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

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"BELGIUM"

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

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The European survey on youth attitudes on drugs indicates that most of the Belgian respondents between the age of 15 and 24 have the opinion that most traditional illicit drugs (ecstasy, heroin and cocaine) should continue to be banned. In their opinion, the priority has to be given to the dealers and traffickers in order to reduce drug related problems. The so-called 'new drugs' or 'legal highs' are increasingly becoming an issue in Belgium. In June 2011, the General Drugs Policy Cell decided to found an ad hoc working group 'legal highs' in order to (1) facilitate efficient information flow between the partners, (2) criminalize the production of and trafficking in legal highs and (3) develop appropriate prevention strategies. In the same period, a 'Consensus Conference in the matter of drug-addictions' was held on the initiative of the minister of Health of the Wallonia-Brussels Federation (FWB). This conference was based on two shared objectives of the French speaking federate entities, namely to delay the age of first use and to encourage the complementarity of available resources through networking. Due to the lack of accurate treatment for people in a crisis situation, the Inter-ministerial Conference instructed an ad hoc working group 'demand reduction' to develop an action plan with coherent and structural measures regarding the needs on the level of prevention, treatment and harm reduction. Concerning the drug-related public expenditure, the General Drug Policy Cell decided in May 2012 to coordinate the analysis of drug-related public expenditure on a yearly basis.

Drug use in the general population and sub-groups

Figures about drug use in the general population are lacking for 2011. The European survey on youth attitudes on drugs of 2011 shows that 28.3 % of the youngsters in Belgium used cannabis once in their lives. The life time prevalence of 'legal highs' is 4%. A stable time trend of drug use among school students was found. Only cannabis use is increasing. Besides cannabis, the highest lifetime prevalence's among the oldest school students (17-18y) were reported for amphetamines and ecstasy. Homeless young people smoke their first joint on the age of 12 or 13 years, they sniff their first speed when they are 13 or 14 and they experiment with heroin or cocaine when they are 15 or 16 years old. Cannabis (43.1%) is the most popular illicit drug in the Flemish nightlife scene, followed by ecstasy (16.1%), cocaine (13.4%), amphetamine (8.2%), GHB (3.0%) and ketamine (1.9%). Between 2003 and 2009, cocaine and ecstasy became more popular than amphetamine. Substance use among sex workers differes significantly between the type of sex work. The highest lifetime prevalences were reported for the traditional substances like cannabis, cocaine, ecstasy and amphetamine use. 46.0% reported to use more than one psychoactive substance. Cannabis

is the most used illegal substance among youngster in prostitution. Cocaine use follows at the second place. Regarding illicit substance use among Belgian army applicants, 10.6% of them tested positive in 2011.

Prevention

The prohibition of smoking in all enclosed public places including cafés, bars, and nightclubs since July 1st, 2011 (B.S.19.12.2009) has been introduced as an environmental prevention strategy. Universal prevention has a strong tradition in schools. In the last few years, more activities are being introduced in primary schools and higher education. There are several programs aimed at training parental skills. In 2011, VAD started the development of an interactive 1 session program for parents based on a video-interaction methodology. More people made use of the drug help lines in Belgium in 2011. Most of the questions the Belgian drug help lines are receiving, are related to canabis, cocaine and/or alcohol. Selective prevention projects targetted several groups in 2011: children of parents with a drug problem, young people with a mild mental handicap, youngsters in special need education, ethnic minority youth, Moroccan and Turkish communities and the nightlife scene. Both Breakline and Vitalsounds developed a new website in 2011 to inform party people about health risks in nightlife settings. Partywise will fade out in 2012 and will be replaced by a new concept Quality Nights (French community), in order to reach a national coverage. Regarding indicated prevention the ESBIRTES project was developed. The objective of the ESBIRTES project is to identify and develop effective tools for Screening Brief Interventions and Referral to Treatment for young adults presenting at the emergency departement with problems related to (poly)drug use.

Problem drug use

In 2011, the prevalence rate (per 1000 inhabitants, aged 15-64 years) of ever-injecting drug use was estimated to be 3.4 (95% CI: 2.5-4.8) and the total number of ever-IDUs in Belgium to be 24,810 (95% CI: 18,286-36,896). 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. A survey among IDUs who are in contact with a syringe exchange program indicated that opiates were the primary injected drug of choice, followed by stimulant drugs. In total, 13% of the participants in a syinge exchange program reported to have had at least one drug overdose the last year. Moreover, 9.9% of the participants were even younger than 15 years when they injected for the first time. A survey within the party scene in Wallonia indicated that 9.3% used at least three different products in 2011.

Drug-related treatment: treatment demand and treatment availability

During treatment, there are several possible interventions offered by different organisations. Two specific treatment methods, namely the CRA + vouchers treatment method and the intensive treatment of patients with dual diagnosis proved to be effective in 2011. The CRA + vouchers treatment method addresses cocaine use. Results show that the number of days of cocaine use in the CRA group decreased compared to the normal group. In addition, the number of completely abstinent persons was higher in the CRA group. The intensive treatment of patients with dual diagnosis has a better influence on psychic functioning, quality of life and the general functioning in short or long term compared to the classic treatment. 68.1% of the clients who started treatment in 2011 were registered in outpatient centres, 22.7% in inpatient centres and 9.2% in low-threshold agencies. The main illicit substances for which a client went into treatment were opiates (in 39.5% of the treatment demands) and cannabis (22.3%). The most prevalent main substance diagnosis for clients in general hospital services was opioid dependence (21.6%) and for clients in psychiatric hospital services polysubstance dependence (37.5%), followed by opioid (28.1%). The proportion of admissions with a substance related disorder in psychiatric hospital services as main diagnosis increased slightly between 1998 (3.6%) and 2010 (5.6%).

Health correlates and consequences

A percentage of 1.3% (95% CI:0.5%-2.1%) of the persons newly diagnosed with HIV being probably attributable to injecting drug use. The HIV-seroprevalence 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;938]), respectively. 64% of the IDUs in contact with syringe exchange in the Flemish community reported in 2011 not to have shared syringes and injecting equipment during the last month. This is less compared with previous years. Nevertheless, distributive sharing with a sex partner during the last month was reported less frequently (2010: 26%, 2011: 20.5%). 3.8% of the injecting drug users frequenting the Free Clinic in 2011 tested positive for syphilis which is comparable with the prevalences observed for previous years. The tuberculosis incidence rate was 9.5 cases per 100.000 person years in 2011. These results clearly indicate that extreme injecting risk behavior is not ruled out. 53.9% of the clients who started drug treatment in 2011 were classified as having a dual diagnosis. 1.7% of all admissions in psychiatric services were diagnosed as having primarily a substance induced disorder. The most prevalent sub diagnosis was substance induced anxiety disorder (2010 data). 46 drug-induced deaths were observed in the Flemish region and 18 in the Brussels Capital region in 2010. Especially, young males between the ages of 20 and 24 are at a higher risk of directly dying from drug use.

Responses to health correlates and consequences

Concerning the early warning system, 8 “official” warnings were sent by the BEWSD to the network regarding new psychoactive substances or dangerous combinations of drugs or high concentrations of classic illicit drugs. In 2011, three casualties linked to the use of 4-methylamphetamine have been reported to the BEWSD, along with three intoxications. In the first half of 2012, two casualties linked to the consumption of 4-methylamphetamine have been reported. In response to these casualties, a risk assessment was carried out on the federal level. The syringe exchange programmes in Belgium have a recuperation rate of 97.4% in the Flemish Community and 84.7% in the French Community. These recuperation rates, however, decreased in comparison with last year. The results of the evaluation of the syringe exchange programme in Flemish Community indicate that 73% of the IDUs in the needle exchange programme also visit pharmacists to obtain injecting material. Nevertheless, 15.1% of the IDUs dispose their injecting equipment in an unsafe manner.

Social correlates and social reintegration

Around 10% of the drug users in demand for treatment were not living in a stable accommodation in 2011. 28% of the new clients entering treatment did not have an eduction or did only have a primary level of education. This makes them very vulnerable on the labour market. Consequently, 18% of the clients entering the registration system are unemployed. Due to the poor education and the unemployment, the legal financial sources of most of the drug users are scarce as well. The TDI data shows that cocaine and opiate users seem to have the most difficulties on these life domains. The research among daily drug users in Antwerp shows that loneliness is a big problem for most daily drug users. In order to encounter these problems, different social projects were available in 2011. Although different housing projects are introduced in Antwerp, Brussels, Charleroi and Liège, there is still a lack of specific initiatives for minors in 2011. In Charleroi, Ghent and Antwerp education projects are introduced. Low-threshold employers in Antwerp, Ghent and Namur are guiding drug users in order to improve their working skills and to refer them to the common working circuit. Both in the Flemish community as in the French community, activation projects are organised in order to ‘teach’ drug users social, educational and practical skills.

A few researches were published about drug use among socially exlused groups, such as homeless youth, migrants, persons with disabilities, minors who committed a crime and sex workers, in 2011. Drug use among socially excluded groups has some common characteristics. First of all, drug use starts often at an earlier stage in comparison with the general population. Secondly, most of those people became daily users because they wanted to avoid reality. Only for persons with a mental disability, this is not completely true. It

is possible that these persons have nowadays easier access to the drug market than before. Thirdly, financial resources play an important role in their drug use.

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

The federal police registered 35,765 drug law offences in 2011. This is a decrease of 9% in comparison with 2010. 73% of these drug law offences are related to cannabis and 8% to cocaine. 13.6% of the persons who had contact with the police committed at least one drug-related offence in their life. The majority of these offences are classified as psychopharmacological crimes. 19.9% of all property offences, 7.3% of all violent cases and 19.9% of all sexual offences are related to illicit drugs. Regarding driving under the influence of drugs, 1,384 blood samples were analysed by NICC in 2011. 52.5 % of the blood samples were only related to cannabis. 14.6 % of drivers used amphetamine as only substance, 9% were under the influence of cocaine and 2.3% were only related to opioids. The DRUGCRIM study indicated that 65.8% of the drug users had driven already once in their life time under the influence of illicit drugs. Regarding interventions of the criminal justice system, the study of 2011 about mediation in criminal matters in 2007 indicates that people who committed a drug-related crime (defined in this study as use, possession or dealing) have a bigger change to achieve an agreement in comparison with crimes against persons and offences in family context. In 73.1 % of the drug-related cases involved in a mediation procedure, an agreement was achieved. 5.2% of the drugs or doping related cases entered the prosecution system of first line courts in 2011. The majority of these cases were related to drugs. 56.5% left the prosecution system without consequence in 2011. Nevertheless, the drug-related suspensions at court level have decreased over the last 10 years from 11.6% to 6.11%. 3% of the total prison population revceived OST in 2011. In 2012, the ‘Short Duration Drug Program of six weeks is installed in the prison of Bruges.

Drug markets

In 2011, 75.4% of seizures involved cannabis. 1070 plantations were seized. The largest increase was observed in the number of so-called “mini plantations”. The THC concentration in cannabis showed a slight decrease in 2011.Most of these seizures originated from The Netherlands or Belgium itself. The most frequent country of origin for seized cannabis resin was Morocco. Most of the seizures in 2011 were destined for export to The Netherlands. The number of heroin seizures decreased markedly. Most of the seizures were imported from Turkey. Only 36% of the quantity seized in 2010 was seized in 2011 (140.3 kg). As consequence, a significant increase in the street price of heroin was observed. Concentrations in seized heroin and cocaine samples are relatively stable. The predominant country of origin for cocaine was Colombia, although seizures from the Dominican Republic

were also significant. The number of cocaine seizures in Belgium as transit country continues to decline. However, it has to be noted that the total quantity of cocaine seized in 2011 is markedly increased compared to previous years. Also, cocaine purity is relatively high in Belgium. As in previous years, amphetamines and ecstasy were mostly produced in Belgium or imported from The Netherlands. The amount of seized amphetamine was significantly less compared to previous years. Also a low number of amphetamine labs were dismantled in 2011. Nevertheless, a methamphetamine lab was dismantled for the first time in 2011. The reported street prices for amphetamine have slightly decreased. (Meth)amphetamine purity is relatively low in Belgium. Around double the amount of ecstasy-tablets were seized in 2011 compared to the previous year. The maximum amount of MDMA base found in one ecstasy tablet in 2011 was 150.51 mg, which is a sharp decrease compared to 2010. Smaller amounts of LSD were seized in 2011

Residential treatment for drug users in Europe

Traditionally psychiatric hospitals and psychiatric services in general hospitals are more oriented towards alcohol and psychotropic drug addicts. Nevertheless, more and more of these centres are also treating people addicted to illegal drugs recently. Besides this RIZIV-INAMI finances various treatment programs such as 4 therapeutic communities in Wallonia, 3 in the Brussels region and 7 in the Flemish Community, 2 crisis centres in Wallonia, 1 in Brussels and 5 in the Flemish Community. More than one third of the persons who seek treatment are self-referred. The minimum and maximum estimates of government expenditure on the basis of hospitalisation days and the average day-care price of illicit drugs in 2008 amounted to € 36 015 839 and € 102 699 032 respectively. Due to the importance of networking, a networking project, called “Réseau WAB, is created in order to help clients in difficulties. This network is composed of different stakeholders (psychologist, social worker, nurse…) from residential and outpatient services of Wallonia and Bruxelles helping drug users. 8 local networks can be identified so far in Wallonia. A point to be improved is the adaptation of (inter)national guidelmines for substance abuse treatment. Working with evidence-based guidelines is not imposed by the Belgian government. Moreover, almost no guidelines for substance abuse treatment have been developed at a national level so far.

Recent trends of drug related public expenditures and drug services

The study ‘Drugs in figures III’ focuses on the direct nature of the public expenditure. The study refined the methodology of ‘Drugs in figures I and II’ in order to carry out a new estimation of public expenditures on illegal drugs and a first estimation for legal drugs. 98.45% of the identified expenditures came from official accounting documents. 75.85% of the identified expenditures were processed by the unit expenditure calculations, 15.48% by

proration technique and only 8.67% were labelled expenditures. For the categories prevention, harm reduction and 'other', most expenditure is labelled. The opposite is the case for the categories treatment and enforcement, where most of the expenditures are non-labelled. Between 2004 and 2008, the government expenditures for drug policy have increased quite substantially by more than 61 million Euros (18.57%), with 92.75% of this increase going to supply reduction programmes. Increasing expenditures were observed for each level of the criminal justice system. The total public expenditures for prevention decreased with 7,18% between 2004 and 2008. A small increase in expenditure was observed for treatment. The Flemish program 'needle exchange' still increased with approximately 120.000 Euros.

Note

More detailed information about the methodology of specific datasources (excluded scientific reports, papers and articles) used in this National Report can be found on the website of the Belgian Monitoring Centre for Drugs and Drugs Addiction:
http://workspaces.wiv-isp.be/BMCDDA > BAR > Methodological overview

Part A

New developments and trends

Chapter 1.

Drug policy: legislation, strategies and economic analysis

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1. Introduction

In 2011 and 2012, the implementation of the Communal Declaration of January 25th of 2010 of the Inter-ministerial Conference (B.S. 15.04.2010) continued.

In this Communal Declaration, the integral and integrated Belgian drug policy is grounded and institutionalized. This concept is the core of the Belgian drug policy. The global and integrated drug policy is based upon the following pillars: prevention (including early detection and early intervention), treatment (including risk reduction for problem drug users) and law enforcement for producers and traffickers.

The development of the Belgian drug policy is executed in close cooperation with the people in the work field, i.e. the bottom-up approach, and it is supported by objective data. These data are, among others, collected and provided by scientific research.

Finally, the Belgian drug policy is in line with the European drug policy.

2. Legal framework

In comparison to last year, only one new initiative was taken to implement a new. In Februari 2012, a draft of a third Royal Decree about the implementation of the law on the police about road traffic regarding oral fluid and blood analysis is discussed. Please refer to the annual report of last year for the most recent information on this topic in Belgium.

Nevertheless, a survey conducted by The Gallup Organization about the youth attitudes on drugs is worth mentioning. This survey reports on the perception of youth about the drug policy in Belgium. Most of the Belgian respondents (more than 90%) between the age of 15 and 24 have the opinion that illicit drugs (ecstasy, heroin and cocaine) should continue to be banned. However, the opinion of the respondents is more divided concerning the cannabis policy. 47.6 % of them want that cannabis stay illegal, compared to 43.7 % who thinks that cannabis have to be regulated. Those respondents were also asked about their perception about the appropriate way to handle new substances that imitate the effects of illicit drugs, the so-called ‘legal highs’. 18% of the Belgian youth (between the age of 15 and 24) thinks that these substances have to be regulated. 43.8% thinks that legal highs have to be banned in case they pose a health risk and 32.5 % have the opinion that these substances have to be banned in any case (The Gallup Organisation. 2011).

According to the Belgian respondents of the ‘youth attitudes on drugs’ survey are 1) tough measures against drug dealers and traffickers (59.4%); 2) information and prevention

campaigns (53.1%); 3) tough measures against drug users (41.3%) and 4) treatment and rehabilitation of drug users (26.1%) the most effective strategies to reduce drug related problems. This survey shows that the perception of the Belgian population, between the age of 15 and 24 years respectively, do not always correspond with the Belgian drug policy (The Gallup Organisation. 2011). The current drug policy gives priority to prevention and treatment above law enforcement of drug users (Interministeriële Conferentie Drugs 2012a).

3. National action plan, strategy, evaluation and coordination

3.1. National action plan and/or strategy

3.1.1. Federal level

During the meeting of the General Drugs Policy Cell of the 22nd of June 2011, the results of the 'First international multidisciplinary forum on new drugs', was discussed. This forum was organized by the EMCDDA on the 15th and 16th of May 2011 in Lisbon. The so-called 'new drugs' or 'legal highs' are indeed increasingly becoming an issue in Belgium as well. As is the case in other EU member states, this issue necessitates the adaption of the existing registration systems and changes in the legislation.

At the meeting of June 2011, the General Drugs Policy Cell decided to found an ad hoc working group 'legal highs'. The working group is made up of, among others, the Federal Agency for the Safety of the Food Chain, the Federal Agency for Medicines and Health products, the National Institute for Criminalistics and Criminology, the Scientific Institute of Public Health and the Board of Attorney-Generals and representatives of the Ministers of Public Health and the Interior. This working group developed a strategic note 'legal highs', which was approved unanimously by the General Drugs Policy Cell. Following this approval, the note was presented and approved by the Inter-ministerial Conference on May 15th of 2012 as well.

The approach for 'legal highs' is based upon three pillars.

The first pillar is aimed at removing the judicial and operational obstacles hampering a swift and efficient flow of information between each of the partners involved. Up till now, some laboratories invoke the secrecy of the investigation to send their information on legal highs either too late or not at all to the Early Warning System while the EWS is in particular aimed at notifying the authorized services instantly. A change in the law, as proposed in the strategic note, should put an end to this situation.

A second pillar is aimed at the criminalization of the production of and trafficking in legal highs. To this end, two judicial measures are taken. Firstly, the Belgian Drug law will be adapted: the production, offer, sale and provision, even without charge, for human consumption of substances with a psycho-active effect will be criminalized. Some legal substances with a psycho-active effect will stay out of the scope of the changes in the Drug law. This is for instance the case for alcoholic beverages, tobacco and some medicines. Secondly, some substances with a psycho-active effect will be prohibited based upon the basic structure of these substances. Consequently, possible changes in the molecules of these substances would still be prohibited. As such, for instance, the synthetic cannabinoids will fall under the prohibitions provided in the law.

Finally, the third pillar of the approach for legal highs will consist of the development of appropriate prevention strategies, to optimally inform potential users of legal highs about the health risks involved and to discourage their use. To achieve this goal, the Belgian authorities will cooperate with the EMCDDA.

3.1.2. Federate level

On the 10th of June 2011, a 'Consensus Conference in the matter of drug-addictions' was held on the initiative of the minister of Health of the Wallonia-Brussels Federation (FWB). It was conceived as the extension of two former "round tables" held in the framework of the "common policy declaration" and the "concerted plan" in the matter of drug addictions between the French-Speaking federate entities. Political responsibles, professionals and members of administrations were present at that working session.

Aiming to prepare that session, two working groups of professionals in the work field had been entrusted by the federate entities, respectively, to define the main guidelines of work of the different departments of drug-addictions: prevention, treatment, harm reduction ("Concept group"), and to realize an inventory of the available services, along with an introduction to a training implemented since January 2011 in the University Institute for Continuous Training – IUFC - ("Training group").

The "Concept group" developed the issue of harm reduction, as that type of intervention often remains too poorly recognized to benefit of structural budgets, especially with emerging projects, seemingly difficult to endorse for political representatives. The specificity of the other sectors (treatment, prevention), the operators and their missions, was also stated in a recapitulation document. Lacking time, the "Training group" was not able to realize the

inventory as foreseen, and instead presented a complete inventory of the operator's demands.

On the political side, the cabinet of the minister of Health in FWB conceived a future coordination structure which would represent the three French-speaking federate entities: the "French-speaking political health and drug-addictions cell". The latter will pursue three aims: 1) the organization of priorities of the French-speaking federate entities to be presented at federal level; 2) the elaboration of actions to make the offer of services more visible and accessible; 3) the organization of increased complementarity and de-compartmentalization of resources between the community, regional, municipal and provincial levels. The first task of the cell would be to propose a concerted plan in prevention, harm reduction and treatment to the field. The strategies that ought to generate that plan are in course of elaboration through a broad construction with actors of the field, conducted by the Socio-Epidemiologic Observatory Eurotox in a 2-years process (12/2010-12/2012) funded by the FWB ("Concerted strategies in drug-addictions"). Moreover, the functioning of the cell would include the appointment of a coordinator, funded by all three entities. The latter could lean on a work-group composed of specialized actors of the field.

Furthermore, to pursue the consensus conference, the French-speaking federate entities presented a "common political framework", gathering various global or specific objectives, some of them shared by the three levels, some linked to one level only. One can quote the global and common objective "diminishing the consumptions", the specific and shared objectives "to delay the age of first consumptions" and "to encourage the complementarity of available resources, in an aim of networking".

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

3.2.1. Federal level

In 2009, the General Drugs Policy Cell made up an inventory of the treatment offer for people with drug related problems. To this end, several hearings were organized with representatives of this sector. Based upon the information gathered during these hearings, an overview was developed including the most important bottlenecks with regard to the treatment of drug users. The most pressing problems identified were the lack of accurate treatment for people in a crisis situation that is linked to their drug use; the financing of alternative judicial measures; and a number of projects subsidized by the security and prevention plans (of the Federal department of internal affairs) and by the justice department.

To supplement the inventory made for drug treatment, the General Drugs Policy Cell instructed the Health Drugs Policy Cell to make an inventory of the needs with regard to drug prevention and harm reduction. To this end, the secretariat of the Health Drugs Policy Cell organized a number of hearings with representatives of both sectors and they analysed the relevant policy documents and discussion notes. This resulted in a note that was presented to the General Drugs Policy Cell. With regard to prevention, the following needs were identified: a lack of people working in the field, a lack of stability and continuity for these field workers; the need for better coordination on the policy level; the need for evaluation of the effectiveness of prevention strategies; the need for more attention for legal drugs, including alcohol; the need for evidence based practices and well trained field workers; the need for more attention for problems related to internet use, gaming and gambling; the need for a prosecution policy and more strict regulations regarding advertisements; the expansion of target groups; and the need for more support for the non-specialised sector.

With regard to harm reduction, the sector identified the following challenges: the need for an expansion of the regulation of needle and syringe exchange; the need to increase the attention in drug treatment for harm reduction and needle and syringe exchange; more attention for hepatitis B and C; the need for pill testing initiatives; and the need for user rooms and distribution machines for syringes.

On the 25th of January 2012 the Inter-ministerial Conference took note of the bottlenecks with regard to drug treatment. During their meeting of May 15th, 2012 the Conference took note of the bottlenecks with regard to prevention and harm reduction as well (which were presented to the Conference by the General Drugs Policy Cell).

In response to these notes, the Inter-ministerial Conference instructed an ad hoc working group ‘demand reduction’ to develop an action plan with coherent and structural measures with regard to prevention, treatment and harm reduction and to present this action plan to the Inter-ministerial Conference. This working group is part of the General Drugs Policy Cell and is made up of representatives of each of the competent Departments of both the federal and federate levels. The ad hoc working group ‘demand reduction’ will present its note in September of 2012.

Next to these initiatives, in 2011, the Belgian Federal Science Policy Office initiated and financed a number of scientific studies, to execute the Communal Declaration of January 25th of 2011. These studies are:

1) The production of cannabis in Belgium: evaluation of the nature, the harmful effects and implications for priority setting
2) Compulsive internet use: knowledge base in Belgium, a mixed approach
3) The drug treatment court in Ghent: a qualitative outcome evaluation
4) The use of alcohol, illicit drugs, sleep medication and tranquilizers. Prevention and treatment by general practitioners and the supervision of health on the job by the medical officer. Knowledge, needs and services
5) Indicators with regard to the offer of illicit drugs.

3.2.2. Federate levels

The minister of Health of the French Community (today "Wallonia-Brussels Federation" – FWB) has ordered a private consortium, in 2010, to evaluate the Health Promotion monitoring system of the FWB. The evaluation report was published in march 2011. It pointed mainly the lack of a real planning of Health policy and its implementation, but also of a real evaluation of the effects of the policy and the program of Health Promotion. On that basis, the minister has presented the orientations of the reformed competences in June of 2011. Two main measures are emerging: the writing of a new Health Act aiming to give more transparency to the legal framework (note: the current decree governing Health Promotion was published in 1997), and the creation of an Organization of Public Interest (OIP) which will pilot the health policy in the FWB. The main competences to be transferred to the OIP are: research, data collection, evaluation, observation, documentation, communication, advising, recommendations, programs piloting, screening and vaccinations. These tasks are, at the present time, entrusted to various operators (Community Services for Health Promotion; Reference centres for Screening; thematic observatories; and some NGOs). The latter are supposed to disappear partially or totally, as their missions will be progressively integrated to the OIP. Notice that the volume and the framework of employment, according to the Minister, would be preserved, since not only the same volume of work will be funded, but also the responsible workers will be invited to pursue their tasks in the walls of the OIP.

Nonetheless, a hearing on that evaluation report have been organized by the parliament of the FWB. Indeed, some deputies had been questioned by several NGOs of the field of Health Promotion, regrouped in a "Collective of the actors in Health Promotion" on the methodology of the evaluation study, on the fact that the study had failed to evaluate the needs of the clients (drug users), and on the fact that, according to them, too few of the concerned field services had been consulted (and mostly through a written questionnaire) to realize the study. The Collective also addressed a "Plea for an ambitious policy" in the matter of Health Promotion to the Minister, and published it in a professional review. One of the

concerns of the collective was to see that the Promotion of Health becomes increasingly defined from a strictly medical point of view, neglecting progressively the “fundamental determinants of Health”, as described in the Charter of Ottawa adopted by the World Health Organization (WHO). Moreover, the Superior Council for the Promotion of Health (Conseil Supérieur de Promotion de la Santé – CSPS) had also published a critical advice on the methodology and the context of the evaluation report.

