P2_2011_BE_11	Serology prevalence of DRID: anti HBc, Antwerp, 2010.	VAD	Free Clinic	6

ST/SQ	Title	Submitted by	Data provider	BAR chapter(s)**
ST9P2_2011_BE_12	Serology prevalence of DRID: anti HBs, Antwerp, 2010.	VAD	Free Clinic	6
ST9P2_2011_BE_13	Serology prevalence of DRID: syphilis, Antwerp, 2010.	VAD	Free Clinic	6
ST9P3_2011_BE_01	DRID: behavioural surveillance, Antwerp, 2010.	VAD	Free Clinic	6
ST9P4_2011_BE_01	Notified cases of HCV, Belgium, 2005-2010.	Sentinel Laboratory network	Sentinel Laboratory network	6
ST9P4_2011_BE_02	Notified cases of HBV, Belgium, 2005-2009.	Sentinel Laboratory network	Sentinel Laboratory network	6
ST10_2011_BE_01	Syringe availability, Flemish Community, 2010.	VAD	Free Clinic	7
ST10_2011_BE_02	Syringe availability, French Community, 2010.	Eurotox	Modus Vivendi	7
ST11_2011_BE_01	Drug law offences, Belgium, 2008-2010.	Federal police	Federal police	9
ST12_2011_BE_01	Drug use among prisoners, Belgium, 2010.	FOD Justice, Service Health care prisons	FOD Justice, Service Health care prisons	9/11
ST13_2011_BE_01	Number and quantity of seizures of illicit drugs, Belgium, 2008-2010.	Federal police	Federal police	10
ST14_2011_BE_01	Purity at street level of illicit drugs, Belgium, 2008-2010.	BMCDDA	BEWSD	10
ST15_2011_BE_01	Composition of tablets, Belgium, 2008-2010.	BMCDDA	BEWSD	10
ST16_2011_BE_01	Price at street level of some illicit drugs, Belgium, 2008-2010.	Federal police	Federal police	10
ST16_2011_BE_02	Price at street level of some illicit drugs, French Community, 2008-2010.	Eurotox	Outreach workers, Syringe exchange desks	10
SQ23_2011_BE_02	Harm reduction measures, French Community, 2010	Eurotox		7

Bibliography

ST/SQ	Title	Submitted by	Data provider	BAR chapter(s)**
SQ23_2011_BE_03	Harm reduction measures, Flemish Community, 2010	VAD		7
ST24_2011_BE_01	Access to treatment, Belgium, 2010	BMCDDA	NRSB/ ENTS	5
SQ27P1_2011_BE_01	Treatment programmes, Belgium, 2010.	BMCDDA		5
SQ27P2_2011_BE_01	Quality assurance treatment, Belgium, 2010.	BMCDDA		
ST32_2011_BE_01	Drug policy, evaluation and coordination, Belgium, 2010.	IRCP, Ghent University		1
ST_Public_expenditure_2011_BE	Public expenditure, Belgium, 2008	IRCP, Ghent University		
ST_TDI_2011_BE_01	TDI in outpatient centres ,Belgium 2010.	BMCDDA	BTDIR	5
ST_TDI_2011_BE_02	TDI in inpatient centres ,Belgium 2010.	BMCDDA	BTDIR	5
ST_TDI_2011_BE_03	TDI in low threshold centres ,Belgium 2010.	BMCDDA	BTDIR	5
ST_EDDRA_2010_BE_02	Exchange on Drug Demand Reduction Action, Belgium.	VAD	VAD	
ST_EDDRA_2011_BE_01	Exchange on Drug Demand Reduction Action, Belgium.	VAD	University of Leuven - Faculty of Psychology and Educational Sciences	

* ST/SQ for which 'no new data' was reported are excluded from this list

Please refer to the EMCDDA statistical bulletin for an overview of the data in these Standard Tables and Standard Questionnaires.

List of uncited Belgian research publications 2010

- Anthierens, S., Pasteels, I., Habraken, H., Steinberg, P., Declercq, T., & Christiaens, T. (2010). Barriers to nonpharmacologic treatments for stress, anxiety, and insomnia: family physicians' attitudes toward benzodiazepine prescribing. *Canadian Family Physician* 56(11):e398-406.
- Anthierens, S., Tansens, A., Petrovic, M., & Christiaens, T. (2010). Qualitative insights into general practitioners views on polypharmacy. *BMC Family Practice*, 15 (11), 65.
- Baert, B., & De Spiegeleer, B. (2010). Quality analytics of internet pharmaceuticals. *Analytical and Bioanalytical Chemistry* 398(1), 125-136.
- Bagyánszki, M., Krecsmarik, M., De Winter, B.Y., De Man, J.G., Fekete, E., Pelckmans, P.A., Adriaensen, D., Kroese, A.B., Nassauw, L.V., & Timmermans, J.P. (2010). Chronic Alcohol Consumption Affects Gastrointestinal Motility and Reduces the Proportion of Neuronal NOS-Immunoreactive Myenteric Neurons in the Murine Jejunum. *The Anatomical Record* 293(9), 1536-1542.
- Bosier, B., Muccioli, G.G., Hermans, E., & Lambert, D.M. (2010). Functionally selective cannabinoid receptor signalling: therapeutic implications and opportunities. *Biochemicam Pharmacology* 80(1), 1-12.
- Bosier, B., Sarre, S., Smolders, I., Michotte, Y., Hermans, E., & Lambert, D.M. (2010). Revisiting the complex influences of cannabinoids on motor functions unravels pharmacodynamic differences between cannabinoid agonists. *Neuropharmacology* 59(6), 503-510.
- Brabant, C., Alleva, L., Quertemont, E., & Tirelli, E. (2010). Involvement of the brain histaminergic system in addiction and addiction-related behaviors: A comprehensive review with emphasis on the potential therapeutic use of histaminergic compounds in drug dependence. *Progress in Neurobiology* 92(3):421-441.
- Broekaert, E., Autrique, M., Vanderplasschen, W., & Colpaert, K. (2010). 'The human prerogative': a critical analysis of evidence-based and other paradigms of care in substance abuse treatment. *The Psychiatric Quarterly* 81(3), 227-238.
- Bruffaerts, R.P., Bonnewyn, A., Demyttenaere, K. (2010). Effect van vroege psychische stoornissen op opleidingsniveau in België. Een bevolkingsstudie. *Tijdschrift voor psychiatrie* 52(3),133-142.
- Cordovil De Sousa Uva, M., Luminet, O., Cortesi, M., Constant, E., Derely, M., & De Timary, P. (2010). Distinct Effects of Protracted Withdrawal on Affect, Craving, Selective Attention and Executive Functions among Alcohol-Dependent Patients. *Alcohol and Alcoholism*,45 (3), 241-246.
- De Letter, E.A., Stove, C.P., Lambert, W.E., & Piette, M.H. (2010). Post-mortem (re)distribution of 3,4-methylenedioxymethamphetamine (MDMA, "ecstasy"): human and animal data. *Current Pharmaceutical Biotechnology* 11(5), 453-459.
- De Maeyer, J., Vanderplasschen, W., & Broekaert, E. (2010). Quality of life among opiate-dependent individuals: a review of the literature. *The International Journal on Drug Policy* 21(5), 364-380.

Bibliography

- Degenhardt, L., Dierker, L., Chiu, W.T., Medina-Mora, M.E., Neumark, Y., Sampson, N., Alonso, J., Angermeyer, M., Anthony, J.C., Bruffaerts, R., de Girolamo, G., de Graaf, R., Gureje, O., Karam, A.N., Kostyuchenko, S., Lee, S., Lépine, J.P., Levinson, D., Nakamura, Y., Posada-Villa, J., Stein, D., Wells, J.E., & Kessler, R.C. (2010). Evaluating the drug use "gateway" theory using cross-national data: consistency and associations of the order of initiation of drug use among participants in the WHO World Mental Health Surveys. Drug and Alcohol Dependence 108(1-2), 84-97.
- Dom, G., Francque, S., & Michielsen, P. (2010). Risk for relapse of alcohol use after liver transplantation for alcoholic liver disease: a review and proposal of a set of risk assessment criteria. Acta Gastroenterologica Belgica. 73 (2), 247-251.
- Drieskens, S., Van Oyen, H., Demarest, S., Van der Heyden, J., Gisle, L., & Tafforeau, J. (2010). Multiple risk behaviour: increasing socio-economic gap over time? European Journal of Public Health 20(6), 634-639.
- D'Souza El-Guindy, N.B., Kovacs, E.J., De Witte, P., Spies, C., Littleton, J.M., de Villiers, W.J., Lott, A.J., Plackett, T.P., Lanzke, N., & Meadows, G.G. (2010). Laboratory Models Available to Study Alcohol-Induced Organ Damage and Immune Variations: Choosing the Appropriate Model. Alcoholism, Clinical and Experimental Research 34(9), 1489-1511.
- Elseviers, M.M., Vander Stichele, R.R., & Van Bortel, L. (2010). Drug utilization in Belgian nursing homes: impact of residents' and institutional characteristics. Pharmacoepidemiology and Drug Safety 19(10), 1041-1048.
- Genetic Risk and Outcome in Psychosis (GROUP) Investigators (2011). Evidence that familial liability for psychosis is expressed as differential sensitivity to cannabis: an analysis of patient-sibling and sibling-control pairs. Archives of General Psychiatry 68(2), 138-147.
- Gheuens, S., Michotte, A., Flamez, A., & De Keyser, J. (2010). Delayed akinetic catatonic mutism following methadone overdose. Neurotoxicology. 31(6), 762-764.
- Janssens, F., de Suray, N., Piessevaux, H., Horsmans, Y., de Timary, P., & Stärkel, P. (2010). Can Transient Elastography Replace Liver Histology for Determination of advanced Fibrosis in Alcoholic Patients: A Real-life Study. Journal of Clinical Gastroenterology, 44(8), 575-582.
- Katoonizadeh, A., Laleman, W., Verslype, C., Wilmer, A., Maleux, G., Roskams, T., & Nevens, F. (2010). Early features of acute-on-chronic alcoholic liver failure: a prospective cohort study. Gut 59(11), 1561-1569.
- Kuntsche, E., Kuntsche, S., Knibbe, R., Simons-Morton, B., Farhat, T., Hublet, A., Bendtsen, P., Godeau, E., & Demetrovics, Z. (2010). Cultural and Gender Convergence in Adolescent Drunkenness: Evidence From 23 European and North American Countries. Archives of Pediatrics and Adolescent Medicine 165(2), 152-158.
- Luminet, O. (2010). Commentary on the paper "Is alexithymia a risk factor for major depression, personality disorder, or alcohol use disorders? A prospective population-based study". Journal of Psychosomatic Research 68 (3), 275-277.

- Noens, L., Soyez, V., & Thienpont, J. (2010). Bereiken, ondersteunen en begeleiden van familieleden van allochtone drugsgebruikers. Verslaving. Tijdschrift over verslavingsproblematiek 6(4), 72-83.
- Polshin, E., Rudnitskaya, A., Kirsanov, D., Legin, A., Saison, D., Delvaux, F., Delvaux, F.R., Nicolai, B.M., & Lammertyn, J. (2010). Electronic tongue as a screening tool for rapid analysis of beer. Talanta 81 (1-2), 88-94.
- Quoilin, C., Didone, V., Tirelli, E., & Quertemont, E. (2010). Ontogeny of the stimulant and sedative effects of ethanol in male and female Swiss mice: gradual changes from weaning to adulthood. Psychopharmacology 212(4), 501-512.
- Salgado, R.A., Jorens, P.G., Baar, I., Cras, P., Hans, G., & Parizel, P.M. (2010). Methadone-induced toxic leukoencephalopathy: MR imaging and MR proton spectroscopy findings. AJNR American Journal of Neuroradiology 31 (3), 565-566.
- Soyez, V., De Wilde, J., Vandeveld, S., Vander Beken, T., Todts, S., & Broekaert, E. (2010). Screening en assessment van psychiatrische stoornissen in Belgische gevangenen. Sensitiviteit en specificiteit van de BJMHS en SSI-A. Verslaving. Tijdschrift over verslavingsproblematiek 6 (1), 41-57.
- Stärkel, P., De Saeger, C., Strain, A.J., Leclercq, I., & Horsmans, Y. (2010). NFkappaB, cytokines, TLR 3 and 7 expression in human end-stage HCV and alcoholic liver disease. European Journal of Clinical Investigation 40 (7), 575-584.
- Stove, C.P., De Letter, E.A., Piette, M.H., & Lambert, W.E. (2010). Mice in ecstasy: advanced animal models in the study of MDMA. Current Pharmaceutical Biotechnology 11 (5), 421-433.
- Tempier, R., Vasiliadis, H.M., Gilbert, F., Demyttenaere, K., Bruffaerts, R., Bonnewyn, A., Lépine, J.P., Gasquet, I., Mosier, K., Lesage, A., Puchala, C., Lepnurm, M., & Kovess-Masféty, V. (2010). Comparing mental health of francophone populations in Canada, France, and Belgium: 12-month prevalence rates of common mental disorders (part 1). Canadian Journal of Psychiatry 55 (5), 289-294.
- Van Dongen, M.C., Lentjes, M.A., Wijckmans, N.E., Dirckx, C., Lemaître, D., Achten, W., Celis, M., Sieri, S., Arnout, J., Buntinx, F., Siani, A., Cappuccio, F.P., de Lorgeril, M., Iacoviello, L., & Dagnelie, P.C. (2011). Validation of a food-frequency questionnaire for Flemish and Italian-native subjects in Belgium: The IMMIDIET study. Nutrition 27(3), 302-309.
- Van Roy, R., Van Den Eede, F., Peeters, K., Kenis, C., Sabbe, B.G.C., & Claes, S.J. (2010). Comorbide angststoornissen en stoornissen in alcoholgebruik bij bipolaire I-stoornis; onderzoek in een Vlaamse populatie. Tijdschrift voor psychiatrie 52 (2), 69-78.
- van Winkel, R. (2011). Genetic Risk and Outcome of Psychosis (GROUP) Investigators. Family-based analysis of genetic variation underlying psychosis-inducing effects of cannabis: sibling analysis and proband follow-up. Archives of General Psychiatry 68(2), 148-157.*
- Vander Laenen, F., Vandam, L., & Colman, C. (2010). Met velen aan tafel: goede voorbeelden van een integraal en geïntegreerd drugsbeleid. Verslaving. Tijdschrift over verslavingsproblematiek 6(4), 54-71.

Bibliography

Willem, L., Bijttebier, P., & Claes, L. (2010). Reactive and self-regulatory temperament dimensions in relation to alcohol use in adolescence. Addictive Behaviors 35(11), 1029-1035.

Annexes

Annex 1.

Methodology Overview of databases used

a) Database title	AIDS/HIV register
b) Abbreviation	
c) Host(s)/ Organisation(s)	WIV-ISP, HIV/AIDS/STI Surveillance Programme
d) Main objective / research question	Monitoring the HIV-AIDS incidence
e) Type of study	Epidemiological Register
f) Year of data collection/fieldwork	Since 1984-85 (Data reports cover results of the previous semester and each calendar year).
g) Study location	Belgium
h) Population sample	All newly diagnosed HIV and AIDS cases
i) Methods	All serums with positive screening test results are submitted for confirmation to one of the seven AIDS Reference Laboratories (ARL). ARL use documented, reliable and validated ELISA tests, Western blot or immunoblot tests and/or the detection of p24 antigen following an algorithm following common principles for all ARL to confirm or exclude an HIV infection, and to specify if it is an infection with HIV-1 or HIV-2. When an HIV infection is confirmed for a patient, this result has to be confirmed on a second sample, since sample errors, labelling errors and contaminations are frequent. A standardised form sent by the ARL to the general practitioner is used to collect data on age, sex, nationality, risk behaviour and clinical stage when diagnosed. Following dimensions are available: Region, province, district, municipality, calendar year, age, sex, nationality, sexual orientation, probable mode of HIV transmission and CD4 count at the time of HIV diagnosis. More information on the methodology is available on the website of the ARL/LRS.
j) Data quality/methodological concerns	AIDS cases are validated by an experts Commission referring to the definition adopted by the Centers for Disease Control and Prevention (CDC; 1982, 1987, 1992) and the European Centre for the Epidemiological Surveillance of AIDS (EUROHIV; 2006). Data are validated for duplicate recording and included in a HIV-AIDS database maintained at the WIV/ISP-PH&S since 1985.
k) Main publication	N/A
l) Database website address	https://www.wiv-isp.be/epidemiology/EPIEN/AIDSEN/ARLEN/INDEX.HTML
m) Chapter(s) BAR	4, 6

a) Database title	Belgian Early Warning System on Drugs
b) Abbreviation	BEWSD
c) Host(s)/ Organisation(s)	Belgian Monitoring Centre for Drugs and Drug Addiction (WIV-ISP)
d) Main objective / research question	1) Registration of notifications of new and high-risk psychoactive substances identified in Belgium; 2) Monitoring of composition of known illicit substances; 3) Monitoring dangerous trends.
e) Type of study	Epidemiological Register
f) Year of data collection/fieldwork	Since 2002
g) Study location	Belgium
h) Population sample	Not applicable
i) Methods	The reporting of the analysis results to the BEWS is regulated by 2 Royal Decrees (Federale Overheidsdienst Volksgezondheid 2003; Federale Overheidsdienst Volksgezondheid 2006). These Royal Decrees make the reporting of analytical results to the BEWS mandatory for the toxicological laboratories in Belgium, except for cannabis. The reporting of analytical results by clinical laboratories is only mandatory for new substances
j) Data quality/methodological concerns	Representativeness of the laboratory network
k) Main publication	N/A
l) Database website address	http://ewsd.wiv-isp.be
m) Chapter(s) BAR	7, 10

a) Database title	Belgian Treatment Demand Indicator Register
b) Abbreviation	BTDIR
c) Host(s)/ Organisation(s)	Belgian Monitoring Centre for Drugs and Drug Addiction (WIV-ISP)
d) Main objective / research question	Registration of all new treatment demands for illegal drug/alcohol addiction in treatment centres in Belgium.
e) Type of study	Epidemiological Register
f) Year of data collection/fieldwork	2009-2010
g) Study location	Belgian treatment centres for substance related disorders
h) Population sample	Belgian inhabitants starting treatment for a illegal drug/alcohol related disorder
i) Methods	Interviews collecting socio-demographic data and substance use data at the beginning of the treatment
j) Data quality/methodological concerns	Doubles cannot be avoided. Hospitals are not participating yet at this registration. No information available on interne reporting rate (patient not registered)
k) Main publication	van Bussel, J. C. H. (2010a).
l) Database website address	http://workspaces.wiv-isp.be/tdi/
m) Chapter(s) BAR	5,8,12

a) Database title	De Druglijn
b) Abbreviation	
c) Host(s)/ Organisation(s)	VAD
d) Main objective / research question	Monitoring the questions and concerns on alcohol and drug use amongst the Flemish population that contact the help- and info line
e) Type of study	Registration and monitoring
f) Year of data collection/fieldwork	Continuous from 1994 up to date
g) Study location	Flemish Community of Belgium
h) Population sample	Approx. 5500 respondents in 2010. About 2/3 rd female; about 1/3 rd consumers
i) Methods	The following items are registered: background (drug user, parent, partner, other family members, etc), age, type of drug (incl. Alcohol, gambling and medication), emotional and relational problems, need for referral, actual referral, occurrence of domestic violence, date and length of contact+ main focus of the question (legal issues, pregnancy, drug testing, overdose prevention, etc.). Each year, the registered data are analysed and the results are published in the annual report. Ad hoc data across the years are compared to assess evolutions.
j) Data quality/methodological concerns	The anonymity that the helpline guarantees is a limitation in collecting data on the respondents.
k) Main publication	Evenepoel, T. (2011). De DrugLijn. Jaarverslag 2010. Brussel: VAD.
l) Database website address	www.druglijn.be/over-de-druglijn.aspx
m) Chapter(s) BAR	3

a) Database title	Federal Addiction Fund
b) Abbreviation	
c) Host(s)/ Organisation(s)	FOD/SPF Health: DG1
d) Main objective / research question	The fund has been created to finance projects related to drug-addiction. It gives an overview of all projects funded.
e) Type of study	Administrative source
f) Year of data collection/fieldwork	2006
g) Study location	Belgium
h) Population sample	N/A
i) Methods	N/A
j) Data quality/methodological concerns	N/A
k) Main publication	N/A
l) Database website address	http://www.health.belgium.be/eportal/Myhealth/Risksanddiseases/Healthrisks/drugs/18040722_FR
m) Chapter(s) BAR	1, 5, 12

a) Database title	General National Database Federal Police
b) Abbreviation	GND
c) Host(s)/ Organisation(s)	Federal Police
d) Main objective / research question	(1) assistance in the monitoring of people, vehicles, etc; (2) assistance in the investigation of offences and (3) assistance in the policy development.
e) Type of study	Administrative source
f) Year of data collection/fieldwork	Since 2001.
g) Study location	Belgium
h) Population sample	All criminal reports
i) Methods	Every police zone (local and federal) puts the information from the police reports in standardized tables. After the control of these tables, the information is uploaded to the GND.
j) Data quality/methodological concerns	(1) The data collection depends on the working (speed, accuracy,...) of the separate police services. Therefore, it takes some time before all information is available at national level. Results can be updated, f.e. after laboratory analysis of the drugs; (2) The database is a specific police database: only to be consulted by the police and only suited for the objectives mentioned above.
k) Main publication	http://www.polfed-fedpol.be/crim/crim_statistieken/stat_2010_trim4_nl.php http://www.polfed-fedpol.be/crim/crim_statistieken/stat_2010_trim4_fr.php
l) Database website address	
m) Chapter(s) BAR	9, 10