Two successive auditions took place in the parliament. Questions were addressed, during the first audition, to the authors of the report, the president of the CSPS and the General Director of Health Administration in FWB. The second audition was the occasion for three representative of the field (one NGO, one “Community Service for the Promotion of Health”, and the services “Promotion of Health at School”) to meet the political representatives, to state the position of the field and to answer questions. It appeared that the field did not reject the evaluation report as a whole, and recognized the necessity of a reform, but pleaded for a contradictory evaluation and a large debate to guide it, to avoid a “top-down” reform. They also pointed that the current paths emerging from the study do not carry unanimous adherence.

Following this process, the minister invited four members of the CSPS to take part to a working group, along with a representative of the services “Promotion of Health at School” and the concerned members of the cabinet. The workgroup accompanies the writing of the draft project of the new Health Code (regular meetings). After the writing, the final version of the Code will have to be approved by the CSPS itself. The final text should be submitted to the government by the end of 2012, and to the parliament in the first semester of 2013.

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 2011), which contains the measurement of the public expenditures for the year 2008. The public expenditures of 2008 were compared in the last year annual report with the ones of 2004, derived from ‘Drugs in figures II’ (De Ruyver et al. 2007). For more detailed information about the recent trends of drug-related public expenditures and drug services, please refer to Chapter 12 of this annual report.

The General Drug Policy Cell decided in May 2012 to coordinate the analysis of drug-related public expenditure on a yearly basis. This agreement of the different governments and the public services in Belgium has the objective to monitor the public expenditures of the drug

policy. Each government proposes one responsible to provide the relevant information. Besides this, the Secretary of the General Drug Policy Cell has the possibility to appael to experts or institutions who are specialised in the drug problem (Interministeriële Conferentie Drugs 2012b). The collection of this information is based on the same methodology and pillars as defined by 'Drugs in figures III' (Vander Laenen 2011). This will assure the comparability of the yearly collected information in an database. As such, more reliable data have to be available the next years.

4.2. Budget

In the framework of the Federal Drug Policy Note of 2001, it is important to know which projects are financed by the Federal governement. In order to have a picture of the national implementation of the different initiatives, an overview is given about the new (pilot) projects financed by the Federal department of Health and the Federal Addiction Fund. This overview gives the possibility to indicate the projects which are continued over the years. Most of the projects are lasting though a few years.

The Federal department of Health is financing five pilot projects related as part of the Federal Drug Policy Note of 2001. Table 1.1 reports about the financing of the different projects for the years 2009, 2010 and 2011. The Federal department of Health was only financing the INCANT project in 2009 (217,922 €) and the first four months of 2010 (72,030 €). From May 2010 on, the Federal Addiction Fund is financing this project. The financing of these projects remains globally the same over the years. Only the financing of the TADAM project is fluctuating between 205,160 € and 296,742 €.

Table 1 1: Budget pilot projects financed by the Federal department of health for the years 2009, 2010 and 2011

Pilot Project	Years		
	2009	2010	2011
Project 'International Cannabis Need of Treatment (INCANT)'	217,922 €	72,030 €	From May 2010 on, these projects are financed by the Federal Addiction Fund.
Project 'coordination and care'	374,177€	374,177 €	374,177 €
Project 'crisis intervention units and case-management'	3.534,303€	3,536,890 €	3,536,890 €
Evaluation of the project 'medically controlled supply of diacetylmorphine (TADAM)'	247,062 €	205,159.6 €	296,742.04 €
Project 'dual diagnosis'	923,700 €	927,090 €	927,090 €

Source: Federal Public Health Service

Previous Belgian National Report reported on 22 projects which were financed in 2008-2009, by the Federal Addiction Fund. For this period, the budget amounted to a total of €1,909,363. This year, it is the purpose to give an overview about the budget of the Federal Addiction Fund of three years, namely 2009 (table 1.2), 2010 (table 1.3) and 2011 (table 1.4). In 2009, the Federal Addiction Fund financed 14 projects focussing on the treatment of (illicit) drug addictions. For this period the budget amounted to a total of € 1,401,204.

Table 1 2: Funded projects by Federal Addiction Fund 2009

Institution	Title of the Project	Budget
Centre ALFA	Projet CAMELEON	31,000 €
Centre Autrement	Familles et assuétudes: prise en charge et sensibilisation	77,186 €
D.U.N.E.	Renfort de l'offre de soins du comptoir d'échange de seringues et travail de rue de Bruxelles-Capitale	57,494 €
DE KIEM	Ambulante hulp aan drugverslaafden binnen de regelgeving van Alternatieve Gerechtelijke Maatregelen, proefzorg en drugsbehandelingskamer	55,000 €
DE SLEUTEL	Versterken van kwantiteit en kwaliteit in de preventie, vroegdetectie en hulpverlening	99,640 €
FREE CLINIC	Buddysysteem voor ondersteuning van druggebruikers bij hepatitis C- behandeling	49,466 €
IDA	Campagne Alcool	673,118 €
IDA	Ontwikkeling van richtlijnen voor vroegdetectie en kort advies met betrekking tot de risico's van alcoholgebruik bij conceptie, zwangerschap en borstvoeding	51,175 €
INFOR-DROGUES	Base de données en ligne bibliodrogues spécilisée dans les assuétudes	35,295 €
Interstices CHU St Pierre	Projet Liaison Alcools	62,600 €
KATARSIS	Begeleiden en/of aanleren van het ouderschap bij verslaafde personen die in behandeling zijn in Katarsis	32,462.18 €
KOMPAS	Crisishulp aan huis	46,768 €
VAD	Ontwikkeling van Good Clinical Practice in de herkenning en behandeling van ADHD bij (jong)volwassenen met verslavings problemen	67,500 €
VAD	Kwaliteitsbevordering in de verslavingszorg	62,500 €
Total		**1,401,204 €**

Source: Federal department of Health, Food chain safety and Environment

In 2010, the Federal Addiction Fund financed 25 projects focussing on the treatment of (illicit) drug addictions. For this period the budget amounted to a total of € 1,415,450.50. In comparison with 2009 we see an increase in the number of projects wile the budget stays quit stable.

Table 1 3: Funded projects by Federal Addiction Fund 2010

Institution	Title of the Project	Budget
ASL	Verslavingsspreekuur	24,956 €
CAAT	Exploration du besoin de considération du toxicomane	29,000 €
CAD LIMBURG	CANNABISHULP: een website met informatie over cannabis en online begeleiding bij cannabisproblemen.	50,175 €
Centre ALFA	Projet CAMELEON	30,000 €
CGG KEMPEN	CRA methodiek en een buurtwerking	30,000 €
CHU BRUGMANN	Evaluation, prise en charge et soutien à la prise en charge des adolescents souffrant d'une assuétude: approche familiale multi dimensionnelle	120,000 €
D.U.N.E.	Renfort de l'offre de soins du comptoir d'échange de seringues et travail de rue de Bruxelles-Capitale	72,000 €
DE KIEM	Ambulante hulp aan drugverslaafden binnen de regelgeving van Alternatieve Gerechtelijke Maatregelen, proefzorg en drugsbehandelingskamer	60,000 €
DE SLEUTEL	Versterken van kwantiteit en kwaliteit in de preventie, vroegdetectie en hulpverlening	88,729 €
DE SPIEGEL	Handleiding "drugs-drugsgebruik-behandeling" ten behoeve van ouders en partners in contact met de drugshulpverlening	41,190,96 €
FREE CLINIC	Buddysysteem voor ondersteuning van druggebruikers bij hepatitis C- behandeling	44,500 €
IDA	IDA-web: uitbreding van vlaams en ontwerp van franstalig interactive platform voor professionelen en intermediairen	110,430 €
Interstices CHU St Pierre	Projet Liaison Alcools	68,800 €
KATARSIS	Begeleiden en/of aanleren van het ouderschap bij verslaafde personen die in behandeling zijn in Katarsis	27,984.54 €
KOMPAS	Crisishulp aan huis	49,235 €
LA CAHO asbl	Implémentation d'un projet de sevrage à domicile de personnes alcoolo-dépendantes	35,500 €
Le RESSORT	Service Plan drogues commune de Tubize	89,500 €
MSOC OOSTENDE	Outreachende, geïntegreerde en pro-actieve begeleiding van	76,640 €

	drugafhankelijke ouders met jonge kinderen via A(ssertive) C(ommunity) T(reatment)	
NAMUR ENTRAIDE SIDA	Développement d'un pôle infirmier et médical dans le comptoir l'Echange	65,450 €
PopovGGZ	Optimalisatie van de zorg voor mensen met een verstandelijke beperking en een verslavingsprobleem	71,000 €
Psychiatrisch Centrum OLV	Psychiatrische thuisbegeleiding voor jongeren (16-35j) met een psychotische stoornis in combinatie met middelenmisbruik (alcohol, drugs)	52,600 €
THAIS	Soutien à des personnes toxicomanes dans leur fonction parentale	28,000 €
VAD	Ontwikkeling en implementatie van screeningsinstrument ASSIST en bijhorende kortdurende interventie voor alcohol- en drugproblemen in de eertslijns welzijns- en gezondheidzorg	39,650 €
VAD	Kwaliteitsbevordering in de verslavingszorg	73,135 €
VAD	Ontwikkeling van Good Clinical Practice in de herkenning en behandeling van ADHD bij (jong)volwassenen met verslavings problemen	36,975 €
Total		**1,415,450.50**

Source: Federal department of Health, Food chain safety and Environment

In 2011, the Federal Addiction Fund financed 35 projects focussing on the treatment of (illicit) drug addictions. For this period the budget amounted to a total of € 2.932.391. In comparison with 2009 we see both an increase in the number of projects and an increase of the budget (52%).

Table 1 4: Funded projects by Federal Addiction Fund 2011

Institution	Title of the Project	Budget
CAD Limburg	alcoholhulp.be + CANNABISHULP	185.000 €
Centre ALFA	Jeunes et consommation	55.300 €
Centre Autrement	Approche psychothérapeutique pour des clients en démarche d'insertion	32.450 €
CGG KEMPEN	CRA methodiek en een buurtwerking	30.000 €
CHU BRUGMANN	Evaluation, prise en charge et soutien à la prise en charge des adolescents souffrant d'une assuétude: approche	170.000 €

	familiale multi dimensionnelle	
Comptoir	Consultations médicales gratuites et dispensaire de soins infirmiers pour usagers de drogues	72.100 €
D.U.N.E.	Renfort de l'offre de soins du comptoir d'échange de seringues et travail de rue de Bruxelles-Capitale	72.000 €
DE KIEM	Ambulante hulp aan drugverslaafden binnen de regelgeving van Alternatieve Gerechtelijke Maatregelen, proefzorg en drugsbehandelingskamer	59.516 €
De Kiem	Implementatie van een cocainespecifiek behandelingsprogramma CRA + vouchers	89.465,86 €
DE SLEUTEL	Versterken van kwantiteit en kwaliteit in de preventie, vroegdetectie en hulpverlening	89.000 €
Ellipse	CASA : Projet d' accompa-gnement à domicile de per-sonnes souffrant ou ayant souffert d'assuétude(s)	135.470 €
Het Verhuis-Siddartha (MSOC Vlaams Brabant	Opvoedingsondersteuning aan druggebruikende ouders en hun kinderen in Vlaams-Brabant en deskundigheidsbevordering van de laagdrempelige hulpverlening aan druggebruikende ouders en hun kinderen in Vlaanderen	57.780 €
IDA	IDA-web: uitbreding van vlaams en ontwerp van franstalig interactive platform voor professionelen en intermediairen	47.000 €
IDA	Projet national d'information et sensibilisation : -16 pas d'alcool	78.825 €
IDA	Intervention spécifique sur les problèmes d'alcool dans les services des urgences	79.410 €
Interstices Bruxelles	Bruxelles-cannabis … Vers la formation d'un réseau spécialisé	34.800 €
Interstices CHU St Pierre	Projet Liaison Alcools	70.000 €
KOMPAS	Crisishulp aan huis	57.720 €
LA CAHO asbl	Implémentation d'un projet de sevrage à domicile de personnes alcoolo-dépendantes	95.500 €
MASS Bxl- Fédasil	Projet de collaboration FEDASIL et LAMA - M.A.S.S. - Interstices C.H.U. Saint-Pierre	90.051,98 €

MSOC Gent	Opvang van opiaatafhankelijken in de eerstelijnsgezondheidszorg	87.050 €
MSOC Gent	Klinisch Casemanagement en intervisie voor hulpverleners voor drugverslaafde zwangeren en drugverslaafde ouders met jonge kinderen	69.150 €
MSOC OOSTENDE	Outreachende, geïntegreerde en pro-actieve begeleiding van drugafhankelijke ouders met jonge kinderen via A(ssertive) C(ommunity) T(reatment)	79.950 €
NAMUR ENTRAIDE SIDA	Développement d'un pôle infirmier et médical dans le comptoir l'Echange	75.450 €
Petits-Riens	Synersanté	90.000 €
PopovGGZ	Optimalisatie van de zorg voor mensen met een verstandelijke beperking en een verslavingsprobleem	75.200 €
Psychiatrisch Centrum OLV	Psychiatrische thuisbegeleiding voor jongeren (16-35j) met een psychotische stoornis in combinatie met middelenmisbruik (alcohol, drugs)	51.350 €
PZ Sint Camillus	Projectvoorstel intensieve outreach voor het opvolgen van personen met een alcoholafhankelijkheid	127.954 €
Relais Social Urbain Namurois	Cellule assuétudes intégrée au relais santé	77.718,15 €
Réseau Hépatite C	Accompagnateur social au profit de l'asbl Réseau Hépatite C – Bruxelles	39.636 €
ULB & Collaborateur (5 partenaires)	Benzodiazépines : Formations de médecins généralistes et d'autres intervenants de santé	158.669 €
VAD	Screening van riskant of problematisch middelengebruik via online 'zelftest'-vragenlijsten	55.930 €
VAD	Ontwikkeling en implementatie van screeningsinstrument ASSIST en bijhorende kortdurende interventie voor alcohol- en drugproblemen in de eertslijns welzijns- en gezondheidzorg	63.230 €
VAD	Kwaliteitsbevordering in de verslavingszorg	75.715 €
VAD	Vroeginterventie door middel van groepswerking met jongeren die riskant of beginnend problematisch gebruiken	204.000 €
Total		**2.932.391 €**

Source: Federal department of Health, Food chain safety and Environment

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Chapter 2.

Drug use in the general population and specific targeted-groups

van Bussel JCH. and De Donder E.

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 (Demarest et al. 2001;Demarest et al. 2002;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 (Decorte et al. 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 school survey (VAD Leerlingenbevraging, VAD-LLB) and the European study on youth attitudes on drugs, a study commissioned by the European Commission. Data on drug use was also available through studies in specific contexts like the study on substance use among youngsters in the city of Antwerp, the party scene (Drogues Risques Moins), subgroups like Belgian army applicants (Medical Registration Belgian Defence) and drug use among sex workers in Belgium.

2. Drug use in the general population

The most recent BHIS with a self-completion module on psychoactive substance use was conducted in 2008 (Bayingana et al. 2006a;Bayingana et al. 2006b;Gisle 2010a;Gisle 2010b). The results of this national general population survey (n= 11026; 15-64y) are described in detail in the 2011 Belgian Annual Report (van Bussel and Antoine 2012). In 2011, the Surveys, Lifestyle and Chronic Diseases (SLCD) research group of the Institute of Public Health (WIV-ISP) started the preparation of the 2013 wave of the BHIS. The researchers hereby largely depend on the priorities set by the EHIS which coordinates the national EU surveys and guards the use of common methods. The EHIS work group preparing the second EHIS wave, tends to decrease the number of questions related to substance use from four to one. Nevertheless, the SLCD research group tends to maintain the items of the 2008 survey, being the lifetime, last year and last month use of cannabis; the

age of first time cannabis use, the last year use of cocaine, amphetamines, ecstasy, LSD, heroin, methadone and buprenorphine; and the frequency of last month cannabis use.

3. Drug use in the school and youth population

3.1. Drug use among Belgian youth

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). Although the study does not focus only on the use of illicit substances, but merely on attitudes to – and perceptions about – drugs and related issues (see also Chapter 6 and 10 of this Belgian Annual Report), information is available about the use of cannabis and 'new substances that imitate the effects of illicit drugs', the so-called legal highs.

For Belgium, 502 telephone interviews were conducted with young people between 15 and 24 years of age. Of these youngsters, 28.3% used cannabis once in their lives, of which 9.2% in the last 12 months and 8.0% in the last 30 days (The Gallup Organisation 2011). As for the new substances that imitate the effects of illicit drugs, 4% answered that they have used such a substance at least once in their lives.

The final report does not provide detailed information on the socio-demographic background of the Belgian youngsters that used one of the mentioned substances. Based on the responses of the total European sample, the researchers concluded that cannabis use was higher among young men than young women, and that the "younger respondents (15-18 year-olds, full-time students and those who had not (yet) completed more than primary education) were more likely to say that they had never used cannabis". In addition, the researcher found that two third of the respondents in the "non-working" households never used cannabis compared to 72-75% of the "working" young people (The Gallup Organisation 2011).

3.2. Drug use among Belgian school students

In Belgium, several large-scale surveys (using self-completion questionnaires) are conducted on a regular basis in school students of the Flemish and French Communities: the Health Behaviour in School-aged Children survey (HBSC) (Favresse and De Smet 2008;Hublet et al. 2011;Godin et al. 2011), the European School Survey Project on Alcohol and other Drugs (ESPAD), Vlaams schoolonderzoeksproject naar alcohol en andere drugs, (VLASPAD) (Lambrecht and Andries 2008;2011) and the VAD Leerlingenbevraging (Kinable 2011). While

the HBSC and ESPAD surveys are conducted every 4/5 years and target both the Flemish and French Communities, the VAD-LLB is conducted on an annual basis in Flemish school students - by the Flemish Vereniging voor Alcohol- en andere Drugproblemen vzw (VAD), the regional focal point for drugs and drug addiction.

Although the HBSC, ESPAD and VAD-LLB all focus on school students and use self-completion questionnaires, large differences exist in their methodology. 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. In 2011, a joint report “Vergelijken van Vlaamse school surveys over middelengebruik” was published. The researchers concluded that the three surveys measure the life, last year and month prevalence of cannabis use in a valid, reliable and comparable way (Lambrecht et al. 2011). Further comparisons were also found to be valid and reliable: “the prevalences, frequencies and the availability of illicit substances other than cannabis (VAD-LLB and VLASPAD), the use of substances by friends (VAD-LLB and VLASPAD), the harm perception of substance use (VAD-LLB and VLASPAD) and negative experiences caused by illicit substance use (VAD-LLB and VLASPAD).”

As for 2011, only the VAD-LLB was conducted. Results are expected to be available at the beginning of 2013. In 2010, the VAD-LLB, VLASPAD and HBSC surveys were all conducted in the Flemish Community, the French Community only participated in the HBSC. The results were summarized in the 2011 Belgian Annual Report (van Bussel and Antoine 2012). Briefly, the prevalences found in the 2010 VAD-LLB confirm previous Belgian studies (Lombaert 2010;Godin et al. 2011;Lambrecht and Andries 2011;Kinable 2011;Hublet et al. 2011) reporting an increase over the age groups ending at a point where almost half of the oldest school students (17-18y) used cannabis at least once in their lives. All studies also reported that a higher proportion of male school students use cannabis compared to female school students. Male school students were also found to use cannabis more frequently. The most frequently reported reasons to use cannabis were sociability, relaxation, curiosity, “to get stoned”, “because it was offered to me”, “to forget problems” and “to feel good”. Important reasons not to use cannabis were: 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 (Kinable 2011).

The use of illicit psychoactive substances other than cannabis is rather limited in the population of school students (Kinable 2010). Indeed, the highest lifetime prevalence’s among the oldest school students (17-18y) were reported for amphetamines (between 3.10% (Godin et al. 2011) and 6.50% (Lombaert 2010), and ecstasy 12.20% (Lambrecht and

Andries 2011). The reported lifetime prevalence of cocaine use in the Flemish Community for the oldest school students (17-18y) was found to be around 3.9% (Kinable 2011). As for opiates, both regional and local school surveys held in the Flemish Community (Lombaert 2010;Kinable 2011) found a lifetime prevalence of opiate (heroin) use of about 1% in the oldest school students. As for trends, based on the previous waves of the VAD Leerlingenbevraging, Kinable (2011) 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.

3.3. Drug use among “youths of the streets” and “youths on the streets”

In 2011, a study on substance use among youngsters in the city of Antwerp was conducted by the Instituut voor Sociaal Drugsonderzoek of the UGhent (Decorte and Nachtergale 2012). The study (AMJADII), funded by the city of Antwerp, builds on the methodology and results of earlier monitoring projects in the same city (ADAM I 2007 (Decorte and Janssen 2011) and AMJAD I 2009 (Tieberghien and Decorte 2010)) and aims to meet the lack of reliable and relevant local level data for the purpose of an evidence-based local drug policy. The design of the study consisted of qualitative methods (like in-depth interviews with key informants and ethnographic fieldwork) based on the results from national and international youth drug monitoring systems.

In their report Decorte and Nachtergale (2012) focus on homeless young people, youngsters in prostitution, minor truants and youngsters who have commited criminal facts, and ‘hard core’ young people.

Homeless young people often start to experiment with illicit substances on an early age: they smoke their first joint on the age of 12 or 13 years, they sniff their first speed when they are 13 or 14 and they experiment with heroin or cocaine when they are 15 or 16 years old. Within the group of homeless youngsters the authors distinguish different groups. A first group consists of heroin and cocaine using boys who have frequent contacts with older users. A second group includes young people who are mainly using amphetamines but also regularly use ecstasy and GHB. These youngsters have grown up within special youth care institutions. Additionally Decorte and Nachtergale (2012) mention two groups of vulnerable homeless youngsters: young people with 'limited' skills and those without residence papers.

Cannabis is the most used illegal substance among youngsters in prostitution: ‘it helps to forget’. Cocaine use follows at the second place.

The group of minor truants and youngsters who have committed criminal facts have similar characteristics. They mainly use the ‘classical drugs’ like alcohol, cannabis, speed, cocaine and ecstasy.

Finally, the group of ‘hard core’ youngsters consists of mostly immigrant men of 18 years and older who have spent their youth in juvenile institutions and who have been (repeatedly) committed crimes. Other problems are (excessive) substance use, problematic home situation (eg. absent parents, single parents, blended families), homelessness, etc. They use cannabis on a daily basis and cocaine or speed when they go out (Decorte and Nachtergale 2012).

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

4.1. Drug use in recreational settings in Belgium

Several reports of Belgian student surveys (Kinable 2010) (Lombaert 2010) (Rosiers et al. 2011) highlighted the fact that recreational and nightlife settings like pubs, clubs, parties, etc. are preferred settings for the use of illicit substances. However the gap in drug use between music lovers and non-lovers narrowed, music lovers are still more likely to use (frequently) illicit drugs in comparison with people who do not like dance music (Van Havere et al. 2011;Van Havere et al. 2012). 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 by, respectively, the Research in nightlife settings (VAD-Uitgaansonderzoek) and the risk reduction project (“Drogues Risques Moins”) coordinated by Modus Vivendi (Casero et al. 2010). The methodological approaches of these monitors are significantly different and were described in detail in previous Belgian Annual Reports (van Bussel and Antoine 2012).

In 2012, a study was published about illicit drug use in the Flemish nightlife scene between 2003 and 2009. In this study data was used from the research in nightlife settings (VAD-uitgaansonderzoek) conducted by VAD during four following years, namely 2003, 2005, 2007 and 2009. In total, 2.8212 party people, selected at dance festivals, rock festivals and clubs in the Flemish Community, filled in a questionnaire on their use of cannabis, ecstasy, cocaine, amphetamine, GHB and ketamine (Van Havere et al. 2012).

Across the four survey years, cannabis (43.1%) was the most popular illicit drug, followed by ecstasy (16.1%), cocaine (13.4%), amphetamines (8.2%), GHB (3.0%) and ketamine (1.9%). Over the years, cocaine and ecstasy became more popular than amphetamines. It is

noticeable that in 2009, cocaine changed places with ecstasy to become the second most commonly used drug (Van Havere et al. 2012).

The trend analysis shows an increase of almost all substances (cannabis, cocaine, GHB and ketamine) reported in this study. Although the last year use of GHB was 3.1% in 2009, the frequency of use almost doubled in comparison with the survey in 2003. The use of amphetamines remained stable over these years. Ecstasy was the only substance that showed a decrease in use. Nevertheless, this does not mean that the quantity of ecstasy diminished (Van Havere et al. 2012).

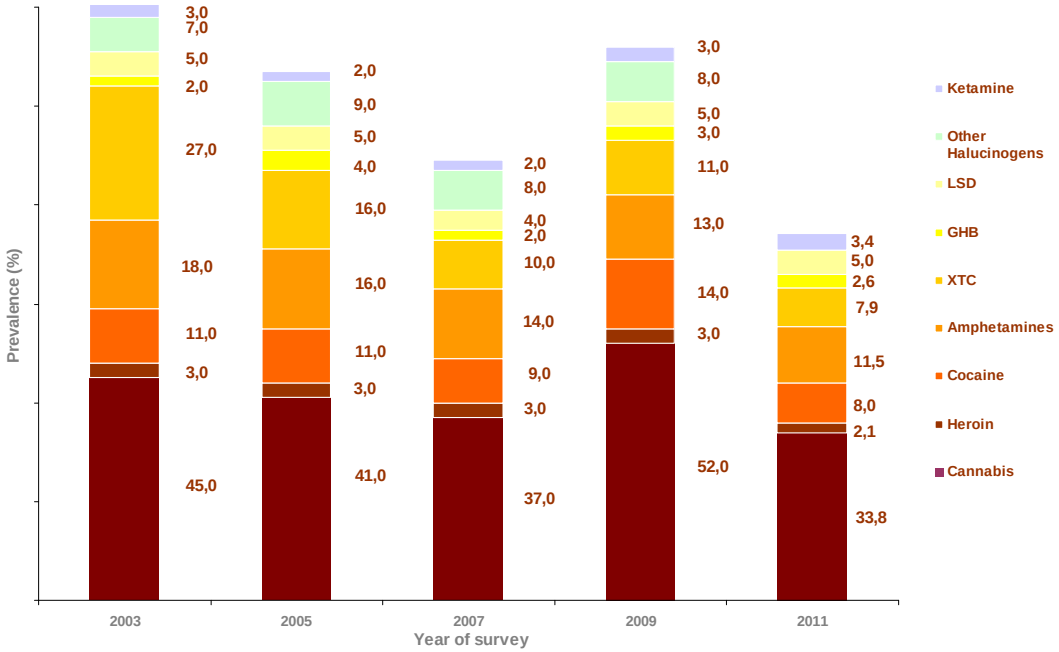
An earlier publication of this study showed a positive relationship between the reported frequency of visiting pub, clubs and parties during the last month and higher use of all substances investigated. Only people reporting to be rock music lovers and attendees of rock festivals seems to use less frequently. Dance music is positively associated with the use of cannabis, ecstasy and cocaine. Ecstasy is replaced by amphetamine use when goa parties are concidered (Van Havere et al. 2011).