a) Database title	Federal Mortality Register
b) Abbreviation	
c) Host(s)/ Organisation(s)	Vlaams Agentschap Zorg en Gezondheid (Flanders), Observatoire de la Santé et du Social de Bruxelles-Capitale (Brussels), Direction générale opérationnelle Pouvoirs locaux, Action sociale et Santé (Wallonia). FPS Economy – Directorate-general Statistics and Economic Information (Belgium)
d) Main objective / research question	The Federal register of deaths is the legal register of the ADSEI/DGSIE, which is the main official statistical institution in Belgium. The dissemination of the population statistics (including the total number of deaths in Belgium) is one of its main responsibilities.
e) Type of study	Administrative source
f) Year of data collection/fieldwork	Since 1960. Data are collected on daily basis. Belgian regulations stipulate that mortality data of a given year x need to be available by July 31 st of the year x+1 (Ministerie van Economische Zaken / Ministère des Affaires Economiques, 04/09/1999, KB/AR 17/06/1999).
g) Study location	Belgium
h) Population sample	Belgian inhabitants that died (exhaustive)
i) Methods	The numbers and causes of deaths are collected through the statistical death certificates. According to Belgian law,

j) Data quality/methodological concerns	<p>Medical doctors need to register the cause of death according to the ICD-10 (since 1998; previously ICD-9).</p> <p>Given the legal context, the data collected by ADSEI/DGSIE are the most accurate. The quality of mortality statistics has been found to be improved during the period 1980 until 1997 (Aelvoet et al. 2005). Factors contributing to this improvement are, according Aelvoet et al. (2005): “external comparisons through the participation in international studies; contacts with the French WHO Coding Reference Centre; collaboration with researchers; and the comparison of vital statistics data with those of specialised registers (cancer register, Ischaemic Heart Disease Register, ...), coding supervision; collaboration of the persons in charge of coding of the Communities; querying the certifiers about unclear items in the by them completed certificates; and initial and continuing training of the coders and centralisation of coding in Flanders in 1993 as well as similar initiatives in Wallonia”.</p> <p>Causes of coding errors of the past were, according Aelvoet et al. (2005), largely due to “a certificate not in conformity with the international model; the inadequate initial training of the coders; their multitask duties, with other priorities set than coding death certificates; and, to a sub-optimal error screening programme.”</p> <p>Another factor complicating the use of the database of death certificates is the upgrade of the ICD-9 coding system to the ICD-10 coding system (in 1998). This may affected the inter- and intra-rater reliability of both the certifying medical doctors and the coders.</p> <p>Given the differences between ICD-9 and ICD-10, no international standard conversion table exists. The CORPH developed a conversion table based on the work performed in other organisations (Flemish Community, Central Office for Statistics (CBS) of the Netherlands, Eurostat, CDC in USA) and applied it in SPMA.</p>
k) Main publication	
l) Database website address	https://www.wiv-isp.be/epidemi/spma/
m) Chapter(s) BAR	6

a) Database title	GINGER
b) Abbreviation	N/A
c) Host(s)/ Organisation(s)	VAD
d) Main objective / research question	Monitoring of alcohol and drug prevention activities in the Flemish Community.
e) Type of study	Registration and monitoring
f) Year of data collection/fieldwork	Continuous registration (1998-...); annual reporting
g) Study location	Flemish Community of Belgium
h) Population sample	Yearly around 70-80 professional prevention workers.
i) Methods	The following items are registered: type of activity, geographical range, participating sector(s), target group, item of the activity (alcohol, drugs, medication, gambling), used prevention materials, evaluation. Each year, the registered data are analysed and the results are published in the annual Ginger monitoring report.
j) Data quality/methodological concerns	Underrepresentation local prevention workers vs. overrepresentation regional prevention workers
k) Main publication	Rosiers, J. (2010). Ginger. Preventie van alcohol- en andere drugproblemen. Rapport 2010. Monitoring van activiteiten. Brussel: VAD.
l) Database website address	www.vadginger.be

m) Chapter(s) BAR	3
--------------------------	---

a) Database title	Ida-web
b) Abbreviation	
c) Host(s)/ Organisation(s)	VAD / Fédito Wallonne / Fédito Bruxelles
d) Main objective / research question	The main objective is to organise or follow all activities on health related to illegal or legal drugs in Belgium.
e) Type of study	N/A
f) Year of data collection/fieldwork	N/A
g) Study location	Belgium
h) Population sample	N/A
i) Methods	N/A
j) Data quality/methodological concerns	N/A
k) Main publication	N/A
l) Database website address	http://www.ida-web.be
m) Chapter(s) BAR	5

a) Database title	Infordrogues
b) Abbreviation	N/A
c) Host(s)/ Organisation(s)	N/A
d) Main objective / research question	To inform, make sensitive, raise awareness, listen to, have a dialogue, support, give an advice every person confronted with a problematic situation in connection with drug use.
e) Type of study	N/A
f) Year of data collection/fieldwork	2010
g) Study location	French community
h) Population sample	No sampling method
i) Methods	N/A
j) Data quality/methodological concerns	N/A
k) Main publication	Infor-drogues activity report
l) Database website address	www.infordrogues.be
m) Chapter(s) BAR	3

a) Database title	Intego
b) Abbreviation	
c) Host(s)/ Organisation(s)	Katholieke Universiteit Leuven (KULeuven)
d) Main objective / research question	Development of a database on morbidity that can give information about incidence and prevalence of illness in Flanders.
e) Type of study	Epidemiological registration
f) Year of data collection/fieldwork	1990-2008
g) Study location	Flanders
h) Population sample	Patients from 92 GPs (2008) in Flanders
i) Methods	These GPs report diagnostics and different socio-economical variable to a computerised network.
j) Data quality/methodological concerns	N/A
k) Main publication	Bartholomeeusen S, Buntinx F, Heyrman J. Ziekten in de huisartspraktijk: methode en eerste resultaten van het Intego-netwerk. Tijdschrift voor Geneeskunde 2002; 58: 863-871.
l) Database website address	http://www.intego.be
m) Chapter(s) BAR	5

a) Database title	Minimum Clinical Data
b) Abbreviation	MCD
c) Host(s)/ Organisation(s)	FOD/SPF Health: DG1
d) Main objective / research question	The MCD is a compulsory registration of clinical data on day cases (traditional hospitalization and ambulatory care) in non-psychiatric hospitals, and since 1 October 2003 emergency care. One of the registered variables is the number of hospital discharges after an in-patient medical treatment. Data are available for the following calendar years: 1995 until 2007. Following dimensions are available: Region, province, district, age, sex, and nationality. The MKG/RCM is a register of the FOD/SPF Health: DG1.
e) Type of study	Administrative registration
f) Year of data collection/fieldwork	1990-2008 (Data are collected on annual basis with data submissions every semester. Data are available 18 months after the end of the year of reference.)
g) Study location	Belgian non-psychiatric hospitals.
h) Population sample	All individuals admitted in Belgian non-psychiatric hospitals.
i) Methods	MCD Discharge registration forms are completed by hospital staff using the 9th revised version of the International Statistical Classification of Diseases and Related Health Problems - Clinical Modification (ICD-9-CM: U.S. Public Health Services, 1996). Discharges are classified into diagnostic groups using the International shortlist for hospital morbidity tabulation (ISHMT: version 2008-11-10; WHO 2008) and the All Patient Refined Diagnostic Related Groups (APR-DRG: Fetter et al., 1991).
j) Data quality/methodological concerns	Several studies illustrated the moderate validity of the early MCD registration (Aelvoet, 2008; Gilbert et al, 2004). Annual feedback reports of later MCD registration periods refer to several direct and indirect quality

	indicators of the MCD registration (FOD/SPF Health: DG1, 2001; 2002). For example, most of the hospitals use standardized registration templates, verification or validation software, and designate the codification of the data to trained professionals. Further, most of the responding hospitals declare the use of the MKG data for internal purposes.
k) Main publication	More information about the methodology is available in Van De Sande et al. (2006) and Terryn et al. (2007).
l) Database website address	http://www.health.fgov.be/eportal/Healthcare/Healthcarefacilities/Registrationsystems/MCD(MinimumClinicalData)/index.htm
m) Chapter(s) BAR	5

a) Database title	Minimum Psychiatric Data
b) Abbreviation	MPD
c) Host(s)/ Organisation(s)	FOD/SPF Health: DG1
d) Main objective / research question	The MPG/RPM is a compulsory registration of clinical data on day cases (traditional hospitalization and ambulatory care) in psychiatric hospitals and psychiatric units of general hospitals (PAAZ).
e) Type of study	Administrative registration
f) Year of data collection/fieldwork	1996-2008 (Data are collected on annual basis with data submissions every semester. Data are available 18 months after the end of the year of reference.)
g) Study location	Belgian psychiatric hospitals and psychiatric units of general hospitals
h) Population sample	All individuals admitted in Belgian psychiatric hospitals and psychiatric units of general hospitals
i) Methods	MPD Discharge registration forms are completed by hospital staff using the 4th revised version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV: American Psychiatric Association, 1994). Discharges are classified into diagnostic groups using the International shortlist for hospital morbidity tabulation (ISHMT: version 2008-11-10; WHO 2008) and the All Patient Refined Diagnostic Related Groups (APR-DRG: Fetter et al., 1991).
j) Data quality/methodological concerns	N/A
k) Main publication	More information about the methodology is available in Van De Sande et al. (2006).
l) Database website address	http://www.health.fgov.be/eportal/Healthcare/Healthcarefacilities/Registrationsystems/MPD(MinimumPsychiatricData)/index.htm?fodnlang=fr
m) Chapter(s) BAR	5, 6

a) Database title	National Substitution Treatment Register
b) Abbreviation	NSTR
c) Host(s)/ Organisation(s)	Institut Pharmaco-épidémiologique belge (IPhEB) / Instituut voor Farmaco-Epidemiologie in België (IFEB)
d) Main objective / research question	Registration of substitution treatments based on prescription data collected by reimbursement organisations

e) Type of study	Epidemiological registration
f) Year of data collection/fieldwork	2004-2009
g) Study location	Belgium
h) Population sample	Belgian inhabitants receiving substitution treatment
i) Methods	N/A
j) Data quality/methodological concerns	N/A
k) Main publication	N/A
l) Database website address	N/A
m) Chapter(s) BAR	5

a) Database title	Poison centre
b) Abbreviation	
c) Host(s)/ Organisation(s)	Belgische antigif-centrum – Centre Antipoisons Belge
d) Main objective / research question	First aid help for poisoning, prevention and information provision
e) Type of study	Administrative registration, Database on telephone enquiries related to acute or suspected poisoning
f) Year of data collection/fieldwork	Since 2000
g) Study location	Belgium
h) Population sample	N/A
i) Methods	N/A
j) Data quality/methodological concerns	N/A
k) Main publication	N/A
l) Database website address	http://www.poissoncentre.be/
m) Chapter(s) BAR	6

a) Database title	Sentinel Laboratory Network
b) Abbreviation	SLN
c) Host(s)/ Organisation(s)	Scientific Institute Public Health (WIV-ISP)
d) Main objective / research question	Monitoring of infectious diseases in the general population
e) Type of study	Epidemiological registration; Database on laboratory results
f) Year of data collection/fieldwork	Since 1983
g) Study location	Belgium
h) Population sample	Laboratory results from network of 100 laboratories, representing 58% of all Belgian laboratories.
i) Methods	The SLN is a sentinel of about 100 voluntary, unpaid microbiology laboratories (representing 58% of all in

	2009 certified private or hospital microbiology laboratories situated in 33 of 43 Belgian districts). The primary tasks of the program are the. The registration by the laboratories is continuous with daily real-time feedback through an electronic programme (Epi-Lab) or by Internet, or by weekly paper reporting. More information on the methodology is available on the website of the SLN.
j) Data quality/methodological concerns	Data on the incidence of all infections monitored by the SLN is available for the following calendar years: 1983-2009. Following dimensions are available: Region, province, district, calendar year, age, and sex.
k) Main publication	One study (Vandenberghe, 2004) concluded that the SLN has a good level of national representativeness.
l) Database website address	N/A
m) Chapter(s) BAR	https://www.wiv-isp.be/epidemiology/epinl/index8.htm
	6

a) Database title	TBC register
b) Abbreviation	
c) Host(s)/ Organisation(s)	Scientific Institute Public Health (WIV-ISP)
d) Main objective / research question	Monitoring of micro-organisms in the general population
e) Type of study	Epidemiological registration
f) Year of data collection/fieldwork	Since 1983
g) Study location	Belgium
h) Population sample	Laboratory results from network of 100 laboratories, representing 58% of all Belgian laboratories
i) Methods	N/A
j) Data quality/methodological concerns	N/A
k) Main publication	N/A
l) Database website address	https://www.wiv-isp.be/epidemiology/epinl/index8.htm
m) Chapter(s) BAR	6

Annex 2.

Methodology Overview of cited studies

a) Study/survey title	Assu-études.
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	PAA of Brussels
d) Main objective / research question	to identify the expectations and the needs of the school actors concerning risk behaviours and addictions of the pupils.
e) Type of study	Descriptive
f) Year of data collection/fieldwork	2010
g) Study location	N/A
h) Population sample	N/A
i) Methods	The information was collected by semi-directive interviews. Teachers speak about consumption of products and first of all alcohol (especially during the school journeys), then of the consumption of cannabis and its side effects directly perceived in class (aggressiveness, fatigue, absence, incapacity to attend the course).
j) Data quality/methodological concerns	N/A
k) Main publication	Vérgairinsky 2011
l) Study/Survey website address	N/A
m) Chapter(s) BAR	3

a) Study/survey title	Behavioural questionnaire Spuitenruil
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Spuitenruil Vlaanderen, coordinator Tessa Windelinckx
d) Main objective / research question	Evaluation of the needle exchange services
e) Type of study	Administrative registration
f) Year of data collection/fieldwork	since 2001
g) Study location	Flanders
h) Population sample	All patients visiting needle exchange services in Flanders
i) Methods	questionnaire
j) Data quality/methodological concerns	N/A
k) Main publication	Windelinckx, T. (2011). <i>Evaluatie Onderzoek Spuitenruil Vlaanderen 2010.</i> , Free Clinic, Antwerp.
l) Study/Survey website address	http://www.free-clinic.be/spuitenruil/index.html
m) Chapter(s) BAR	6

a) Study/survey title	Belgian Health Interview Survey
b) Abbreviation	BHIS
c) Researcher(s)/ Organisation(s)	Department of Surveys, Life style and Chronic Diseases, Scientific Institute of Public Health
d) Main objective / research question	The HIS Belgium is the National Health Interview survey organised in Belgium. The European Health Interview survey initiative (EHIS) launched by Eurostat is aiming at the coordination of the national surveys in EU and the use of common methods. The HIS in Belgium is a project coordinated by the WIV/ISP:PH&S. It aims to measure the prevalence of several health indicators (health status, life style, prevention, medical consumption, health & society and health status and needs of elderly) in the general population.
e) Type of study	Self-administered questionnaire completed on paper
f) Year of data collection/fieldwork	Four waves were conducted in Belgium: 1997, 2001, 2004 and 2008.
g) Study location	Belgium
h) Population sample	Every wave of the HIS Belgium consists of a sample of more than 10.000 respondents, stratified per region, province and community, and constructed on the basis of the Rijksregister / Registre National using the household as sample unit.
i) Methods	The HIS Belgium consists of a (I) household -, (II) face to face - and a (III) self-completion questionnaire. More information about the methodology is available in the HIS Belgium -reports (Bayingana et al., 2006; Demarest et al., 2002; 2001).
j) Data quality/methodological concerns	Remarks regarding sample size: Total gross sample size: The total gross sample size was 14549 households. Not known in terms of respondents because at this initial level of sampling, a sample of households is selected. Valid gross sample size: 10555 households. Net response for total age range covered: 5809 households or 11254 respondents. Weighting by age, gender, region, province and household size. Drug use is only questioned for people aged 15-64.
k) Main publication	Van der Heyden J, Gisle L, Demarest S, Drieskens S, Hesse E, Tafforeau J. Gezondheidsenquête België, 2008. Rapport I. Gezondheidstoestand. Operationele Directie Volksgezondheid en surveillance, 2010; Brussel, Wetenschappelijk Instituut Volksgezondheid, ISSN: 2032-9172 - Depotnummer. D/2010/2505/06 – IPH/EPI REPORTS N°2010/004.
l) Study/Survey website address	http://www.iph.fgov.be/epidemie/epien/index4.htm
m) Chapter(s) BAR	2

a) Study/survey title	Brussels JeugdOnderzoeksPlatform Monitor
b) Abbreviation	Brusselse JOP-monitor
c) Researcher(s)/ Organisation(s)	Research group Tempus Omnia Revelat (Vrije Universiteit Brussel), research group Sociale Agogiek (UGent) and research group Youth Criminology of the Katholieke Universiteit Leuven (K.U.Leuven)
d) Main objective / research question	To have periodical estimations about the living conditions, the convictions and behaviour of young people in Brussels.
e) Type of study	Observational: survey
f) Year of data collection/fieldwork	2010

g) Study location	Brussels, Secondary schools offering education in Dutch (except for special needs education and first education for migrants).
h) Population sample	Secondary school students 12 – 20 years old. Response rate at school level: 76.19% (n=32); response rate at individual level (within the 32 schools): 88.58% (n=2513).
i) Methods	Based on literature reviews and the JOP-monitor 1 and 2, the JOP-monitor Brussels was created to fulfil the needs for this specific research. The survey was held in school. A shorter and easier version of the survey was used for the 12-13 years olds compared to that for the 14-20 year olds. Data are weighted for gender, education level and educational system.
j) Data quality/methodological concerns	Not all students understood the Dutch well enough to complete all the questions. There is thus an underrepresentation of these students in some questions.
k) Main publication	
l) Study/Survey website address	http://www.jeugdonderzoeksplatform.be/ned/index.htm
m) Chapter(s) BAR	2, 9

a) Study/survey title	De CRA+vouchers methodiek: is het belonen van abstinentie bij cocaïnegebruikers effectief?
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	De Kiem (Ghent)
d) Main objective / research question	The aim of the study was to compare the Community Reinforcement Approach (CRA) + vouchers treatment method to the standard treatment method for cocaine users.
e) Type of study	
f) Year of data collection/fieldwork	2009-2010
g) Study location	Gent
h) Population sample	18 drug-users were tested with this new treatment and 16 with the old treatment
i) Methods	Drug users are paid for their abstinence with a bonus system where they can earn up to €1265 (in credit tickets) during a 6 months period
j) Data quality/methodological concerns	N/A
k) Main publication	Vanderplasschen W. <i>et al.</i> , 2011.
l) Study/Survey website address	N/A
m) Chapter(s) BAR	5

a) Study/survey title	De invloed van de detentie op het gebruik van legale en illegale drugs.
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Vandam, L.; De Ruyver, B. and Vander Beken, T.
d) Main objective / research question	To investigate the effect of detention on drug use

e) Type of study	Observational
f) Year of data collection/fieldwork	2009
g) Study location	2 Belgian prisons
h) Population sample	91 detainees who were about to be released
i) Methods	A structured face-to-face questionnaire and a more in dept interview in a specific sample
j) Data quality/methodological concerns	N/A
k) Main publication	Vandam, L., De Ruyver, B., & Vander Beken, T. (2010). De invloed van de detentie op het gebruik van legale en illegale drugs. In: <i>Actualia strafrecht en criminologie 2010.</i> , L. Pauwels & G. Vermeulen, eds., pp. 265-286. Maklu, Antwerpen.
l) Study/Survey website address	N/A
m) Chapter(s) BAR	9

a) Study/survey title	Definition and measurement of drug-related crime
b) Abbreviation	DRUGCRIM
c) Researcher(s)/ Organisation(s)	De Ruyver B. (UG), Lemaitre A. (ULG), Born, M. (ULG)
d) Main objective / research question	1) To make visible quantitatively what the proportion is of drug related crime in the totality of registered crimes; 2) To develop a replicable method for measuring the drug related crime in Belgium; 3) The elaboration of policy recommendations for the development of a differentiated policy in the area of drug related crime.
e) Type of study	Observational and method development
f) Year of data collection/fieldwork	1 Oct.2006 – 31 Dec 2008
g) Study location	Belgium
h) Population sample	Police files
i) Methods	1) Literature study to make the phenomenon of drug related crime into an operational concept; 2) Study of judicial files to know the proportion of drug-related crime in the totality of registered crimes; 3) Development of a replicable method, based on quantitative part and a part based on self-report. A first measurement of the criminality will be used to adjust and complete the method.
j) Data quality/methodological concerns	N/A
k) Main publication	De Ruyver, B., Lemaitre, A., Born, M., Colman, C., Pirenne, C., & Vandam, L. (2008a). <u>Definition and measurement of drug-related crime.</u>
l) Study/Survey website address	http://www.belspo.be/belspo/fedra/proj.asp?l=en&COD=DR/30
m) Chapter(s) BAR	9