For 2011, data are only available through the French Community “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 who are interested. The primary objective of the accompanying survey (paper questionnaire; in 2011 N = 2778, 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 illicit psychoactive substance in the monitored population in the Belgian recreational settings. In 2011, the ‘current’ cannabis use found in the French Community was 33.8 % (Eurotox, personal communication) (Figure 2.1). 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).

Amphetamines were the second most used illicit substance in the outgoing population of the French Community (Figure 2.1) with 11.5 % of the French outgoing respondents reporting the use of cocaine in the month before the survey was conducted (Eurotox, personal communication). As for ecstasy, hallucinogenic mushrooms, volatile substances (poppers) and amphetamines, the reported last month use of the contacted respondents was rather stable since 2007 (Casero et al. 2010).

Figure 2. 1: Relative proportion (%) of 'current' use of psychoactive substances in recreational settings in the French Community, 2003, 2005, 2007, 2009, and 2011.



Source: Modus Vivendi, courtesy of Eurotox 2011

4.2. Drug use among 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 2011, a sample of 4,823 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 illicit psychoactive substances. Of these applicants, 510 (10.6%) tested positive (Decrem and Ponthier 2012). Compared to 2010 (8.5%), 2009 (8.69%) and 2008 (7.86%) (Decrem and Ponthier 2011), the number of identified substance using applicants increased significantly based on the calculated confidence intervals. It should be noted, however, that systematic testing of all applicants only started in February 2011. Before this date, only applicants for a position as a pilot, diver or member of the special forces were systematically tested. No differentiation by substance was available.

4.3. Drug use among sex workers in Belgium

From October 2008 until February 2011, a study on substance use in the population of sex workers was conducted by the Instituut voor Sociaal Drugsonderzoek of the University of

Ghent and the university of Antwerp (Centre for evaluation of vaccinations (CEV) and University Scientific Institute for Drugproblems (UWiD)) (Decorte et al. 2011). This study, funded by the Federal Science Policy (BELSPO), aimed to study the nature and the extent of legal and illicit drug use among female sex workers (window prostitution, sex work in private houses, bars, street prostitution and escort sector) in five large Belgian cities (Antwerp, Brussels, Charleroi, Ghent and Liège) (Decorte et al. 2011;Decorte et al. 2012).

For their study, Decorte et al. (2011) used a multimethod design combining a face to face semi-structured interview of 528 sex workers, qualitative in-depth interviews by privileged access interviewers with a subsample of 25 sex workers, and focus groups with key actors in the domain of sex work. The participants were between 18 and 73 years old (mean: 35.7 years) and their experience as a sex worker ranged between 1 and 43 years (mean = 10 years). For most of the women (83.5%), their activities as a sex worker was their main source of income.

In general, the prevalences of illicit substance use reported by Decorte et al. (2011) were higher than found in the general population and differed significantly between the type of sex work. Sex workers on the street reported more often the use of illicit substances, compared to sex workers in private houses and escorts (Decorte et al. 2012).

The reported lifetime and last month prevalences of (illicit) psychoactive substances use by sex workers as found by Decorte et al. (2011) are summerized in Table 1. A significant finding is the fact that about a quarter of the interviewed sex workers reported the last month (current) use of benzodiazepines, especially the older respondents with a longer carrier. Most of them (63.4%) used these benzodiazepines on a daily basis.

The highest lifetime prevalences were reported for the traditional substances like cannabis, cocaine, ecstasy and amphetamine use, all above 25%. The last month prevalences are substantially lower, a prevalence of only 1.7% of ecstasy compared to a lifetime prevalence of 33.3%.

Table 2. 1: Lifetime and last month use of illicit substances by sex workers in five large Belgian cities (Antwerp, Brussels, Charleroi, Ghent and Liège) (2010)

Substance	Lifetime (%)	Last month (%)
Benzodiazepines	n/a	25.9
Cannabis	58.5	24.8
Cocaine	45	16.7
ECSTASY	33.3	1.7
Amphetamines	26.7	3.8
Heroin	15.5	7.2
Methadone	12.5	7.8
LSD	8.1	0
Crack	7.9	3.4
Inhalants	4.4	0
Buprenorphine	2.7	0.6
Methamphetamine	1.9	0.2
Other (poppers, mushrooms and other hallucinogens, GHB, ketamine (Special K), 'party drugs', and Other medicines)	15.9	5.3

Source: (Decorte et al. 2011)

Decorte (2011) also studied the polydruguse of the sex workers. Of their study sample, 46.0% reported the use of more than one psychoactive substance. Main products were alcohol and cannabis. As for the combined use, 32.2 of the current users reported the use of different substances at the same time: "33,0% combined alcohol and cannabis, 28.0% alcohol and cocaine, 16.0% alcohol and benzodiazepines" (Decorte et al. 2011). The combination of alcohol and cocaine was found to help them keep doing the sex work, while the use of benzodiazepines (after the use of cocaine) helps to sleep.

4.4. Drug use among prisoners in Belgium

Drug use among prisoners and health risks are monitored biannually by the Federal Department Health Care in Prisons (Todts et al. 2007;Todts et al. 2009;Van Malderen et al. 2012). The most recent survey (sample n= 1,251) was conducted in 2010 (Van Malderen et al. 2012) of which the results were described detailed in the 2011 Belgian Annual Report (van Bussel and Antoine 2012). Preparations for the launch of a new wave of this study in the summer of 2012 started in 2011. A last update about drug use and drug treatment availability in prisons is described in chapter 9.

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.

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Chapter 3.
Prevention

Laudens F. and Casero L.

1. Introduction

FLEMISH COMMUNITY

Monitoring data from the Ginger program give a good overview on the alcohol and drug prevention activities (Rosiers 2011). In 2011, 80 prevention workers took part in this annual registration. In total 6.339 valid alcohol and drug prevention activities were registered.

Prevention is mainly oriented towards actors in the health and educational sector. In the educational sector, more than three out of four activities are organized in secondary schools. Prevention activities in these schools mostly consist of training students and teachers, and organizing consultation with teachers and the school board.

In the health sector most prevention activities take place with the regional mental health centres. Most activities in this sector focus on consultations and more specifically on information exchange and coordination and on the development of prevention concepts and materials.

Three out of four prevention activities 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. Taking into account that the Ginger registration is monitoring single prevention activities and not prevention projects or processes, this is a high percentage.

Since 2006, the Flemish government formulated goals concerning the use of tobacco, alcohol and drugs (TAD) in a region-wide health conference with all the actors involved in prevention (Vlaams Agenstschap Zorg en Gezondheid 2006). In 2008 a Flemish Action Plan on tobacco, alcohol and drugs 2009-1015 was developed and accepted by the Flemish parliament. 3 structural and 4 strategic objectives were defined. These objectives were described in previous annual report.

Only for the first structural objective activities were developed in 2011. Concerning this objective of the organization of the prevention actors, structures, responsibilities and collaboration between actors the following was decided on April 30th 2011:

- partner organizations play a pivotal role in the development of methodologies concerning TAD;

- the dissemination of TAD methodologies is the responsibility op locally organized health consultation services (LOGO's);
- prevention workers working in regional mental health centres will support the implementation of TAD methodologies through training and consulting activities.

In September 2011 the different roles of LOGO's and regional prevention workers on the local level were clarified during an event hosted by VAD and VIGEZ. LOGO's will motivate municipalities in a proactive way to develop a preventive health policy. Regional prevention workers will support municipalities in the development of a TAD policy. During this event an overview of tobacco, alcohol and drug related prevention materials was presented to different actors and organizations working in the field.

In the course of 2011 the Flemish Workgroup TAD developed a concept note in support of the sixth strategic objective to develop strategies for smoking cessation and early intervention for alcohol and drug problems. For early interventions on drug problems, young people were chosen as the most important target group and a variety of interventions were identified to develop in a cascade system. The note also states that training, new methodologies and registration are necessary conditions for the development of an efficient early intervention network.

A number of new projects were started by the end of 2011. Four of these projects target families. The first project supports the educational skills of parents concerning the use of tobacco, alcohol and drugs by youngsters aged 10 to 15 years. A group training program for parents will be developed based on a video-interaction methodology.

The second project concerns an information campaign on the risks of tobacco, alcohol and drugs before, during and after pregnancy. Using different media channels a simple and clear message will be given to women and their partners. Extra attention will be given to families with lower socioeconomic status.

The third project targets children of substance abusing parents. The project consists on the one hand of an awareness campaign towards children and on the other hand of a training for professionals to respond to these children via help lines, mail and chat programs.

In a 4th program a website for parents will be developed with all kinds of educational issues concerning healthy eating, fitness, tobacco, alcohol and drugs.

Finally a pilot project “drug prevention for ethnic minority youth” was started. This project uses a Rapid Assessment and Response (RAR) – methodology and is conducted in three regions in Flemish Community. Prevention actions will be set up in these regions and a script will be developed on how to reach this target group using a RAR.

WALLONIA-BRUSSELS FEDERATION

Prevention actions in the French Community are articulated around the concept of “health promotion” (Ottawa charter, 1986). The strategies of interventions are defined in the quinquennial programs of health promotion, which are then translated into Operational community plans (PCO). The current operational community plan concerns the period from 1st January, 2008 till 30th June, 2013.

Prevention of addictions and harm reduction in French Community is situated in a global approach and does not aim a particular product or the illicit products exclusively (except certain actions of harm reduction). It is also question of the dependences “without psychotropic product” (Internet, sexuality, games)

The Minister of Health in the French Community launched in 2010 an evaluation of the health promotion sector (Evaluation des dispositifs de la politique de santé en Communauté française, 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 organization and the structures; the relevance of the operational means and finally, the evaluation procedures. Year 2011 and 2012 was mainly dedicated to the revision of the legal health code. A proposal of the new code will be presented to the council of health promotion, to the government and to the parliament. Only later reforms will be effective.

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. During 2012 five working groups were established: “family”, “school”, “festive”, “street” and “prison” environment. Every working group will produce a specific action plan which will contribute to the elaboration of the global action plan.

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.

2. Environmental prevention

FLEMISH COMMUNITY

There are numerous projects in different sectors (cultural, welfare, social economy, crime prevention, local community development, etc.) which improve directly or indirectly neighborhood cohesion and climate. The activities of these projects focus on access to decent housing, access to the health system, access to education and professional integration (refer also to chapter 8).

Measures to improve the protective school environment and enhance the school climate form a intrinsically part of most school-oriented prevention and health promotion programs. These programs use a wide range of structural measures but at the core of this is often the enhanced participation of parents and pupils in school related matters.

Other structural measures used in programs tackling substance use, bullying and unhealthy eating habits are more in collaboration with external organizations concerning leisure and sport, better equipped playgrounds, free provision of water,...

WALLONIA-BRUSSELS FEDERATION

Since 2010, the social cohesion projects (PCS) were developed in many municipalities of the Walloon Region (Décret relatif au plan de cohésion sociale dans les villes et communes de Wallonie, novembre 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 PSSP ("plans stratégiques de sécurité et de prevention). The PSSP are developed by the municipalities with a financing of the Federal department of internal affairs.

2.1. Alcohol and tobacco policies

2.1.1 Alcohol policies

The law of December 28th, 1983 (B.S.30.12.1983) defines that the Federal department of Finance has the competence to provide the franchise allowing the sale of spirits and on which conditions. For that purpose, a set of guarantees of morality is required via an examination of the police record.

In response to the World Health Organization (WHO) appeal, the Inter-ministerial Conference of Public Health gave, in 2005, mandate to the Policy Health Drugs Cell (PHDC) (PHDC is a commission composed of representatives of different Ministers with competencies regarding health. It meets monthly since June, 2001. Meetings are organized by the Federal department of Health) to draft a policy document concerning alcohol. The PHDC worked on the development of a National Alcohol Action Plan (NAAP) (2008-2011). This gave rise to the signature of a joint declaration of the Health Ministers resuming the major objectives of the plan. The NAAP objectives are threefold: prevent damage from alcohol use, fight unsuitable, excessive, problematic and risky consumption of alcohol and elaborating a policy targeting at risk groups and at risks situations.

Alcoholic beverages are subject to the normal rate of the 21% Value-added tax (VAT). The Royal order of 2005 (B.S.22.08.2005), modifying the law of January 7th, 1998 concerns the structure and the rates of excise taxes on alcohol and alcoholic drinks. It proceeds to a 5,5 % increase of excises on liquor. This measure is taken within the framework of the prevention against alcoholism. At this moment the excise taxes are 17.52 EUR for one liter of spirits, 0.47 EUR for one liter of wine and 0.02 EUR for one liter of beer.

On May 12th, 2005 the Federal Minister of Public Health signed a convention with the alcohol industry regulating the publicity for alcoholic beverages. The most important terms of this convention are:

- no association between alcohol consumption and social, sexual or professional success or positive physical of psychological effects
- no publicity in social, health and professional settings
- alcohol-related publicity is banned in movies, programs, magazines,..... targeting minors
- alcohol-related publicity may not target pregnant women or suggest the possibility of driving
- publicity must mention the baseline ‘Enjoy, but drink in moderation’

There is a national council with a self disciplinary jury which can recommend to change or stop publicity in violation of the convention.

The law of December 10th, 2009 (B.S.31.12.2009) forbids selling, serving or offering, to youngsters under the age of 16, any beverage with contains more than 0.5% alcohol by volume. Serving, selling or offering spirits is only allowed to persons having reached the age of 18 years. Each person willing to buy alcohol can be asked to prove his/her age. Health inspectors of the federal administration and also the police reinforce this law and are allowed to fine offenders. In 2011 a national awareness campaign targeting retail shop owners, youngster and their parents was carried out. A total of 140.000 stickers were distributed in 16.000 retail shops. The message mentioned on the stickers was “No alcohol under the age of 16, no liquor under the age of 18”.

On April 1st 2009 a collective labor agreement came into effect which obliges private organizations to develop an alcohol and drug policy in the workplace.

Concerning driving under the influence (DUI), the maximum legal limit is 0.5% Blood Alcohol Content (BAC) by volume. The law provides 5 levels of severity in the penalty for offenders ranging from a immediate 137.5 EUR fine (ban to drive during 3 hours) up to a fine between 1.100 and 11.000 EUR (ban to drive during 6 hours and immediate withdrawal of the drivers licence for 15 days minimum). Sobriety tests are performed by the police the year round though each year the months of December and January see an intensification of the number of tests. During these months there is also a national awareness campaign against DUI.
There is no federal law regulating alcohol consumption in public except in case of public drunkenness. Public drunkenness is punishable by fine. The police may also decide in some cases to arrest the person and place him in custody (from two to twelve hours). Municipalities can, using a local police regulation, prohibit alcohol consumption in public places.

FLEMISH COMMUNITY

The media decree of March 27th 2009 (B.S.30.04.2009) resumes the most important terms of the national convention but adds a term which forbids the sponsoring by alcohol related companies of TV-programs targeted at children. The ‘Vlaamse Regulator voor de Media’ is the independent body controlling if the terms of the decree are followed.

WALLONIA-BRUSSELS FEDERATION

A regulation of the government of the French Community of January 18th, 1995 (B.S.19.04.1995) stipulates that the radio campaigns for alcoholic beverage or medicines

have to give rise next year to a free spots, of equivalent spaces intended for Health promotion. The prevention of the addictions including alcohol is a part of this campaigns which have to occupy these free spaces.

2.1.2 Tobacco policies

The law of December 10th, 1997 (B.S.11.02.1998) prohibits the advertising for tobacco and sponsoring by tobacco industry. This law bans any communication or action which aims, directly or indirectly, at promoting the sale of tobacco regardless the place, the used media support or used techniques. The ban does not apply to advertising for the tobacco products made in foreign newspapers and periodicals; the fortuitous advertising for tobacco products made within the framework of the communication of an event which takes place abroad and the display of the brand of a product of tobacco inside stores of tobacco and stores of newspapers which sell tobacco products.

Tobacco is subject to the normal rate of the 21% Value-added tax (VAT). There are four types of excise taxes for tobacco. For cigarettes, the total amount of all excise taxes can not be lower than 90 % of the amount accumulated by the same taxes applied to cigarettes belonging to the most wanted class of prices (article 3, & 4 of the law of April 3rd, 1997). For the first time since 2008, fiscal receipts on the tobacco decreased in 2011. Because of the announced increase of excises taxes in 2012, fiscal receipts for tobacco will increase probably again in the next years.

Since December 1st 2004 (B.S.10.11.2004) it is prohibited to sell tobacco to youngsters under the age of 16. Each person willing to buy tobacco can be asked to prove his/her age. The use of tobacco by youngsters under the age of 16 is not prohibited though. Two types of warnings appear in black and white on the packages of cigarettes namely a general warning on the front and a health warning accompanied by a photo on the back. The Ministerial decree of May 28th, 2009 (B.S.02.07.2009) makes compulsory the mention of the Tobacco Stop Line number on all packages of cigarettes from January 1st, 2011.

Since July 1st, 2011 (B.S.19.12.2009), smoking is forbidden in all enclosed public places including cafés, bars, and nightclubs. It is however allowed to settle a smoking room or to smoke on the opened terraces. Health inspectors of the federal administration and also police reinforce the law and have the right to fine offenders.

Belgium was the first EU country to introduce pictorial health warnings in 2006 and to print the number of the Tobacco Stop Line on all cigarette packs in 2011.

FLEMISH COMMUNITY

Since September 2008 (B.S.18.07.2008) a total smoking ban is effective in all schools. Smoking is prohibited for all persons (pupils, teachers, parents ...) within the boundaries of the school parcel.

WALLONIA-BRUSSELS FEDERATION

The decree concerning the prevention of the smoking and the ban to smoke at the school, adopted by the Parliament of the French Community May 2nd, 2006 (M.B.21.06.2006), forbids smoking in areas frequented by the pupils as well as in all the opened places situated within the school.

2.2. Other social and normative changes

Social norms and normative believes regarding the use of alcohol in certain settings and by certain groups of people are changing.

There is growing public recognition that alcohol consumption by youngsters can have detrimental effects on their development. This recognition translates in a number of new laws in 2009 (see 3.1) regarding the selling, ordering or offering of alcohol to youngsters and alcohol publicity targeted at minors.

The public acceptability of DUI has also changed during the last decennium. The laws regulating DUI exist for a long time. Since 1995 the Belgian Institute for Traffic Safety (BIVV) undertakes each year a international acclaimed awareness campaign built around the same concept (Go for zero 2012). As a result DUI is perceived the longer the more as an antisocial, unacceptable behavior.

3. Universal prevention

3.1. School

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 programs 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 2010-2011, 66 schools (and 28.606 pupils) took part in this project. Since 1998 the project had 883 subscriptions and more than 462.652 pupils were involved in this evaluation.

Within the framework of the drug policy at school, there is a wide range of universal prevention programs 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).

WALLONIA-BRUSSELS FEDERATION

The French Community (Wallonia – Brussels Federation, CFWB) adopted two decrees reorganizing the school medicine (the decree of 12-20-2001 concerning the promotion of the health at the school and the decree of 05-16-2002 concerning the promotion of the health in the higher education, except universities). The missions of the new decrees are assured by «the health promotion service in schools" (" P.S.E services ") 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 region.

The December 20th 2001 Decree set up the Promotion committee of the Health at the School (M.B.17.01.2002) which has for main mission to look to the Government of the opinions on any question relative to the promotion of health at school.

In the perspective to strengthen links between the specialized network regarding prevention of the addictions and the school environment, the Government of the French Community intended to mobilize its skills to promote the collaboration between the school and the specialized structures in prevention of the addictions. That is why, the Government planned the creation of an experimental project "Support points at schools regarding prevention of the addictions» (PAA) .The project is under the responsibility of the Local Centres of Health Promotion (CLPS). The Support Addiction points play the role of interface between the school actors and the specialized structures regarding addictions. The PAA has different missions: (1) to provide an offer list of prevention actions, (2) to inform the professionals

about the resources, services and tools available and (3) contribute to the creation or the strengthening of networks.

Actions in schools are based on the following principles: analyze the demand and clarify the situation; adapt the action to the educational project and to the institution’s resources; act "for" rather than "against"; recognize the role of prevention to the adults in connection with the young people; act together and create a dynamics of participation; guarantee to all the respect for the confidentiality. Concretely, actions can review for example the question of drugs, prepare a meeting with parent’s association, and prepare a session to teachers, educators for the prevention of the addictions.

At the school level a big variety of actors are involved in preventive actions: the police who comes to speak about drugs, or still to propose programs of personal fulfillment; the representatives of certain municipal organizations, the associations of prevention of the addictions and still others actors in a more punctual way.

In 2011 the PAA of Brussels realized a survey concerning 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 behaviors and addictions of the pupils. For more information see previous report.

3.2. Family

FLEMISH COMMUNITY

Universal prevention initiatives for parents are mainly integrated in programs of adult organisations and at a local level. There are several programs aimed at training parental skills.

These programs are open to all parents (not only parents with drug using children) and have a broad objective to develop “life skills”. The best known programs are Op zoek naar een kick (1 session) and Europarents (4 sessions).

The VAD started the development of an interactive 1 session program for parents based on a video-interaction methodology in 2011. This program will be ready for implementation in the second half of 2013.

WALLONIA-BRUSSELS FEDERATION

The specific projects targeting families of drug users are underway in Wallonia-Brussels Federation. Nevertheless, it is important to mention that they are open to all parents with a broad objective to develop “life skills”.

In Luxembourg province, the communal service SAP implements a specific project to support families. The interventions specifically focused into parents and relatives in demand of help are completed by the presence of social workers who intervenes with families during emergency situations. Two types of actions are privileged: the follow-up of families and the auto-support groups.

The « drug-addiction » department of the mental health of Charleroi (Walloon region) which targets among others weakened families develop as well 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 parents.

3.3. Community

3.3.1. 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.

FLEMISH COMMUNITY

The annual figures for the DrugLijn in 2011 show a small increase of 199 contacts as compared to 2010 (Evenepoel 2011) (n=5.747). These inquiries consisted of telephone calls and e-mails. This overall increase of 3.6% is completely due to the increase in the number of e-mail-enquiries (n= 2.491). This number increased with 38,2% as compared to 2010. The number of telephone calls (n= 3.256) decreased with 13,1% compared to 2010. 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: 43.3% of the enquiries is made online.

The DrugLijn is no emergency helpline and is therefore not operated 24 hours per day. Outside of the staffed hours (Mon-Fri 10h00-20h00), 2.041 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 503 hoax calls.

The percentage of inquiries on cannabis decreased slightly in 2011 (see table 3.1) as well as the number of questions concerning psychoactive medicines (after a relatively strong increase between 2009 and 2010). The percentage of illegal substances such as heroin and amphetamine showed also a slight decrease. The number of inquiries related to cocaine remained stable whereas there was a slight increase in the number of questions concerning ecstasy and alcohol.

Table 3. 1: Frequency of substances in related calls (% and n), Infor-Drogues, Druglijn 2011

	Infor-Drogues				Druglijn*			
	2010		2011		2010		2011	
	%	N	%	N	%	N	%	N
Number of contacts*		4,168		4.347		5,548		5.747
Gender								
Males	43,2	1994	52,0	2260	41.6	2.306	41,1	2.362
Females	51,3	2367	43,0	1869	57.5	3.190	57,1	3.283
Unknown	5,4	251	5,0	218	0.9	52	0.8	102
Involved substances in contacts								
Cannabis	34.4	1.196	37.0	1.090	36.8	1.729	35,2	1.694
Cocaine	15.2	528	18.5	544	14.5	679	14,7	709
Ecstasy	1.1	37	2.6	77	3.0	140	3,9	188
Heroin	9.3	323	8.5	252	5.2	243	4,6	224
Alcohol	15.8	548	12.7	374	24.9	1.169	26,3	1267
Psychoactive medicines	8.2	286	8.0	235	14.8	694	12,6	607
Crack**	2.1	74	1.8	54	n.a	n.a	n.a.	n.a.
Methadone	5.5	193	5.2	154	2.7	126	2,0	n.a.
LSD	0.6	22	1.1	33	1.0	46	0,8	38
Amphetamine	2.8	99	1.5	45	9.4	440	8,9	427

* Figures for the DrugLijn include telephone calls as well as enquiries by e-mail. Percentages for 'involved substances in contacts' are calculated on the total number of persons that mention at least 1 drug (4.697 persons in 2010 and 4.818 persons in 2011).

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

Source: Infordrogue, 2011; 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 still people from 36-49 years old. Younger people contacting the helpline (mainly e-mailers) are more often drug users and students, whereas the 36-49 year olds (and mainly callers) contain a large number of parents. Since 2011, the DrugLijn promotes actively the possibility to use Skype.

De DrugLijn has an online early intervention section on their website. This section contains 4 online assessment tests (cannabis, cocaine, ecstasy and amphetamines) for adults as well as knowledge tests for the former three. In 2011, 26.845 self assessment and 13.041 knowledge tests were filled in on the website. This section was also updated with a online assessment test for cannabis use targeted at minors (-18 years). Finally 400 persons used the self-help program for cannabis and 181 persons signed in on the self-help program for cocaine.

The Centra voor Alcohol- en andere Drugproblemen (CAD) runs an online treatment program for cannabis. In 2011 the website counted 25.562 unique visitors which resulted in 221 who registered for treatment.

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4.347 calls were made to the helpline in 2011, a slightly rise of 4% on the previous year (4.168). As it was the case in 2010, an important percentage of these calls (27, 19%) were made by two callers who generated respectively 891 and 291 calls.

Every received call does not generally limit itself to a single request. So, it is common that a single caller ask for several things during the same call. For example, the information about a product, the explanations on the functioning of detoxification centres, emergency assistance & support, etc.

The Infor-drogues helpline operate 24 hours a day and 7/7 days. Concerning the period of contact, three categories are distinguished in the registration system: during working hours (from 8:30 am till 6:30 am), at nights (from 6:30 am till 8:30 am) and at weekends. In 2011, 66 %, of the calls come in at usual office hours (2848 calls), 15% at nights (670 calls) and 19% during week-end (829 calls).

Current target groups of Infor-drogues helpline are users, relatives and professionals. The percentage of callers categorized as "users" passed from 47 % in 2010 to 56 % in 2011. So, this represents an increase of 9 % in one year. This can be explained by the 1.182 calls

made by “the two callers” belonging to the “user” category. 36.1% of calls were made by relatives and 7.5% by professionals.

Concerning calls made by relatives, we noticed that if they call the helpline less than in 2010 (1609 calls in 2010 and 1423 calls in 2011, so decrease of 11%), the proportions of the various subcategories remain appreciably the same. 47% of the relative’s calls are made by mothers (663/1423) followed by family other members (266/1423, so 19%), partner (202/1423 so 14%), father (157/1423 so 11%) and others (135/1423 so 9%).

294 professionals (7.5%) contacted the telephone line in 2011. For this category we distinguish: the healthcare professionals (58%), the educational sector (23%), the professionals of the justice sector (6%), the journalists (8.5%) and the public authorities (4%).

There was very little change from 2010 in the distribution of age of user’s callers. Most of them were male 26-35 year old (54.4%). The age group 36-50 represent 27% of the user’s calls. The users who contact Infor-drogues are essentially male. We notice that the users calling the line are male whose age oscillates mainly between 26 - 50 years. The female callers are more rare.

Amongst those calls for whom the geographical origin was known, most were from Brussels (1336), the Hainaut province (469), Liège province (213) and Brabant Walloon province (181). The proportion of callers by province has varied little since 2008. This proportion can be attributed to: on one hand, "drugs" stays a rather urban theme, and on the other hand, there is a geographical nearness of Infor-drogues centre and opportunities which it brings in terms of consultation, documentation…

2.945 products were evoked during contacts in 2011. In a five-year period (2007-2011), we observe no real change in the percentage of the product evoked during calls. Cannabis is the most evoked product (37.0%) followed by cocaine (18.5%) and alcohol (12.7%).

Infor-drogues has as well an e-mail service (e-permanence). The association received 228 e-mails in 2011. These 228 e-mails correspond to 145 persons and mails were treated in the 72 hours following the demand. Among the evoked products, the cannabis is the first product mentioned in 42.1 % of the mails. The cocaine and the crack remain very present with 15, 8 % of the mails. As for «legal drugs» (alcohol - medicines), they represent 22, 4 % of the received mails.

The following 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: Fequency by age and contacts (% and N), Infordrogue and Druglijn, 2011.

	Infor-Drogues**		Druglijn*	
Age	%	N	%	N
Under 18	1.1	48	6.8	328
18-25	5.1	220	23.4	1129
26-35	31.7	1379	24.0	1158
36-49	31.6	1377	28.4	1371
50 and older	8.9	391	17.5	847
Unknown	21.4	932	-	-

* Figures mentioned refer to a sample of 82% of all callers and 87% of all e-mailers

** Figures mentioned refer to a sample of callers (N=4347)

Source: Infordrogue, 2011; De Druglijn, 2011

3.3.2. Local Alcohol and Drug Policy

FLEMISH COMMUNITY

In 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.

This method consists of 7 steps, using the local network and partners and a local analysis to implement actions concerning rules and regulation, structural measures, information and sensibilisation and early intervention and access to primary healthcare and welfare services.

This process of a local alcohol- and drug policy in communities or cities is supported by regional and local prevention workers.

4. Selective prevention in at-risk groups and settings

4.1. At-risk groups

FLEMISH COMMUNITY

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 a 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 these young people, it encourages them not to use alcohol or cannabis. CAD, which operates exclusively in the province of Limburg, developed a program 'straffe stappen' targeting youngsters in special needs education. They also have a program for people with a mental handicap. Both programs were financed by a provincial development fund (Limburg Sterk Merk).

CAD has a long tradition organizing 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 neighborhood; (2) disclosure of prevention and aid support towards grass-roots organizations; (3) Europarents towards multicultural group of women and (4) the Tuppercare-project: low-threshold drug prevention for women of foreign origin

The pilot project "drug prevention for ethnic minority youth" mentioned in 3.1 target youngsters with a Turkish background in the province of Limburg and the city of Antwerp and youngsters with a Moroccan background in the city of Ghent. In each of these 3 regions prevention activities will be developed and undertaken in 2012 based on the local situation and needs.

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Snowball Survey for at-risk groups (BDN)

The "Snowball operations" are a peer prevention program 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. This project aims several objectives: on the one hand reducing the risks linked to the use of drugs and on the other hand raising awareness and spread information to the most marginalized public. The data collection itself is not the 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 program, to follow the evolution of the consumptions, to identify the risk-takings, new tendencies, etc.

From February 2011 to February 2012, 2 BDN operations have been organised in the French community: in Charleroi and Liège (Rapport d'activités, Modus Vivendi 2011). The project targets "active" users, that is, «people who declared to have consumed a psychotropic product other than tobacco and alcohol during last month". Data concerns 134 of 140 collected questionnaires (96 %), according to the following distribution: Charleroi 44 % and Liège 56 %. Concerning the age, 46, 3 % of the respondent are «> 35 years old» followed by «26-35 years old» (38, 1 %). The proportion of the youngest «25 years and less» stays the lowest category (15, 7 %). The mean age of the respondents is 34, 7 year old.

47% of DU (n=100) declare to have practiced the injection in the last month and to have consumed at least one psychotropic product. Furthermore the proportion of IDUs to have been on methadone treatment is 73, 9% (n=99). About 38% of the DUs reported having ever had an overdose.

Snowball Survey in prison

Since 2006, the Snowball operations are also led in prison. If the expenses of these operations are assumed by the Federal department of Justice, the whole work supplied of the projects is subsidized by the Wallonia-Brussels Federation. Besides all the objectives inherent to the "classical Snowball surveys", the operations led in prison fix additional objectives: to assign a mission to prisoners, to approach the RdR under the angle of prison reality, and to make sensitive the professionals in the necessity of leading projects of RdR in prison.

Four snowball operations were organised in prison in 2011. Berkendael, Brussels (6 jobistes, 38 contacts); Jamioulx, Charleroi (9 jobistes, 39 contacts); Arlon, Luxembourg (13 jobistes, 70 contacts) and St-Hubert (10 jobistes, 80 contacts). 49 prisoners started the project, 38 "jobistes" (peer consumers) participated in all the stages of the operations, creating 227 contacts with prisoners.

In 2011, the Federal department of Justice translated the prevention brochure «la santé en prison, gardons le cap! » into Dutch. So, the brochure is potentially available in all the penitentiaries of Belgium. This year, healthcare professionals in French prisons (UCSA saint Michel and Montmédy) wished to be inspired by the brochure " Gardons le cap" to create their own tool. They benefit of the Modus vivendi expertise. This support was deeply appreciated by the consultations and ambulatory prison team.

Ethnic groups

Specific actions for ethnic groups are seldom or not available.
However, the Espace P (a centre that gives orientation and assistance to sex workers, their customers and their entourage) organization - 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 last year's national report

4.2. At-risk families

FLEMISH COMMUNITY

In 2011 VAD published a booklet for children of parents with a drug problem aimed at children between 14 and 18 years old. 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. 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 programs 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.

VAD coordinates a project targeting children of substance abusing parents (see also 3.1). Implementation of the project will take place in 2012 and 2013.

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Various projects are underway in CFWB. Here, we present some examples of interventions.

ALFA NGO in Liège has a "Parenthood" department. The objective of this service is double: allow addict parents to preserve their parental rights in the best psychological and social

conditions for the child; and to work in network with various structures that play an important role in these complex situations of parenthood and drug addiction. The target population of the project is: pregnant women requiring a medical care, addict parents in trouble risking to lose the guarding of their children, parents wishing or requiring a support in the education of their child, children of addicted parents questioning about addictions.

“Parentalité-Addiction” (“Parenthood-Addiction) is a multidisciplinary team created in the framework of a public clinic (Saint-Pierre, public hospital of the Public Centre of Welfare in Brussels). The objective of the project is double. It aims, on one hand, to identify, to strengthen and to support the parental skills and, on the other hand, to set up, if possible in association with the parents the necessary measures to mitigate the family deficiencies and support the development of children. The project has an appropriate space “the alizes” who allows the meeting with other families. It gives to parents and children, the opportunity to learn the socialization. It is a space of prevention: prevention of the relational disorders, psychomotor and linguistic development, and risk prevention of psychosocial degradation. The project follows the families after deliveries.

17 births were followed in 2011. 14 mothers were referred by the ambulatory Centre in Brussels and 3 by others centres. 12 mothers consumed tobacco; 6 cannabis, 5 cocaine, 3 heroin, 3 multiple addiction, 1 opiates and 1 alcohol.

The public centre of social help (CPAS) of Charleroi (Walloon region) has a specific drug-addiction cell. Specific projects of parenthood are developed by this structure. For more information see previous report.

4.3. Recreational settings

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 done with party tips, videos, posters, banners, etc. at major events such as Tomorrowland, I love techno, Bassleader, 10daysoff ...). Partywise will fade out in 2012 and will be replaced by a new concept Quality Nights (cfr. Wallonia-Brussels federation). VAD started in 2011 with the development of this new prevention program.

Peer support was introduced in the Flemish Community as a promising new method to work on risk minimisation in the nightlife in the Flemish Community, 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 up to 29 in 2011. 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. Both projects cooperate closely with Partywise to create a healthy and safer nightlife in the Flemish Community.

WALLONIA-BRUSSELS FEDERATION

Parties, festivals, bars, clubs …

The Label «Quality Nights» aims to reduce the risks connected to the festive circles (health, addictions, return at home, conflict/violence, noise pollutions, STI etc.) by working in association with the evening organizers, the owners and their staff on the party environment. The project was born in 2007 in Brussels and since 2009 it extends gradually in Walloon Region. Collaboration with the VAD for the extension of the label in Flemish Region is also in progress so that the project quickly reaches a national dimension.

The evaluation of the project in terms of impact and process will be gradually organized. It will be made in particular via the creation of new tools, the methodological support to the local operators and with the support of the “Party +” network and European partners of the NEWIP.

The sustainability of the project is reflected through an empowerment of the partners (by specific methodological guides) and a research for commercial partnerships for the provision of ear plugs and condoms or water dispensers for example.

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 project “Mobile team” reaches a young public, whose consumes psychotropic products, including alcohol, and which is little in touch with the socio-sanitary sector. It is a question for this festive and entertaining public of a first contact with an institution of the “health promotion

/ drug sector" network. The Mobile team also works with the festive professionals and the public authorities (raising awareness even negotiations during the preparation of the interventions).

The activities undertaken are: stand of information and distribution of brochures; relaxed zone; flying team ("jobistes"); distribution of material such as kits of sniff, condoms, flyers, etc; water distribution; needle exchange and testing.

Six festivals were covered by the project in 2011. Relaxed Zone was organized during three festivals: Esperanzah, Dour and City Parade in Brussels. In 2011, 243 people were welcomed in the Relaxed Zone, which is a 44 % increase with regards to 2010 and of 59 % with regards to 2009. The mean age of the people welcomed in Relaxed Zone is 22 years (min. 12 years - Max. 40 years). There were of 22 in 2010, 21 in 2009 and 23 in 2008. The majority of the public welcomed in Relaxed Zone are men. Concerning the raison of admissions, fatigue remains in the first position, by being quoted by 67, 8 % of the welcomed persons. Follow the cold (29, 4 %), problems of disorientation (18, 7 %), fears (15, 9 %) and nausea (14 %) which seem to be the reflection of an important and/or badly mastered consumption. In 2011, 77, 4 % of the persons, who answered the question (N=130), told to have consumed at least one psychotropic during the event. It emerges that the alcohol continues to be the most consumed product. On the other hand, this year, it is the ecstasy which arrives for the first time in the second position, before the cannabis.

DR- is a harm reduction information project in festive places. It is under way in Wallonia-Brussels Federation since 2001. In the project, all products (legal and illegal) and different types of consumption (occasional, entertaining, regular, problematic, compulsive, etc.) are approached. Harm reduction information is spread via a stand held in festivals, discotheques, bars, concert halls etc, by jobistes as well as by socio-medical professionals. For its implementation the project benefits from a network of more than 30 partners. Partners are distributed on the whole Wallonia-Brussels Federation (Liège province, Luxembourg, Province of Namur, Province of Hainaut, Louvain-la-Neuve and Brussels.).

DR- project is coordinated by Modus Vivendi NGO. The coordination assure the coherence and the efficiency, in terms of objectives, approach (to guarantee the respect for the values of the promotion of the health) and methodology.

In 2012 a new "carnet de risque" will be published. It will present the results of data collected from 2005 to 2010".During this period, 15.967 questionnaires were collected by the partners. The study shows that brochures knowledge decreased appreciably during the last years (68.5% in 2005 and 59.1% in 2010).

5. Indicated prevention

FLEMISH COMMUNITY

5.1. 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 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 the ASSIST, developed by the World Health Organization, was translated into Dutch (Claessens and Defillet 2010). The instrument exists in a paper version and an electronic version. A separate manual 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 objective of the ESBIRTES project is to identify and develop effective tools for Screening Brief Interventions and Referral to Treatment (SBIRT) for young adults presenting at the Emergency Departement (ED) with problems related to (poly)drug use. More specific, the project aims at developing an electronic version of the tool. This European project started in May 2011 and will be implemented in Belgium, the Netherlands, Hungary, Spain and United Kingdom.

ED staff will be provided with tools to deliver an e-SBIRT for clients whose substance use may put them at risk of health problems and for clients who are already experiencing substance related problems. After being treated for their acute health problem, all clients meeting the inclusion criteria will be screened. The screening can result in 3 different outcomes: low risk, moderate risk and high risk.

Clients whose score is in the low risk range receive a brief motivational advice and a link to local/national drug information website(s). Moderate-risk-clients are referred to an online self help module. Clients in the high risk range receive a brief motivational advice to find professional help. This is possible by using an online alcohol and drug specific referral guide. Those who are not motivated for referral to treatment will be directed to the self help module. For more information, please refer to www.esbirtes.eu.

5.2. Early intervention

There is an increasing interest in indicated prevention and the detection of hazardous substance misuse at an early stage.

Youngsters are 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). 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 and 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) (Baeten et al. 2009).

5.3. Self care and self-help

The DrugLijn-site contains a section with a number of online assessment-tests and online self help-programs for cannabis and cocaine users (see 3.3.3).

6. National and local media campaigns

Neither the national nor the local government did not develop new media campaigns in 2011 regarding illicit drugs.

Chapter 4.
Problem Drug Use

Bollaerts K., Hogge M. & Sasse A.

1. Introduction

In this chapter, aspects of problematic drug use following EMCDDA's current definition as 'injecting drug use or long duration or regular use of opioids, cocaine and/or amphetamines', are presented. National estimates of the prevalence 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_2012_BE_01). Characteristics of the injecting population are investigated through a yearly survey at syringe exchange in the Flemish Community (Windelinckx 2012a). Indications of problematic drug use, of which some do not strictly follow the EMCDDA case definition of problematic drug use, among persons visiting recreational settings within the French community were obtained through the survey 'Drogues Risquer Moins (Modus Vivendi).

2. Prevalence and incidence estimates of PDU

2.1. Indirect estimates of problem drug use

2.1.1. HIV-multiplier method

The benchmark-multiplier method was applied to estimate the prevalence of ever injecting drug users (aged 18-64 years) in Belgium using data from the national HIV/AIDS register and from a sero-behavioral study among injecting drug users (Plasschaert et al. 2005). However, the national HIV/AIDS register suffers from missing risk factor information and lacks follow-up of the non-AIDS cases, hampering its use as benchmark. To overcome these limitations, statistical corrections were required, which allows avoiding seriously biased estimates of the size of the injecting drug using population. In particular, imputation by chained equations (van Buuren S. et al. 1999) was used to correct for the missing risk factor information whereas stochastic mortality modelling was applied to account for the non-AIDS. Monte Carlo confidence intervals were obtained properly reflecting the uncertainty resulting from the statistical corrections (the results are reported in section 2.1.3). For a thorough presentation of the methods, the reader is referred to (Bollaerts, 2012).

2.1.2. Data sources

National HIV/AIDS register

In Belgium, HIV-screening is widely used with an average of 56 screening tests per 1000 inhabitants per year, excluding tests related to blood donations, during the period 2000-2010 (National Institute for Sickness and Invalidity Insurance). All serums of which the screening test result was positive, are submitted for confirmation to one of the seven AIDS Reference Laboratories (ARLs) in Belgium. The registration results of the seven ARLs are validated for duplicate recording and included in the national HIV/AIDS register, being hosted by the Scientific Institute of Public Health, Brussels (WIV-ISP) and which exists since 1985-86. The register is deemed to be exhaustive as the seven ARLs are the only laboratories subsidized for performing HIV confirmation tests.

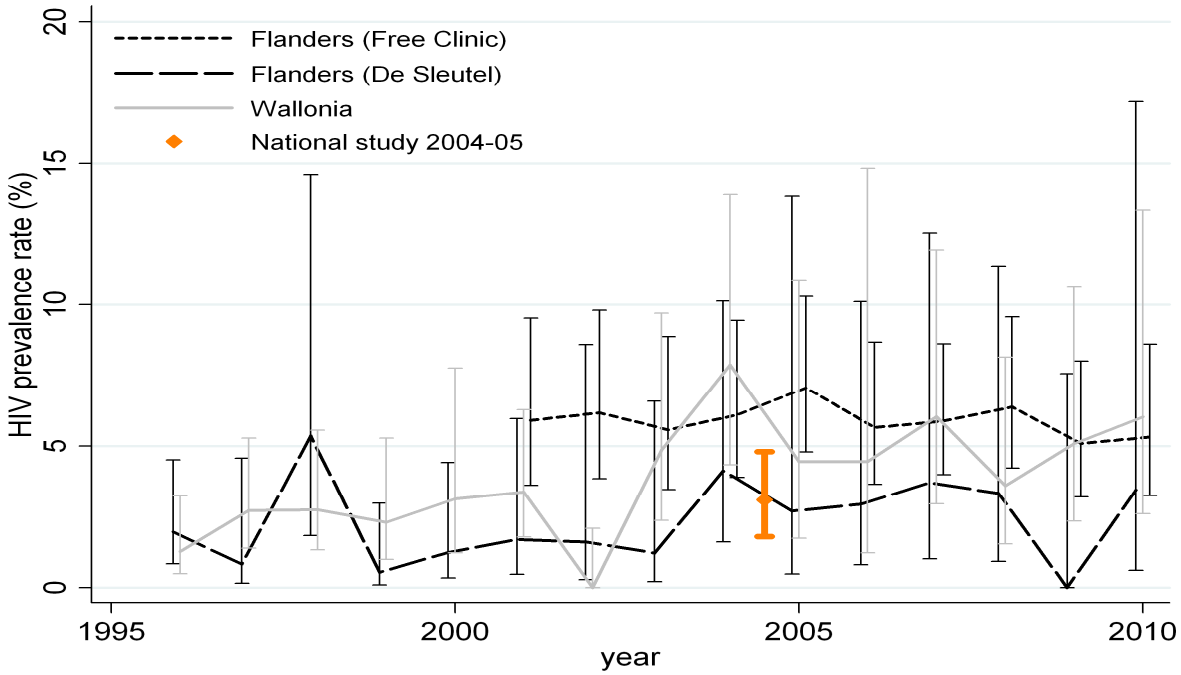
For each confirmed HIV-positive test, a standardized form is sent to the patient's clinician to collect additional information on nationality, residence, sexual orientation, probable mode of HIV transmission and CD4 count at time of HIV diagnosis. The response categories for probable mode of HIV transmission are homo- and heterosexual transmission, transmission through blood transfusion or through injecting drug use and mother-to-child transmission. Unfortunately, the standardized forms are not always fully completed returned to the WIV-ISP, resulting in missing risk factor information. Cases which developed AIDS are subject to follow-up. Each year, data is collected on last consultation and possible death. The non-AIDS cases are not subject to follow-up.

Sero-behavioral prevalence study

In Belgium, a sero-behavioral study among drug users in contact with drug treatment facilities or imprisoned was carried out in 2004-05 (Plasschaert et al. 2005). In total, 1005 drug users in treatment and 117 incarcerated drug users (15-40 years) enrolled at 65 different drug treatment facilities and 15 different prisons geographically dispersed over Belgium. 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. Intravenous blood samples were taken to determine the HIV- as well as the Hepatitis B (HBV) and -C (HCV) status of the participants. The HIV-seroprevalence 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;938]), 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]) (see figure 4.1).

In addition to serological studies, the HIV prevalence rate among IDUs can be obtained from routine diagnostic testing, of which the results are yearly available, allowing the investigation of time trends (see figure 4.1). However, a concern regarding the (geographical) representativeness of the data exists. In line with (Western) European trends (EMCDDA 2010), no significant time trends in HIV prevalence rates among IDUs were observed during the last 10 years in Belgium based on the results from routine diagnostic testing (Deprez et al. 2012). Therefore, the HIV prevalence rate from the sero-behavioral study conducted in 2004-05 (Plasschaert et al. 2005) was assumed to apply for the entire period 2000-2011.

Figure 4. 1: HIV-prevalence rates among injecting drug users and 95% Wilson's confidence intervals by year and source, 1995-2010



Sources: Walloon Region: l'Observatoire socio-épidémiologique alcool-drogues (EUROTOX), Flemish region: VAD – De Sleutel – Free Clinic, National study 2004-05: Plasschaert et al. (2005).

2.1.3. Results and discussion

The results are summarized in Table 4.1. In 2011, the prevalence rate (per 1000 inhabitants, aged 15-64 years) of ever-injecting drug use was estimated to be 3.4 (95% CI: 2.5-4.8) and the total number of ever-IDUs in Belgium to be 24,810 (95% CI: 18,286-36,896). No significant time trends were found.

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.

Table 4. 1: Numbers and prevalence rates (/1000) of ever-injecting drug use in Belgium (15-64yrs), 2000-2011

	Nr. Alive IDUs		Prevalence (/1000)	
Year	Est.	95% CI	Est.	95% CI
2000	14952	[10472;20759]	2,2	[1.6;3.1]
2001	15162	[10394;21070]	2,3	[1.5;3.1]
2002	15323	[10503;21804]	2,3	[1.6;3.2]
2003	16191	[11297;22622]	2,4	[1.7;3.3]
2004	16345	[10987;23485]	2,4	[1.6;3.4]
2005	15734	[10667;22292]	2,3	[1.6;3.3]
2006	15513	[10727;21311]	2,2	[1.6;3.1]
2007	15771	[10787;22831]	2,3	[1.5;3.3]
2008	15839	[10877;22527]	2,2	[1.5;3.2]
2009	15382	[10619;21312]	2,2	[1.5;3]
2010	15063	[10341;21052]	2,1	[1.4;2.9]
2011	24810	[18286;36896]	3.4	[2.5 ;4.8]

Source: BMCDDA

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 the Flemish Community are collected using a structured, voluntary, anonymous questionnaire since 2001 (Windelinckx 2012a). 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 2011, a total of 257 IDUs participated. The age of the participants ranged from <20 to 56-59 years, with an average age of 35.9 years. Compared to previous year, the average age of the IDUs is increasing. The majority of the participants were male (76%). Almost 25% of the IDUs live in an unstable environment (homeless, squads, etc.). The vast majority of the participants reported non-concurrent polydrug use (on average 2 different types of drugs injected, on average 4 different types of drugs used). Opiates (48%) were the primary injected drug of choice, followed by stimulant drugs (36%) and drug cocktails (15%). Compared to previous year, cocaine (2010: 41%, 2011: 47%), methadone (2010: 4.6%, 2011: 8.7%) and snowballs (2010: 19.2%, 2011: 26.6%) were more frequently injected whereas amphetamines (2010: 41%, 2011: 35.4%) were less frequently injected. Smoking of freebase cocaine was reported by 45.5% of the participants. Up to 45% of the participants reported to be initiated into injecting drug use before the age of 21 years and 66% reported to be injected by someone else during first injection. The majority of the participants reported not to have shared syringes and injecting equipment (64%) during the last month. Compared to previous year, distributive sharing with a sex partner during the last month was reported less frequently (2010: 26%, 2011: 20.5%). In total, 13% of the participants reported to have had at least one drug overdose the last year and 20.5% reported never having been in treatment.

Similar as previous years, the main concern of the researchers was the young age at initiation into injecting drug use, with 9.9% 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 getting in contact with risk and harm reduction programmes. The results of the survey apply to IDUs in contact with the syringe exchange programmes in the Flemish Community 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 Drug use within the party scene

Drug use in nightlife settings within the Flemish Community is investigated through the Partywise Uitgaansonderzoek by the VAD (Rosiers 2010), being organised the first time in 2003. Up to 2009, the research rotates every two years between qualitative research targeting professional workers and quantitative research (survey research) targeting users. Due to reorganisations at the VAD, the initially planned survey of 2011 did not take place and is postponed to 2012. From 2012 onwards, the survey will be repeated every three years. For prevalences of daily substance use within nightlife settings in the Flemish Community, 2003-2009, we refer to the previous Belgian Annual Report on Drugs (Deprez et al. 2012).

Indications regarding injecting drug use and 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. 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 prevalence of injecting drug use were stable over the years, fluctuating around 4.4% and 1.7% respectively. Polydrug use remained stable as well over the years with 9.3% (in 2011) to 14% (in 2012) 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	2005 (N=1950)	2006 (N=2402)	2007 (N=2618)	2008 (N=3917)	2009 (N=2969)	2010 (N=2111)	2011 (N= 2778)
Injecting							
Lifetime	2.7%	2.7%	3.2%	3.2%	3.5%	4.6%	4.4%
Last month	1.8%	1.7%	1.3%	1.1%	1.5%	2.1%	1.7%
During event	-	-	0.6%	0.7%	1.1%	1.2%	0.9%
Polydrug use*							
2 products**	20.6%	18.6%	16.9%	23%	18.7%	17.3%	17.0%
≥3 products**	14%	13.2%	11.5%	12.9%	10.1%	12.7%	9.3%

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

Source**:** Drogues Risquer Moins, Modus Vivendi

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

In the Flemish Community, drug use among university and high school students is investigated through the web-based survey 'In hogere sferen'. Problem drug use is in this study defined as the daily use of ecstasy, amphetamine, cocaine and cannabis among. The survey was carried out in 2005 (Van Hal et al. 2007) and in 2009 (Rosiers et al. 2011). A new wave of the survey is planned for 2013. See also Chapter 2 of previous Belgian Annual Report on Drugs (van Bussel and Antoine 2012) for more details on the survey and a description of the results for 2009 (Deprez et al. 2012).

3.4 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 and psychiatric diseases (including pychosis). 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) (Flemish Community). The most recent waves of the HBSC and the VLASPAD were carried in 2010. For a summary of the results, we refer to previous Belgian Annual Report on Drugs (Deprez et al. 2012). The next wave of the VLASPAD is planned in 2014 and of the HBSC in 2015.

Acknowledgements chapter 4:

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Chapter 5.

Drug-related treatment: treatment demand and treatment availability

Antoine J. and Van Bussel JCH.

1. Introduction

This chapter describes current drug-related treatment activities in Belgium. First, a description of the available treatment services in Belgium is provided, with a focus on ongoing treatment projects. Secondly, the in-treatment population for drug related problems and disorders is described using five data sources: the Belgian Treatment Demand Indicator register, the Flemish general practitioners network (Intego), the Minimum Psychiatric Data (MPD) recorded in Belgian psychiatric hospital services, the Minimum Clinical Data (MCD) recorded in Belgian general hospital services and the substitution treatment database.