a) Study/survey title	Determination of the yield of an illegal indoor cannabis plantation
b) Abbreviation	YILCAN
c) Researcher(s)/ Organisation(s)	Van Damme P. (UG), De Ruyver, B. (UG)
d) Main objective / research question	To estimate the average yield of an illegal indoor cannabis plantation.
e) Type of study	Experimental
f) Year of data collection/fieldwork	1/12/2009 – 31/05/2011
g) Study location	N/A
h) Population sample	N/A
i) Methods	At the onset of the project, as much information as possible on indoor cannabis cultivation in Belgium will be collected from grey literature sources (predominantly from the internet). Additional information will be retrieved from the Belgian Federal Police. This information will be used in the experimental design so as to adequately imitate a typical illegal indoor cultivation setting. Factors that are investigated include: four cannabis varieties, two plant densities: 16 and 20 plants per m ² ; two different substrates: potting soil and hydroponics; two light intensities: 600 W/m ² and 400 W/m ² . Results of this investigation of agricultural yield will be used in a criminological research component in which the monetary value
j) Data quality/methodological concerns	N/A
k) Main publication	Van Hove et al, 2011, Vandamme et al, 2011
l) Study/Survey website address	http://www.belspo.be/belspo/fedra/proj.asp?l=en&COD=DR/56
m) Chapter(s) BAR	10

a) Study/survey title	Do's and don'ts in a comprehensive and integrated drug policy
b) Abbreviation	DODONBEL
c) Researcher(s)/ Organisation(s)	Brice De Ruyver (UGent); André Lemaître (ULg); Michel Born (ULg); Paul Ponsaers (UGent); Lieven Pauwels; Freya Vander Laenen; Wouter Vanderplasschen (UGent); Sara Van Malderen (UGent); Mathieu Chapeau (ULg); Sofie Vindevogel (UGent); Filip Cammaert (UGent); Anne Moës (ULg); Annelies Devue (UGent); Liesbeth Vandam (UGent)
d) Main objective / research question	1) To identify the policy actors, building blocks and pre conditions needed for the implementation of an effective integral and integrated drug policy; 2) To see if they are present in Belgium and how they can be implemented in an integral and comprehensive drug policy; 3) Investigate if policy directives can be evaluated on the basis of social science criteria of reliability and validity methods and techniques.
e) Type of study	Observational
f) Year of data collection/fieldwork	/11/2007-31/10/2008
g) Study location	Belgium
h) Population sample	N/A

i) Methods	1) Literature study to identify good practices; 2) Mapping of the actors and competent authorities, using law texts, guidelines, existing researches. Survey amongst drug coordinators to identify existing collaborations; 3) The feasibility study was carried out by means of interview and focus groups to sound out the; 4) possibilities and sticking points for the implementation of good practice in framework of an integral and integrated drug policy; 4) Development of an evaluation method, based on an literature inventory
j) Data quality/methodological concerns	N/A
k) Main publication	De Ruyver, B., Lemaitre, A., Born, M., Ponsaers, P., Pauwels, L., Vander Laenen, F., Vanderplasschen, W., Van Malderen, S., Chapeau, M., Vindevogel, S., Cammaert, F., Moës, A., Devue, A., & Vandam, L. (2008b). <u>Do's and don'ts in a comprehensive and integrated drug policy.</u>
l) Study/Survey website address	http://www.belspo.be/belspo/fedra/proj.asp?l=nl&COD=DR/33
m) Chapter(s) BAR	9

a) Study/survey title	Driving Under the Influence of Drugs, Alcohol and Medicines: Injured drivers study
b) Abbreviation	DRUID
c) Researcher(s)/ Organisation(s)	University of Ghent: Toxicological Laboratory, part of the European DRUID project Belgian Institute for Road Safety
d) Main objective / research question	To assess the situation in Belgium (Europe) regarding the prevalence of alcohol and other psychoactive substances in drivers involved in injury accidents
e) Type of study	Observational: biological testing and survey
f) Year of data collection/fieldwork	2008-2010
g) Study location	Ghent-Namur-Liège-Brussels-Leuven
h) Population sample	Injured drivers who were admitted in one of the following hospitals: Ghent University Hospital, Regional Hospital of Namur, University Hospital Sart Tilman (Liège), Leuven University Hospital and Brussels University Hospital. (n= 1078)
i) Methods	The data collection took place in the emergency departments of the selected hospitals. A flow chart on the data collection procedure and a thesaurus for the medical personnel were prepared. Blood samples were taken. Samples were stored in freezers at the hospitals. Shipments (under cooled conditions) to the laboratory of the Department of Clinical chemistry, microbiology and immunology of Ghent University were done on regular basis. The following patient information was obtained: age, gender, time and date of sampling, medication/fluids administered prior to blood sampling and MAIS-score. Accident data consisted of time and date, type of vehicle, type of accident (single/multi vehicle), road type and safety belt use.
j) Data quality/methodological concerns	Unknown refusal-rate in some hospitals
k) Main publication	DRUID-Deliverable 2.2.5. Prevalence of alcohol and other psychoactive substances in injured and killed drivers.
l) Study/Survey website address	www.druid-project.eu
m) Chapter(s) BAR	7

a) Study/survey title	Driving Under the Influence of Drugs, Alcohol and Medicines: Road side Survey
b) Abbreviation	DRUID
c) Researcher(s)/ Organisation(s)	University of Ghent: Toxicological Laboratory, part of the European DRUID project Belgian Institute for Road Safety
d) Main objective / research question	To assess the situation in Belgium (Europe) regarding the prevalence of alcohol and other psychoactive substances in drivers in the general traffic
e) Type of study	Observational: biological testing and survey
f) Year of data collection/fieldwork	2008-2009
g) Study location	Data was collected in the catchments areas of the 5 collaborating hospitals in the DRUID injured drivers study located in 5 different provinces in the three administrative regions of Belgium (Flanders, Wallonia and Brussels). For practical reasons, it was decided to include 9 police zones for each catchment area. These were selected according to information from the emergency services. The nine police zones from which most accidents were transported to the participating hospitals in the years before the DRUID road side study started.
h) Population sample	N= 2949
i) Methods	Between January 2008 and September 2009, randomly selected drivers (stopped by police officers at an aselect alcohol control) were included in a roadside survey. Each volunteer was asked to fill in a questionnaire and to provide a blood sample and an oral fluid sample. Samples were analysed for ethanol (by means of an enzymatic method) and 11 other illicit substances (UPLC-MS/MS and GC-MS).
j) Data quality/methodological concerns	High non-response rate
k) Main publication	DRUID Deliverable 2.2.3: Prevalence of alcohol and other psychoactive substances in drivers in traffic in general in 13 member states.
l) Study/Survey website address	www.druid-project.eu
m) Chapter(s) BAR	9

a) Study/survey title	Drug use among female sex workers in Belgium
b) Abbreviation	DRUSEB
c) Researcher(s)/ Organisation(s)	Decorte, T. (UG), Van Damme, P. (UA), Van Hal, G. (UA)
d) Main objective / research question	1) To study the nature and the extent of legal and illegal drug use among female sex workers in Belgium; 2) To map the most frequent drug-related health problems, and to understand these health problems in-depth; 3) To explore (a) their specific needs for preventive and curative drug-related health care, (b) their knowledge on existing drug treatment, their motivations and experienced obstacles for addressing the existing drug related services; 4) To test the findings of previous objectives against existing initiatives and practices.
e) Type of study	Observational
f) Year of data collection/fieldwork	1/10/2008 – 28/02/2011

g) Study location	5 cities in Belgium
h) Population sample	At least 500 respondents will be subjected to a structured questionnaire. The perspective of at least 25 female sex workers is central to explore the underlying processes and meanings.
i) Methods	By means of a literature study a detailed picture will be obtained concerning the use of drugs, drug-related health problems and -needs and experiences with drug treatment among female sex workers. Two instruments (a quantitative and a qualitative instrument) will be developed based upon (a) existing instruments and (b) a focus group. Several objectives require a quantitative component: a reliable estimation of drug use as well as drug-related health problems and -needs and of experiences with the drug treatment necessitates quantitative measurement. Within the qualitative component a checklist with open questions in a variable order will be used during an interview. After the data-analysis, five focus groups will be organised with invitees that work in the field. They will be able to discuss their interpretation of the results. Furthermore, these groups will reflect about suitable work methods and strategies to tackle drug-related health problems and –needs.
j) Data quality/methodological concerns	N/A
k) Main publication	Decorte, T., Stoffels, I., Leuridan, E., Van Damme P., & Van Hal, G. (2011). <u>Middelengebruik onder sekswerkers in België: een kwantitatieve en kwalitatieve studie in vijf sectoren van de seksindustrie.</u> Academia Press, Gent.
l) Study/Survey website address	http://www.belspo.be/belspo/fedra/proj.asp?l=en&COD=DR/38
m) Chapter(s) BAR	8

a) Study/survey title	Drug use in Belgian prisons: Monitoring of health risks
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Prison Health Care Service of the Directorate-general of Penitentiary Institutions of the Federal Department of Justice (organisation of survey) Ghent University (processing and analysing the data; development of one uniform database)
d) Main objective / research question	To enable a systematical and representative data collection on drugs in prison: the focus is mainly on epidemiological side of drugs in prison, and to a lesser degree the health responses. Illicit drugs as well as alcohol are taken into account. Next to the most common illicit drugs, respondents are asked to report any other product use. Not the use of medicines on prescription (except for opiate substitution medicines) but the misuse of these drugs is included in the survey.
e) Type of study	Observational: self-report questionnaire
f) Year of data collection/fieldwork	2-yearly, since 2006 (last edition in 2010)
g) Study location	Belgian prisons
h) Population sample	Through a random sampling procedure, a minimum of 10% of all categories of Belgian prisoners is targeted

i) Methods	<p>in each prison. Gender and penal status (remand and convicted prisoners, mentally-ill or interned prisoners) is taken into account to obtain a representative sample (n = 1251).</p> <p>The standardised self-report questionnaire used for this monitoring includes about sixty questions covering six main topics (of which one related to drug use and one to infectious diseases). The researchers are independent from the prison system, and get a training and follow-up.</p> <p>Prisoners are approached on their willingness to participate to an anonymous survey on health issues in prison. On agreement to participate they receive the questionnaire and an envelope to enclose the questionnaire after completion. The questionnaire is self-administered, but exceptions can be made for mentally-ill prisoners or the feeble-minded. In that case, the questionnaire is administered together with a researcher.</p>
j) Data quality/methodological concerns	For the upcoming years it is the objective to further refine the questionnaire in order to make it more consistent and uniform in terms of definitions used and within the prospect of EMCDDA's guidelines.
k) Main publication	Van Malderen, S., Pauwels, L., Walthoff-Born, C., Glibert, P., & Todts, S. Drug use in Belgian prisons: monitoring of drug related health risks 2010. Brussels: Federal Departement of Justice . 2011.
l) Study/Survey website address	N/A
m) Chapter(s) BAR	9, 11

a) Study/survey title	Drugs in figures III
b) Abbreviation	DIF III
c) Researcher(s)/ Organisation(s)	De Ruyver, B (UG); Vander Laenen, F (UG), Caulkins, J. (Carnegie Mellon University)
d) Main objective / research question	1) To give an overview of the public expenditures related to drugs and drug addiction in Belgium and to compare the data with previous research and other international data; 2) To draw up a scenario allowing other authorities afterwards to estimate their expenditures.
e) Type of study	Observational
f) Year of data collection/fieldwork	1/01/2010-31/08/2011
g) Study location	Belgium
h) Population sample	N/A
i) Methods	<p>1) Define the concept of 'public expenditure' and draw up an inventory of methods used in (inter)national studies that estimate public expenditures on illegal and legal drugs; 2) Identify the different actors involved in the policy on (il)legal drugs; 3) Refinement of the method used in DIF I and II.</p> <p>Data collection: top-down and check on top-down; Data processing: Drug specific, Proration technique & Unit expenditure; Classification of Reuter (2004)prevention, treatment, harm reduction, enforcement and other</p>
j) Data quality/methodological concerns	N/A
k) Main publication	Vander Laenen, F., De Ruyver, B., Christiaens, J., & Lievens, D. (2011). <u>Drugs in figures III (in press)</u> . Ghent: Academia Press. (in print)
l) Study/Survey website address	http://www.belspo.be/belspo/fedra/proj.asp?l=en&COD=DR/57

m) Chapter(s) BAR	1
--------------------------	---

a) Study/survey title	Elaboration d'un cadastre des actions de prévention des assuétudes et de réduction des risques liés à l'usage de drogues.
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Eurotox
d) Main objective / research question	To identify prevention and harm reductions actions caring by the organisations financed by « plans de cohésion sociale » and « Plans stratégiques de sécurité et de prévention »
e) Type of study	Cross-sectional study
f) Year of data collection/fieldwork	2008-2010
g) Study location	French community
h) Population sample	118 institutions
i) Methods	Questionnaire and interviews
j) Data quality/methodological concerns	survey's response rate
k) Main publication	Casero et al. 2008. Elaboration d'un cadastre des actions de prevention des assuétudes et de reduction des risques lies à l'usage de drogues subsidiées par les pouvoirs publics en Communauté française.
l) Study/Survey website address	www.eurotox.org
m) Chapter(s) BAR	3

a) Study/survey title	Essential and supplementary preconditions for the interaction of justice and drug treatment services
b) Abbreviation	Justhulp
c) Researcher(s)/ Organisation(s)	De Ruyver, B. (UG), Ponsaers, P. (UG), Lemaitre, A. (ULG), Schoenaers, F. (ULG)
d) Main objective / research question	1) To identify the essential preconditions and critical success factors for the interaction between justice and drug treatment services; 2) To develop a guide for the actors concerned, including the organisational preconditions for the implementation and the follow-up of projects within the framework of a 'conditional dismissal'.
e) Type of study	Observational
f) Year of data collection/fieldwork	1/10/2008 – 31/10/2009
g) Study location	Belgium
h) Population sample	Involved actors
i) Methods	1) Analysing the (inter)national literature to identify the possibilities and obstacles in the cooperation between the criminal justice system and treatment services; 2) Organising a focus group, adding to the evaluation of the 'Proefzorg-project': 3) Feasibility study by means of a semi-structured face-to-face interview with involved actors; 4) Developing guidance; 5) The research will be complemented with a quantitative component. A

	codebook and database (including variables related to the profile of the clients, previous arrests, convictions for drug offences, etc.) will be developed to allow simple registration and monitoring to follow the trajectory of the client.
j) Data quality/methodological concerns	N/A
k) Main publication	De Ruyver, B., Lemaître, A., Schoenaers, F., Ponsaers, P., Pauwels, L., Vander Laenen, F. et al. (2009). <u>Essential and supplementary preconditions for the interaction of justice and drug treatment services</u>
l) Study/Survey website address	http://www.belspo.be/belspo/fedra/proj.asp?l=en&COD=DR/36
m) Chapter(s) BAR	9

a) Study/survey title	Etude sur les demandes et les prises en charge dans les services d'accueil spécialisé de la petite enfance
b) Abbreviation	SASPE
c) Researcher(s)/ Organisation(s)	Observatoire de l'Enfance, de la Jeunesse et de l'Aide à la Jeunesse
d) Main objective / research question	To provide information on requests sent to the Specialized Home Services for Early Childhood, those requests origin being private (parents, relatives, front line social services) or specialised Youth Help, in order to characterize those requests.
e) Type of study	Observatory
f) Year of data collection/fieldwork	1 st Feb-31 st July 2008
g) Study location	French Community and Brussels
h) Population sample	Specialised Youth Help services and parents/relatives/front line social services
i) Methods	Questionnaire filled in by each of the 17 Specialized Home Services for Early Childhood
j) Data quality/methodological concerns	N/A
k) Main publication	Etude sur les demandes et les prises en charge dans les services d'accueil spécialisé de la petite enfance (SASPE)
l) Study/Survey website address	http://www.oejaj.cfwb.be/fileadmin/sites/oejaj/upload/oejaj_super_editor/oejaj_editor/pdf/Rapport_final_SASPE.pdf
m) Chapter(s) BAR	12

a) Study/survey title	Evaluation of Crisis and Case Management
b) Abbreviation	ECCAM
c) Researcher(s)/ Organisation(s)	Demyttenaere K. (KUL), Bruffaerts R. (KUL), Van Hal G. (UA), Beutels P. (UA), Broekaert, E. (UG), Vanderplasschen, W. (UG), Hermans, S., Fraeyman, J. (UA), Baudoncq (UG)
d) Main objective / research question	1) the methods, target population and realisations of the services that are involved in crisis management for persons with substance use disorders in Belgium will be described; 2) Precise description of the concept 'crisis'; 3) Description of the key features of case management (CM); 4) Health economic analysis of the

e) Type of study	crisis units for persons with substance use disorders; 5) Formulating recommendations for optimising crisis and case management for substance misusers Observational + review
f) Year of data collection/fieldwork	1/10/2008 – 30/04/2010
g) Study location	Belgium
h) Population sample	Involved actors
i) Methods	1) An epidemiological mapping will be made; 2) Both qualitative and quantitative methods will be used to further specify this definition; 3) Characterisation the target population, case-load, objectives, methods and goal attainment of CM-projects is based on existing database; interviews and focus groups with CM; 4) The measurement of costs will be based on the existing registration of patients data within these pilot projects and based on incomes and expenditures of these projects; 5; The Summary and cluster conclusions are based on the results of the previous four goals. Based on a SWOT-analysis, recommendations will be formulated for both crisis and case management, on the level of clinical care, the organisation of the treatment facility, and the overall policy, in order to create a better match between service demand and provision. The results and recommendations will be linked to the daily practice, based on analyses about the monitoring of different models of case management.
j) Data quality/methodological concerns	N/A
k) Main publication	Bruffaerts, R., Vanderplasschen, W., Van Hal, G., & Demyttenaere, K. (2010). <u>Crisisopvang voor middelengebruikers in België: een formele evaluatie en aanbevelingen voor een duurzaam beleid - De Evaluatie van Crisis en Case Management (ECCAM) - studie</u> http://www.belspo.be/belspo/fedra/proj.asp?l=en&COD=DR/39
l) Study/Survey website address	
m) Chapter(s) BAR	7

a) Study/survey title	Genderspecifieke hulpverlening aan drugsverslaafde vrouwen
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Claeys, N. / Free Clinic)
d) Main objective / research question	To describe integrated strategies and guidelines to treatment based on research and clinical practice.
e) Type of study	Review/Essay
f) Year of data collection/fieldwork	
g) Study location	Antwerp
h) Population sample	
i) Methods	Essay
j) Data quality	N/A
k) Main publication	Genderspecifieke hulpverlening aan drugsverslaafde vrouwen
l) Study/Survey website address	N/A

m) Chapter(s) BAR	12
--------------------------	----

a) Study/survey title	GH@PRO/connecte
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	
d) Main objective / research question	
e) Type of study	Administrative registration
f) Year of data collection/fieldwork	
g) Study location	
h) Population sample	Sex workers
i) Methods	
j) Data quality/methodological concerns	
k) Main publication	
l) Study/Survey website address	
m) Chapter(s) BAR	2

a) Study/survey title	Health Behaviour in School-aged Children (Flanders)
b) Abbreviation	HBSC
c) Researcher(s)/ Organisation(s)	Department of Public Health of the University of Ghent (UGhent)
d) Main objective / research question	The HBSC is a cross-national research study conducted in collaboration with the WHO Regional Office for Europe. The study aims to gain new insight into, and increase our understanding of young people's health and well-being, health behaviours and their social context.
e) Type of study	Repeated school survey
f) Year of data collection/fieldwork	2010
g) Study location	Flanders and Dutch-speaking secondary education in the Brussels Capital Region
h) Population sample	full time attendance schooling; schools dedicated to disabled pupils excluded; Sampling procedure: psu=class; step 1: schools, step 2: classes; stratified
i) Methods	Self administered questionnaire, substance use questions included among others; questionnaire sealed in a plain envelope by pupil
j) Data quality/methodological concerns	N/A
k) Main publication	Vereecken C, Maes L. (in press) Comparison of a computer administered and paper and pencil administered questionnaire on health and lifestyle behaviors. Journal of Adolescent Health.
l) Study/Survey website address	http://www.jongeren-en-gezondheid.ugent.be/
m) Chapter(s) BAR	2

a) Study/survey title	Health Behaviour in School-aged Children (French Community)
b) Abbreviation	HBSC
c) Researcher(s)/ Organisation(s)	School of Public Health of the Université libre de Bruxelles (ULB).
d) Main objective / research question	The HBSC is a cross-national research study conducted in collaboration with the WHO Regional Office for Europe. The study aims to gain new insight into, and increase our understanding of young people's health and well-being, health behaviours and their social context.
e) Type of study	Repeated school survey
f) Year of data collection/fieldwork	2010
g) Study location	Wallonia and French-speaking secondary education in the Brussels Capital Region
h) Population sample	full time attendance schooling; schools dedicated to disabled pupils excluded; Sampling procedure: psu=class; step 1: schools, step 2: classes; stratified
i) Methods	Self administered questionnaire, substance use questions included among others; questionnaire sealed in a plain envelope by pupil
j) Data quality/methodological concerns	N/A
k) Main publication	N/A
l) Study/Survey website address	N/A
m) Chapter(s) BAR	2