2. General description, availability & quality assurance

2.1. Strategy/Policy

Strategies to support drug users are listed in the last joint statement of the inter-ministerial Conference on Drugs named “A global and integrated drug policy in Belgium” from January 2010 (Interministeriële Conferentie Drugs 2010) (Conférence Interministérielle Drogues 2010). The main recommendations are 1) the promotion of a global support strategy starting from a health approach and integrating other dimensions; 2) this support must provide treatment as well as care and caring; 3) the provision of a large choice of facilities, specifically dedicated to drug users or global health care and well-being services; 4) the balanced geographic repartition of the settings based on an estimation of the needs; 5) the availability of drug-free treatment, withdrawal treatment, substitution treatment, harms reduction, reintegration and post-cure; 6) the promotion of integrative treatment with attention to dual diagnosis, employment, housing, psychosocial problems; 7) the development of collaborative care networks offering general and specific treatment approaches; 8) the training of new health care workers in order to avoid waiting lists; 9) promotion of case management focused on individualized support in specific groups.

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 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) (Vereniging voor Alcohol- en andere Drugproblemen v.z.w. 2011b).

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 clients. 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-help 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 (Informatie over Drugs en Alcohol, and Information sur les Drogues et l'Alcool).

Informal care and self-help. 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 people in similar situations and the possibility of crisis intervention and weekly meetings with fellow peers. Various self-help initiatives exist related to drug addiction such as: SOS nuchterheid*:* active in 17 cities in Flanders and Brussels and via a 24h help, service and information number. Narcotics Anonymous Belgium present in 6 cities in the whole country and providing a helpline in French, Dutch and English.

The **street corner social workers** are looking for drug users in their own environment (on the street, in bars, at home, etc) and are available for help and advice. They first build a close relationship with drug users, and try to convince those having problems 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 Flemish Community and "Coin de rue" in the French Community are the 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 the Flemish Community, Centres d'action sociale globale-CASG in Wallonia), services for domiciliary care, youth advisory centre (Jongeren Advies Centra-JAC in the Flemish community, Infor-jeunes in the French Community), and public welfare centres (Openbare Centra voor Maatschappelijk Welzijnswerk-OCMW in the Flemish Community and Centre Public d'Action Sociale-CPAS in the French Community). The Alto network (part of the Scientific society of general practice) is composed with a group of general practitioners who are dealing with drug users and their relatives. The network is a meeting and formation place to support general practitioners in this problematic.

Specialized outpatient care

*Medical and Social Care Centres (*Medisch en Sociaal Opvangcentrum-MSOC or Maison d'Accueil Socio-Sanitaire-MASS) 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. Some MSOC's and MASS's also propose a needle exchange program. There are five MSOC's in the Flemish Community (Antwerp, Limburg, Oostende, Gent, Vlaams-Brabant) and four MASS's in the French Community (Brussels, Charleroi, Liège, 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 relatives or friends. 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 clients 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 and in some units psychological and medical help. These units are generally part of the commune services.

Not all *Centres for mental health care (*Centra voor Geestelijke Gezondheidszorg-CGG or Service de Santé Mentale-SSM) are specialized in the treatment of substance-related disorders. 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. Clients with more complex problems, such as dual 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 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. Clients 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. Clients 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 unit 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 illicit substances. With medical and psychiatric personnel taking a personal approach, clients 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 society. The difference with treatment in psychiatric hospitals is that the latter often use drugs/medicine to facilitate detoxification and to reduce craving and therapeutic communities are more based on educational approaches.

2.2.2. Organisation and quality assurance

In this section we will discuss about quality assurance aimed to improve the quality and effectiveness of drug treatment. First of all, the VAD review of evidence based treatment guidelines will be discussed. Secondly, the main results of two new national studies regarding effectiveness and outcome of interventions. Thirdly, we will go through the different ongoing pilot projects targeting the improvement of treatment.

The VAD review of evidence based treatment 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 critically evaluated on their methodology, intelligibility and presentation, possibility of objectives, flexibility and the independence of the authors (Vereniging voor Alcohol- en andere Drugproblemen v.z.w. 2011a). This work builds on a research project funded by the Belgian Science Policy (BELSPO) (Pham et al. 2005), from which the findings were published in a monograph (Autrique et al. 2007) including a list of reviewed guidelines. New reviewed guidelines published in 2011 and 2012 concern mainly the treatment of clients with a dual diagnosis (Snoek et al. 2012).

The ADAPT-Youth project

In 2011, a research project on “adapting best practice guidelines for the detection, prevention and treatment of substance abuse among children and youngsters to a local Belgian context” (the ADAPT-YOUTH project) was launched (Hannes et al. 2011). This project is funded by the Belgian Science Policy and is conducted by researchers from the University Leuven (Centre for Methodology of Educational Research, Belgian Centre for Evidence-Based Practice), the University of Ghent (Department of Special Education), the University of Antwerp (Department of Primary and Interdisciplinary Care), the Scientific Institute Public Health (Substance Use and Related Disorders), and the Vereniging voor Alcohol- en andere Drugproblemen. The main objective is the development of best practice guidelines for the treatment of substance misuse among children and youngsters age 12 to 25, using the

ADAPTE process. The researchers hereby postulate that “using existing guidelines as a resource may be a sensible and cost-saving alternative to de novo guideline development and an opportunity to involve relevant stakeholders in the process of adaptation to ensure maximum relevance to their particular settings” (Hannes et al. 2011).

The researchers started with a systematic review of the existing guidelines (Bekkering et al. 2012) and applied a “stepwise approach focussing on the assessment of the quality of existing guidelines, their consistency, their applicability and appropriateness for a Belgian context” (Hannes et al. 2011). In a next phase, the use of a set of draft guidelines will be piloted in a potential user groups. Based on the results of this pilot study, a final “(set of) context-specific, best practice guideline(s) on the treatment of alcohol and drug abuse among children and youngsters” will be published by the end of 2013 (Hannes et al. 2011).

The UP TO DATE research project

In 2012, a research project on the “use of alcohol, illegal drugs, hypnotics and tranquilizers in the Belgian population” (the UP TO DATE project) was launched (Vanmeerbeek et al. 2012). This project is funded by the Belgian Science Policy and is conducted by researchers from the University of Liége (Department of General Practice/Family Medicine; the Service de Santé au Travail et Education pour la Santé; Institute for Human and Social Sciences; and the Faculté de Médecine Service de Psychiatrie et de Psychologie médicale), the University of Leuven (Department of occupational, environmental and insurance medicine), the University of Antwerp (Department of Primary and Interdisciplinary Care; and the Collaborative Antwerp Psychiatric Research Institute), and the Vereniging voor Alcohol- en andere Drugproblemen. The starting point of this research is the important position and role of both general practitioners (GP) and occupational physicians (OP) in detecting and managing problems related to substance use. Subsequently, the main objective of the researchers is to know 1) what the current demand is for care in the front line; 2) to what extent GPs and OPs are involved in this problem, and 3) what resources they are able to use for providing appropriate response to all types of requests for treatment of substance abuse (Vanmeerbeek et al. 2012). The first work package of this project is the collection within practices of GP’s of epidemiological data focusing on the problematic use of alcohol, illegal drugs, hypnotics and tranquilizers, and the employment status. The researchers planned this data collection to take place in the first half of 2013 by the "Sentinel GPs’ network" of the service Health Care Research of the Scientific Institute of Public Health (WIV-ISP).

Pilot-projects

Three on-going pilot-projects related to drug treatment are funded by the Cell Drugs of the Federal department Health (DG1): the project “Community Reinforcement Approach” (CRA); the project “Intensive treatment of patient with dual diagnosis” and the project “Treatment Assisted by Diacetylmorphine”. The fourth project “Polysubstance use” is financed by the Belgian Science Policy.

A study is conducted in the outpatient centre De Kiem in Ghent. The aim of the study is to compare the Community Reinforcement Approach (CRA) + vouchers treatment method to the standard treatment method for cocaine users. Drug users are 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 €1,265 in a six-month period if they can prove their abstinence, by means of a saliva test. If they cannot, the participants receive a ticket worth €2,50. 18 drug users were tested with this new treatment and 16 with the old treatment. Results reported by Vanderplasschen and colleagues (Vanderplasschen et al. 2011) 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%).

The chance to be abstinence was 3 times higher in the CRA + vouchers group six months after the beginning of the treatment. On the other hand, the use of products such as alcohol and cannabis is higher in the CRA + voucher group. Encouraged by these good results, the authors of the study recommend the further development of this type of treatment for cocaine users (Vanderplasschen et al. 2011).

The project Intensive treatment of patients with dual diagnosis was launched in 2002 in two dual 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 clients with a substance-related disorder and psychotic disorders. Results show that an intensive and integrated treatment of young adults presenting a dual 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). This pilot project is prolonged until March 2013.

The first heroin-assisted treatment in Belgium started in Liège in January 2011. The "Treatment Assisted by Diacetylmorphine" study (TADAM) is an open-label randomised controlled trial comparing a heroin-assisted treatment with the existing oral methadone treatment for 200 participants. The TADAM project originated from a claim by the public services of the city of Liège, supported by methadone centres, that a new heroin-assisted treatment could help heroin addicts where methadone treatment is unsuccessful. The introduction of the TADAM trial was recommended in Liège owing to the significant number of heroin addicts and to the availability of the methadone treatment. However, the enrolment of the 200 participants is expected to be difficult so that an inclusion period of 12 months will be necessary. In addition, as the TADAM project targets clients who already participated in methadone treatment, collaboration of the physicians and the institution treating the participating clients will be essential to the success of the trial (Demaret et al. 2011).

The objectives of the research project on polysubstance use are the mapping of the prevalence and the characteristics of polysubstance use in treatment centres. The project also wants to explore the extent and type of psychiatric complaints and disorders among persons following substance abuse treatment, and to compare the characteristics and psychiatric profile of polysubstance users with that of persons who only use one substance. A final report with results from all studies conducted has been published (Vanderplasschen et al. 2012). Overall, the various sources indicate a high prevalence of polysubstance use and misuse and a high comorbidity of psychiatric problems among treatment seeking persons. According to the researchers, the significant association between polysubstance use and mental health problems prompts an adapted approach at conceptual, methodological, organisational and policy level (Vanderplasschen et al. 2012).

3. Access to treatment

3.1. Characteristics of treated clients (BTDIR data included)

3.1.1. The BTDIR registration

The TDI registration in Belgium was officially approved by the inter-ministerial conference on Public health in 2006 (Conférence interministérielle Santé publique 2006) (Interministeriële Conferentie Volksgezondheid 2006) and a new Belgian TDI protocol was adopted in 2010. This protocol became operational on January 1st 2011 for centres offering treatment for

persons with a substance-related disorder. This protocol is based on the EMCDDA Protocol version 2 (Simon et al. 2000).

The registration concerns all treatment episodes followed by a client in a treatment centre for his problem with illicit drugs as well as alcohol. Around twenty variables are collected about socio-demographic data, treatment history and addiction profile of clients. More variables can be registered in function of the type of centres and their specific needs. There are actually 4 types of forms based on a basic minimal common version. The identification of clients is made through the use of their national identification number. The privacy commission approved this protocol and the use of the national identification number after its coding by a trusted third party (Comité sectoriel de la sécurité sociale et de la santé.Section "Santé" 2010;Sectoraal comité van de Sociale Zekerheid en van de Gezondheid.Afdeling "Gezondheid" 2010;Comité sectoriel du Registre national 2011;Sectoraal comité van het Rijksregister 2011). This allows to avoid double counting and to achieve longitudinal follow-up of the clients.

The specialized residential (ST_TDI_2012_BE_02) and ambulatory centres (ST_TDI_2012_BE_01) are using since 2011 an online form to encode their clients or are sending their formatted file containing all records through a repository module. Around 60 centres are participating to this TDI registration.

In addition, 25 hospitals also have been invited to test the TDI registration through a pilot-project running from august 2011 to august 2012.

Even though 52.3% of the records in the TDI register concern alcohol problematic, this will not be presented here. We are only discussing the illicit drug data.

Description of clients starting treatment in 2011 at national level

The total number of clients registered in 2011 through the BTDIR was 6526. A large majority of clients (68.1%) was registered in outpatient centres, 22.7% in inpatient centres and 9.2% in low-threshold agencies. Table 5.1 shows the number of clients in treatment by main substance and by gender. The unknown gender records were not indicated.

Table 5. 1: Absolute number and relative proportion (%) of persons starting treatment in Belgium, by main illicit substance and gender (2011)

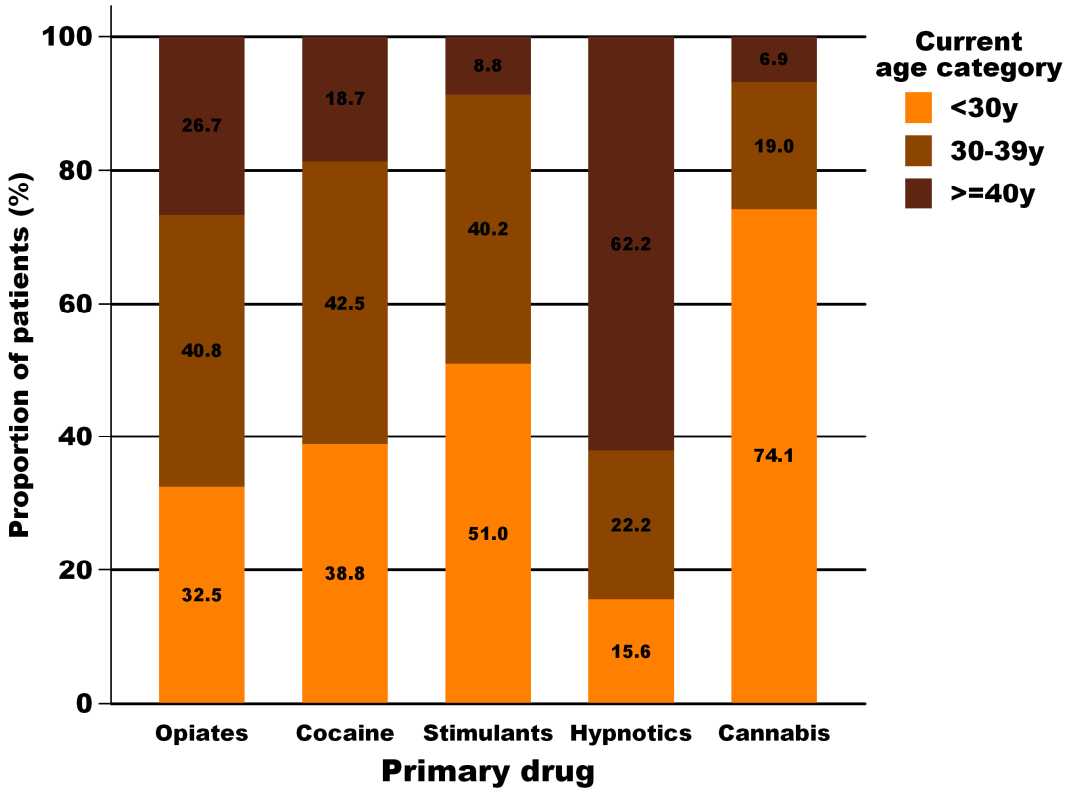
Main substance	Male		Female		Total	
	N	%	N	%	N	%
Opiates	2115	42,4	464	30,3	2579	39,5
Cocaine	794	15,9	195	12,7	989	15,2
Stimulants	543	10,9	271	17,7	814	12,5
Hypnotics and Sedatives	246	4,9	292	19,1	538	8,2
Hallucinogens	4	0,1	2	0,1	6	0,1
Volatile inhalants	7	0,1	3	0,2	10	0,2
Cannabis	1205	24,1	250	16,3	1455	22,3
Other substances	66	1,3	37	2,4	103	1,6
Not known/Missing	14	0,3	18	1,2	32	0,5
Total	**4994**	**100.0**	**1532**	**100.0**	**6526**	**100.0**

Source: BTDIR, 2012.

The main illicit substances for which a client went into treatment were opiates (in 39.5% of the treatment demands) and cannabis (22.3%). The other substances were cocaine (15.2%), stimulants such as amphetamines (12.5%), hypnotics and sedatives (8.2%).

Figure 5.1 represent the age distribution of clients in treatment by primary illicit drug. Clients in treatment for hypnotics are the oldest: 62.2% of them are aged 40 years or older. On the opposite end of the spectrum, clients in treatment for cannabis are the youngest, with 74.1% of them being under the age of 30. The percentage of new clients under the age of 30 who are being treated for a stimulant-, cocaine- or opiate-related disorder, is 51.0%, 38.8%, and 32.5%, respectively.

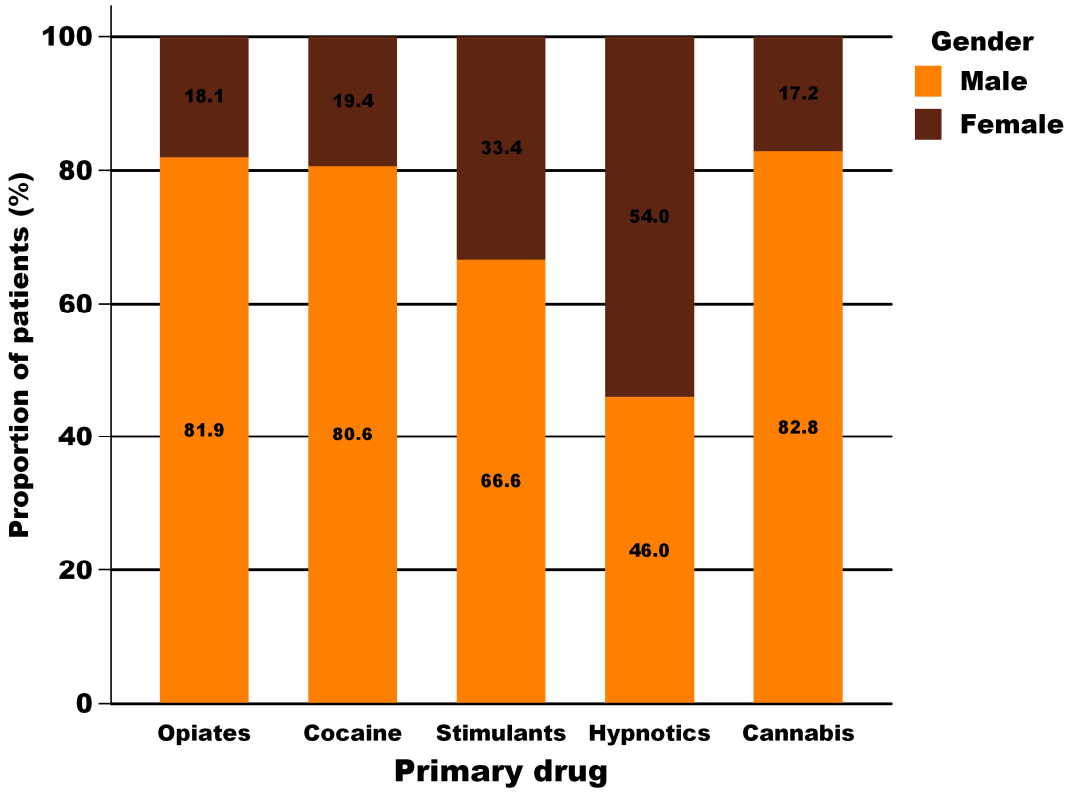
Figure 5. 1: Relative proportion (%) current age of persons in treatment in Belgium for illicit substance use, by primary illicit drug (2011)



Source: BTDIR, 2012.

The gender distribution of clients in treatment by primary illicit drug is presented in Figure 5.2. Clients in treatment for the misuse of hypnotics are the group with the greatest percentage of women (54.0%), followed by patient in treatment for stimulants (33.4%). The percentages of women among clients in treatment for opiates, cocaine or cannabis are 18.1%, 19.4%, and 17.2%, respectively.

Figure 5. 2: Relative proportion (%) of gender of persons in treatment in Belgium for illicit substance use, by primary illicit drug (2011)

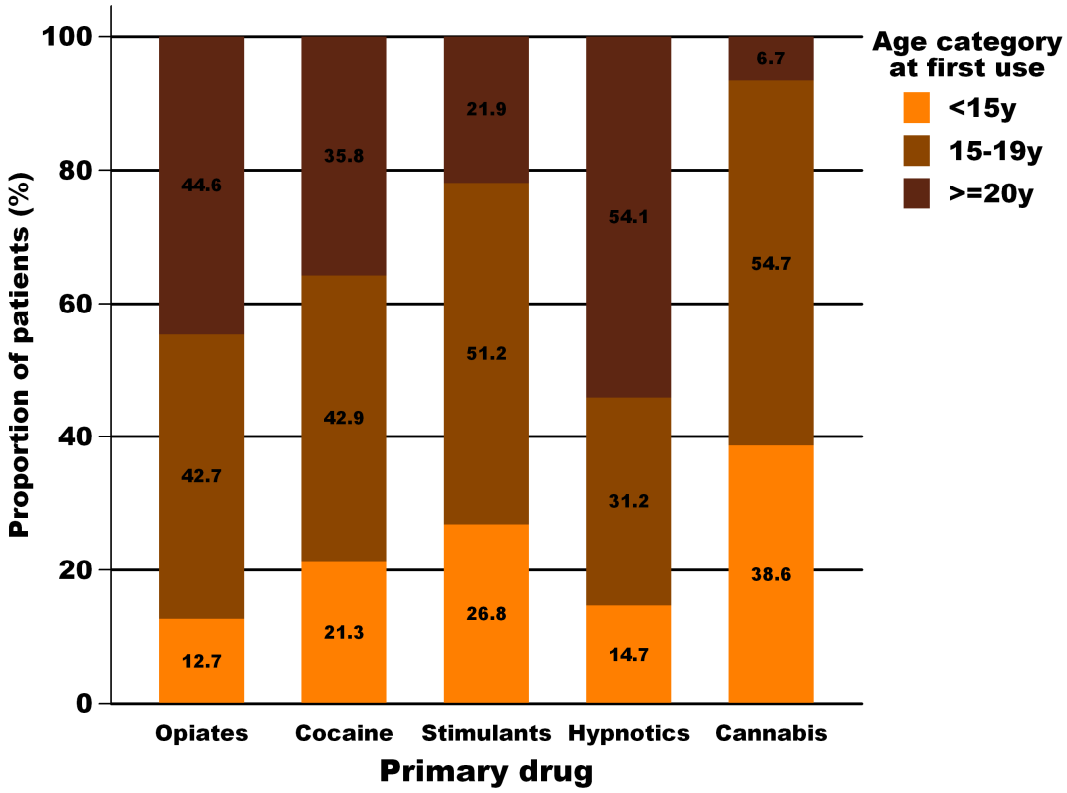


Source: BTDIR, 2012.

Figure 5.3 describes the relative proportion of the age at first use by substance type. Cannabis and stimulants are the substances used for the first time at the earliest age. The proportion of clients using the substance for the first time before the age of 15 is 38.6% and 26.8% for cannabis and stimulants respectively. The age of first use is higher for opiates, cocaine, and hypnotics users. In these cases, the proportion of clients having consumed the substance for the first time after the age of 20 is 44.6%, 35.8%, and 54.1%, respectively.

The injecting behaviour of clients is important to highlight the risk behaviour of drug users. Among clients in treatment, 18.6% of men and 15.7% of women have already injected substances during their life (currently doing or previously) and 6.3% of men and 4.6% of women are currently injecting substances (at least once during last month).

Figure 5. 3: Relative proportion (%) of age at first use of persons in treatment in Belgium for illicit substance use, by primary drug (2011)



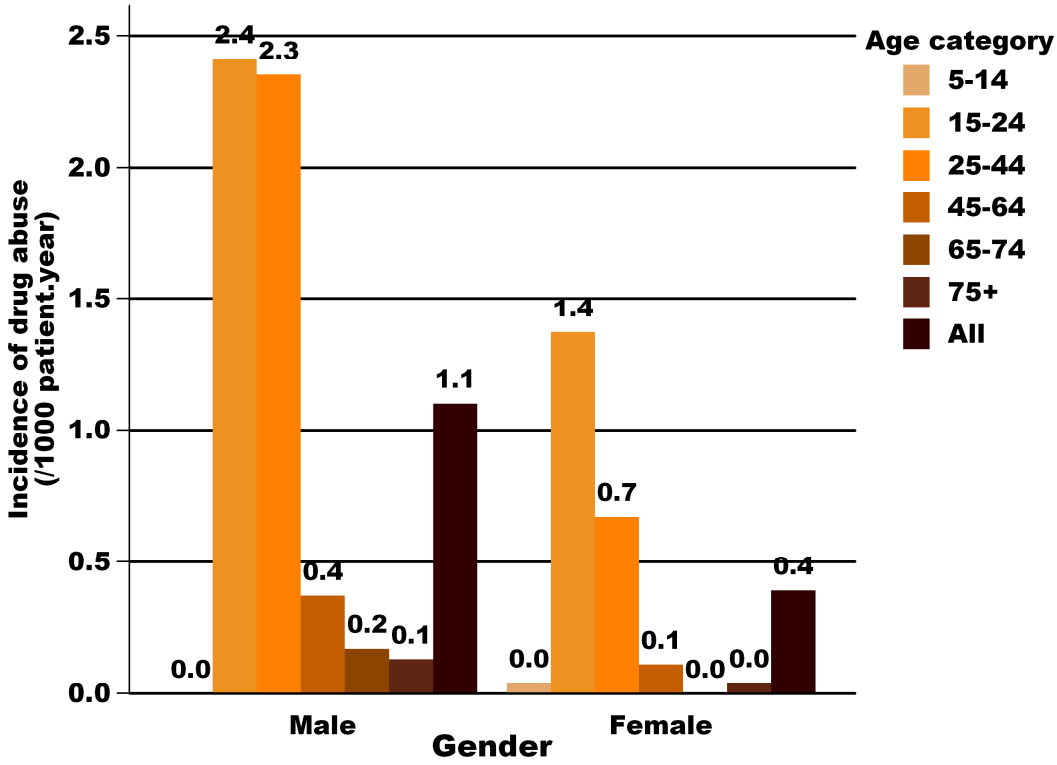
Source: BTDIR, 2012.

3.1.2. Clients entering primary care

Since 1994, an integrated computerised network called INTEGO (Department of general practice 2011), hosted by the Academisch Centrum voor Huisartsgeneeskunde (ACHG) of the University of 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, illicit drug misuse (code P19) is considered here to assess the proportion of clients going to their general practitioner with an illicit drug misuse problem. As for 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 years, standardized for the Flemish population of 2008.

Figure 5.4 shows the repartition per age category and sex for the period 2008-2010. During this period, 330 diagnosis of illicit drug misuse were registered in the network. The incidence is highest for males in both age categories 15-24 (2.4 per 1000 patient.year) and 25-44 years old (2.3 per 1000 patient.year). For females, the highest rate is for the age category 15-24 (1.4 per 1000 patient.year) and is divided by 2 in the next age category 25-44 (0.7 per 1000 patient.year). Incidence is 3 times lower for females compared to males, all ages confounded (0.4 per 1000 patient.year vs 1.1 per 1000 patient.year for males).