a) Study/survey title	In hogere sferen 2
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Vereniging voor Alcohol- en andere Drugproblemen vzw; Universitair Wetenschappelijk Instituut voor Drugproblemen (UWiD) of Antwerp University, Research group "Health promotion" of the University of Ghent
d) Main objective / research question	A survey of substance use and abuse among university and college students in Antwerp and Ghent
e) Type of study	Stratified random websurvey, based on a structured questionnaire. All questions concerned alcohol and drug (ab)use and contextual aspects of this (ab)use.
f) Year of data collection/fieldwork	2010
g) Study location	Antwerp and Ghent
h) Population sample	University and college students, Stratified random sample based on individual participation of respondents (questionnaire)
i) Methods	Stratified random survey, based on a structured questionnaire. All questions concerned alcohol and drug (ab)use and contextual aspects of this (ab)use.
j) Data quality/methodological concerns	
k) Main publication	Rosiers, J., Hublet, A., Van Damme, J., Maes, L., & Van Hal, G.r. (2011). In hogere sferen? Volume 2. Een onderzoek naar het middelengebruik bij Vlaamse studenten. Universiteit Antwerpen Antwerp.
l) Study/Survey website address	http://www.vad.be/alcohol-en-andere-drugs/onderzoek/studentenbevraging.aspx

m) Chapter(s) BAR	2
--------------------------	---

a) Study/survey title	International Cannabis Need of Treatment
b) Abbreviation	INCANT
c) Researcher(s)/ Organisation(s)	Cannabis clinic (Brugman Hospital)
d) Main objective / research question	To validate a therapeutic method in the field of addictions in adolescence (MDFT- Multidimensional Family Therapy) and to develop means of evaluation of psychotherapies.
e) Type of study	Randomized controlled trial
f) Year of data collection/fieldwork	Since 2003
g) Study location	In 5 European countries (Belgium, France, Germany, Nederland and Switzerland)
h) Population sample	Around 120 adolescents 12-18y with a recent (last year) DSM-IV diagnosis of cannabis misuse or dependence with at least one legal representative
i) Methods	A randomized controlled trial which compares MDFT with treatment as usual.
j) Data quality/methodological concerns	N/A
k) Main publication	
l) Study/Survey website address	www.incant.eu
m) Chapter(s) BAR	5

a) Study/survey title	JeugdOnderzoeksplatform-monitor 1 and 2
b) Abbreviation	JOP-1, JOP-2
c) Researcher(s)/ Organisation(s)	VUB: Tempus Omnia Revelat (TOR); UGent: Vakgroep Sociale Agogiek; K.U.Leuven: Leuvens Instituut voor criminology (LINC).
d) Main objective / research question	To have periodical estimations about the living conditions, the convictions and behaviour of young people in Flanders.
e) Type of study	Observational: survey by post
f) Year of data collection/fieldwork	(1) 2005, (2) 2008
g) Study location	Flanders
h) Population sample	(1) The sampling was based on the national register number for the 14-18y olds, and on a commercial database for the 18-25y olds. (14-18y: N = 2503; 18-25y: N =2325); (2)The sampling was based in the national register number. A response rate of 46.38% was achieved. People aged 12 – 30 years: (12-13y: N = 462; 14-30y: N = 3248)
i) Methods	(1) The JOP monitor 1 was the result of a study-round, an internal discussion within JOP, a first consultation of people outside JOP and a test survey among 14 to 25 year olds. This JOP monitor 1 was considered as a 'preliminary' product which had to be reconsidered after a first study, to create the final JOP monitor 2. (2) Based on literature reviews and the JOP-monitor 1, the JOP-monitor 2-survey was created to fulfil the

j) Data quality/methodological concerns	needs for this specific research. It was a postal survey, according to the <i>total design procedure</i> (people are contacted 4 times by mail). Afterwards, a 5 th digital wave was organised, as the response rate was still low. A shorter and easier version of the survey was used for the 12-13 years olds compared to that for the 14-20 year olds.
k) Main publication	N/A
l) Study/Survey website address	http://www.jeugdonderzoekplatform.be/ned/index.htm
m) Chapter(s) BAR	2, 9, 10
<hr/>	
a) Study/survey title	Kwalitatieve evaluatie van het pilootproject “Drugbehandelingskamer”
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	De Ruyver, B. (UG); Vander Laenen, F. (UG); Vanderplasschen, W. (UG); Colman, C. (UG); Broekaert, E. (UG)
d) Main objective / research question	To evaluate the pilot project ‘Drugbehandelingskamer’ qualitatively: how do involves actors experience their role, the structure and the design of the ‘Drugbehandelingskamer’; how do clients experience the structure and design, and which recommendations can be made?
e) Type of study	Observational
f) Year of data collection/fieldwork	Feb 2009 – April 2010
g) Study location	Ghent
h) Population sample	Involved actors and clients
i) Methods	1) Semi-structured interviews with the direct involved actors (judges, magistres, case management coordinator, etc.) (N=30), an indirect actor (network care circuit substance misuse) and clients themselves; 2) Focus group to complete and clarify the interviews. 12 actors (from aid services and justice) participated.; 3) File study based on clients who started a treatment between mai 1 st 2008 and December 31 st 2009 (N=114).
j) Data quality/methodological concerns	N/A
k) Main publication	De Ruyver, B., Vander Laenen, F., Vanderplasschen, W., Colman, C., & Broekaert, E. (2010). De Drugbehandelingskamer. Kwalitatieve evaluatie van het pilootproject 'Drugbehandelingskamer'.
l) Study/Survey website address	N/A
m) Chapter(s) BAR	9
<hr/>	
a) Study/survey title	Kwantitatieve evaluatie van het pilootproject ‘Drugbehandelingskamer’ aan de Rechtbank van Eerste Aanleg te Gent
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	De Keulenaer, S.; Thomaes, S. (Service Criminal Policy)

d) Main objective / research question	To evaluate the pilot project 'Drugbehandelingskamer' quantitatively
e) Type of study	Observational
f) Year of data collection/fieldwork	May 2008 – December 2009.
g) Study location	Ghent
h) Population sample	People in contact with the project 'Drugbehandelingskamer'.
i) Methods	Based on files in the database of the project. The database includes variables related to: Way and reason of referral, Socio-demographic variables, Criminality, Substance of misuse, Treatment trajectory, Sentencing
j) Data quality/methodological concerns	N/A
k) Main publication	De Keulenaer, S. & Thomaes, S. (2010). Kwantitatieve evaluatie van het pilootproject 'Drugbehandelingskamer' aan de Rechtbank van Eerste Aanleg te Gent.
l) Study/Survey website address	N/A
m) Chapter(s) BAR	9

a) Study/survey title	L'usage de drogues « en milieu festif »
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Modus Vivendi
d) Main objective / research question	Prevention and harm reduction responses to drug use in recreational settings
e) Type of study	Survey
f) Year of data collection/fieldwork	2010
g) Study location	French Community
h) Population sample	N=2111 (1009 males, 684 females and 418 unknown); mean age = 21.8 (min:11; max:56); median age: 20
i) Methods	Risk reduction activities take place in a specific visible space (a stand) where professionals and jobistes (drug users trained in harm reduction) provide information, advices and risk reduction tools (folders, sniff kit, condoms, etc.) to users, potential users and everyone interested in the subject/reach by the staff. The contact with people is followed by the completion of an auto-administered questionnaire addressing different topics (drugs used, risks taken, problems related to drug use encountered, etc.), which can be the start of further advices provision. Theses harm reduction activities take place in the whole French Community thanks to a partnership between Modus Vivendi and local prevention services, through the project "Drogues Risquer Moins".
j) Data quality/methodological concerns	The coverage of events is not sampled but depends mainly of partnerships. The sample of collected questionnaires is mostly composed of people attending to the stands during the events covered, even if some partners are more proactive and contact people out of the stand, and double counting cannot be excluded. The data are therefore not representative of the whole public present in recreational settings but rather of people interested in or met to received specific information concerning mainly drug use and harm reduction. Finally, the questionnaire is rather a contact tool than a specific data collection tool, and its completion is not truly standardized. These data are then indicative rather than representative of drug use recreational settings.

k) Main publication	N/A
l) Study/Survey website address	http://www.modusvivendi-be.org/spip.php?rubrique29
m) Chapter(s) BAR	2, 4

a) Study/survey title	Maternité et toxicomanie : état des connaissances.
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Van Woensel, G. & Beyra-Vanneste, A.L.
d) Main objective / research question	Review on addiction and motherhood in order to provide General Practitioners the essential elements for the follow-up of those patients
e) Type of study	Review
f) Year of data collection/fieldwork	N/A
g) Study location	N/A
h) Population sample	N/A
i) Methods	Review
j) Data quality/methodological concerns	N/A
k) Main publication	
l) Study/Survey website address	N/A
m) Chapter(s) BAR	12

a) Study/survey title	Middelengebruik bij 12- tot 18-jarige scholieren in Brugge
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Department Scientific Research, De Sleutel
d) Main objective / research question	Prevalence and risk factors of substance use
e) Type of study	Repeated school survey substance related questions, risk taking behaviour, psychosocial wellbeing.
f) Year of data collection/fieldwork	2010
g) Study location	Secondary schools of Bruges
h) Population sample	Students in secondary schools; year 1 (age 11-12) till year 7 (age 18+) of secondary schools, all education levels.
i) Methods	Anonymous Paper survey
j) Data quality/methodological concerns	N/A
k) Main publication	Lombaert, G. (2010). <u>Middelengebruik bij 12 tot 18-jarige scholieren in Brugge</u> , De Sleutel, Gent.
l) Study/Survey website address	www.desleutel.be
m) Chapter(s) BAR	2

a) Study/survey title	Needle exchange data Modus Vivendi
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Modus Vivendi
d) Main objective / research question	Monitoring
e) Type of study	Observational
f) Year of data collection/fieldwork	
g) Study location	Walloon Region, Needle Exchange Points
h) Population sample	N/A
i) Methods	Monitoring of needle distribution and recuperation in specialist sites with NSP, and unofficial needle distribution sites. Some pharmacies participate in the Sterifix project, offering a kit which contains 2 seringues, 2 swabs, 2 sterile water flasks, harm reduction information and local addresses.
j) Data quality/methodological concerns	Not all structures that deliver needles are known. For the Sterifix project, it is unknown whether all Sterifix kits dispatched were effectively sold in 2010.
k) Main publication	N/A
l) Study/Survey website address	N/A
m) Chapter(s) BAR	4, 7

a) Study/survey title	Needle exchange data Spuitenruil
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Spuitenruil Vlaanderen, coordinator Tessa Windelinckx
d) Main objective / research question	Monitoring
e) Type of study	Observational
f) Year of data collection/fieldwork	
g) Study location	Flanders, Needle Exchange Points
h) Population sample	
i) Methods	Monitoring of needle distribution and recuperation in specialist sites with NSP, pharmacy based NSP and street corner work/outreach projects
j) Data quality/methodological concerns	
k) Main publication	Windelinckx, T. & Bosschaerts, W. (2011). <u>Project Spuitenruil Vlaanderen. Werkjaar 2010. Eindrapport Spuitenruil Vlaanderen.</u> , Free Clinic, Antwerp.
l) Study/Survey website address	
m) Chapter(s) BAR	4, 7

a) Study/survey title	Needs assessment Special Youth Care
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Inge Baeten, Johan Rosiers (VAD)
d) Main objective / research question	Needs assessment survey on alcohol and drug policy in special youth assistance organisations
e) Type of study	Survey
f) Year of data collection/fieldwork	2010
g) Study location	Flemish Community of Belgium
h) Population sample	164 representatives of special youth assistance organisation, with proportional participation from all types of organisation
i) Methods	432 representatives of special youth assistance organisation were invited to participate in an online needs assessment survey. The questionnaire consisted of three major parts: 1) perception of alcohol and drug problems in the life of their young clients and in the organisations, 2) current approaches and policies within the organisations to handle alcohol and drug issues, 3) needs assessment in supporting and training special youth assistance organisations to handle alcohol and drug issues.
j) Data quality/methodological concerns	N/A
k) Main publication	Baeten, I., & Rosiers, J. (2010). Alcohol- en druggebruik in de bijzondere jeugdzorg. Vragen over aanpak en begeleiding anno 2010. Brussel : VAD.
l) Study/Survey website address	http://www.vad.be/materiaal/dossiers/nodenbevraging-bijzondere-jeugdzorg.aspx
m) Chapter(s) BAR	3

a) Study/survey title	Perceived pleasures and pains of cocaine use
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Tom Decorte, Ghent University, Dept. of Penal Law and Criminology
d) Main objective / research question	Changes over time in perceived benefits and disadvantages of cocaine use
e) Type of study	Naturalistic and ethnographic study; twelve year follow-up study
f) Year of data collection/fieldwork	Between 1997 – 2009
g) Study location	Belgium
h) Population sample	56 cocaine users; mean age of 40; 50% male
i) Methods	Semi-Structured questionnaires
j) Data quality/methodological concerns	Panel conditioning, recall bias and attrition
k) Main publication	N/A
l) Study/Survey website address	N/A
m) Chapter(s) BAR	8

a) Study/survey title	Poly drug use and mental health among drug users who ask for treatment
b) Abbreviation	POLYMEH
c) Researcher(s)/ Organisation(s)	Broekaert, E. (UG), Sabbe, B. (UA), Dom, G. (UA), Vanderplasschen, W. (UG), Rea, A. (ULB), Ravndal, E. (University of Oslo)
d) Main objective / research question	1) map the prevalence of poly drug use and the characteristics of poly drug users treatment; 2) explore the extent and type of psychiatric disorders among persons following substance misuse treatment in Belgium and the prevalence and type of DSM Axis I and II-disorders in this population; 3) compare the characteristics and psychiatric profile of poly drug users with that of persons who only use one substance.
e) Type of study	
f) Year of data collection/fieldwork	1/12/2009 – 30/06/2011
g) Study location	N/A
h) Population sample	N/A
i) Methods	1) literature review; 2) quantitative analysis of available databases; 3) presentation and discussion of the research findings and formulation of recommendations
j) Data quality/methodological concerns	N/A
k) Main publication	N/A
l) Study/Survey website address	http://www.belspo.be/belspo/fedra/proj.asp?l=en&COD=DR/55
m) Chapter(s) BAR	5, 6

a) Study/survey title	Prix des drogues en rue
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Eurotox / outreach workers and syringe exchange desks
d) Main objective / research question	Monitoring of drug prices
e) Type of study	Observational
f) Year of data collection/fieldwork	2010
g) Study location	French Community
h) Population sample	N/A
i) Methods	The data are collected once a year, during 2 months in spring, with the help of outreach workers and syringes exchange desks in French Community through a repeated survey, EUROTOX asked each association partner to fill out the questionnaire with the user. They ask them to try to reach 20% of their public during two months.
j) Data quality/methodological concerns	1) The sample is small and do not cover equally all the French Community. 2) Prices reported are not based on weight samples of substances. 3) The sampling is strictly limited to people reached by outreach workers and syringe exchange desks.
k) Main publication	N/A

l) Study/Survey website address	N/A
m) Chapter(s) BAR	10

a) Study title	Prosecutor's office statistics
b) Abbreviation	
c) Host(s)/ Organisation(s)	College of the Procurator General
d) Main objective / research question	Gives an overview of the cases entering and leaving the prosecutors' offices of the first line courts in Belgium Forms the intermediary link between the police statistics and the sentencing statistics
e) Type of study	Observational
f) Year of data collection/fieldwork	From 2003 onwards
g) Study location	Belgium
h) Population sample	Cases entering and leaving the prosecution
i) Methods	The database completely relies on the data available in the databases of the prosecutors' offices of the first line courts. The statistics contain information about the detection and prosecution of criminal cases by the correctional courts.
j) Data quality/methodological concerns	
k) Main publication	http://www.om-mp.be/sa/start/n/home.html
l) Study/survey website address	http://www.om-mp.be/sa/start/n/home.html
m) Chapter(s) BAR	9

a) Study/survey title	Psychiatric comorbidity in patients from De Sleutel
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	De Sleutel
d) Main objective / research question	Client clinical assessment
e) Type of study	Epidemiological registration
f) Year of data collection/fieldwork	N/A
g) Study location	Flanders
h) Population sample	All patients entering treatment in one of the centres of De Sleutel
i) Methods	EuropASI intake interview
j) Data quality/methodological concerns	N/A
k) Main publication	N/A
l) Study/Survey website address	www.desleutel.be
m) Chapter(s) BAR	6

a) Study/survey title	Quality of life among opiate-dependent individuals 5 to 10 years after starting MMT
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Jessica De Maeyer, Wouter Vanderplasschen, Eric Broekaert Ghent University, Dept of Orthopedagogics
d) Main objective / research question	Current quality of life and its determinants among opiate-dependent individuals 5 to 10 years after starting methadone treatment
e) Type of study	Cross sectional study
f) Year of data collection/fieldwork	2008-2010
g) Study location	Ghent, Belgium
h) Population sample	159 individuals who started a methadone treatment in the region of Ghent between 1997 and 2002. Mean age of 36,6; 74,8% male
i) Methods	Surveys: Lancashire Quality of Life Profile, EuropASI, Brief Symptom Inventory, Verona – Substitution Treatment Satisfaction Questionnaire
j) Data quality/methodological concerns	N/A
k) Main publication	N/A
l) Study/Survey website address	N/A
m) Chapter(s) BAR	8

a) Study title	Routine Diagnostic Testing De Sleutel
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	De Sleutel
d) Main objective / research question	Monitor the infectious diseases in drug users
e) Type of study	Observational
f) Year of data collection/fieldwork	From 1997 onwards, continuous
g) Study location	Regional, patient of De Sleutel (drug treatment centres (8)), in different cities
h) Population sample	Ever IDU's, no restriction on age, gender or time since first injection
i) Methods	Biological testing is performed for clients seen by a doctor. Criteria for seeing a doctor are not linked to the type and/or the way of product-use, but at least all clients getting substitution and/or other medication see a doctor. The informed consent is needed. Test are done for: HBsAg, antiHBc, antiHBs, HIV Ab, HCV Ab.
j) Data quality/methodological concerns	N/A
k) Main publication	Medische registratie druggerelateerde infectieuze aandoeningen 2004. Interne publicatie. De Sleutel, Gent, 9p.
l) Study/survey website address	N/A
m) Chapter(s) BAR	6

a) Study title	Routine Diagnostic Testing Free clinic
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Free Clinic
d) Main objective / research question	
e) Type of study	Observational
f) Year of data collection/fieldwork	Continuous, since 2001
g) Study location	Drug treatment centre (maintenance), in Antwerp
h) Population sample	Ever IDU's, no restriction gender or time since first injection; Age restriction: 18-99y
i) Methods	Diagnostic testing, Informed consent required; Exhaustive sampling; Serum is used for HBsAg, antiHBc, antiHBs, HIV Ab, HCV Ab, HCV RNA, anti HAV, syphilis
j) Data quality/methodological concerns	N/A
k) Main publication	N/A
l) Study/survey website address	N/A
m) Chapter(s) BAR	6

a) Study title	Self-reported Infectious Diseases Eurotox
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Eurotox / treatment centres
d) Main objective / research question	
e) Type of study	Observational
f) Year of data collection/fieldwork	Since the late 90's, continuous
g) Study location	Walloon Region, inpatient (7), outpatient (17) and low threshold (4) treatment centres
h) Population sample	Ever IDU's, no restriction on age, gender or time since first injection
i) Methods	Informed consent needed; Self-report questions about HIV seroprevalence are asked to patients in combination to the completion of the treatment demand indicator (TDI). However, because of the sensible aspect of these questions and the difficulty to asked it during the first consultation, these questions are not systematically asked, depending on the medical staff disposal. When available, the questions are answered based on the medical files of the patients (29% of the cases for 2010 data).
j) Data quality/methodological concerns	Specimen used not known
k) Main publication	N/A
l) Study/survey website address	N/A
m) Chapter(s) BAR	6

a) Study title	Service for Criminal Policy: statistics
b) Abbreviation	
c) Host(s)/ Organisation(s)	Service for criminal policy
d) Main objective / research question	The database collects the information about sentences, internments and suspension of cases in all courts.
e) Type of study	Observational
f) Year of data collection/fieldwork	Since 1995
g) Study location	Belgium
h) Population sample	N/A
i) Methods	Data on the sentences and suspensions from all courts in Belgium are gathered at detail-level 3.
j) Data quality/methodological concerns	There is a large time delay and not all data for legal person are available
k) Main publication	http://www.dsb-spc.be/web/index.php?option=com_content&task=view&id=28&Itemid=47
l) Study/survey website address	http://www.dsb-spc.be/
m) Chapter(s) BAR	9

a) Study/survey title	Sewage epidemiology
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	University of Antwerp
d) Main objective / research question	Gain knowledge about the consumption of illicit drugs through wastewater samples, complementary to the conventional socio-epidemiology
e) Type of study	Analytical
f) Year of data collection/fieldwork	2007-2008: Cocaine in Water-COWAT project in Belgium; 2009-2010: Extensive sampling campaign in Brussels targeting several illicit drugs; 2011: European collaboration with 11 countries on several substances
g) Study location	Belgium / Europe
h) Population sample	N/A
i) Methods	The sewage epidemiology approach consists of four different steps: 1) measurement of the concentrations of illicit drugs and/or metabolites in influent wastewater, 2) transformation of the concentrations into mass loads (g/day), 3) backcalculation of the mass loads to the amount of consumed illicit drug based on knowledge of the substance excretion and 4) normalisation of the consumed amount by the amount of inhabitants served by the wastewater treatment plant (WWTP). The technique of liquid chromatography coupled to tandem mass spectrometry (LC-MS/MS) has been used
j) Data quality/methodological concerns	N/A
k) Main publication	Van Nuijs A.L.N. <i>et al.</i> , 2011 Science of the Total Environment
l) Study/Survey website address	N/A
m) Chapter(s) BAR	10