Figure 5. 4: Incidence (‰) of illicit drug misuse diagnosis by Flemish general practitioners, by age category and gender (2008-2010)



Source: Intego.be, 2011

3.1.3. Clients in psychiatric hospital services

The Minimum Psychiatric Data (MPD) is a registration system by the Belgian Federal department of Health (HFDPSE DG1, Data management), collecting data of every psychiatric inpatient admission. This registration was made compulsory for all psychiatric hospitals or psychiatric units 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 89,273 in 2010. Of the 5,038 (5.2%) (see table 5.2) admissions registered in 2010, 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, 2012). The most prevalent main diagnosis was polysubstance dependence (37.5%), followed by opioid (28.1%), cannabis (9.4%), cocaine (5.4%), amphetamine (4.1%), other or unknown substance (2.6%), hallucinogen (0.2%), and inhalant (0.1%) related disorder (dependence).

Table 5. 2: Relative proportion (%) of admissions with an illicit substance related disorder as main diagnosis in Belgian psychiatric hospital services (1998-2010)

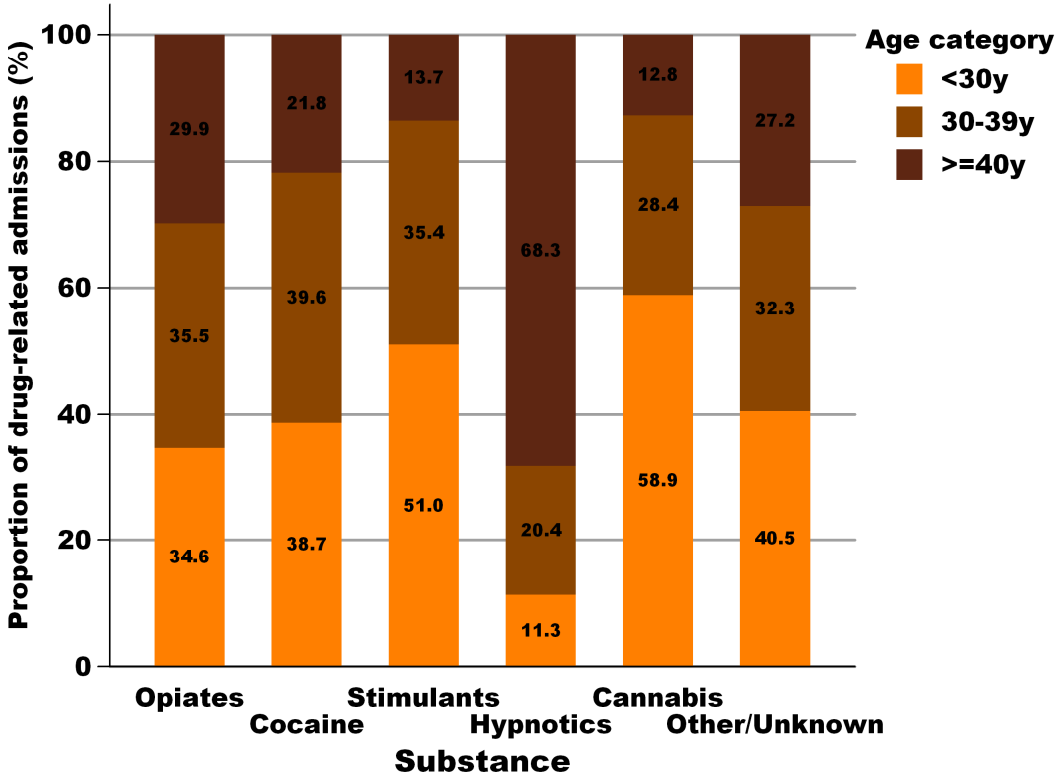
	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
	%	%	%	%	%	%	%	%	%	%	%	%	%
Opioid													
dependence (304.00)	12.7	14.8	15.8	17.5	17.3	16.5	15.9	14.5	17.5	16.8	18.0	29.7	28.1
abuse (305.50)	4.3	3.3	3.0	3.1	3.2	2.4	2.2	2.8	2.4	2.0	1.7	1.3	1.3
Cocaine													
dependence (304.20)	3.9	5.3	5.3	6.5	6.5	8.4	7.6	6.5	8.8	8.3	9.8	5.4	5.4
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	2.1	2.2
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	9.6	9.4
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	4.8	4.6
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	3.6	4.1
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	2.1	2.4
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	0.2	0.2
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	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	0.1	0.1
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	37.9	37.5
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	1.7	2.6
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	1.6	1.8

Total (N)	**2912**	**3395**	**3182**	**3601**	**3591**	**4213**	**4075**	**4260**	**4500**	**4655**	**4533**	**5057**	**5038**

Source: MPD (FPSHFDSE DG1, 2012)

Figure 5.5 shows the proportion of all substance-related admissions by substance and by age category in 2010. 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).

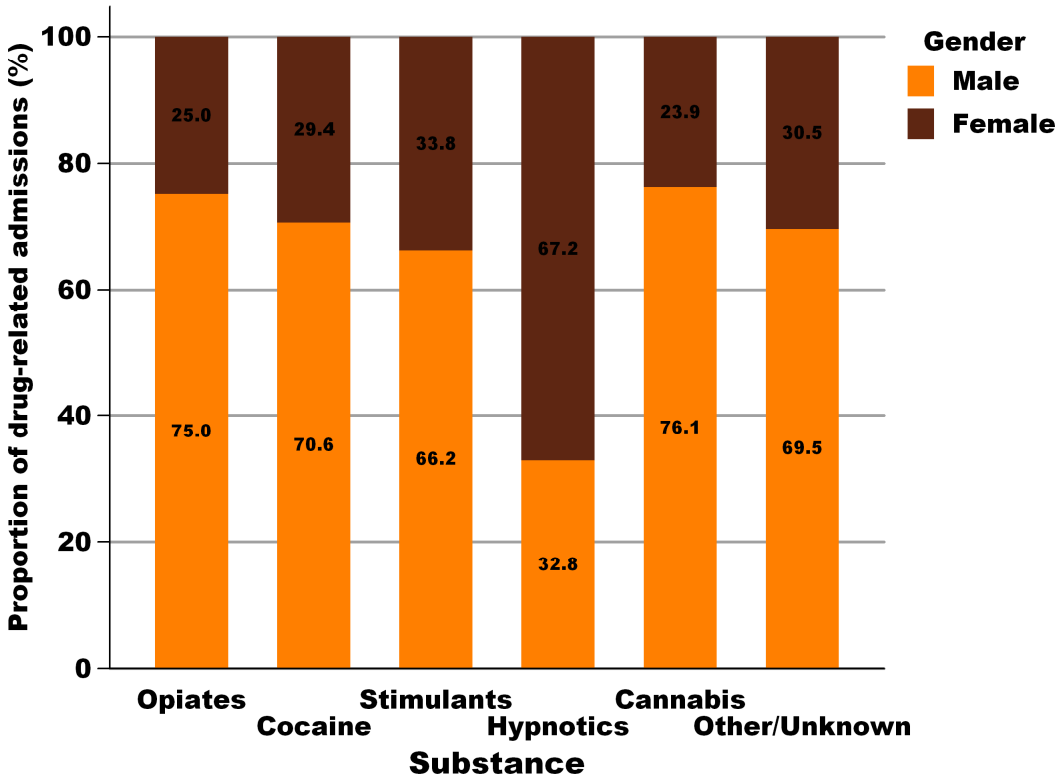
Figure 5. 5: Relative proportion (%) of drug-related admissions by age category and substance in Belgian psychiatric hospital services (2010)



Source: MPD (FPSHFDSE DG1, 2012)

Figure 5.6 presents the proportion of substance-related admissions in 2010 by gender and substance. Compared with the BTDIR data, the proportion of women is more important. Where the proportion of women is around 20% for Opiates and Cocaine in BTDIR data, this proportion is around 25-30%. There is also a high proportion of women entering an hospital for a hypnotics-related disorder (67.2%) where this proportion was only 36.3% in the BTDIR.

Figure 5. 6: Relative proportion (%) of drug-related admissions by gender and substance in Belgian psychiatric hospital services (2010)



Source: MPD (FPSHFDSE DG1, 2012)

In 2011, Windey and Gorissen visualized for each Belgian district the difference between the number of substance-related admissions registered in the MPD 2008 and the number of substance-related admissions expected for these districts, using the Standardised Admission Ratio. The results were summerized in the 2011 Belgian Annual Report (Antoine and van Bussel 2012). An update of these calculations based on the MPD data 2010 is expected to be available in the beginning of 2013 and will be reported in next Belgian Annual Report.

3.1.4. Clients in general hospital services

Substance-related admissions (both in- and outpatient) are also registered in Belgian general hospitals and collected in the Minimum Clinical Data register (MCD). This registration of the Federal department of Health (DG1, Data management), uses the International Classification of Diseases - Version 9 - Clinical Modification, (ICD-9-CM). The integration in 2008 of the MCD in the broader MHD resulted in a substantially higher number of registered admissions. Therefore, comparisons with results of previous years should be made cautiously. As for the recent registration periods, the quality of the MHD is found to be satisfactory (Gilbert et al. 2004;Terryn et al. 2007;Aelvoet 2008). For the results reported hereafter, multiple registrations for the same patient were excluded on hospital level.

In 2008, 13,906 patients were admitted with a substance related disorder diagnosis (both main and secondary) (ICD-9-CM 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). The most prevalent diagnosis was opioid dependence (21.6%). Dependency and abuse of “sedative, hypnotic or anxiolytic” related disorders were diagnosed in respectively 14.0% and 13.5% of the patients. Cannabis dependency and abuse accounted for 11.8% and 10.4% of the substance related diagnoses. Less prevalent disorders were cocaine, amphetamine, hallucinogen, and other or unknown substance related disorders (See Table 5.3). More detailed analyses on the sociodemographical characteristics of the patients’ admitted in Belgian general hospitals are foreseen in next years’ Belgian Annual Report.

Table 5. 3: Relative proportion (%) of clients admitted with an illicit substance related disorder in Belgian general hospital services (1998-2008)

	2000	2001	2002	2003	2004	2005	2006	2007	2008
	%	%	%	%	%	%	%	%	%
Opioid									
dependence (304.00)	19.3	17.3	16.6	17.8	19.6	18.5	20.3	19.9	21.6
abuse (305.50)	1.7	2.4	1.7	2.0	2.0	2.4	2.8	3.8	3.4
Cocaine									
dependence (304.20)	4.4	3.7	4.5	5.0	5.3	5.6	6.8	7.7	8.4
abuse (305.60)	1.5	2.1	2.4	2.9	2.8	2.6	3.4	4.2	4.1
Cannabis									
dependence (304.30)	4.4	5.2	8.1	7.6	11.8	9.9	11.3	13.9	11.8
abuse (305.20)	1.8	2.7	4.6	7.1	6.9	10.0	10.7	13.1	10.4
Amphetamine									
dependence (304.40)	1.2	0.9	1.0	1.4	1.7	1.9	2.0	1.6	2.1
abuse (305.70)	0.8	1.8	1.5	0.8	1.9	2.5	2.2	2.6	2.2
Hallucinogen									
dependence (304.50)	0.4	0.1	0.2	0.1	0.4	0.2	0.2	0.2	0.2
abuse (305.30)	0.7	0.5	0.4	0.8	0.7	0.5	0.3	0.5	0.4
Sedative, hypnotic or anxiolytic dependence									
dependence (304.60)	9.5	8.9	9.4	9.8	10.2	10.2	9.2	8.2	14.0
abuse (305.30)	11.1	10.3	11.8	8.8	8.9	8.6	11.0	8.7	13.5
Combinations of drug dependence									
With opioids (304.80)	0.7	1.1	1.5	2.2	3.6	4.0	2.6	1.4	1.4
Without opioids (305.30)	1.0	1.2	1.8	1.2	1.7	1.1	1.6	2.3	1.6
Other (or unknown) substance									
dependence (304.90)	12.2	8.7	7.2	8.9	6.3	5.3	5.1	4.3	4.9

unspecified dependence (304.90)									
abuse (305.90)	31.2	33.3	27.2	23.8	21.9	23.1	19.0	17.9	15.9
Total (N)	**1063**	**1141**	**1367**	**1729**	**1918**	**2043**	**2049**	**2215**	**13906**

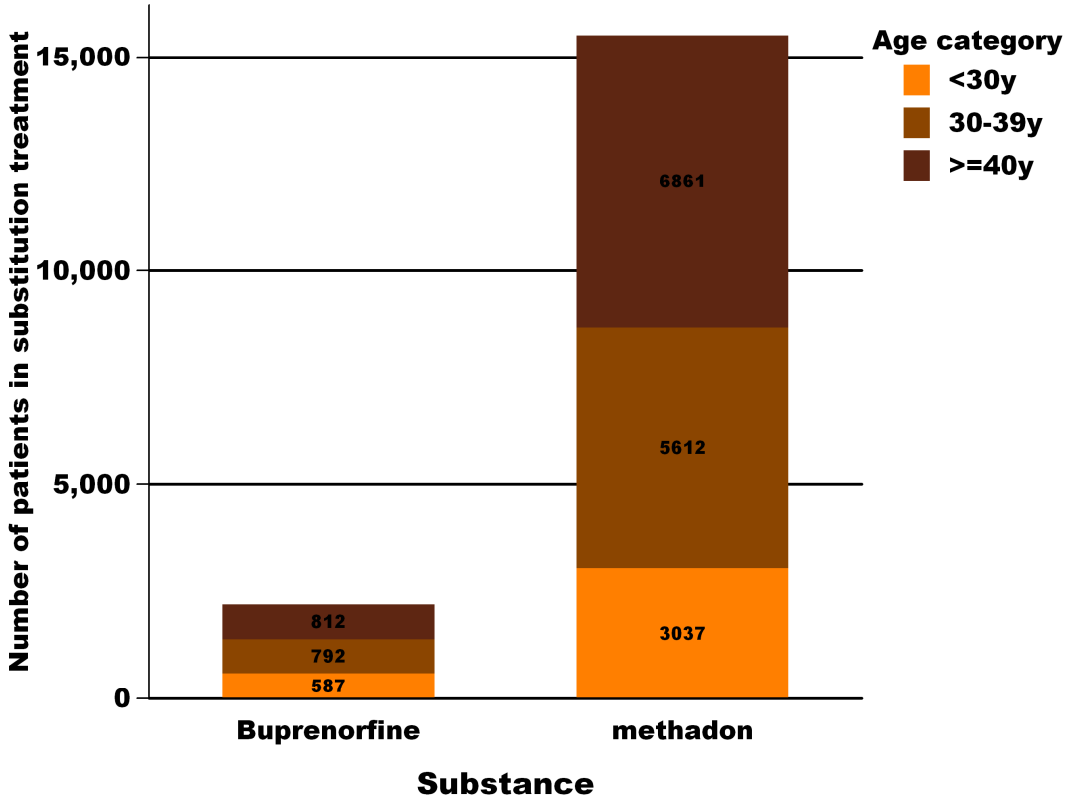
Source: MCD (FPSHFDSE DG1, 2012)

3.1.5. Clients receiving 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 (Federale Overheidsdienst Volksgezondheid 2004;Service public fédéral Santé publique 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 5.7 represents the number of clients undergoing a substitution treatment in 2011, by age category and by substance. Of the 15,510 persons in treatment for methadone, 19.6% were younger than 30, 36.2% were between the ages of 30 and 39, and 44.2% were over the age of 40. Among those in treatment with buprenorphine (n=2,191), 26.8% were under the age of 30, 36.1% were between the ages of 30 and 39, and 37.1% were over the age of 40.

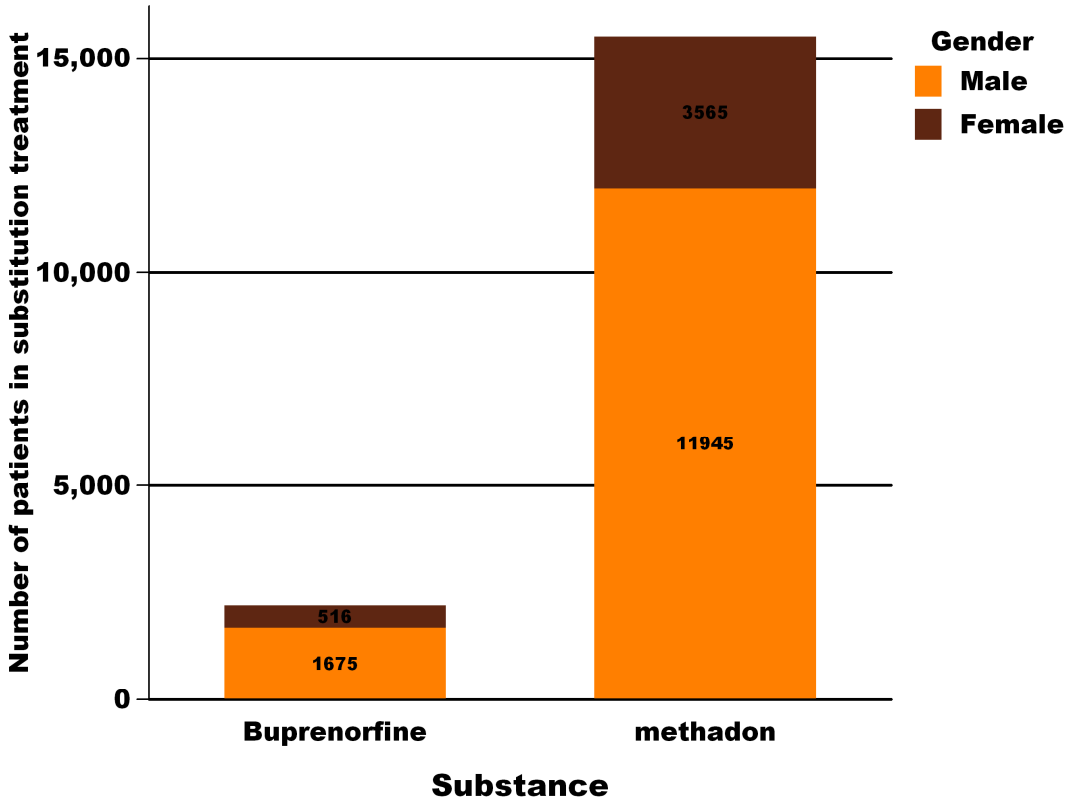
Figure 5. 7: Number of clients in substitution treatment in Belgium, by substance and age category (2010)



Source: Pharmanet, 2012

In Figure 5.8 the proportion of women in substitution treatment is relatively the same for both substances: 23.6% for buprenorphine and 23.0% for methadone.

Figure 5. 8: Number of clients in substitution treatment in Belgium, by substances and gender (2010)



Source: Pharmanet, 2012

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

3.2.1. Clients in the TDI register

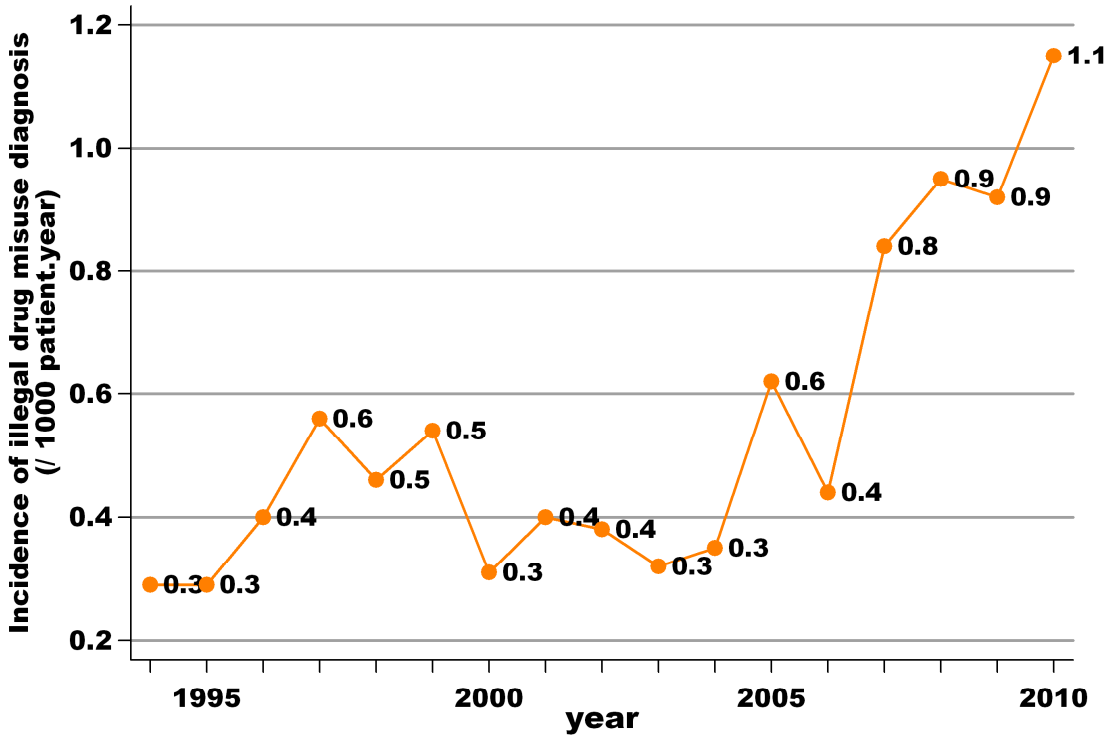
As the TDI register only started in a new version of the registration since 2011, no trend data are available for the moment. We will be able to produce trend analysis from next year on.

3.2.2. Clients entering primary care

Figure 5.9 indicates the incidence of illegal drug misuse diagnoses for the years 1994 - 2010. Noteworthy is the fact that the registration guidelines in primary care were improved the last 10 years. As consequence, since a few years family doctors are more alert and willing to register the diagnoses of substance misuse or dependency. Between 1994 and 2006 the incidence varied around 0.5 per 1000 patient.year (from 0.29 per 1000 patient.year in 1994 to 0.62 per 1000 patient.year in 2005) and the last four years, incidence reached almost 1.0 per 1000 patient.year (0.84 per 1000 patient.year in 2007 to 1.15 per 1000 patient.year in

2010. As mentioned earlier, no differentiation by substance is available for the INTEGO registration.

Figure 5. 9: Incidence (‰) of illegal drug misuse diagnosis by Flemish general practitioners between 1994 and 2010



Source: Intego.be, 2012

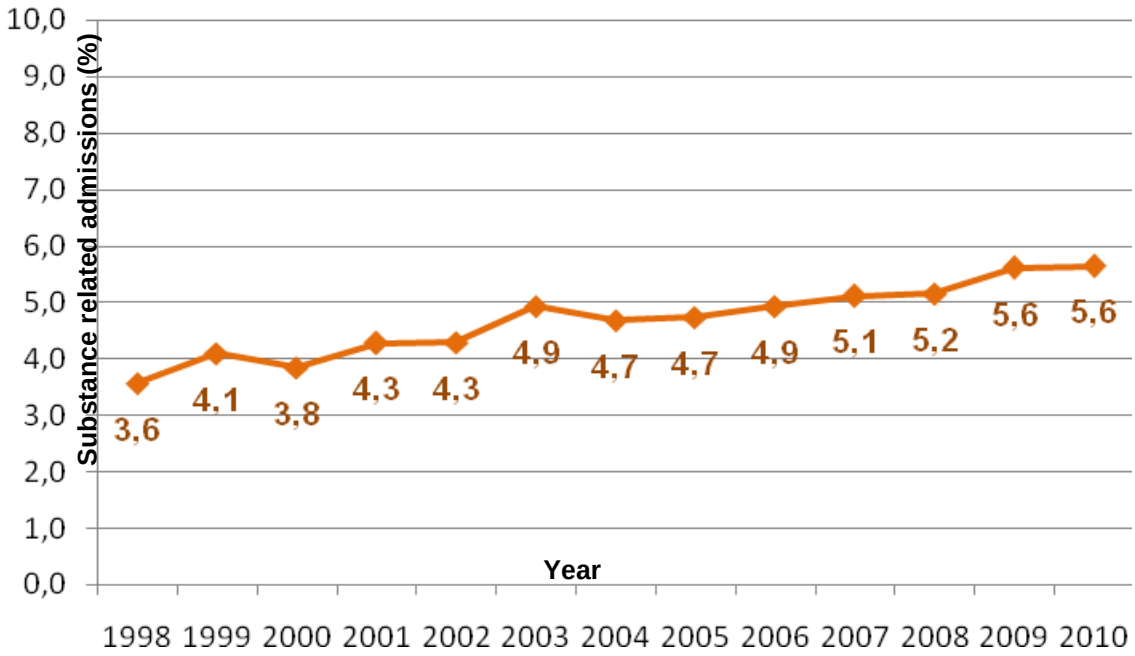
3.2.3. Hospitalized clients

In psychiatric hospital services, 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 between 1998 (3.6%) and 2010 (5.6%) (Gorissen, 2012). Certanly if you know that the diagnoses became more accurate the last years, this increase is relatively small and constant over the years (Figure 5.10). An increase was found for opioid dependence, cocaine dependence, cocaine abuse and cannabis dependence as main diagnosis (Table 5.2). 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.

Given the previously reported methodological changes, trend analysis based on the data of the general hospital services should be made cautiously. In spite of this limitation, one can conclude that opioid, cannabis and "sedative, hypnotic or anxiolytic" related disorders remain the most prevalent disorders admitted in Belgian general hospitals since the first year of registration (2000) (Table 5.3). Also, cannabis and cocaine related admissions clearly increased from 2000 and 2008. In contrast, hallucinogen related disorders remain a marginal problem and even tend to further decrease.

A publication by the Substance Use and Substance Related Disorders program of the WIV-ISP and the Federal department of Health (DG1, Data management), with a detailed analysis of the trends in the drug-related admissions based on the MCD and MHD is in progress and will be summerized in next year's annual report.