a) Study/survey title	Snowball Survey in the street
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Modus Vivendi
d) Main objective / research question	Peer-to-peer prevention concerning AIDS, hepatitis and other risks associated with drug use among street drug users. The first objective of snowball operation is to make users aware of the risks related to their practice and inform them how to reduce these risks. The second is to inform users about the local services available to reduce risks (syringe exchange facilities, etc.). The third is to gather information about users with the help of a questionnaire to adapt prevention programmes appropriately.
e) Type of study	Survey
f) Year of data collection/fieldwork	2010
g) Study location	French Community
h) Population sample	N=526 (388 males, 115 females and 23 unknown); mean and median age = 34 y.o. (min:14; max:70)
i) Methods	Snowball operation is a prevention participative project that consists of training during about five sessions recruited active drug users (called jobsite) to talk to other users about AIDS, hepatitis, and other risks related to drug use. The training sessions include mainly presentation of the project, highlight of the role of peers in prevention, medical information training, and a role-playing session. The rationale underlying the operation is that prevention and harm reduction messages can spread in the same way the virus follows. Jobiste is a volunteer, paid to contact ten peers and talk to them about risks related to drug use, with the help of a questionnaire that serves as a contact tool addressing different topics (drugs used, risks taken, etc.). Jobiste is also asked to recruit a future jobsite candidate. A collective followed by an individual evaluation take place with the jobistes at the end of each operation.
j) Data quality/methodological concerns	The samples are mostly determined by the social network of peers. Therefore the data are not necessarily representative, and double counting cannot be excluded. Moreover, the questionnaire is rather a contact tool than a specific data collection tool, and its completion is not truly standardized. These data are then indicative rather than representative of drug use in street publics.
k) Main publication	Analyses quantitatives des opérations Boule-de-neige en rue. In Rapport d'activité Communauté française 2010. Modus Vivendi asbl : Bruxelles.
l) Study/Survey website address	http://www.modusvivendi-be.org/spip.php?article13
m) Chapter(s) BAR	3, 4, 6

a) Study/survey title	Study of part of locally cultivated cannabis on Belgian market of the drug
b) Abbreviation	GEOCAN
c) Researcher(s)/ Organisation(s)	Charlier, C. (ULG), Verstraete, A. (UG), De Ruyver, B. (UG)
d) Main objective / research question	A differentiation of the various phenotypes of hemp that can be produced (drug or fibre type) according to their content in cannabinoids; determination of the geographical area of cultivation of seized cannabis plants or flowers (national or cross-border production or importation); juridical comparison of different laws

e) Type of study	concerning cannabis cultivation and possession in Europe Observational
f) Year of data collection/fieldwork	1/10/2007 – 30/09/2009
g) Study location	N/A
h) Population sample	N/A
i) Methods	Analysis of different species of cannabis plants during growth to evaluate the evolution of the content in various cannabinoids. Seeds or cuttings were cultivated and sampling was performed each week, followed by analysis through HPLC-DAD Use of various methods (DNA analysis, ICP-MS, IRMS) to try to identify a particularity that could be specific of locally cultivated cannabis
j) Data quality/methodological concerns	The availability of cannabis plants from different international locations (most are from Belgian or Dutch origin)
k) Main publication	N/A
l) Study/Survey website address	http://www.belspo.be/belspo/fedra/proj.asp?l=en&COD=DR/34
m) Chapter(s) BAR	10

a) Study/survey title	Substance use and abuse in people with Intellectual Disabilities (ID)
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Stijn Vandevelde, Wing Ting To; Ghent University College
d) Main objective / research question	Prevalence of substance use and abuse in people with an intellectual disability (ID)
e) Type of study	Descriptive study
f) Year of data collection/fieldwork	2010
g) Study location	East-Flanders, Belgium
h) Population sample	34 professionals who worked with persons with ID and substance related problems
i) Methods	Online survey
j) Data quality/methodological concerns	N/A
k) Main publication	Neyrinck, S., Vandevelde, S., Vandewalle, J., Soyez, V., Vanderplasschen, W., Broekaert, E. et al. (2011). An exploration of substance use and abuse in people with ID. <u>Journal of applied Research in Intellectual Disabilities.</u> , 23, 524.
l) Study/Survey website address	
m) Chapter(s) BAR	8

a) Study/survey title	TEN D by night
b) Abbreviation	

c) Researcher(s)/ Organisation(s)	Consepi, Italy; Open youth, Bulgaria; University of Turin, Italy; Rīga Stradins university, Latvia; S. &T. Soc. Cooperation, Italy; “Safe Driver” foundation, Poland; Responsible young drivers, Belgium; University of Valencia, Spain.
d) Main objective / research question	Develop a prevention programme to: (1) increase young people’s awareness of the influence of alcohol and psychoactive substances upon their driving capacity; (2) publishing correct and effective information in the effects of both alcohol and psychoactive substances; (3) defining a European approach to the prevention of road accidents caused by the consumption of alcohol and psychoactive substances; (4) contributing toward improving knowledge about young people’s alcohol and psychoactive substance consumption in their regular meeting places
e) Type of study	Cross-sectional
f) Year of data collection/fieldwork	2009?
g) Study location	Several recreational venues, selected based on their geographical location , presence of target population and willingness of owners and managers of the venues.
h) Population sample	5000 young driving licence holders (16 – 24 years old), who attended recreational venues during weekend nights: 1000 of them in Belgium/The Netherlands
i) Methods	Participants are recruited at the entre of the recreational venues. Anonymity is guaranteed by working with numbered bracelets. A first questionnaire is filled in by the participants, a breathalyzer test is carried out and a reaction time test is done before entering the venue. When leaving the venue, an exit questionnaire, a second breathalyzer, a drug test and second reaction time test is done.
j) Data quality/methodological concerns	(1) The voluntary recruitment of participants and the selection of the intervention places on the basis of their willingness to participate can diminish the representativeness; (2) The measurement of drugs does not allow an exact determination of the quantity of drugs used; (3) Participants sometimes consider the questionnaire and drug test too time consuming
k) Main publication	Berchiolla, P et al. (2010). TED D by night project. S&T Soc. Coop., Italy.
l) Study/Survey website address	N/A
m) Chapter(s) BAR	7, 9

a) Study title	The annual statistics of the courts.
b) Abbreviation	
c) Host(s)/ Organisation(s)	Permanent office for Statistics and Work load Measurement
d) Main objective / research question	To measure the workload of the collaborators of the courts in order to define the personnel needs of each court. At the same time, courts can use this instrument to compare and improve their working processes.
e) Type of study	Observational
f) Year of data collection/fieldwork	Since 2008
g) Study location	Belgium

h) Population sample	N/A
i) Methods	The annual statistics are collected in the framework of the workload measurement of all the courts.
j) Data quality/methodological concerns	N/A
k) Main publication	Vast bureau Statistiek en werklastmeting (2010). Justitie in cijfers. Bureau Permanent Statistiques et Mesure de la charge de travail (2010). Justice en chiffres.
l) Study/survey website address	http://www.vbsw-bpsm.be/
m) Chapter(s) BAR	9

a) Study/survey title	Toxicomanies et Parentalité
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Jacques, C. / General Practicioners members of the ALTO-SSMG network.
d) Main objective / research question	To provide data to support thinkings on parenthood in the framework of addiction
e) Type of study	Observational study
f) Year of data collection/fieldwork	October to December, 1995
g) Study location	Brussels and Wallonia
h) Population sample	N=515; 78% were men; Mean age: 28 for men, 26 for women
i) Methods	General Practicioners filled in a questionnaire for each patient consulting at least for the second time for addiction problem
j) Data quality/methodological concerns	Double coding of patients
k) Main publication	Toxicomanies et Parentalité : enquête réalisée auprès de médecins généralistes belges francophones accompagnant des usagers de drogues
l) Study/Survey website address	N/A
m) Chapter(s) BAR	12

a) Study/survey title	Trace detection of synthetic drugs production in waste waters
b) Abbreviation	GEOAMP
c) Researcher(s)/ Organisation(s)	Charlier, C. (ULG), Verstraete, A. (UG), Dewulf, J. (UG)
d) Main objective / research question	To establish if it is possible to link the presence of some markers in water samples to the existence of illegal amphetamine synthesis.
e) Type of study	Observational: waste water sampling
f) Year of data collection/fieldwork	1/10/2008 – 30/11/2009
g) Study location	Water Treatment plants in Antwerp, Hasselt and Oupeye
h) Population sample	N/A
i) Methods	The following substances were searched in the waste water form water treatment plants in the North (Antwerp and Hasselt) and South (Oupeye) of Belgium: amphetamine, MDA, MDMA, N-acetylamphetamine, N-formyl-MDA en N-acetyl-MDA. Two sampling campaigns were organised. Sampling was conducted using

j) Data quality/methodological concerns	an automatic device giving a representative picture of the flow during a day. Solid phase extraction followed by LC-MSMS was used for analysis. Lack of internal standards and difficulties in developing significantly sensitive methods for detecting other waste molecules related to amphetamine production
k) Main publication	N/A
l) Study/Survey website address	http://www.belspo.be/belspo/fedra/proj.asp?l=en&COD=DR/37
m) Chapter(s) BAR	10
<hr/>	
a) Study/survey title	VAD Leerlingenbevraging
b) Abbreviation	VAD-LLB
c) Researcher(s)/ Organisation(s)	Vereniging voor Alcohol- en andere Drugproblemen vzw
d) Main objective / research question	Survey about use of legal and illegal drugs in connection with a drug policy at school
e) Type of study	Repeated survey amongst students in secondary schools in Flanders
f) Year of data collection/fieldwork	School year 2009-2010 (1 September - 30 June)
g) Study location	Flemish secondary schools
h) Population sample	Students in secondary schools; year 1 (age 11-12) till year 7 (age 18+) of secondary schools, all education levels
i) Methods	All students are questioned per school, creating a database of approximately 40.000 records per school year; at the end of each school year a proportionate stratified sample is taken which is representative of age, gender, type of education and type of institution.
j) Data quality/methodological concerns	No specific concerns about the answers of students; About the sample: the schools enrol themselves in the survey, if they want to evaluate their drug policy. This can create a systematic error in sampling.
k) Main publication	Kinable 2010.
l) Study/Survey website address	http://www.vad.be/alcohol-en-andere-drugs/onderzoek/leerlingenbevraging.aspx
m) Chapter(s) BAR	2, 10
<hr/>	
a) Study/survey title	VAD Partywise
b) Abbreviation	
c) Researcher(s)/ Organisation(s)	Vereniging voor Alcohol- en andere Drugproblemen vzw
d) Main objective / research question	Substance use and nightlife trends : questions about substance use, patterns of going out, preventive measures and demographic questions
e) Type of study	Repeated survey
f) Year of data collection/fieldwork	2009
g) Study location	7 festivals, dance events or rock festivals in Flanders
h) Population sample	Individuals (N= 670) at festivals, dance events and rock festivals; Age between 16-24

i) Methods	Anonymous, at random : every 5th visitor.
j) Data quality/methodological concerns	N/A
k) Main publication	Rosiers, J. (2010).
l) Study/Survey website address	http://www.vad.be
m) Chapter(s) BAR	2

a) Study/survey title	Vlaams schoolonderzoeksproject naar alcohol en andere drugs
b) Abbreviation	VLASPAD
c) Researcher(s)/ Organisation(s)	Department of Clinical and Lifespan Psychology, Vrije Universiteit Brussel (VUB).
d) Main objective / research question	The overall aim with the project is to repeatedly collect comparable data on substance use in as many European countries as possible.
e) Type of study	Repeated enlarged school survey of the ESPAD-study (i.c. substance related questions, risk taking behaviour, psychosocial wellbeing)
f) Year of data collection/fieldwork	2010
g) Study location	Flanders and Dutch-speaking secondary education in the Brussels Capital Region
h) Population sample	Students regular secondary education; international grade 7 - 12; age 11 - 18 years (max. 21, 1 outlier 22 year; 1 outlier 24 year; excluded in these prevalence rates); representative for the three educational networks: Community education (G.O.): 40 schools, 153 classes and 1210 respondents; Subsidised public authority education (O.V.O.): 16 schools, 63 classes and 652 respondents; and Subsidised private authority education (V.G.O.): 99 schools, 441 classes and 5285 respondents. It contains respondents of the four educational networks: General (academic) secondary education (G.E.), Technical secondary education (T.E.), Secondary education for arts (E.A.), and Vocational secondary education (V.E.). The method of sampling could be defined as two : proportionated stratified sampling of classes
i) Methods	After giving standardized instructions to students, staff members were instructed not to circulate in the classroom except to answer any individual question about particular items. The survey was administered under confidential conditions (for students and schools) according to the Belgium Law on Privacy Protection (December 8th 1992). Students were instructed that they should not write their names, class or address on the survey or envelope and were assured that their answers were strictly confidential and would not be shown to their parents or teachers. Students were informed about the nature and methods of the research through a written description at the cover of questionnaire administration and were informed that they could refuse or discontinue participation. The questionnaires were placed in sealed individual envelopes and collected in a sealed bulk envelope.
j) Data quality/methodological concerns	Age groups 11 years and 18 years are relatively small; especially girls and boys at the age of 11 are less than 100 respondents. use of amphetamines could be misinterpreted by the younger (male) respondents: 'vitamins' what could be the explanation of the high prevalence (LTP, LYP and LMP) of amphetamines compared to the older age groups. Data is weighted for educational network (4) x international grade (6) x

Annexes

k) Main publication	gender (2). N/A
l) Study/Survey website address	http://www.vlaspad.be (only in Dutch)
m) Chapter(s) BAR	2, 4, 10

Annex 3.

List of abbreviations

Abbreviations	Explanation
2-CB	4-bromo-2,5-dimethoxyphenethylamine
3-FMA	3-fluoromethamphetamine
3-FMC	3-fluoromethcathinone / 2-methylamino-1-(3-fluorophenyl)propan-1-one
4-FMA	4-fluoromethamphetamine
4-FMP	4-Fluoroamphetamine / 1-(4-Fluorophenyl)propan-2-amine
4-MA	4-Methylamphetamine / 1-(4-methylphenyl)propan-2-amine
6-MAM	6-mono-acetylmorphine
ADAM	Antwerpse Drugs en alcoholmonitor
ADHD	Attention Deficit Hyperactivity Disorder
AIDS	Acquired Immune Deficiency Syndrome
ALFA	Aide Liégeoise aux Alcooliques et à leur Famille
ALTO	Alternative aux Toxicomanies
AMJAD	Antwerpse Monitor Jongeren, Alcohol en Drugs
anti HBc	Hepatitis B core antigen
anti HBs	Hepatitis B surface antigen
APES	Appui en promotion et éducation pour la santé
ARL	AIDS Reference Laboratories
ASBL	Association sans but lucratif
ASL	Arbeitsgemeinschaft für Suchtvorbeugung und Lebensbewältigung
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
AVAT	Aide Verviétoise aux Alcooliques et Toxicomanes
AZ	Algemeen ziekenhuis
BBB	bed bath, bread
BDN	Boule de Neige
BELSPO	Belgian Science Policy
BELTA	Belgian Lung and Tuberculosis Association
BEWSD	Belgian Early Warning System on Drugs
BHIS	Belgian Health Interview Survey
BITS	Belgian Institute for Traffic Safety
Bk-PMMA	1-(4-methoxyphenyl)-2-(methylamino)propan-1-one, (4-methoxymethcathinone)
BMCDDA	Belgian Monitoring Centre for Drugs and Drug Addiction
BMK	Benzylmethylketon
BTDIR	Belgian Treatment Demand Indicator Register
BZP	1-benzylpiperazine (1-benzyl-1,4-diazacyclohexane-dihydrochloride)
CAAJ	Conseils d'Arrondissement de l'Aide à la Jeunesse

Abbreviations	Explanation
CAD	Centra voor Alcohol en andere Drugproblemen
CAP	Central Intake Unit for drug using prisoners
CAP	Centraal aanmeldingspunt voor druggebruikers
CAW	Centrum Algemeen Welzijnswerk
CBJ	Comité voor Bijzondere Jeugdzorg
CCAJ	Conseil Communautaire de l'Aide à la Jeunesse
CD4	Cluster of differentiation 4
CFWB	Communauté Française Wallonie - Bruxelles
CGG	Centra Geestelijke gezondheidszorg
CGOP/B	Service police policy support, Policy data federal police
CHR	Centre Hospitalier Régional
CHU	Centre Hospitalier Universitair
CI	Confidence interval
CIC	Crisis Intervention Centres
CLB	Centrum voor leerlingenbegeleiding
CLPS	Centre local de promotion de la santé
COCOM	Commission Communautaire Commune
COWAT	Cocaine and its metabolites in Belgian waste and surface water
CPAS	Centre Public d'Aide Sociale
CRA +	Community Reinforcement Approach
CSM	Centre de santé mentale
CTB-ODB	Concertation Toxicomanies Bruxelles - Overleg Druggebruik Brussel
DAST - 10	Drug Abuse Screening Test (10 items)
DBK	Drugbehandelingskamer
DGAJ	Direction général de l'Aide à la Jeunesse
DGJ-DJP	General Directorate of Judicial Police - Direction of crime against persons
DIF	Drugs in Figures
DOC	2,5-dimethoxy-4-chloroamphetamine
DODONBEL	Do's and don'ts in a comprehensive and integrated drug policy
DPIA	Di-(β -phenylisopropyl)amine
DR-	Drogues Risquer moins
DRD	Drug Related Deaths
DRID	Drug Related Infectious Diseases
DRUGCRIM	Definition and measurement of drugrelated crime
DRUID	Driving under the Influence of Drugs, Alcohol and Medicines
DRUSEB	Drug use among female sex workers in Belgium
ECCAM	Evaluation of crisis and case management
EDDP	2-ethylidene-1,5-dimethyl-3,3-diphenylpyrrolidine
EDDRA	Exchange on Drug Demand Reduction Action

Abbreviations	Explanation
EDND	European Database on New Drugs
EMCDDA	European Monitoring Centre for Drugs and Drug Addictions
EPSI	Eenheid voor psychiatrische spoedinterventie
ESPAD	European School Survey Project on Alcohol and Other Drugs
Etaqualone	3-(2-ethylphenyl)-2-methyl-quinazolin-4-one
EU	European Union
EU-DAP	European Drug Addiction Prevention Trial
FAMHP	Federal Agency for Medicines and Health Products
FARES	Fonds des Affections Respiratoires
FESAT	European Foundation of Drug Helplines
Flephedrone	4-fluoromethcathinone / 2-methylamino-1-p-fluorophenyl-propan-1-one
FPS	Federal Public Service
GC-MS	Gaschromatography-Mass Spectrometry
GDP	Gross Domestic Product
GDPC	General Drugs Policy Cell
GEOAMP	Trace detection of synthetic drug production in waste waters
GEOCAN	Study of part of locally cultivated cannabis on Belgian market of drug
GHB	Gamma-hydroxybutyrate
GMR	General Mortality Register
GND	General National Database
GP	General Practitioners
GPS	General Population Survey
HAV	Hepatitis A virus
HBeAG	Hepatitis B "e" antigen
HBsAg	Hepatitis B surface antigen
HBSC	Health Behaviour in School-aged Children
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HCV Ab	Hepatitis C virus antibody
HCV-RNA	Hepatitis C Virus - Ribonucleic acid
HIV	Human Immunodeficiency Virus
HIV Ab	Human Immunodeficiency Virus Antibody
IDA	Information about drugs and alcohol
IDU	Injecting Drug use
INCANT	International Cannabis Need of Treatment project
IRCP	Institute for international research on criminal policy
IRMEP	Royal military institute for physical training
IRQ	Injecting Risk Questionnaire
JGD	Jugendgerichtsdienst

Abbreviations	Explanation
JHD	Jugendhilfedienst
JOP	Jeugdonderzoekplatform
JUSTHULP	Essential and supplementary preconditions for the interaction of justice and drug treatment services
JWH-018	Naphthalen-1-yl-(1-pentylindol-3-yl)methanon
JWH-203	2-(2-chlorophenyl)-1-(1-pentylindol-3-yl)ethanone
KMILO	Royal military institute for physical training
KOPP	Kinderen van Ouders met Psychiatrische Problemen
KOPS	Kommunikation – Prävention – Sicherheit
LC-MS/MS	liquid chromatography tandem mass spectrometry
LMP	Last month pervalence
LSD	Lysergide / Lysergic acid diethylamide / 9,10-didehydro-N,N-diethyl-6-methylergoline-8 β -carboxamide
LYP	Last year prevalence
MASS	Maison d'Accueil Socio-Sanitaire
MCD	Minimum Clinical Data
mCPP	1-(3-chlorophenyl)piperazine
MDA	3,4-Methylenedioxy-amphetamine
MDEA	3,4-Methylenedioxy-N-ethylamphetamine
MDFT	MultiDimensional Family Therapy
MDMA	3,4-Methylenedioxymethamphetamine
Mephedrone	4-methylmethcathinone
Methedrone	1-(4-methoxyphenyl)-2-(methylamino)propan-1-one, (4-methoxymethcathinone)
Methylone	3,4-methylenedioxymethcathinone
MPD	Minimum Psychiatric Data
MSOC	Medisch sociaal opvangcentrum
MUG	Mobile Urgence Group
MUG	Medische Urgentie Groep
NEP	Needle exchange project
NGO	Non-governmental organisation
NICC	National Institute for Criminalistics and Criminology
NIHDI	National Institute for Health and Disability Insurance
NSTR	National Substitution Treatments Register
OCMW	Openbare Centrum voor Maatschappelijk Welzijn
OEJAJ	Observatoire de l'Enfance, de la Jeunesse et de l'Aide à la Jeunesse
ONE	Office de la Naissance et de l'Enfance
OST	Opiate Substitution Therapy
PAA	Points d'appui assuétudes
PCO	Plan Communautaire Opérationnel

Abbreviations	Explanation
PCR	Polymerase chain reaction
PCS	Plans de cohésion sociale
PDR	Prix des drogues en rue
PDU	Problem Drug Use
PMS	Centre Psycho-Médico-Social
POLYMEH	Poly drug use and mental health among drug users who ask for treatment
PSE	Service de promotion de la santé à l'école
PSSP	Plans stratégiques de sécurité et de prévention
RAPID	Risico Analyse Project Identificatie van Drugs
RFP	Regional focal Point
RFPLC	Reversed Phase Liquid Chromatography
SAJ	Service d'Aide à la Jeunesse
SASPE	Services d'Accueil Spécialisé de la Petite Enfance
SD	Standard deviation
SEM-J	Screeningsinstrument Ervaringen met Middelengebruik – Jongeren
SES	socio-economic status
SMUR	Medische Urgentie Groep
SPJ	Service de Protection Judiciaire
SQ	Standard Questionnaire
SSM	Service de Santé Mentale
ST	Standard Table
STI	Sexual transmittable infection
SUBANOP	Analysis and optimisation of substitution treatment in Belgium
TAD	Tobacco, Alcohol and Drugs
TADAM	Traitement Assisté par DiAcétylMorphine
TBC	Tuberculosis
TC	Therapeutic Community
TEPSI	Toxicomanie-Eenheid voor Psychiatrische SpoedInterventie
TFMPP	1-(3-trifluoromethylphenyl)-piperazine
THC	Δ^9 -tetrahydrocannabinol
THCCOOH	11- <i>nor</i> -9-carboxy-delta-9-tetrahydrocannabinol
ULB	Université Libre de Bruxelles
UPSIE	Universitaire Psychiatrische Spoed Interventie eenheid
UZ	Universitair Ziekenhuis
VAD	Vereniging voor Alcohol- en andere Drugproblemen
VAD-LLB	Leerlingenbevraging van de Vereniging voor Alcohol en andere drugproblemen
VLASPAD	Vlaams schoolonderzoeksproject naar alcohol en andere drugs
VLASTROV	Vlaams straathoek overleg
VRGT	Vlaamse Vereniging voor Respiratoire Gezondheidszorg en

Abbreviations	Explanation
	Tuberculosebestrijding
VUB	Vrije Universiteit Brussel
VVBV	Vlaamse Vereniging Behandelingscentra Verslaafdenzorg
WHO	World Health Organisation
WIV-ISP	Scientific Institute for Public Health
WWTP	wastewater treatment plant
XTC	Ecstasy (MDMA)
YILCAN	Determination of the yields of an illegal indoor cannabis plantation

Annex 4.