Figure 5. 10: Relative proportion (%) of substance-related admissions (main diagnosis) in Belgian psychiatric hospital services (2000-2010)



Source: MPD (FPSHFDSE DG1, 2012)

Acknowledgements chapter 5:

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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 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 2012a) 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 2000-2009/10 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

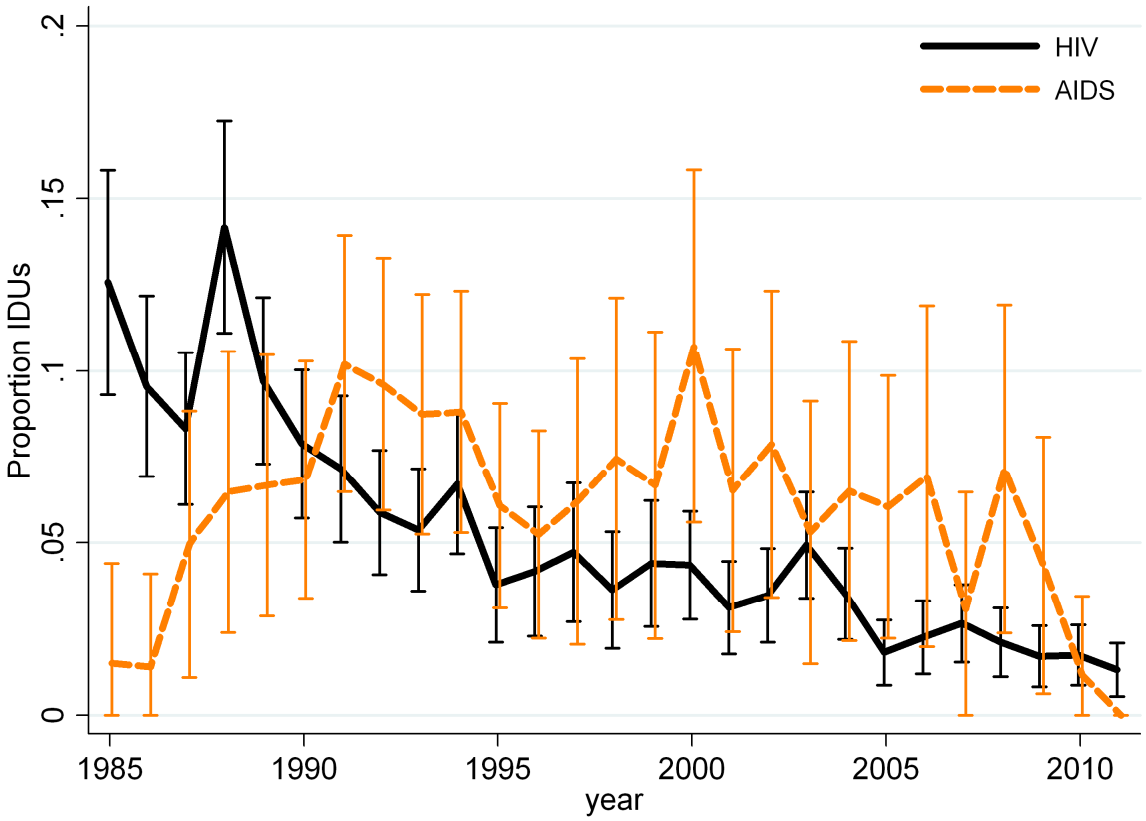
2.1.1. National AIDS/HIV register

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 sero-positive 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 to be exhaustive.

In 2011, 11 persons newly diagnosed with HIV, reported intravenous drug use as the probable mode of HIV transmission, yielding a percentage of 1.3% (95% CI:0.5%-2.1%) of the persons newly diagnosed with HIV being probably attributable to injecting drug use. Potentially as a result of reporting delay, no new AIDS diagnoses related to injecting drug use were reported for 2011. 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 (see 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, 1985-2011



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

2.1.2. HIV diagnostic testing

The prevalence rate of HIV-sero-positivity among ever-IDUs at treatment and other diagnostic settings, as collected through Standard Table 9, was obtained based on mainly self-reported data in the Walloon region and serological data in the Flemish region. However, the results from the Walloon region for 2011 can not be considered as representative due to recent changes in registration and the resulting small sample size. For the Flemish regions, the prevalence estimates are 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). The data from De Sleutel and Free Clinic are not fully comparable due to differences in testing and reporting, as a result of differences in patient population and clinical setting. De Sleutel, treating clients for a relatively short period of time, collects serological information for

clients entering treatment whereas Free Clinic, a low threshold centre following up clients for several years, (repeatedly) collects serological information on all clients. For the Flemish region, the HIV prevalence rate in 2011 was estimated to be 8.3% (N = 48) and 4.6% (N =328) based on test results of blood screening collected through De Sleutel (an institution of several ambulatory and residential treatment centres located throughout the Flemish Community) and through Free Clinic (an outpatient clinic located in Antwerp city). An overview of the prevalence rates for the period 2005-2011 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, 2005-2011

	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)	0.0% (N = 47)	5.1% (N = 118)
2010	5.3% (N = 282)	3.4% (N = 29)	6.0% (N = 83)
2011	4.6% (N = 328)	8.3% (N=48)	0.0% (N=36)

* prevalence rates based on self-reporting

Source: ST9P2_2006-2012_BE

2.1.3. The Sentinel Laboratory Network (SLN)

The Sentinel Laboratory Network (SLN), coordinated by the Scientific Institute of Public Health (WIV-ISP), collects demographic and laboratory data on 40 infectious diseases since 1983 (Ducoffre et al. 2010). Due to ongoing optimizations of the network, the responsible persons of the Belgian SLN network decided not to report on hepatitis B and C notifications for the year 2011.

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 2004-2011 are given in Table 6.2 and Table 6.3, respectively. Regarding Hepatitis B, 3.7% (Free Clinic) and 4.3% (De Sleutel) of the clients tested in 2011, tested positive for HbsAg, 55.1% (Free Clinic) and 16.7% (De

Sleutel) for antiHBC and 52.3% (Free Clinic) and 81.5% (De Sleutel) for antiHBs. Regarding Hepatitis C, 81.5% (Free Clinic) and 42.3% (De Sleutel) of the clients tested positive for HCVab in 2011. 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 2011 prevalences with previous years, does not reveal significant time trends.

Table 6. 2: Prevalence rate of Hepatis B among ever-IDUs at treatment and other diagnostic settings, Free Clinic – De Sleutel, Flemish Community, 2004-2011

		2004	2005	2006	2007	2008	2009	2010	2011
Free Clinic									
HBsAg	**%**	3.5%	3.0%	1.5%	2.6%	4.0%	4.2%	2.8%	3.7%
	N	255	330	334	307	328	336	281	326
antiHBc	**%**	58.3%	58.8%	55.0%	53.5%	57.3%	56.1%	56.3%	55.1%
	N	252	323	329	303	323	330	277	323
antiHBs	**%**	48.8%	50.5%	-	-	50.2%	51.8%	55.2%	52.3%
	N	252	327	-	-	327	334	279	327
De Sleutel									
HBsAg	%	0%	0%	0%	0%	1.9%	0%	0%	4.3%
	N	89	35	63	45	54	44	29	47
antiHBc	%	16.7%	8.1%	15.8%	25.0%	2.6%	7.1%	0.0%	16.7%
	N	66	37	38	28	38	28	22	36
antiHBs	%	15.9%	10.8%	12.3%	11.1%	18.4%	25.0%	20.0%	25.5%
	N	88	37	57	45	49	40	30	47

Source: ST9P2_2005-2012_BE

Table 6. 3: Prevalence rate of Hepatis C among ever-IDUs at treatment and other diagnostic settings, Free Clinic – De Sleutel, Flemish Community, 2004-2011

		2004	2005	2006	2007	2008	2009	2010	2011
Free Clinic									
HCVab	**%**	76.0%	80.7%	78.7%	80.1%	80.9%	80.9%	80.0%	81.5%
	N	258	337	342	311	335	345	295	340
De Sleutel									
HCVab	%	37.5%	50.0%	36.2%	34.0%	27.0%	30.4%	28.1%	42.3%
	N	96	38	69	53	63	46	32	52

Source: ST9P2_2005-2012_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 2011, 11 out of the 287 clients (3.8%) tested positive for syphilis (ST9P2_2012_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 French community. 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 9.5 cases per 100.000 person years in 2009. In 2010, an increase was observed with an incidence rate of 10.3 per 100.000 person for that year. In 2011, the incidence rate was at the same level as in 2009 with again 9.5 registered cases per 100.000 person years. The highest incidences in 2011 were observed for Brussels (31.4/100.000), Antwerp (19.2/100.000), Liège (19.5/100.000) and Charleroi (19.2/100.000). Of the 1044 cases registered in Belgium in 2012, 81% (N=849) had known risk factor of which 1.3% (N=11) was 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 programs located in the Flemish Community have been collected using a structured, voluntary, anonymous questionnaire (Windelinckx 2011). Every IDU contacting one of the syringe exchange programs 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 6.4. In 2011, the majority of the participants reported not

having shared syringes with sex partners (receptive: 83%, distributive: 79%). Not sharing other injecting equipment during the last four weeks is less frequently reported: spoons (receptive: 60%), water (receptive: 55%) and filters (receptive: 62%). These results are in line with the results from 2010.

Table 6. 4: Responses to the Injecting Risk Questionnaire (IRQ), Spuitenruil Vlaanderen, 2011

During the last 4 weeks, how often have you …	N	0	1	>2	Don't know
shared injecting equipment?	257	64%	11%	16%	9%
given used needle/syringes to a sexual partner?	190	79%	12%	8%	0%
lent used needle/syringes from a sexual partner?	188	83%	12%	5%	0%
injected with needles/syringes that had already been used by someone else?	254	77%	12%	4%	8%
filled your syringe from one that already been used by someone else (frontloading/backloading) ?	255	78%	13%	7%	2%
used a spoon that has already been used by someone else?	258	60%	18%	17%	5%
drawn up from a container or spoon into which someone else had put a used syringe?	258	60%	18%	17%	5%
used a filter into which someone else had put a used syringe?	256	62%	16%	16%	6%
used the same water or bleach as someone else for flushing out?	256	55%	17%	22%	6%
used old syringes that had been kept in the same container as someone else's old syringes?	255	74%	7%	10%	8%
During the last 4 weeks, with how many different people have you shared injecting equipment?	251	56%	26%	10%	

Source: Spuitenruil Vlaanderen (Windelinckx, 2012)

Similar as before, the percentage of participants who claimed not to have shared needles/syringes is lower compared with previous years. As such, the researchers (Windelinckx 2012a) 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 behavior.

2.3.2. Risk behaviour in Injecting Drug Users recruited at the street in the French Community

Data on risk behaviour among Injecting Drug Users in the French community is collected using “snowball operations” (opérations 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-hours 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 6.5 for the years 2004-2011. 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’ and because the questionnaire is mainly a contact tool for which the completion is not truly standardized. Moreover, the geographic coverage of snowball operations may vary from year to year depending on the supply and demand of harm reduction activities at local level. Nevertheless, the results indicate that injecting risk behavior remains common among the recruited sample, with the last-six month percentage of receptive needle/syringe sharing varying from 13.8% to 42.4% during the period 2004-2011. The time trends of these percentages are difficult to interpret due to the limits exposed above. 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 behaviors, they clearly indicate that extreme injecting risk behavior is not ruled out.

Table 6. 5: Injecting Risk behaviour among street-recruited Injecting Drug Users, Modus Vivendi (Opérations Boule de Neige), French Community, 2004-2011

Year	2004	2005	2006	2007	2008	2009	2010	2011
Sample size	**451**	**405**	**135**	**236**	**228**	**119**	**196**	**63**
During the last 6 months, did you …								
injected with needles/syringes that had already been used by someone else?	28.8%	30.4%	30.4%	42.4%	31.1%	33.6%	13.8%	19.0%
injected with needles/syringes found at the street?	3.1%	7.4%	6.7%	5.9%	5.7%	0.8%	1.5%	1.6%
use injecting equipment already used by someone else?	43.2%	50.9%	47.4%	53.8%	56.6%	29.4%	26.0%	31.7%
given or lent used needles/syringes to someone else?	34.8%	32.1%	32.6%	38.6%	35.1%	20.2%	24.0%	17.5%
given or lent used injecting equipment to someone else?	37.5%	37%	31.1%	25.8%	26.3%	21.0%	35.2%	34.9%

Source: Eurotox

2.3.3. Risk behaviour in Injecting Drug Users in prison

See Chapter 9, Section 5.2.

3. Other drug-related health correlates and consequences

3.1. Non-fatal overdoses and drug-related emergencies

3.1.1. Telephone enquiries related to drug intoxications

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. An overview of the number of telephone enquiries received by substance, 2009-2011, is given in Table 6.6. In 2011, 346 telephone enquiries were related to drug intoxications (Dr. Mostin, personal communication). For 67% of the enquiries (N= 232), only one substance was involved, of which the majority was related to cannabis and their

derivates (N=50) and to ethanol-based products (N=35), which is comparable with previous years.

Table 6. 6: Number of telephone enquiries received by the Belgian national Poison Centre by substance, Belgium, 2009-2011

	2009	2010	2011
Illicit substance related inquiries	299	337	346
Multiple substances	97	124	114
One substance, of which	202	213	232
Ethanol based products	27	24	35
Inhalants/solvents	12	21	19
Nitrites/poppers	11	6	11
Cannabis	34	32	50
GHB/GBL	14	20	12
Cocaine	24	18	16
Heroin/opiates	15	17	15
Amphetamine/CNS stimulants	16	13	17
Ecstasy	4	9	10
New synthetic drugs	0	7	2
Synthetic cannabinoids	0	0	0
Ketamine**			4
Mushrooms/hallucinogenic plants**			8
LSD**			4
Other/unknown	45	46	29
Total	**53,272**	**51,152**	**25.861**

** These substances were included in the class 'Other/unknown' for the years preceding 2011.

Source: NPC 2011

3.2. Other topics of interest

3.2.1. Psychiatric co-morbidity

Psychiatric co-morbidity registered in Belgian psychiatric hospital services

The Minimum Psychiatric Data (MPD) is a registration system by the Belgian Federal department of 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 and psychiatric services within general hospitals in 1996 and for psychiatric nursing homes in 1998. The unit of registration is admission and not patient.

In 2010 (see table 6.7), 1.7% (n=1,510) of all admissions in psychiatric services, were diagnosed as having primarily a substance induced disorder (DSM-IV code 292), a decrease compared to 1998 (n= 1853, 2.3%), but an increase compared to the two most recent registration periods (Table 6.7). The most prevalent sub diagnosis was substance induced anxiety disorder (73.6%), 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 amnestic disorders (0.5%), and substance induced persisting dementia (0.4%).

Table 6. 7: Admissions (%) with an illicit substance induced disorder as main diagnosis in Belgian psychiatric hospital services (1998-2010)

	1998 %	1999 %	2000 %	2001 %	2002 %	2003 %	2004 %	2005 %	2006 %	2007 %	2008 %	2009 %	2010 %
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	7.1	7.0
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	9.6	6.8
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	5.0	4.1
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	2.5	4.4
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	0.1	0.1
Substance induced persisting amnestic 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	0.2	0.8
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	1.2	1.2
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	71.7	73.6
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	2.6	2.0
Total (N)	**1853**	**1649**	**1646**	**1567**	**1566**	**1460**	**1384**	**1428**	**1381**	**1427**	**1245**	**1345**	**1510**

Source: MPD (FPSHFDSE DG1, 2012)

Psychiatric co-morbidity registered in Belgian general hospital services

Substance-related admissions (both in- and outpatient) are also registrated in Belgian general hospitals and collected in the Minimum Hospital Data (MHD, previously Minimum Clinical Data register, MCD). This registration of the Belgian Federal department of Health (DG1, Data management), uses the International Classification of Diseases - Version 9 - Clinical Modification, (ICD-9-CM). The integration in 2008 of the MCD in the broader MHD resulted in a substantially higher number of registered admissions. Therefore, longitudinal interpretations should be made cautiously. As for the recent registration periods, the quality of the MHD is found to be satisfactory (Gilbert et al. 2004;Terryn et al. 2007;Aelvoet 2008) In 2008, 3,483 clients admitted in a Belgian general hospital, were diagnosed as having primarily a substance induced disorder (DSM-IV code 292) (Table 6.8). The most prevalent sub diagnosis was Substance intoxication delirium (43.5%), followed by substance withdrawal (31.2%), substance induced psychotic disorder + hallucinations (10.4%), and substance induced anxiety disorders (8.9%). Other subtypes were less prevalent.

Table 6. 8: Admissions (%) with an illicit substance induced disorder as main diagnosis in Belgian general hospital services (2000-2008)

	2000 %	2001 %	2002 %	2003 %	2004 %	2005 %	2006 %	2007 %	2008 %
Substance withdrawal (292.0)	48,5	47,3	40,8	43,8	36,4	33,8	29,7	30,3	31,2
Substance induced psychotic disorder + delusions (292.11)	1,0	3,3	5,6	6,9	2,1	2,1	2,5	2,7	1,9
Substance psychotic disorder + hallucinations (292.12)	10,1	8,8	8,8	5,6	7,0	7,9	11,0	7,7	10,4
Substance intoxication delirium (292.81)	26,3	22,0	32,0	30,6	41,7	31,3	35,2	34,9	43,5
Substance induced persisting dementia (292.82)	4.0	3.3	3.2	1.4	2.1	0.4	0.0	0.8	0.7
Substance induced persisting amnestic disorders (292.83)	0.0	1.1	0.0	0.7	0.0	0.4	0.4	0.8	0.2
Substance induced mood disorders (292.84)	0.0	2.2	4.0	0.0	2.1	2.9	0.9	1.9	0.8
Substance induced (anxiety) disorders (292.89)	5.1	12.1	5.6	11.1	6.4	5.4	5.9	9.2	8.9
Substance -related disorders NOS (292.9)	7.1	3.3	1.6	2.8	3.7	20.4	16.5	14.6	5.7
Total (N)	**99**	**91**	**125**	**144**	**187**	**240**	**236**	**261**	**3483**

Source: MHD (FPSHFDSE DG1, 2012)

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 the Flemish Community. As part of the intake interview, the European Addiction Severity Index (EuropASI), is administered to all clients 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 (dual diagnosis) is estimated by cross-classifying clients 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'. Clients were then classified as 'moderate dual 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. Clients were classified as 'severe dual 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 2006-2011. For 2011, half the clients entering treatment (53.9%) were classified as dual diagnosis clients, with 12.0% classified as suffering from severe dual diagnosis. These prevalences are comparable with previous years and confirm that psychiatric co-morbidity is common among illicit substance users.

Table 6. 9: Prevalence of psychiatric co-morbidity of clients entering treatment (De Sleutel), the Flemish Community, 2006-2011

	2006	2007	2008	2009	2010	2011
Sample size	631	639	651	814	581	668
Dual diagnosis (%)						
Moderate	37.9%	40.8%	32.9%	37.0%	41.1%	41.9%
Severe	13.9%	12.1%	16.7%	13.6%	12.7%	12.0%
Total	51.8%	52.9%	49.6%	50.6%	53.8%	53.9%

Source: De Sleutel: Lombaert, personal communication

4. Drug-related deaths and mortality of drug users

4.1. Drug-related deaths in the general population

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, centralizes 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 were the death occurred (*de facto* information). Data on drug-induced deaths among non-residents are available at national level.

Recent national data are missing as a result of delays at the level of the Walloon region. 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 could only be obtained from the administration of the Flemish and Brussels Capital region. Data on drug-induced deaths among non-residents are not provided at regional level.

Cases of drug-induced deaths were extracted from the 2000-2009/2010 regional mortality databases using the EMCDDA “Selection B” case definition (European Monitoring Centre for Drugs and Drug Addiction 2009). 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.

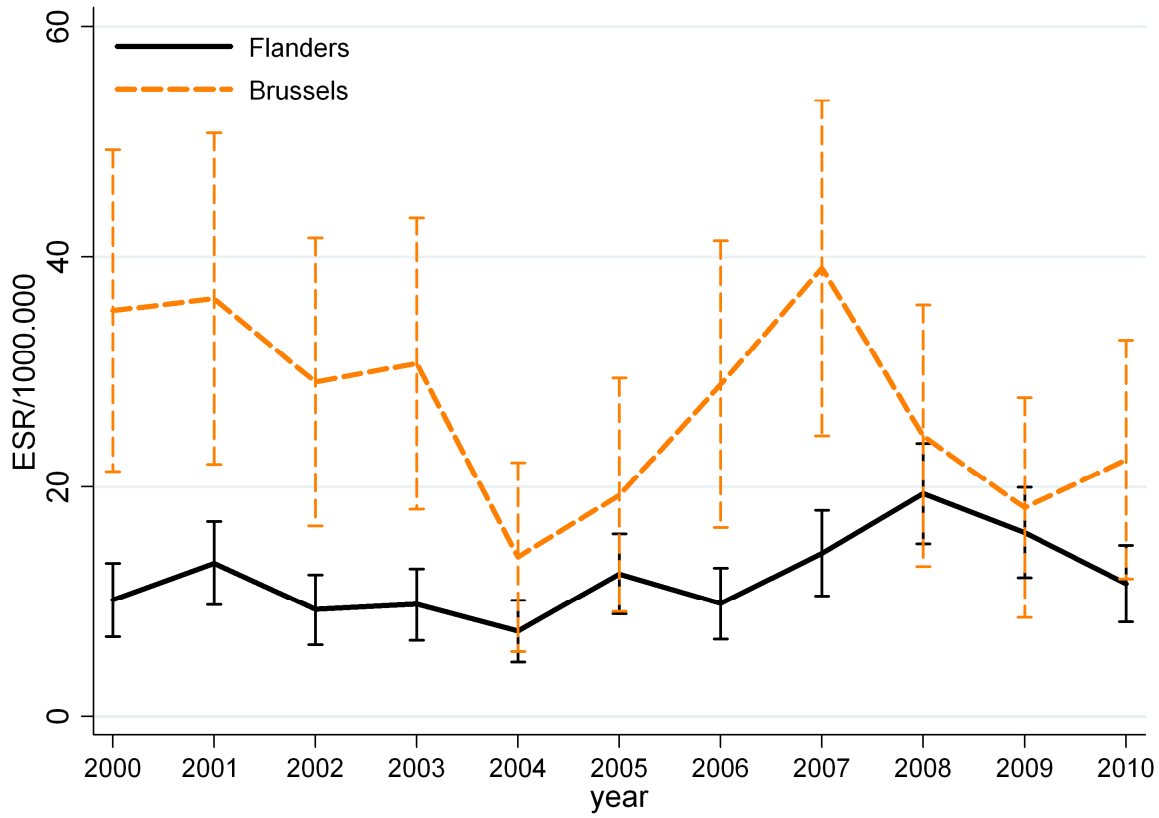
The number of drug-induced deaths by year and region are summarized Table 6.10. In 2010, 46 drug-induced deaths were observed in the Flemish region and 18 in the Brussels Capital region. The standardised (European Standard Population) drug-induced mortality rates per 1000.000 inhabitants are shown in Figure 6.2, indicating that the mortality rates are generally higher in the Brussels Capital Region compared to the Flemish Region. These differences (although no longer significant the last 3 years) are explained by differences in urbanisation degree, with the Brussels Capital Region being the more urbanized. For both the Flemish and Brussels capital region, no clear time trends were observed.

Table 6. 10: Number of drug-induced deaths (15-64yrs) based on the General Mortality Registers (Selection B) for the Flemish and Brussels Capital region, 2000-2010

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Flanders	39	52	36	38	30	49	39	56	76	64	46
Brussels	25	25	22	23	12	14	24	28	19	14	18

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

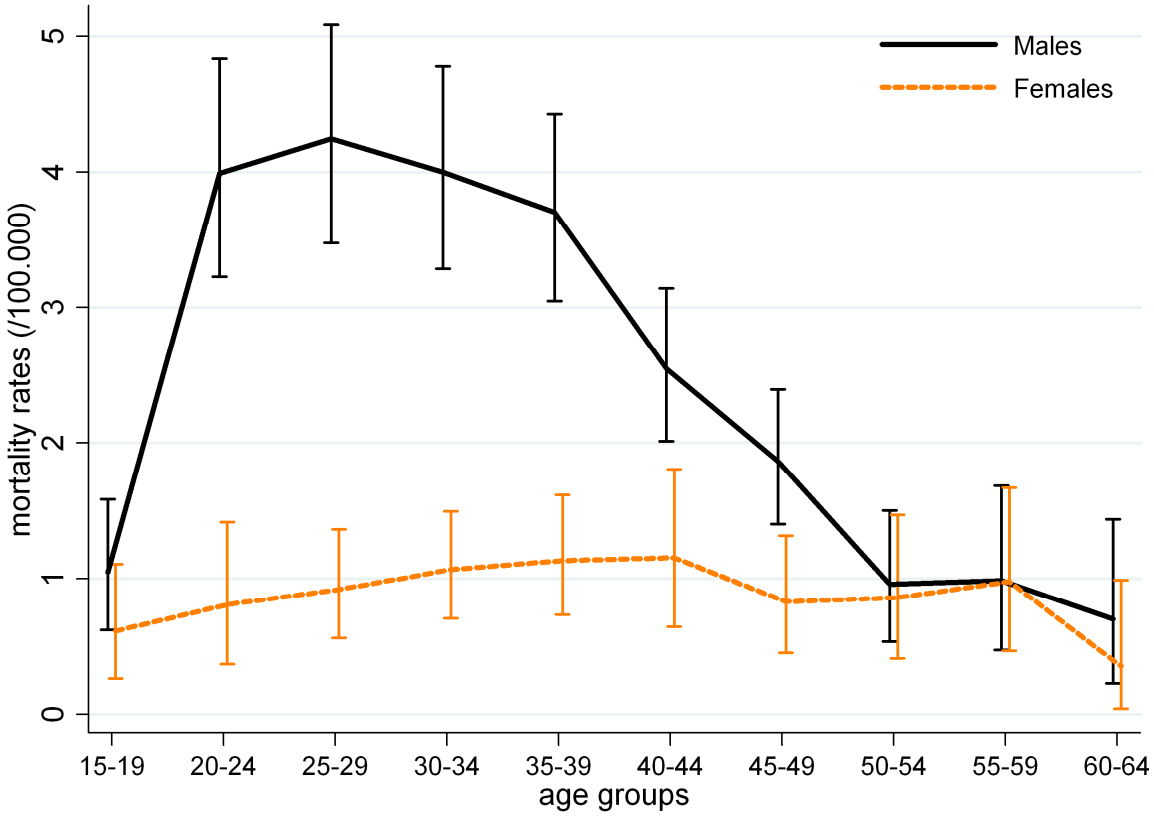
Figure 6. 2: Standardized drug-induced mortality rates (15-64yrs) and 95% confidence intervals by year and region, Flemish and Brussels capital region, 2000-2010



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

The age- and sex-specific crude drug-induced mortality rates are given in Figure 6.3. 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: Age- and sex-specific crude drug-induced mortality rates (per 1000.000 person years), Flemish and Brussels capital region, 2000-2010



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

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Chapter 7.

Responses to health correlates and consequences

Bollaerts K. and Blanckaert P.

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. Also, a comprehensive overview of the Belgian Early Warning System on Drugs alerts and information messages relayed to the network is provided. Finally, the syringe exchange programmes are discussed.

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

2.1. Emergencies

In Belgium, crisis care services are available for drug users who find themselves in a crisis (a state of acute psycho-emotional disequilibrium).

First, there is the national pilot project for the crisis and case management of clients 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 around Belgium (Antwerp, Brussels, Ghent, Genk, Leuven, Bruges, Liège, Namur and Mons). Within these centres, special attention is given to continuing health care. From 2011 onwards, the centres register the number of admissions and the length of stay for every admission on a monthly basis. In 2011, a total of 2649 admissions were reported by the centres. Correcting for missing registrations by single average imputation, this total mounts to 3846 admissions for the year 2011. The average length of stay was 3.4 days and the average occupation degree was 93% and 75% for the short interventions (< 4 hours) and the interventions with overnight, respectively.

Second, crisis intervention in specialising drug treatment centres exists in Belgium since 1980. The so-called Crisis Intervention Centres (CICs) accredited 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 December 2011, the average day capacity of clients available at the 8 CICs geographically dispersed over Belgium, raised from 77 to 81 clients per day (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.

2.2 Drug related deaths

2.2.1. Early Warning System

The Belgian Early Warning System on Drugs (BEWSD) is coordinated in Belgium by the Belgian Monitoring Centre for Drugs and Drug Addiction (BMCDDA) at the Scientific Institute of Public Health (WIV-ISP), and is a partner of the European EWS Reitox network, authorized by the EMCDDA. The functioning of the BEWSD was described in detail in the Belgian Annual Report 2011.