List of tables

Table 1.1: Public expenditures within the criminal justice system (2004 vs. 2008).	32
Table 1.2: Funded projects by Federal Addiction Fund, Belgium, 2008-2009.	34
Table 3.1: Frequency of substances in related calls (% and n), Infordrogues, Druglijn, 2009- 2010. ..	69
Table 3.2: Frequency by age of contacts (% and n), Infordrogues and Druglijn, 2010.....	72
Table 3.3: Modus Vivendi Snowball Surveys, 2005 – 2010.	74
Table 4.1: Prevalences (percentage) of daily substance use within nightlife settings in Flanders, 2003-2009.	92
Table 4.2: Prevalences (percentage) of injecting drug use and polydrug use during event within nightlife settings in Wallonia, 2004-2010.....	92
Table 4.3: Prevalences (percentage) of daily substance use among university students declaring to have used the substance last year, Ghent – Antwerp, 2009.	93
Table 4. 4: Prevalence of regular cannabis use among school students, 2006-2010.	94
Table 5.1: List of projects funded by the Federal Addiction Fund in 2010.	102
Table 5.2: Number and percentage of persons starting treatment in Belgium, by main substance and gender (2009).	108
Table 5.3: Admissions (percentage) with an illegal substance related disorder as main diagnosis in Belgian psychiatric hospital services (1998-2008).	123
Table 6.1: Prevalence rate (%) of HIV-seropositivity among ever-IDUs at treatment and other diagnostic settings, 2005-2010.	128
Table 6.2: Hepatitis C notifications by the sentinel Laboratory network, Belgium, 2006 – 2010.	128
Table 6.3: Prevalence rate of Hepatis B among ever-IDUs at treatment and other diagnostic settings, Free Clinic – De Sleutel, Flemish Community, 2003-2010.	129
Table 6.4: Prevalence rate of Hepatis C among ever-IDUs at treatment and other diagnostic settings, Free Clinic – De Sleutel, Flemish Community, 2003-2010.	130
Table 6.5: Responses to the Injecting Risk Questionnaire (IRQ), Spuitenruil Vlaanderen, 2010.....	131
Table 6.6: Injecting Risk behaviour among street-recruited Injecting Drug Users, Modus Vivendi (Boulevard de Neige), French Community, 2001-2008.	133
Table 6.7: Number of telephone enquiries received by the Belgian national Poison Centre, Belgium, 2009-2010.	134
Table 6.8: Admissions (percentage) with an illegal substance induced disorder as main diagnosis in Belgian psychiatric hospital services (1998-2008).	135
Table 6.9: Psychiatric co-morbidity (percentage) among psychiatric hospital admissions by substance-related disorder, Belgium, 2008.	136

Table 6.10: Prevalence of psychiatric co-morbidity of patients entering treatment (De Sleutel), Flanders, 2006-2010.	137
Table 6.11: Number of drug-induced deaths (15-64yrs) based on the General Mortality Registers (Selection B) for the Flemish and Brussels Capital region, 2000-2008/2009.	141
Table 7.1: Characteristics of patients in crisis care at Crisis Intervention Centres (CICs) within specialized drug treatment centres and at emergency departments of general hospitals (FOD pilot project).....	145
Table 7.2: Overview of other warnings/information sent by the Belgian Early Warning System on Drugs (BEWSD) in 2010.	148
Table 7.3: Overview of warnings/information on the identification of high-risk psychoactive substances sent by the Belgian Early Warning System on Drugs (BEWSD) in 2010.....	149
Table 8.1: Participation in and satisfaction with social life in last year cannabis users and persons who did not use drugs in the past year (15-64y), by gender (Belgium, 2008).....	159
Table 8.2: Self-reported social support quality of last year cannabis users and persons who did not use drugs in the past year (15-64y), by gender (Belgium, 2008).....	159
Table 8.3: Indicators of social exclusion among drug users in demand for treatment, by status and gender (Belgium, 2009).....	161
Table 8.4: Indicators of social exclusion among drug users in demand for treatment, by status and first substance used (Belgium, 2009).....	161
Table 8.5: Indicators of social exclusion among drug users in demand for treatment, by status and age category (Belgium, 2009).	162
Table 8.6: Last year prevalence of drug consumption in unemployed people (15-64y), by gender and type of drugs (Belgium, 2008).	165
Table 8.7: Last year prevalence of drug consumption in sick/disabled people (15-64y), by gender and type of drugs (Belgium, 2008).	165
Table 8.8: Last year prevalence of drug consumption in low educated people* (15-64y), by gender and type of drugs (Belgium, 2008).	166
Table 8.9: Last year prevalence of drug consumption in the general population (15-64y), by gender and type of drugs (Belgium, 2008).	166
Table 8.10: Last year prevalence of drug consumption in unemployed people, by age category and type of drugs (Belgium, 2008).	167
Table 9. 1: Drug-related law offences in relation to the total number of law offences, Belgium, 2006-2010.	173
Table 9.2: Drug-related offences as main offence, by type of drug, Belgium, 2006-2010.....	174
Table 9.3: Percentage of youth reporting to have sold drugs the past year, Flanders and Brussels, 2005-2010.	175
Table 9.4: Drug controls by the Federal Highway Police, urine screening, Belgium, 2006- 2010.	177

Table 9.5: Drug controls by the Federal Highway Police, oral fluid screening, Belgium, 2010.....	177
Table 9.6: Substances detected in blood sample test after positive urine screening, 2010, NICC. ...	178
Table 9.7: Substances detected in blood sample test after positive oral fluid screening, 2010, NICC.	179
Table 9.8: Drug/doping related cases entering the prosecution system of first line court, Belgium, 2006-2010.	182
Table 9.9: Closing decision for drug/doping related cases at prosecution system of first line court, Belgium, 2006-2010.	182
Table 9.10: Drug/medication-related sentences and suspensions , Belgium, 2000 – 2004.	183
Table 9.11: Sentences and suspensions of drug-related cases, Belgium, 2000 – 2004.	185
Table 9.12: Problems experienced as a result of drug use and drug market in prison 2006-2010. ...	190
Table 9.13: Means to obtain drugs in prison 2010	191
Table 10.1: Percentage of youngster being offered drugs in the past year, Flanders, 2008.	197
Table 10.2: Number of drug seizures by substance, Belgium, 2006-2010.	200
Table 10.3: Total quantities of seized drugs by substance, Belgium, 2006 – 2010.	200
Table 10.4: Precursors found in Belgium, 2010.	201
Table 10.5: Number and type of labs dismantled by Belgian police services, 2006 - 2010.....	202
Table 10.6: Number of cannabis plantations discovered, by plantation size, Belgium, 2007-2010....	202
Table 10.7:: Drug prices in euro at street level, Belgium, 2006-2010.	204
Table 10.8: Reported combinations and cutting agents in MDMA-like and (meth)amphetamine containing tablets, seized in the context of the Belgian Early Warning System on Drugs, 2010	211
Table 10.9: Distribution of samples by product type and drug group, Belgium, 2010.....	212
Table 12.1: Number and proportion of treatment demands in the therapeutic community and in <i>De Tipi</i> , 1996-2009.	237
Table 12.2: Strength of the harm evidence related to substances use around pregnancy.....	239
Table 12.3: List of projects addressing drug using parents and/or their children supported by the Federal Addiction Fund (2007-2010).	247
Table 12.4: Projects addressing drug using parents/pregnant women and their children (2000-2011).	249

Annex 5.

List of figures

Figure 1.1: Public expenditures within each pillar, Belgium, 2008.	31
Figure 1.2 Financing for each sector, by the federal of the federate levels, Belgium, 2008.	32
Figure 2.1: Lifetime, last year and last month prevalence (%) of cannabis use in Belgium (15-64years), 2001, 2004, 2008.	38
Figure 2.2: Lifetime prevalence (%) of cannabis use in Belgium (15-64years), by gender, 2001, 2004, 2008.	38
Figure 2.3: Lifetime prevalence (%) of cannabis use in Belgium (15-64years), by age group, 2001, 2004, 2008.	40
Figure 2.4: Lifetime prevalence (%) of cannabis use in Belgium (15-64years), by region, 2001, 2004, 2008.	40
Figure 2.5: Last year prevalence (%) of the use of cocaine, amphetamines or XTC, and opiates in Belgium (15-64year), by gender, 2008.	42
Figure 2.6: Lifetime, last year and last month prevalence (%) of cannabis use in Flemish Community school students (VLASPAD study), 2010.	42
Figure 2.7: Lifetime, last year and last month prevalence (%) of cannabis use in Flemish Community school students (VAD-LLB study), 2010.	44
Figure 2.8: Lifetime, last year and last month prevalence (%) of cannabis use in school students of Bruges (Flemish Community), 2010.	44
Figure 2.9: Lifetime, last year and last month prevalence (%) of cannabis use in French Community school students, 2010.	46
Figure 2.10: Lifetime, last year and last month prevalence (%) of cannabis use in Flemish Community school students, 2010.	46
Figure 2.11: Lifetime prevalence (%) of cannabis use in Flemish Community school students, by gender, 2011.	48
Figure 2.12: Lifetime prevalence (%) of the use of psychoactive substances (other than cannabis) in Flemish Community school students, by age, 2010.	49
Figure 2.13: Lifetime prevalence (%) of use of psychoactive substances (other than cannabis) in French Community school students, by age, 2010.	49
Figure 2.14: Lifetime prevalence (%) of use of psychoactive substances (other than cannabis) in Flemish Community school students, by age, 2010.	50
Figure 2.15: Lifetime prevalence (%) of use of psychoactive substances (other than cannabis) in school students of Bruges (Flemish Community), by age group, 2010.	50
Figure 2.16: Risk and protective factors of psychoactive substance use according to their importance	51
Figure 2.17: Lifetime prevalence (%) of use of psychoactive substances in Flemish university and university college students, 2005, 2010.	53

Figure 2.18: Last year prevalence (%) of use of psychoactive substances in Flemish university and university college students, 2005, 2010.	53
Figure 2.19: Last year prevalence (%) of use of psychoactive substances in recreational settings of the Flemish Community, 2003, 2005, 2007 and 2009.	55
Figure 2.20: Relative proportion (%) of 'current' use of psychoactive substances in recreational settings in the French Community, 2003, 2005, 2007 and 2009.	55
Figure 4.1: Estimated cumulative number of alive seropositive ever-injecting drugs users (15-64yrs) and 95% Monte Carlo confidence intervals based on the Belgian HIV/AIDS register, 2000-2010.	87
Figure 4.2: HIV-prevalence rates among injecting drug users and 95% Wilson's confidence intervals by year and source, 1995-2010.	88
Figure 4.3: Prevalence rate (/1000) and 95% Monte Carlo confidence intervals of ever-Injecting Drugs Users (15-64yrs), 2000-10.	89
Figure 5.1: Relative proportion (%) of persons starting treatment in Belgium, by main substance and age category (2009).	109
Figure 5.2: Relative proportion (%) of persons starting treatment in Belgium, by main substance and gender (2009).	109
Figure 5.3: Relative proportion (%) of persons starting treatment in Belgium, by main substance and age category at first use (2009).	110
Figure 5.4: Relative proportion (%) of persons starting treatment, by main substance in different treatment facilities (2010).	111
Figure 5.5: Relative proportion (%) of persons starting treatment in Belgium, by gender in different treatment facilities (2010).	112
Figure 5.6: Relative proportion (%) of patients starting treatment in Belgium, by age category in different treatment facilities (2010).	113
Figure 5.7: Incidence (‰) of substance misuse diagnosis by Flemish general practitioners, by age category (2006-2008).	114
Figure 5.8: Incidence (‰) of substance misuse diagnosis by Flemish general practitioners, by gender (2006-2008).	115
Figure 5.9: Relative proportion (%) of substance-related admissions by age category and substance in Belgian psychiatric hospital services (2008)	116
Figure 5.10: Relative proportion (%) of substance-related admissions by gender and substance in Belgian psychiatric hospital services (2008).	117
Figure 5.11: Difference (expressed as SAR) between substance-related admissions registered in MPD and substance-related admissions expected, by Belgian district (2008).	118
Figure 5.12: Number of patients in substitution treatment in Belgium, by substance and age category (2010).	119

Annexes

Figure 5.13: Number of patients in substitution treatment in Belgium, by substances and gender (2010).	120
Figure 5.14: Incidence (%) of illegal substance misuse diagnosis by Flemish general practitioners between 1994 and 2008.....	121
Figure 5.15: Relative proportion (%) of substance-related admissions (main diagnosis) in Belgian psychiatric hospitals (2000-2008)	122
Figure 6.1: Proportion (%) of ever-Injecting Drug Users (IDUs) among HIV- and AIDS-cases by incidence year, Belgium, 1985-2010.	127
Figure 6.2: Prevalence (%) of substance use among injured drivers, DRUID Belgium (2008-2010). ..	139
Figure 6.3: Standardized drug-related mortality rates (15-64yrs) and 95% confidence intervals by year and region, Flemish and Brussels capital region, 2000-2008/2009.	141
Figure 6.4: Age- and sex-specific crude drug-induced mortality rates (per 1000.000 person years), Flemish and Brussels capital region, 2000-2008/2009.	142
Figure 7.1: Schematic overview of the Belgian Early Warning System on Drugs (BEWSD).....	147
Figure 7.2: Number of syringes distributed and recuperated in the Flemish Community and in the French Community by Needle Exchange Programmes (NEP) and by pharmacists (Stérifix project) , 1994-2010	151
Figure 7.3: Recovery rate of the syringes distributed by Needle Exchange Programmes (NEP) in the Flemish and French Community, 1994-2010.	151
Figure 9.1: Injecting drug use within prison 2006-2010.	186
Figure 9.2: Tattooing within prison 2006-2010	187
Figure 9.3: Body piercing within prison 2006-2010	188
Figure 9.4: Sexual activities in prison without condom 2006-2010.	188
Figure 10.1: Substance concentration in seized samples, Belgium, 2002-2010.	208
Figure 10.2: Distribution of tablets by drug composition.	209
Figure 10.3: Description of tablets category 'miscellaneous'.	210
Figure 12.1: Proportion of treatment demands made by parents living with their child, by living situation and gender.	238
Figure 12.2: Representation of the different pathways according to the type of specialized help in the French Community.	242
Figure 12.3: Representation of the different pathways according to the type of specialized help in the Brussels Capital Region.....	244
.....	231

Annex 6.

List of maps

Figure 5.11: Difference (expressed as SAR) between substance-related admissions registered in MPD and substance-related admissions expected, by Belgian district (2008).....	118
--	-----

Annex 7.

List of full references of laws in original language

Belgian legislation texts

French

24 février 1921. - La loi concernant le trafic des substances vénéneuses, soporifiques, stupéfiantes, psychotropes, désinfectantes ou antiseptiques et des substances pouvant servir à la fabrication illicite de substances stupéfiantes et psychotropes.

8 avril 1965. – Loi relative à la protection de la jeunesse, à la prise en charge des mineurs ayant commis un fait qualifié infraction et à la réparation du dommage causé par ce fait.

12 juillet 1971. - Arrête´ ministériel portant instructions generales pour les etablissements penitentiaires

4 mars 1991. - Décret relatif à l'Aide à la Jeunesse.

22 janvier 1998. - Arrêté royal réglementant certaines substances psychotropes

19 janvier 2001. - La note de politique relative à la problématique de la drogue, 19 janvier 2001, Bruxelles.

12-décembre-2001. – Décret relatif à la promotion de la santé à l'école.

16 mai 2002. - Décret relatif à la promotion de la santé dan l'enseignement supérieur hors universités.

22 aout 2002. - Loi relative aux droits du patient.

2 septembre 2002. - L'accord de coopération entre l'Etat, les Communautés, la Commission communautaire commune, la Commission de la Communauté française et les Régions pour une politique globale et intégrée en matière de drogues

29 juin 2003. - Arrêté royal relatif à la transmission d'informations au Point Focal belge du réseau européen d'information sur les drogues et les toxicomanies.

29 avril 2004. - Ordonnance relative à l'aide à la jeunesse.

12 janvier 2005. - Loi de principes concernant l'administration des établissements pénitentiaires ainsi que le statut juridique des détenus.

15 mai 2006. - Loi modifiant la loi du 8 avril 1965 relative à la protection de la jeunesse, du Code d'instruction criminelle, le Code pénal, le Code civil, la nouvelle loi communale et la loi du 20 avril 2003 réformant l'adoption.

13 juin 2006. - Loi modifiant la législation relative à la protection de la jeunesse et à la prise en charge des mineurs ayant commis un fait qualifié infraction.

18 juillet 2006. - Circulaire ministérielle n°1785 relative à la problématique des drogues

- en prison.
- 6 octobre 2006. - Arrêté royal modifiant l'arrêté royal du 19 mars 2004 réglementant le traitement de substitution
- 17 octobre 2006. - Arrêté royal modifiant l'arrêté royal du 29 juin 2003 relatif à la transmission d'information au Point focal belge du réseau européen d'information sur les drogues et les toxicomanies.
- 10 juillet 2008. - Loi relative aux hôpitaux et à d'autres établissements de soins, coordonnée le 10 juillet 2008.
- 15 janvier 2009. - Circulaire du Collège des Procureurs généraux aux cours d'appel, relative à la politique des poursuites en matière d'infraction à la législation sur les drogues qui sont commises à l'entrée des et au sein des établissements pénitentiaires.
- 6 février 2009. - Circulaire concernant la concertation avec le ministère public en cas d'infractions à la législation sur les stupéfiants commises à l'intérieur des établissements pénitentiaires.
- 1 avril 2009. - Convention collective de travail n° 100 de 1 avril 2009 concernant la mise en oeuvre d'une politique préventive en matière d'alcool et de drogues dans l'entreprise
- 31 juillet 2009. - Loi relative à l'introduction des tests salivaires en matière de drogues dans la circulation
- 6 octobre 2009. - Arrêt n° 196.675 du Conseil d'État du 6 octobre 2009
- 12 novembre 2009. - Arrêté royal portant création d'un centre fédéral fermé pour mineurs ayant commis un fait qualifié infraction.
- 23 décembre 2009. - Loi portant des dispositions diverses en matière de santé publique
- 25 janvier 2010. - Protocole d'accord concernant le règlement d'ordre intérieur de la Conférence interministérielle Drogues
- 9 février 2010. - Circulaire n° COL 2/2010 du Collège des Procureurs généraux ayant pour objet l'analyse des échantillons d'amphétamine et plus particulièrement l'enregistrement et la comparaison de ces derniers dans et via une banque de données européenne, Bruxelles
- 15 avril 2010. - Déclaration Conjointe de la Conférence Interministérielle Drogues - Une politique globale et intégrée en matière de drogues pour la Belgique (SB, 15.04.2010, p21414-21486)
- 15 avril 2010. - Protocole d'accord concernant le règlement d'ordre intérieur Cellule générale de Politique Drogues.
- 27 mai 2010. - Arrêté du Gouvernement wallon portant application du décret du 30 avril 2009 relatif à l'agrément en vue de l'octroi de subventions et à l'octroi de subventions aux réseaux et aux services d'aide et de soins spécialisés en assuétudes ainsi qu'à la reconnaissance en vue de l'octroi de subventions et à l'octroi de subventions à leurs fédérations
- 2 juin 2010. - Arrêté royal modifiant l'arrêté royal du 4 juin 1999 relatif au prélèvement

Annexes

sanguin en vue du dosage d'autres substances que l'alcool susceptibles d'avoir une influence sur les capacités de conduite d'un véhicule

13 juin 2010. - Arrêté royal portant modification de l'arrêté royal du 22 janvier 1998 réglementant certaines substances psychotropes, et relatif à la réduction des risques et à l'avis thérapeutique

17 septembre 2010. - Arrêté royal relatif au modèle et aux modalités d'application de la check-list standardisée pour la constatation des indications de signes d'usage récent de drogue dans la circulation routière

29 september 2010. - Circulaire n° COL 19/2010 du Collège des Procureurs généraux contenant une politique uniforme de contrôle, de constatation, de recherche et de poursuite relative à la présence dans l'organisme de substances autres que l'alcool qui influencent la capacité de conduite – conduite sous l'influence de drogues, Bruxelles.

1 décembre 2010. - Arrêté du Gouvernement de la Communauté française modifiant l'arrêté du Gouvernement de la Communauté française du 13 juin 2008 fixant le plan communautaire opérationnel de promotion de la santé au sein de la Communauté française pour les années 2008-2009

24 décembre 2010. - Arrêté ministériel allouant une subvention à la ville de Liège à l'appui d'un projet pilote de traitement assisté par diacétylmorphine

29 décembre 2010. - Arrêté Royal relatif à la prolongation des plans stratégiques de sécurité et de prévention 2007-2010

19 janvier 2011. - Note politique du gouvernement fédéral relative à la problématique de la drogue.

8 avril 2011. - Arrêté royal déterminant la date d'entrée en vigueur et d'exécution de diverses dispositions des titres III et V de la loi de principes du 12 janvier 2005 concernant l'administration pénitentiaire ainsi que le statut juridique des détenus.

28 avril 2011. - Arrêté royal relatif à la deuxième prolongation des plans stratégiques de sécurité et de prévention 2007-2010

Dutch

24 februari 1921. - Wet betreffende het verhandelen van giftstoffen, slaapmiddelen en verdovende middelen, psychotrope stoffen, ontsmettingsstoffen en antiseptica en van de stoffen die kunnen gebruikt worden voor de illegale vervaardiging van verdovende middelen en psychotrope stoffen.

8 april 1965. – Wet betreffende de jeugdbescherming, het ten laste nemen van minderjarigen die een als misdrijf omschreven feit hebben gepleegd en het herstel van de door dit feit veroorzaakte schade.

12 juli 1971. - Ministerieel Besluit houdende Algemene Instructie voor de Strafinrichtingen.

27 juni 1985. - Decreet inzake bijzondere jeugdbijstand

22 januari 1998. - Koninklijk besluit houdende regeling van sommige psychotrope

stoffen en betreffende risicobeperking en therapeutisch advies.

- 19 januari 2001. - Beleidsnota van de Federale Regering in verband met de drugproblematiek.
- 22 Augustus 2002. – Wet betreffende de rechten van de patiënt.
- 2 september 2002. - Samenwerkingsakkoord tussen de Staat, de Gemeenschappen, de Gemeenschappelijke Gemeenschapscommissie, de Franse Gemeenschapscommissie en de Gewesten voor een geïntegreerd drugsbeleid
- 29 juni 2003. - Koninklijk besluit betreffende het informeren van het Belgisch Focal Point van het Europees informatienetwerk over drugs en drugsverslaving.
- 12 januari 2005. - Basiswet van betreffende het gevangeniswezen en de rechtspositie van gedetineerden.
- 13 juni 2006. - Wet tot wijziging van de wetgeving betreffende de jeugdbescherming en het ten laste nemen van minderjarigen die een als misdrijf omschreven feit hebben gepleegd.
- 18 juli 2006. - Ministeriële Omzendbrief nr. 1785 betreffende de drugproblematiek in de gevangenissen.
- 6 oktober 2006. - Koninklijk besluit van 6 oktober 2006 tot wijziging van het koninklijk besluit van 19 maart 2004 tot reglementering van de behandeling met vervangingsmiddelen.
- 17 oktober 2006. - Koninklijk besluit tot wijziging van het koninklijk besluit van 29 juni 2003 betreffende het informeren van het Belgisch Focal Point van het Europees informatienetwerk over drugs en drugverslaving.
- 7 maart 2008. - Decreet inzake de Bijzondere jeugdbijstand.
- 10 juli 2008. - Wet betreffende de ziekenhuizen en andere verzorgingsinrichtingen, gecoördineerd op 10 juli 2008.
- 15 januari 2009. - Omzendbrief nr. COL 1/2009 vervolgingsbeleid betreffende inbreuken op de drugwetgeving bij de ingang van en binnen de gevangenissen.
- 6 februari 2009. - Ministeriële Omzendbrief nr. 1806 betreffende het overleg met het openbaar ministerie in geval van inbreuken op de wetgeving inzake verdovende middelen binnen de gevangenissen.
- 1 april 2009. - Collectieve arbeidsovereenkomst nr. 100 van 1 april 2009 betreffende het voeren van een preventief alcohol- en drugsbeleid in de onderneming.
- 5 juni 2009. - Besluit van de Vlaamse Regering betreffende de subsidiëring en erkenning van partnerorganisaties en organisaties met terreinwerking via een beheersovereenkomst.
- 31 juli 2009. - Wet tot invoering van speekseltesten op drugs in het verkeer.
- 6 oktober 2009. - Arrest nr. 196.675 van de Raad van State van 6 oktober 2009.

Annexes

- 12 november 2009. – Koninklijk besluit tot oprichting van een gesloten federaal centrum voor minderjarigen die een als misdrijf omschreven feit hebben gepleegd.
- 23 december 2009. - Wet houdende diverse bepalingen inzake volksgezondheid.
- 25 januari 2010. - Protocolakkoord betreffende het huishoudelijk reglement van de Interministeriële Conferentie Drugs.
- 9 februari 2010. - Omzendbrief nr. COL 2/2010 van het College van Procureurs-generaal inzake de analyse van amfetaminemonsters met het oog op de registratie en de vergelijking ervan in de Europese databank, Brussel.
- 15 april 2010. - Gemeenschappelijke verklaring van de Interministeriële Conferentie Drugs. Een globaal en geïntegreerd drugsbeleid voor België - (SB, 15.04.2010, p21414-21486).
- 15 april 2010. - Protocolakkoord betreffende het huishoudelijk reglement Algemene Cel Drugbeleid.
- 2 juni 2010. - Koninklijk besluit tot wijziging van het koninklijk besluit van 4 juni 1999 betreffende de bloedproef met het oog op het bepalen van het gehalte van de andere stoffen dan alcohol die de rijvaardigheid beïnvloeden.
- 13 juni 2010. - Koninklijk besluit tot wijziging van het koninklijk besluit van 22 januari 1998 houdende regeling van sommige psychotrope stoffen en betreffende risicobeperking en therapeutisch advies.
- 17 september 2010. - Koninklijk besluit betreffende het model en de toepassingsregels van de gestandaardiseerde checklist tot vaststelling van indicaties van tekenen van recent druggebruik in het verkeer.
- 24 december 2010. - Ministerieel besluit tot toekenning van een subsidie aan de stad Luik ter ondersteuning van een proefproject voor de behandeling door middel van diacetylmorfine
- 29 september 2010. - Omzendbrief nr. COL 19/2010 van het College van Procureurs-generaal houdende een eenvormig toezichts-, vaststellings-, opsporings- en vervolgingsbeleid betreffende de aanwezigheid in het organisme van andere stoffen dan alcohol die de rijvaardigheid beïnvloeden - sturen onder invloed van drugs, Brussel.
- 29 december 2010. - Koninklijk besluit betreffende de verlenging van de strategische veiligheids- en preventieplannen 2007-2010.
- 8 april 2011. - Koninklijk Besluit tot bepaling van de datum van inwerkingtreding en uitvoering van verscheidene bepalingen van de titels III en V van de basiswet van 12 januari 2005 betreffende het gevangeniswezen en de rechtspositie van gedetineerden.
- 28 april 2011. - Koninklijk besluit betreffende de tweede verlenging van de strategische veiligheids- en preventieplannen 2007-2010.

German

1 okt. 2008. - Dekret über die Jugendhilfe und zur Umsetzung von Jugendschutzmassnahmen

International legislation texts

September 2nd 1990. - International Convention on the Rights of the Child

August 22nd, 2002. - Law concerning the rights of the patient.

February 6th, 2003. - Council of the European Union (2002) Draft Resolution of the Representatives of the Member States Meeting within the Council on the Treatment of Drug Abusers in Prisons (CORDROGUE 54 REV 4), 10497/4/02.

June 18th 2003. - Council recommendation on the prevention and reduction of health-related harm associated with drug dependence (2003/488/EC)'.

May 10th 2005. - Council decision 2005/387/JHA on the information exchange, risk-assessment and control of new psychoactive substances.

December 20th 2008. - Notices from European Union institutions and bodies: EU drugs action plan for 2009–2012.

December 2nd 2010. - Council Decision on submitting 4-methylmethcathinone (mephedrone) to control measures (2010/759/EU).

Annex 8.

Index of terms

- access, 76, 92, 107, 109, 118, 129, 238
accident, 357
action plan, 25, 27, 28, 30, 31, 76
Action Plan on Tobacco, Alcohol and Drugs
2009-2015, 30, 31, 75, 214, 228, 277, 278,
279, 281, 282, 285
activity, 36, 69, 74, 80, 206, 345, 346
addiction, 30, 36, 47, 76, 77, 80, 81, 90, 91,
92, 99, 109, 118, 128, 189, 280, 281, 288,
290, 292, 293, 301, 304, 305, 341, 342, 360,
370, 382
AIDS, 103, 104, 106, 151, 152, 159, 292, 340,
379
AIDS/HIV register, 151, 340
Alcohol en cannabis zonder boe of bah, 88
Alcohol, Smoking and Substance Involvement
Screening Test (ASSIST), 96, 125
amfepramone, 22, 23
amphetamine, 23, 54, 55, 82, 112, 139, 164,
180, 192, 201, 211, 240, 242, 244, 246, 252,
255, 256, 259, 261, 262, 263, 383
Analysis and optimisation of substitution
treatment in Belgium (SUBANOP), 31
Arbeitsgemeinschaft für Suchtvorbeugung und
Lebensbewältigung (ASL), 74, 76, 80, 81, 90
at-risk, 87
availability, 116, 117, 237, 238, 239, 240, 282,
285, 380
Be Smart Don't Start, 79
behaviour, 91, 97, 102, 122, 133, 157, 159,
160, 190, 227, 230, 279, 280, 291, 292, 353,
367, 370, 385
Belgian Early Warning System on Drugs
(BEWSD), 29, 174, 176, 178, 179, 180, 183,
237, 238, 252, 253, 255, 256, 257, 259, 260,
341
Belgian Health Interview Survey (BHIS), 39,
40, 41, 42, 43, 44, 45, 46, 47, 48, 51, 62,
189, 192, 201, 352
Belgian Lung and Tuberculosis Association
(BELTA), 156
Belgian Treatment Demand Indicator Register
(BTDIR), 116, 128, 129, 130, 131, 132, 133,
134, 135, 136, 137, 140, 167, 190, 196, 197,
198, 289, 341, 377
benzodiazepine, 122
Boules de Neige (BdN), 88, 89, 90, 379
Breakline, 93, 94
Bubbels & Babbels, 91, 304
budget, 34, 35, 122, 277, 298, 360
buprenorphine, 116, 119, 143, 144, 145, 280,
307
campaign, 70, 93, 94, 99, 186, 215, 262, 280,
378
cannabis, 24, 29, 40, 41, 42, 43, 45, 49, 50,
51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62, 63,
64, 65, 68, 71, 78, 79, 81, 82, 84, 85, 87, 88,
95, 109, 112, 113, 122, 123, 124, 126, 130,
133, 135, 139, 146, 161, 164, 165, 167, 168,
170, 176, 186, 191, 192, 193, 195, 199, 200,
201, 211, 214, 215, 216, 218, 219, 221, 224,
226, 230, 238, 239, 240, 241, 242, 243, 244,
245, 246, 247, 252, 253, 255, 259, 260, 291,
293, 341, 351, 355, 367, 380
care, 26, 31, 36, 70, 76, 88, 92, 96, 97, 107,
108, 109, 117, 118, 119, 120, 121, 122, 124,
125, 126, 127, 128, 129, 134, 135, 136, 174,
175, 176, 183, 191, 199, 234, 271, 275, 276,
280, 281, 283, 284, 285, 288, 289, 290, 298,
299, 300, 301, 306, 347, 348, 358, 363, 368
Case Management, 36, 117, 120, 174, 175,
176, 363
Centra voor Alcohol en andere Drugproblemen
(CAD), 88
Centre Local de Promotion de la Santé
(CLPS), 78
centre psycho-médico-social (PMS), 79, 305
Centre Public d'Aide Sociale (CPAS), 36, 92,
119, 189, 302, 306
centres for mental health, 74, 117, 120, 124,
128, 129, 134, 135, 136, 302, 303, 306
characteristics, 294
children, 92, 98, 196, 197, 290, 291, 292, 294,
297, 298, 300, 303, 304, 305
cocaine, 23, 44, 48, 55, 63, 68, 82, 83, 84, 85,
86, 93, 102, 108, 109, 112, 122, 130, 133,
135, 139, 146, 164, 165, 170, 176, 186, 192,
193, 194, 199, 200, 205, 206, 211, 214, 216,
218, 224, 233, 239, 240, 241, 242, 243, 252,
253, 257, 259, 260, 261, 262, 263, 291, 353,
373
college students, 62, 63, 64, 65, 112, 366
communal, 230
Communal Declaration, 22, 27, 28, 29, 30, 277
Community, 25, 30, 31, 47, 49, 51, 52, 53, 54,
55, 56, 57, 58, 59, 60, 66, 67, 68, 69, 70, 74,
75, 76, 77, 78, 79, 80, 81, 87, 88, 89, 90, 91,
92, 93, 94, 96, 99, 109, 110, 117, 118, 119,
122, 124, 125, 128, 129, 154, 156, 160, 177,
181, 183, 184, 185, 191, 248, 249, 250, 251,
252, 262, 280, 288, 293, 294, 295, 296, 297,
303, 342, 344, 345, 353, 362, 365, 369, 372,
374, 379, 385
community centres, 270
Community Reinforcement Approach (CRA+),
122, 124, 191, 353
co-morbidity, 151, 161, 164, 165, 375
competencies, 221, 275, 300, 302, 307

- composition of illicit drugs, 23, 177, 237, 238, 253, 256, 259, 261
- concentrations of drugs, 252, 253, 255
- Concertation Toxicomanies Bruxelles - Overleg Druggebruik Brussel (CTB-ODB), 177
- consequences, 22, 62, 88, 151, 160, 174, 186, 209, 220, 305
- control of child allowance, 297
- coordination and care, 35
- crache test, 94, 99, 186, 215
- criminality, 23, 28, 34, 119, 177, 209, 210, 211, 212, 213, 219, 220, 221, 222, 237, 242, 270, 273, 274, 281, 284, 297, 343, 354, 355, 362, 375, 378
- crisis, 30, 35, 117, 118, 120, 121, 124, 127, 174, 175, 176, 363
- crisis care, 120, 121, 174, 175, 176
- Crisis Intervention Centre (CIC), 120, 174, 176
- crisis intervention units and case-management, 30, 35
- cultivation, 242, 355, 380
- cutting agents, 257, 259, 260
- De Eenmaking, 88
- De Sleutel, 36, 39, 48, 50, 51, 52, 53, 54, 55, 56, 61, 62, 65, 75, 105, 124, 134, 151, 153, 154, 155, 156, 165, 166, 189, 191, 220, 237, 238, 239, 240, 303, 306, 370, 371, 375, 376
- death, 80, 103, 151, 169, 170, 291, 344
- declaration, 24, 28, 293
- decree, 22, 24, 31, 78, 144, 273, 279, 293, 296
- Definition and measurement of drugrelated crime (DRUGCRIM), 213, 219, 354
- detection, 24, 34, 97, 99, 122, 124, 214, 245, 246, 340, 375, 383
- Determination of the yield of an illegal indoor cannabis plantation (YILCAN), 247, 355
- detoxification, 36, 91, 120, 121, 175, 280
- directives, 22, 356
- dismantled, 242, 246
- disorders, 70, 117, 120, 122, 126, 127, 128, 139, 146, 161, 163, 164, 165, 167, 190, 201, 279, 284, 285, 291, 307, 341, 363, 373
- double diagnosis, 117, 120, 126, 165
- driving, 24, 69, 93, 94, 168, 169, 186, 209, 214, 216, 218, 219, 223, 356, 357, 358, 381
- driving accidents, 168, 169, 209, 218, 356, 357, 358
- Driving Under the Influence of Drugs, alcohol and medicines (DRUID), 168, 169, 209, 218, 356, 357, 358
- Drogues Risquer moins (DR-), 95, 96
- drop-out, 88, 190, 191, 195
- Drug Abuse Screening Test (DAST-10), 64, 112
- drug prices, 237, 252, 374
- drug testing, 22, 23, 24, 174, 223, 281, 284, 342
- Drug use among female sex workers in Belgium (DRUSEB), 70, 358
- Drugbehandelingskamer (DBK), 209, 220, 368, 369
- drug-induced deaths, 151, 169, 170, 171
- druglijn, 83, 84, 86, 98, 342
- Drug-Related Death (DRD), 169, 174, 198
- Drug-Related Infectious Diseases (DRID), 151, 183
- Drugs in Figures, 29, 32, 34, 35, 356, 360, 361, 362, 368
- drug-using parents, 93, 289, 293, 298
- drug-using pregnant women, 299
- DSM-IV, 64, 112, 139, 142, 161, 162, 348, 367
- dual diagnosis, 30, 35
- early intervention, 74, 75, 76, 80, 84, 96, 97, 99, 195
- early-intervention programmes, 175
- economic analysis, 175, 363
- ecstasy (XTC), 23, 43, 48, 54, 63, 68, 82, 83, 84, 95, 109, 110, 112, 131, 161, 178, 182, 186, 192, 193, 194, 199, 201, 202, 203, 204, 211, 214, 216, 218, 233, 239, 240, 241, 242, 243, 244, 246, 250, 252, 253, 256, 257, 259, 260, 261, 262, 263, 291, 383
- education, 39, 47, 74, 75, 77, 78, 80, 97, 189, 195, 196, 197, 201, 203, 205, 239, 240, 283, 294, 297, 298, 302, 306, 353, 365, 367, 371, 384, 385
- e-mail, 81, 83, 84, 86, 178
- emergency, 82, 109, 120, 121, 168, 174, 175, 176, 347, 357
- employment, 117, 189, 195, 201, 202, 204, 205, 206, 281, 283
- enforcement, 23, 34, 242, 277, 360
- Espace citoyen de Dampremy, 81, 306
- Essential and supplementary preconditions for the interaction of justice and drug treatment services (JUSTHULP), 220
- European Drug Addiction Prevention Trial (EU-DAP), 75
- European Foundation of Drug Helplines (FESAT), 84
- European School Survey Project on Alcohol and other Drugs (ESPAD), 39, 47, 49, 50, 53, 54, 113, 114, 237, 238, 240, 384, 385
- evaluation, 25, 28, 30, 31, 70, 74, 75, 76, 77, 89, 126, 174, 178, 191, 214, 220, 221, 288, 293, 299, 345, 356, 362, 366, 379
- Evaluation of Crisis and Case Management (ECCAM), 174, 175, 176, 363
- exclusion, 95, 189, 190, 195, 281
- existing, 36, 70, 75, 167, 234, 269, 283, 305, 356, 358, 363
- expenditures, 34, 35, 122, 277, 298, 360
- expression, 302, 303
- family, 50, 85, 91, 92, 97, 118, 124, 126, 191, 195, 289, 292, 294, 298, 301, 306, 342
- Federal Addiction Fund, 35, 36, 122, 124, 125, 299, 300, 342
- Federal Agency for Medicines and Health Products (FAMHP), 31, 144, 177, 245, 246

Annexes

- Federal Department of Justice, 224, 225, 226, 227, 229, 232, 233, 234, 269, 273, 279, 283, 359
- Federal Drug Policy Note, 22, 27, 28, 29, 30, 31, 35, 277, 293
- Federal Public Service, 25, 26, 31, 35, 37, 70, 117, 127, 139, 142, 161, 177
- Federal Public Service (FPS), 169, 174, 177, 344
- Federal Public Service of Health, Food Chain Safety and Environment, 25, 174
- Fonds des Affections Respiratoires (FARES), 156
- forfeiture of parental authority, 297
- forum, 178, 180, 183
- Free Clinic, 36, 105, 124, 153, 154, 156, 304, 352, 364, 372, 376
- frequency, 63, 64, 112, 159, 199, 226, 230, 233
- frequent, 30, 64, 70, 95, 157, 227, 340, 358
- gene zever, 186
- General Drugs Policy Cell (GDPC), 22, 25, 26, 27, 28, 29
- general hospital, 109, 116, 120, 127, 139, 142, 174, 175, 176, 348
- General Mortality Register (GMR), 106, 151, 169, 171
- general population, 39, 40, 51, 62, 87, 96, 168, 183, 184, 200, 201, 203, 224, 349, 350, 352
- government, 22, 24, 25, 26, 27, 31, 33, 74, 75, 116, 117, 122, 128, 270, 276, 282
- guidelines, 22, 121, 262, 275, 284, 288, 307, 356, 360, 364
- harm reduction, 67, 76, 90, 95, 108, 110, 117, 159, 179, 184, 189, 279, 280, 360, 361, 369, 370, 371, 379
- health, 22, 24, 25, 27, 28, 30, 35, 36, 37, 39, 70, 74, 75, 76, 78, 85, 94, 95, 96, 97, 107, 108, 109, 116, 117, 119, 124, 128, 129, 144, 151, 160, 174, 175, 177, 183, 185, 186, 191, 199, 209, 223, 224, 225, 226, 227, 229, 232, 233, 234, 269, 270, 274, 275, 276, 277, 278, 279, 280, 281, 284, 285, 288, 294, 296, 300, 301, 343, 345, 347, 348, 352, 358, 359, 360, 365
- Health Behaviour in School-aged Children (HBSC), 39, 47, 50, 53, 54, 55, 56, 59, 60, 62, 113, 157, 237, 238, 239, 365, 366
- health correlates, 160, 174, 185
- help, 79, 81, 82, 83, 84, 90, 92, 97, 118, 119, 120, 121, 124, 174, 183, 293, 294, 295, 296, 297, 305, 342, 349, 374, 379
- helpline, 81, 82, 83, 84, 85, 86, 160, 161, 179, 349
- helplines, 86
- hepatitis, 124, 151, 152, 153, 154, 159, 227, 280, 282, 284, 292, 308, 379
- Hepatitis B, 104, 154, 200, 282
- Hepatitis C, 36, 89, 124, 153, 154, 159, 292, 376, 377
- heroin, 47, 56, 71, 82, 109, 127, 181, 186, 199, 200, 211, 226, 233, 240, 242, 243, 252, 253, 259, 261, 262, 263, 291
- HIV, 102, 103, 104, 105, 106, 124, 151, 152, 153, 154, 159, 227, 282, 308, 340, 376, 377
- HIV multiplier method, 102
- hoeveelsteveel, 84
- homelessness, 189
- hospitals, 92, 121, 126, 139, 140, 141, 142, 148, 153, 162, 163, 164, 191, 276, 347, 348, 350
- housing, 76, 117, 189, 205, 283, 288
- How is your friend on coke?, 93
- IDA-web, 118, 345
- illicit, 23, 35, 69, 70, 151, 164, 167, 168, 177, 192, 193, 200, 210, 219, 223, 224, 226, 237, 238, 239, 240, 242, 243, 245, 246, 247, 248, 252, 256, 262, 263, 341, 358, 359, 378
- import, 22
- In hogere sferen, 39, 62, 102, 112, 366
- incidence, 102, 104, 106, 137, 138, 145, 152, 156, 291, 340, 346, 350
- indicated, 75, 77, 97, 103, 108, 109, 130, 201
- indicated prevention, 75, 77, 97
- infection, 152, 159, 184, 340
- infectious, 153, 183, 292, 349, 359, 376
- Infodrogues, 83, 86, 346
- injecting, 70, 102, 103, 104, 105, 107, 108, 109, 110, 111, 124, 133, 151, 157, 158, 159, 160, 183, 185, 225, 226, 230, 282
- Injecting Drug Use (IDU), 70, 102, 103, 105, 107, 108, 109, 110, 111, 151, 157, 159, 183, 225, 230, 376, 377
- Injecting Risk Questionnaire (IRQ), 107, 157
- injured drivers, 168, 169, 219, 357
- injury, 184, 357
- inpatient centre, 129, 130, 134, 135, 136
- Intego, 138, 139, 146, 346, 347
- integrated, 22, 25, 26, 27, 28, 29, 30, 80, 116, 125, 126, 137, 220, 293, 301, 356, 364
- intellectual disabilities, 199, 200, 380, 381
- intensive, 30, 97, 120, 124, 126, 127, 247, 280, 281, 301
- Interministerial Conference on Drugs, 22, 27, 28, 30, 293
- International Cannabis Need of Treatment Project (INCANT-project), 35, 126, 366
- intervention, 37, 87, 96, 97, 99, 118, 120, 174, 175, 176, 191, 295, 296, 381
- interview, 88, 151, 165, 205, 206, 219, 354, 356, 358, 362, 375
- intoxication, 163, 164
- JeugdOnderzoeksPlatform monitor (JOP-monitor), 48, 50, 199, 209, 212, 213, 237, 238, 241, 352, 353, 367
- justice, 28, 34, 85, 124, 219, 220, 221, 361, 362, 368
- Juvenile Court, 273, 294, 295, 296, 297

- Klettern statt Kiffen, 80
- Kommunikation – Prävention – Sicherheit (KOPS), 79
- laboratory, 151, 153, 214, 263, 341, 343, 349, 357
- leerlingenbevraging, 39, 47, 50, 51, 53, 54, 55, 56, 57, 58, 62, 65, 77, 237, 238, 239, 365, 383, 384
- legal highs, 23
- legislation, 22, 23, 31, 191, 209, 210, 211, 223, 242, 256, 259, 270, 275, 276, 277, 279, 284, 288, 292, 293, 296, 344, 356
- level, 22, 23, 27, 29, 30, 33, 34, 40, 43, 47, 65, 78, 79, 80, 84, 96, 117, 119, 129, 130, 170, 220, 222, 238, 248, 252, 253, 269, 275, 276, 277, 294, 343, 350, 352, 353, 363, 367, 378
- life skills, 80
- long-term, 121, 189
- low-threshold centre, 119, 128
- manufacture, 245
- market, 230, 232, 237, 241, 242, 380
- mCPP, 254, 256, 257, 259
- MDMA, 23, 43, 48, 54, 63, 68, 82, 83, 84, 95, 109, 110, 112, 131, 161, 178, 182, 186, 192, 193, 194, 199, 201, 202, 203, 204, 211, 214, 216, 218, 233, 239, 240, 241, 242, 243, 244, 246, 250, 252, 253, 256, 257, 259, 260, 261, 262, 263, 291, 383
- MDMA-like, 253, 256, 257, 259
- media, 94, 99, 179
- Medically assisted treatment with diacetylmorphine (TADAM), 35, 127
- medical-social assistance for drug users (MSOC/MASS), 36, 91, 119, 125, 134, 191, 293, 301, 302, 303, 305
- mental handicap, 88
- mental health, 62, 74, 81, 117, 120, 167, 168, 174, 191, 195, 271, 275, 276, 373
- mephedrone, 22, 23, 181
- methadone, 116, 119, 143, 144, 145, 195, 205, 206, 257, 263, 264, 280, 307, 375, 376
- migrants, 71, 88, 89, 353
- Minimal Psychiatric Data (MPD), 139, 140, 142, 143, 147, 148, 151, 161, 163, 165, 348
- Mobile Team, 95
- modi operandi, 242
- Modus Vivendi, 67, 71, 89, 94, 96, 102, 108, 110, 111, 151, 159, 160, 183, 189, 279, 369, 371, 379, 380
- morbidity, 346, 347, 348
- mortality, 103, 106, 169, 170, 171, 172, 291, 344
- Multi-Dimensional Family Therapy (MDFT), 126, 191, 366, 367
- multiplier method, 102, 103, 106
- national AIDS/HIV register, 102, 103, 151
- National Institute for Criminalistics and Criminology (NICC), 23, 216, 218, 264
- National Institute for Health and Disability Insurance (NIHDI), 128, 143, 154, 174, 298
- national pilot project for the crisis and case management, 127, 174
- National Registration of Substitution Treatment (NRST), 106, 116, 143
- needle, 90, 95, 108, 119, 124, 157, 159, 183, 184, 185, 195, 252, 275, 282, 351, 371, 372
- needle exchange, 90, 95, 108, 119, 124, 183, 185, 195, 252, 275, 351
- new psychoactive substances, 177
- nightlife, 67, 93, 94, 109, 110, 111, 384
- note, 27, 28, 29, 184, 185, 209, 219
- Observatoire socio-épidémiologique Alcool-Drogues (EUROTOX), 67, 68, 69, 74, 76, 79, 105, 108, 110, 128, 151, 160, 177, 178, 181, 182, 183, 184, 185, 200, 237, 248, 249, 250, 251, 252, 361, 374, 377
- Observatoire de la Santé et du Social de Bruxelles-Capitale, 171, 172, 344
- offence, 209, 211, 274, 281, 297
- Omdat iedereen erbij wilt! Samen voor een lokaal alcohol- en drugbeleid, 86
- online, 23, 37, 81, 84, 97, 124, 179, 186, 355, 372
- Op zoek naar een kick, 80
- oral fluid, 22, 23, 24, 174, 186, 214, 215, 216, 217, 218, 219, 358
- origin, 85, 88, 90, 237, 238, 241, 362, 380
- outpatient centre, 116, 120, 122, 129, 130, 134, 135, 140
- overdose, 108, 280, 342
- Parent-child sections, 298
- parents, 37, 79, 81, 92, 98, 289, 293, 297, 298, 302, 306, 342
- part-en-relais, 92
- party, 39, 67, 68, 93, 94, 109, 110
- partypeers, 93
- Partywise Uitgaansonderzoek, 39, 66, 67, 68, 69, 87, 93, 94, 102, 109, 110, 384
- patients, 120, 121, 126, 127, 130, 134, 135, 136, 137, 139, 154, 161, 175, 223, 284, 307, 340, 342, 347, 357, 376, 382
- peer support, 93, 94, 121, 189, 280
- penitentiary institutions, 90, 104, 160, 209, 219, 223, 224, 225, 226, 227, 229, 230, 232, 233, 234, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 298, 305, 308, 359
- person-related matter, 298
- pilot-project, 120, 122, 127, 129
- Plan Communautaire Opérationnel (PCO), 30, 75
- Plans de Cohésion Sociale (PCS), 76
- Plans Stratégiques de Sécurité et de Prévention (PSSP), 76
- Poison Centre, 151, 160, 161
- poisoning, 160, 170, 349
- police, 23, 79, 97, 177, 186, 209, 210, 212, 213, 214, 219, 237, 241, 242, 243, 244, 245, 246, 247, 251, 252, 288, 343, 357, 358, 374

Annexes

- policy, 22, 24, 25, 26, 27, 28, 29, 30, 33, 39, 70, 74, 75, 77, 86, 87, 88, 116, 121, 209, 213, 220, 222, 223, 228, 234, 247, 269, 275, 277, 278, 280, 282, 285, 292, 293, 343, 354, 356, 360, 363, 369, 372, 378, 383, 384
- Poly drug use and mental health among drug users who ask for treatment (POLYMEH), 118, 123, 127, 167, 190, 191, 292, 354, 356, 363, 368, 373, 375, 381
- polydrug use, 108, 110, 111, 127, 167, 373
- population, 32, 39, 41, 47, 48, 51, 53, 54, 62, 64, 68, 69, 71, 86, 89, 90, 92, 95, 96, 102, 116, 118, 136, 137, 140, 145, 154, 167, 175, 190, 192, 196, 197, 198, 200, 201, 209, 212, 214, 223, 224, 225, 226, 230, 269, 270, 271, 273, 274, 279, 280, 281, 282, 288, 342, 344, 363, 373, 381
- possession, 23, 210, 211, 221, 274, 293, 380
- precursor, 245, 260
- pregnancy, 35, 36, 91, 288, 290, 291, 292, 293, 298, 299, 301, 303, 304, 306, 307, 308, 342
- prevalence, 31, 40, 41, 42, 43, 44, 45, 48, 49, 50, 51, 52, 54, 55, 56, 57, 58, 59, 60, 62, 63, 64, 66, 67, 68, 69, 71, 102, 103, 105, 106, 110, 113, 128, 152, 153, 154, 159, 165, 167, 168, 199, 200, 201, 202, 203, 204, 212, 219, 224, 225, 262, 288, 346, 352, 357, 373, 385
- prevention, 24, 25, 26, 27, 28, 30, 33, 34, 36, 39, 62, 67, 74, 75, 76, 77, 78, 79, 80, 87, 88, 90, 91, 92, 93, 96, 122, 124, 153, 159, 177, 183, 186, 189, 275, 277, 279, 281, 300, 342, 345, 349, 352, 360, 361, 369, 379, 381
- price, 94, 252
- primary care, 96, 116, 118, 125, 137, 145
- prison, 90, 104, 160, 209, 219, 223, 224, 225, 226, 227, 229, 230, 232, 233, 234, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 298, 305, 308, 354, 355, 356, 359
- problem, 23, 26, 28, 62, 64, 90, 91, 97, 98, 102, 112, 113, 118, 120, 126, 137, 167, 195, 223, 232, 239, 270, 271, 284, 288, 291, 296, 300, 382
- Problem Drug Use (PDU), 102, 113, 167, 195, 223
- problematic, 28, 37, 64, 96, 102, 106, 109, 110, 111, 112, 119, 120, 127, 283, 295, 346
- product type, 259, 260, 261
- production, 23, 26, 29, 210, 241, 242, 246, 247, 260, 263, 291, 380, 383
- production site, 246
- Proefzorg, 209, 220, 362
- project, 30, 31, 32, 35, 36, 47, 67, 70, 76, 77, 78, 79, 80, 81, 84, 88, 89, 90, 91, 92, 93, 94, 95, 96, 109, 121, 124, 125, 126, 127, 167, 168, 174, 175, 176, 184, 186, 189, 191, 200, 209, 213, 218, 219, 220, 221, 241, 247, 261, 262, 263, 264, 279, 280, 281, 288, 298, 299, 303, 304, 352, 355, 356, 357, 358, 362, 368, 369, 371, 378, 379, 382, 384
- prostitution, 89, 200
- psychiatric, 116, 120, 121, 125, 128, 139, 140, 142, 147, 148, 161, 162, 163, 164, 165, 166, 167, 168, 175, 190, 201, 271, 276, 303, 307, 347, 348, 373
- psychiatric co-morbidity, 164, 165, 166, 307
- public, 22, 23, 24, 26, 27, 28, 30, 32, 33, 34, 76, 77, 85, 87, 89, 90, 92, 94, 95, 119, 144, 160, 179, 189, 209, 277, 360, 370, 374, 385
- public expenditure, 32, 33, 34, 360
- purity, 237, 238, 248, 253, 261
- quality, 26, 31, 95, 116, 117, 121, 122, 124, 126, 192, 193, 206, 243, 276, 280, 284, 285, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385
- Quality Night, 94
- recreational, 65, 66, 67, 68, 69, 81, 95, 102, 186, 262, 293, 369, 370, 381
- reintegration, 28, 76, 92, 117, 205
- release, 179, 233, 234, 278, 281, 283, 298
- remand, 271, 280, 359
- reported prevalence, 50
- repression, 26, 27, 28, 33, 34
- responses, 157, 174, 224, 359, 369
- Responsible Young Drivers, 94, 186, 209, 218, 381
- risk behaviour, 79, 133, 159, 223, 224, 227, 229, 279, 280, 340, 351
- risk factors, 157, 370
- routes, 154, 242
- routine diagnostic testing, 105
- sale, 23
- school, 25, 39, 43, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62, 74, 76, 77, 78, 79, 80, 88, 97, 112, 113, 189, 190, 195, 199, 209, 237, 239, 299, 351, 353, 365, 370, 371, 383, 384, 385
- screening instrument for experiences with substance use – youth (SEM-J), 97
- Securetec® DrugWipe 5®, 186
- seizure, 238, 243, 244, 245, 247, 252, 253, 255, 256, 259, 261, 380
- selective prevention, 75
- self help, 84, 98
- sensibilisation, 87
- sentence, 34
- Sentinel Laboratory Network, 153, 349
- sero-behavioral study, 104, 105
- service, 78, 81, 82, 83, 84, 86, 90, 92, 118, 120, 121, 176, 209, 274, 275, 278, 280, 282, 283, 285, 297, 298, 305, 363
- Service de promotion de la santé à l'école (PSE services), 78
- sex workers, 39, 69, 70, 90, 199, 200, 358

- sexual transmittable infection (STI), 340
social exclusion, 189, 195, 196, 197, 201
social reintegration, 121
socio-demographic, 109, 341
Sozial-Psychologisches Zentrum (SPZ), 177
Space, 270, 273, 274
Special Youth Care, 87, 295, 372
Spiritek, 94
Spuitenruil Vlaanderen, 151, 157, 158, 351, 352, 371, 372
strategic security and prevention plans, 24, 76
strategy, 25, 27, 30, 116, 293
street corner workers, 118
students, 31, 47, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62, 65, 74, 79, 80, 84, 112, 113, 240, 353, 383, 384, 385
substitution treatment, 31, 106, 116, 117, 119, 143, 144, 145, 278, 308, 348, 349
suchtsprekstunde, 90
supply, 29, 30, 35, 37, 210, 230, 238
Support Points Addictions, 78
survey, 31, 39, 47, 50, 53, 56, 62, 67, 68, 79, 102, 108, 110, 112, 113, 168, 179, 199, 209, 212, 219, 223, 224, 226, 230, 239, 240, 270, 275, 279, 288, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385
syphilis, 156
syringe, 25, 102, 107, 108, 157, 159, 174, 183, 185, 260, 261, 282, 374, 379
syringe exchange, 25, 102, 107, 108, 157, 174, 183, 185, 374, 379
tablets, 250, 253, 259
Te veel, 97
Ten D by Night, 94, 218, 381
therapeutic community, 117, 190, 191, 281, 289, 363, 368, 373, 375, 381
Towards a smoke-free school, 79
trafficking, 177, 210, 237, 242
training, 25, 74, 77, 79, 81, 87, 88, 91, 92, 97, 117, 159, 189, 205, 280, 281, 283, 284, 285, 302, 303, 304, 344, 359, 372, 379
treated, 128, 130, 142, 145, 174, 175, 280, 281, 307
treatment, 24, 26, 27, 28, 30, 31, 33, 34, 35, 36, 62, 70, 76, 91, 96, 97, 103, 104, 107, 108, 116, 117, 118, 120, 121, 122, 124, 125, 126, 127, 128, 129, 130, 132, 133, 134, 135, 136, 137, 142, 144, 145, 151, 152, 153, 154, 156, 165, 166, 167, 174, 175, 176, 179, 183, 189, 191, 195, 196, 197, 199, 200, 205, 206, 219, 220, 234, 261, 263, 264, 276, 277, 278, 279, 280, 282, 283, 284, 285, 288, 289, 290, 292, 298, 299, 301, 305, 306, 307, 308, 341, 347, 353, 358, 360, 361, 362, 363, 364, 367, 368, 373, 375, 376, 377, 378, 383
treatment demand, 116, 130, 175, 195, 289, 290, 341, 377
Treatment Demand Indicator, 116, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 140, 167, 189, 195, 196, 197, 198, 289, 341, 377
treatment facilities, 28, 31, 36, 62, 70, 91, 104, 105, 116, 117, 118, 127, 128, 129, 134, 135, 136, 137, 151, 153, 165, 174, 175, 176, 220, 261, 301, 341, 376, 377
trend, 34, 53, 106, 110, 113, 153, 156, 170, 211, 212, 243
tuberculosis, 151, 156
universal prevention, 75, 77
university students, 102, 112
urine samples, 177, 186
Vereniging voor alcohol en andere drugsverslavingen (VAD), 25, 37, 39, 47, 51, 53, 56, 57, 58, 62, 66, 67, 74, 77, 86, 88, 91, 93, 95, 102, 105, 109, 110, 121, 125, 177, 178, 179, 180, 181, 182, 183, 237, 238, 239, 261, 303, 305, 306, 307, 342, 345, 372, 383, 384
violence, 342
Vitalsounds, 93, 94
Vlaams Agentschap Zorg en Gezondheid, 171, 172, 344
Vlaamse schoolonderzoeksproject naar alcohol en andere drugs (VLASPAD), 47, 49, 50, 53, 54, 113, 114, 237, 238, 240, 384
Vlaamse Vereniging voor Respiratoire Gezondheidszorg en Tuberculosebestrijding (VRGT), 156
waste water analysis, 379
women, 36, 40, 43, 70, 88, 89, 90, 125, 130, 133, 135, 138, 140, 145, 195, 199, 272, 288, 290, 292, 293, 298, 299, 301, 303, 304, 305, 307, 308, 382
youth, 39, 47, 77, 88, 89, 93, 97, 119, 209, 212, 237, 273, 294, 296, 372, 381
Youth Court, 273, 294, 295, 296, 297
Youth help, 293