To summarize, in Belgium, most of the information reaching the BEWSD results from the analysis of drug samples seized by Belgian law enforcement authorities (federal and local police services, customs, …), or the reporting of clinical or post-mortem samples, usually in a hospital setting. To this end, a total of 20 laboratories (clinical and/or toxicological) participate in the BEWSD-network, and regularly report their analysed drug data. Most seized drug samples in Belgium are analysed by 4 or 5 specialised toxicological laboratories (mainly comprising university laboratories and the National Institute of Criminalistics and Criminology). Although there is one initiative where drug users can submit drug samples to have them tested (Modus Vivendi), this initiative is rather small-scale, and this approach is only implemented in the French speaking part of the country, not throughout Belgium. Exact information on the contents of circulating street drugs in Belgium is thus usually not available. However, the seized drugs data provides a good approximation, as is evident from the large numbers of new psychoactive substances (psychoactive substances not included in the 1971 United Nations Convention on Psychotropic Substances) that are detected each year in Belgium.

The target audience of the BEWSD-network includes different partners: toxicological and clinical laboratories, the regional focal points and prevention and harm reduction services (VAD, Eurotox, PFCSM-OPGG and SPZ), the federal government (police services, the Federal Agency for Medicines and Health Products, the drug department of the Federal department of “Health, Food Chain Safety and Environment), all forensic pathologists and the emergency departments of all hospitals in Belgium.

Table 7. 1: Overview of warnings sent by the Belgian Early Warning System on Drugs (BEWSD) in 2011

Author	Method	Date	Drugs involved	Description
BEWSD	Email to network	January	Speed/amphetamine	One casualty and one severe intoxication after the consumption of possibly contaminated speed/amphetamines
BEWSD	Email to network	January	MDMA	Seizure of several high-dosed MDMA tablets (containing 163-191 mg of MDMA base)
BEWSD	Email to network	February	JWH-019 and MDPV	Detection of two new psychoactive substances in Belgium: JWH-019 and MDPV
BEWSD	Email to network - message in public media	April	Cocaine	Two deaths occurred in the southern part of the country after consumption of cocaine with very high purity
BEWSD	Email to network	May	Cocaine and MDMA	Analysis of cocaine of unusually high purity (> 95%) and tablets with high MDMA content (151 mg)
BEWSD	Email to network	August	MDPV	Two cases of severe MDPV intoxications (psychotic clients armed with knifes) were reported
BEWSD	Email to network	October	4-methylamphetamine	3 casualties due to the use of 4-methylamphetamine were reported, together with 3 acute intoxications
BEWSD	Email to network	December	3-amino-1-phenyl-butane	A white powder (sold as 'speed') was collected from a user and analysed. 3-amino-1-phenyl-butane, a new substance in Europe and Belgium, was identified

Source: Database BEWSD.

In 2011, 8 "official" warnings were sent by the BEWSD to the network regarding new psychoactive substances or dangerous combinations of drugs or high concentrations of classic illicit drugs. An overview is provided in table 7.1. Apart from these EWS alerts, the BEWSD regularly transmits information on a smaller scale regarding new psychoactive substances appearing in Belgium and Europe, specifically to the toxicological and clinical-biology laboratories, to keep their chemical (mostly GC/MS) libraries updated and thus allow them to analyse and adequately detect or confirm these substances.

The warnings sent out by the BEWSD are relayed further to workers in-the-field by the regional focal points VAD and Eurotox. VAD and Eurotox also have internet fora, where drug field workers can post messages regarding developments or dangerous trends observed among drug users. To this end, VAD uses a forum, whereas Eurotox uses a designated Yahoo-group to further disseminate these messages and acquire information from prevention/healthcare workers in the field. The focus in these messages is on the prevention aspect. Table 7.2 provides an overview of the information messages disseminated in 2011 by the regional focal points Eurotox and VAD.

Table 7. 2: Overview of information distributed by the regional prevention services VAD and Eurotox in Belgium in 2011

Author	Method	Date	Psychoactive substances involved	Description
VAD	Forum - EWS Alert	January	Speed	Contaminated speed in circulation
VAD	Forum – EWS Alert	January	MDMA	High-dosed MDMA tablets in circulation
Eurotox	Yahoo group	March	PMMA	Request for more information regarding tablets containing PMMA
VAD	Forum – EWS Alert	March	PMMA	Relaying the message about the circulation of PMMA tablets in the Netherlands
Eurotox	Yahoo group	April	Cocaine	Information regarding cocaine of exceptional purity in circulation
VAD	Forum – EWS Alert	May	MDMA/cocaine	High dosed MDMA tablets and cocaine of exceptional purity in circulation
Eurotox	Yahoo group	June	MDMA	Notification of high-dosed MDMA tablets in circulation (“triangle” logo)
VAD	Forum – EWS Alert	October	4-methylamphetamine	Informing the professional network of the 3 deaths and 3 intoxications in Flanders after the use of speed contaminated with 4-methylamphetamine
Eurotox	Yahoo group	October	“Crocodile” (desomorphine)	Clarifying the rumours about “Crocodile” reaching the EU and Belgium
VAD	Forum – EWS Alert	December	3-amino-1-phenyl-butane	Notification of new substance in Belgium

Source: VAD EWS forum; Eurotox Yahoo group.

During the course of 2011, 43 new psychoactive substances were reported to the BEWSD in Belgium by the participating laboratories. Two major classes of new psychoactive substances were reported in Belgium for 2011: synthetic cannabinoids (11 cannabinoids) and synthetic cathinones (13 cathinones, including pentedrone, pentylone and MDPV). Further, mostly new phenethylamines (e.g. 2-C-X derivatives and substituted amphetamine derivatives including 4-methylamphetamine) and piperazines (mCPP,…) were reported. Also, one new substance (3-amino-1-phenylbutane) was for the first time reported in Europe after discovery of a sample in Belgium.

To improve the impact of the BEWSD-communications towards the different partners, the BEWSD is currently in the process of streamlining and categorising/classifying its EWS-messages, according to severity/perceived threat, to achieve EWS-messages tailored to the specific target population. For example, analytical chemistry data regarding new psychoactive substances are of little to no interest to prevention services and medical emergency departments; however, they are very important for the toxicological laboratories to keep up their detection capabilities in the ever-changing field of new synthetic psychoactive substances. Also, non-targeted messaging implies that some of the BEWSD messages will not be read by the network, and there is a risk of saturating the BEWSD-network with non-specific info. The results of this streamlining process will be presented in the next annual report.

The BEWSD also developed a website containing two sections: a section accessible to the general public, and a section that is login-protected and is meant for the professional BEWSD-network (mainly the toxicological laboratories and prevention services in Belgium). The public section contains alerts and warnings that could have an impact on public health, and where it is deemed necessary to inform the general public. Not all alerts/warnings sent to the professional network are included in this section; the emphasis is on issues related to public health and potential adverse effects to drug users. The closed section of the BEWSD-website contains analytical chemistry information regarding new psychoactive substances discovered in Belgium and Europe, including GC/MS spectra and mass spectral libraries. These are used by the toxicological laboratories in Belgium to constantly update their own spectral libraries, to be able to identify new psychoactive substances more rapidly. Furthermore, clinical and toxicological data (when available) and literature data (including full papers) are also included in this section of the BEWSD-website.

Worth mentioning specifically are the 4-methylamphetamine cases in Belgium: in 2011, three casualties linked to the use of 4-methylamphetamine have been reported to the BEWSD, along with three intoxications. In the first half of 2012, two casualties linked to the

consumption of 4-methylamphetamine have been reported. In response to these casualties, a risk assessment was carried out on the federal level. Also, since 'speed' users are not aware that 'speed' in Belgium could be contaminated with 4-methylamphetamine, a warning message was disseminated to the general public using the press.

3. Prevention and treatment of drug-related infectious diseases

3.1. Needle exchange

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.

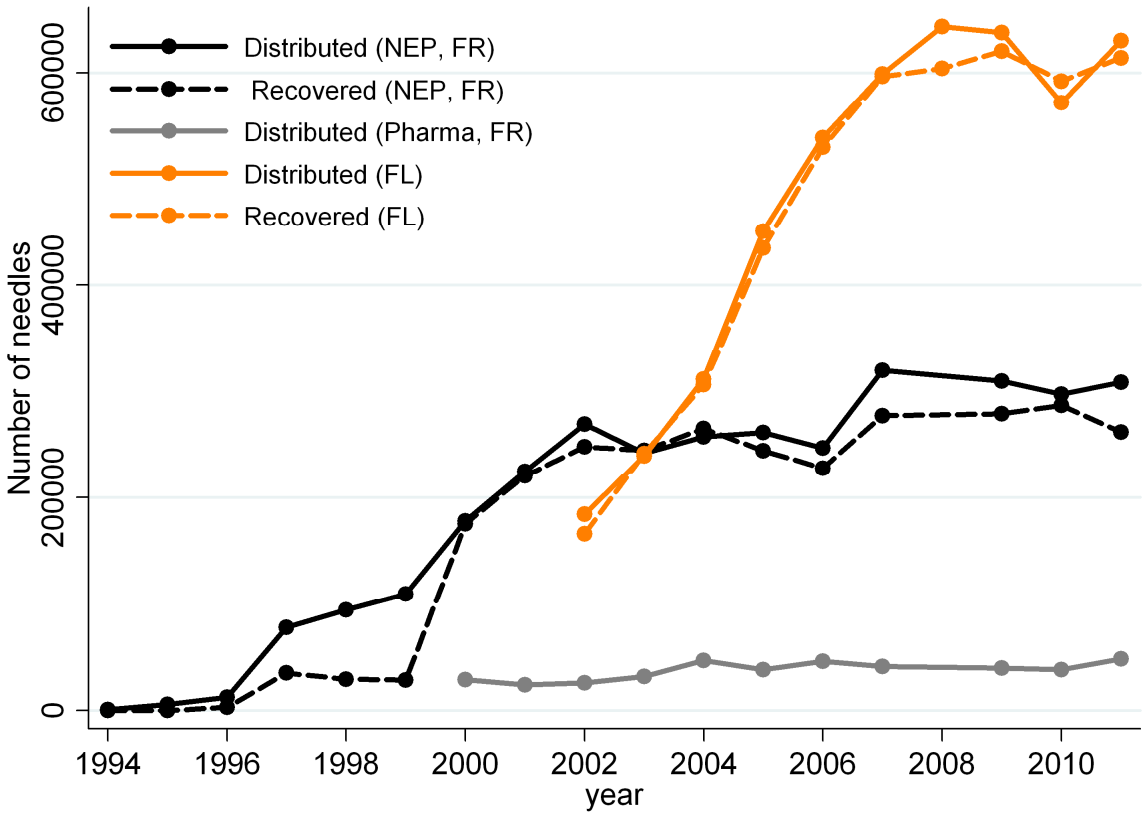
In the Flemish community, the syringe exchange programme, which started in 2001, has been carried out by one regional and five provincial coordinators (one per province in Flanders), working as independents at the Medical and Social Care Centres (MSOCs) for drug users. The provincial coordinator builds 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 is 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. In 2011, a new needle exchange service was initiated in Mons. On top, more than 10 other services distribute injection equipment. However, the number of syringes distributed within these 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, 630,046 syringes were distributed in 2011 (see also ST10_2012_BE_02), and 613,807 were returned, resulting in a "recuperation rate" of 97.4% (Windelinckx 2012b). In the French community, 308,628 syringes were distributed through the 17 official fixed-site and mobile services (see also ST10_2012_BE_01) and 261,552 were returned, resulting in a recuperation rate of 84.7%. In addition, 48470 syringes were dispatched to the network of pharmacists participating to the "Stérifix" project in 2011.

However, there is no information available on the number of syringes effectively sold through this network. Compared to last year, the number of distributed needles slightly increased for Flanders whereas it remained stable for the French community (Figure 7.1). The recuperation rates decreased (Figure 7.2), indicating the continuing need to stress the importance of syringe recuperation to reduce the risks (e.g. needle-stick injury and consequent infection) for the general population.

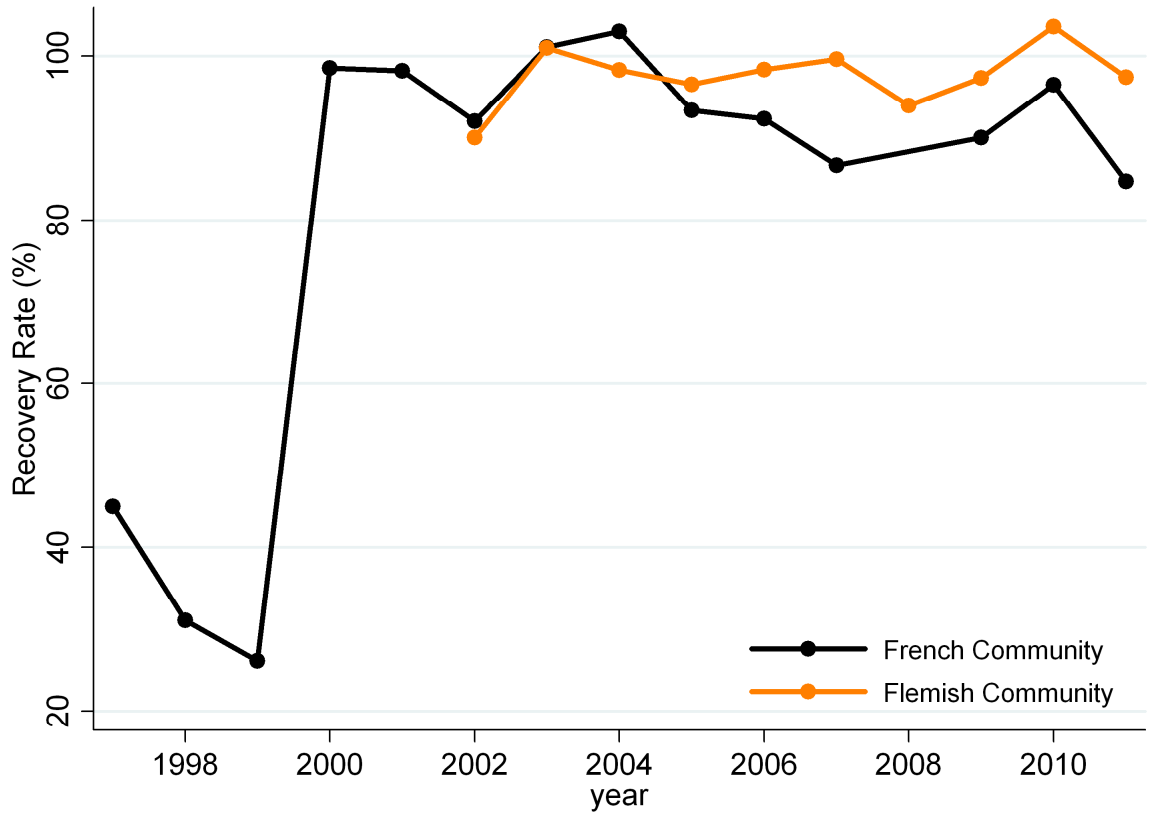
Figure 7. 1: Number of syringes distributed and recuperated in the Flemish Community and in the French Community by Needle Exchange Programmes (NEP) and by pharmacists (Stérifix project), 1994-2011



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

Source: (Casero et al. 2010;Windelinckx 2012a).

Figure 7. 2: Recuperation rate of the syringes distributed by Needle Exchange Programmes (NEP) in the Flemish and French Community, 1994-2011



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

Source: (Casero et al. 2010;Windelinckx 2012a).

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 2011 indicate that, next to the needle exchange programmes, pharmacists play an important role in distributing injecting material, with 73% 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, 15.1% 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).

3.2. Hepatitis C screening

In 2011, a study entitled ‘Hepatitis C: screening and prevention’ (Gerkens et al. 2012) has been carried out by the Belgian Health Care Knowledge Centre. The main objectives of the study were: (a) to document the (cost-) effectiveness of screening for HCV in the general population or specific target groups, (b) to document the (cost-) effectiveness of prevention programs for HCV in injecting drug users and (c) to summarize action plans regarding HCV screening and prevention from neighbouring countries. The researchers conclude that screening within the general population is not cost-effective whereas screening of IDUs is recommended. The decision to treat IDUs should not be taking without having a social and psychological support in place, aiming to improve treatment safety and efficacy.

4. Responses to other health correlates among drug users

Prevention projects, aiming to reduce drug-related health problems among drug users, are discussed in chapter 3 of this annual report.

Acknowledgements chapter 7:

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Chapter 8.

Social Correlates and Social reintegration

Plettinckx E. and Antoine J.

1. Introduction

An important concept in health care is the notion of quality of life (QoL) (De Maeyer et al. 2011a). Namely, treatment has to improve someone's QoL. Nevertheless, the outcome of treatment is often measured according to what is important to the health care professionals (De Maeyer et al. 2011a). However, quality of life has both objective and subjective components. The perception of someone's quality of life is influenced by personal goals, expectations and certain events in life (De Maeyer et al. 2011a). Drug users are not only confronted with health problems of drug use. Drug users have often also other problems related to family, social relations, education, work and poverty (Decorte and Janssen 2011;De Maeyer et al. 2011b;Decorte and Nachtergale 2012). As such, drug users need often psychological and social support besides medical treatment (De Maeyer et al. 2011b).

The following studies will be used in this chapter:

Due to the importance of a holistic approach to treatment, **the Treatment Demand Indicator** (TDI) registers various variables which can tell us something about the social problems drug users might be confronted with. A description is given about 4 exclusion criteria by gender, age and primary drug use. Additionally, several research projects were developed the last years in order to map the potential negative consequences of a drug using lifestyle on various life domains

In 2011, a study (**Antwerp Drug and Alcohol Monitor II**) was published about the characteristics and the lifestyle of daily users of cocaine, heroin, amphetamines and/or benzodiazepines. A qualitative study design was chosen in order to obtain a complete picture of the nature and extent of the problems daily drug users are confronted with. First of all 39 key informants from different sectors (police, judicial authorities, medical and treatment services, prevention services and street workers) in the city of Antwerp were interviewed. Second, ethnographic fieldwork in this city was done by 4 community fieldworkers and researchers. These persons have easier access to the field because community fieldworkers are or have been part of the local Antwerp drug scene,. As such, community fieldworkers are able to interview hidden populations (Decorte and Janssen 2011). The same methodology was repeated for the studies of the characteristics and the lifestyle of vulnerable youngsters (**Antwerp Monitor youth alcohol and drugs I & II**). In these researches 'youngsters' are defined as persons between 18 and 25 years old. This research indicates that drug using youngsters are more vulnerable to be homeless, less educated and unemployed (Decorte and Nachtergale 2012).

In addition, opiates remain the main drug used by people entering drug treatment (in 39.5% of the cases). Opiate dependence is associated with various health and social problems such as mortality, infectious diseases, unemployment, poverty and homelessness (De Maeyer et al. 2009;De Maeyer et al. 2011c). Moreover, opiate dependent persons report significantly worse QoL scores in comparison with the general population or non clinical control groups (De Maeyer et al. 2009). As consequence, a large research project was conducted on the **QoL of opiate-dependent persons** who started methadone treatment 5 – 10 years ago (De Maeyer et al. 2011a). This research project consists of two parts.

The first part is a quantitative, cross-sectional, non randomised study on the current QoL of a cohort of opiate-dependent persons who started outpatient methadone treatment between 1997 and 2002 in the region of Ghent. 159 participants were selected by using various media, by asking staff members of methadone programs for possible participants and through snowball sampling. The persons who were selected had to be over the age of 18 and had to have a diagnosis of opiate dependence. The participation was entirely voluntary and confidential. The respondents received 20 EUR. for participation. Different concepts, namely 'living situation', 'health', 'family relations', 'leisure and social participation', 'finances' and 'safety' where used in order to measure the current (7 days prior to the interview) QoL. Face to face interviews were conducted by using assessment measures such as EuropASI, the Lancashire quality of life profile, the brief symptom inventory and the Verona service satisfaction scale for methadone treatment. These interviews were analysed by using descriptive statistics, linear regression models and path analysis (De Maeyer et al. 2011b;De Maeyer et al. 2011c).

25 respondents involved in the quantitative phase of the study where interviewed for a second time, in order to collect information about opiate-dependent persons' perspectives on their QoL. The purpose was to examine the important components influencing someone's QoL. The advantage of this selection strategy is that the respondents were already familiar with the researchers. The open-ended interviews took place in a setting of participants' choice. This resulted in a higher degree of trust. The respondents were asked in the beginning of the interview to think about the period of their methadone treatment when their QoL was the highest. Qol was defined in terms of satisfaction with various life domains and life in general. The interviews lasted between 40 and 120 min. A cross-case analysis was used to compare persons' perceptions from the various interviews and to identify patterns across the different participants. These analyses were done manually in order to stay close to the data and to gain in depth insight in the different aspects. Data saturation was reached after 20 interviews (De Maeyer et al. 2011a).

As said before, excessive and long-term drug users may have various psychological complains (Decorte and Janssen 2011). These persons are often even more discriminated on various life domains. In 2012, the results of an **evaluation of a labour market programme** for women with mental health problems in a social workplace in East Flanders (Dutch speaking part of Belgium) were published. This labour market programme aimed to develop an outreach strategy in order to activate more women with mental health problems through the social work place. This pilot project was introduced because only 13% of the persons employed in the social workplace were women. Due to the pilot project 17 women actually became involved in the labour market program. Nevertheless, only three women participated for longer than two months and only one of them got actually a job. In order to evaluate this pilot project, all project documents were analysed first. Secondly, 11 women with mental health problems and additionally diagnosed problems of substance dependence who were involved in the activation program were interviewed. The objective was to explore the insider perspectives on the work aspirations through qualitative in depth interviews. The perspectives of the professionals engaged in the projects were also broadly explored. The respondents signed an informed consent that stated the anonymous character of the study. Moreover, the participations had the possibility to end the participation whenever they wanted. The interviews lasted one hour and a half. The interviews where audio-taped, transcribed and returned to the respondents for review, alternation and eventual approval. The data were analysed in an inductive, exploratory and interpretative way (Vandekinder et al. 2012).

Drug use has not only an impact on various life domains. The lifestyle of someone may influence the patterns of drug use as well. Substance use is influenced by personal interactions (e.g. in school, with family and friends) and other environmental factors (e.g. local and economical context) (De Ruyver et al. 2008;Tieberghien and Decorte 2010). The fact that socially excluded people have less perspectives can result in a desperate situation, which gives rise to hopelessness. This can trigger (the vicious circle of) drug misuse (De Maeyer et al. 2011a;Decorte and Nachtergale 2012). The studies about daily and young drug users, funded by the city of Antwerp (methodology described above), give a picture of the way these factors influencing substance use of socially excluded and vulnerable people.

As consequence of the interaction between drug use and various life domains, the inter-ministerial commission decided to determine a global help strategy starting from a health approach and integrating other dimensions including well-being and social integration (Interministeriële Conferentie Drugs 2010) (Conférence Interministérielle Drogues 2010). Therefore, the last section of this chapter focuses on new initiatives to reintegrate (specific

groups of) drug users. In order to identify these new projects and initiatives concerning these topics, we searched the EDDRA database of the EMCDDA, we had contact with the Belgian (sub)focal points, consulted Ida-web, the social map and the project list of the federal 'Addiction Fund', which is intended to launch new initiatives to complement the available treatment offer for drug users. However, it is not possible to give an exhaustive view of all initiatives in Belgium, because these studies and projects are not collected or coordinated in a centralized way.

2. Social exclusion and drug use

The correlation between drug use and social exclusion will be discussed in this paragraph. On the one hand, social exclusion might be the result of drug use. On the other hand, an upset family life, poverty, social isolation and the housing situation have often an influence on someone's drug use pattern (De Ruyver et al. 2008;Tieberghien and Decorte 2010;Decorte and Janssen 2011;Decorte and Nachtergale 2012). In section 2.1 the social exclusion among drug users will be covered, section 2.2 will discuss drug use among socially excluded groups.

2.1 Social exclusion among drug users

Drug users and polydrug users in particular, run the risk to be excluded from school, work, social activities and social services because of the stigma of drug use and addiction (Decorte and Janssen 2011) . This stigma is even bigger for older drug users (Decorte and Janssen 2011). In this section, various life domains, such as housing, education, work and the financial situation and social networks will be discussed.

2.1.1 Housing

The TDI data gives a picture of clients "living in an unstable accommodation" (see table 8.1). It concerns clients who live in the street or does not have a fixed accommodation. Around 10% of the drug users in demand for treatment were not living in a stable accommodation in 2011.

Men (12.5%) are living more often in an unstable accommodation than women (6.8%). Young drug users (15.0% for age category less than 24 years) have a bigger change to live in an unstable accommodation. The proportion is also higher for opiates and cocaine users (16.8% and 11.4%, respectively), in comparison with cannabis and stimulant users (7.8% and 2.4%, respectively).

Table 8. 1: Incidence of people with housing problems among drug users in demand for treatment (by gender, age and primary drug

Category	%	95% CI	N*
Gender			
Men	12.5	11.3-13.7	2732
Women	6.8	5.1-8.5	868
Age			
<24	15.0	11.4-18.6	373
25-34	14.3	12.2-16.4	1021
35-44	12.3	10.4-14.2	1159
45-54	6.3	4.5-8.1	712
55+	3.3	1.4-5.2	335
Substance			
Opiates	16.8	14.7-18.9	1212
Cocaine	11.4	7.5-15.3	255
Stimulants	2.4	0.0-5.1	127
Cannabis	7.8	6.5-9.1	1632
Total	**11.1**	**10.1-12.1**	**3600**

*Total TDI population
Source: Treatment Demand Indicator, Belgium, 2012

This data shows that drug users have often difficulties to find a cheap and liveable place to stay. These findings are supported by different researches. A research done by drug users in Antwerp indicates that (daily) drug users are confronted with waiting lists for social housings, refusals, high rental prices, high guarantees and slumlords (Decorte and Janssen 2011;Decorte and Nachtergale 2012). These problems push drug users away from the housing market and make them vulnerable for homelessness (Decorte and Janssen 2011).

In case they find a place to live, the conditions are far from ideal (Decorte and Janssen 2011). Heroin users, for example, are mostly living in deprived environments of the big cities (De Ruyver et al. 2008). Drug users are sharing their place to live together with other drug users or are offering their place as user place. Due to various problems drug users are confronted with, they are neglecting their housing conditions such as the laundry, cleaning, etc. Additionally, drug users have often debts. As new owner of the house, he or she will receive all overdue accounts again. In these cases, the drug user risks to lose the house again (Decorte and Janssen 2011).

The fact that most of the cheap houses are located in deprived environments, characterised by other drug users and dealers, makes it even more difficult for drug users who are trying to stop using. If they stay, they are afraid to relapse in the former pattern of drug use (De Maeyer et al. 2011a). As such, these environments are not the places where these drug users prefer to live (Decorte and Janssen 2011;De Maeyer et al. 2011b). Especially persons who are not using heroin anymore are in need of starting all over again in a new environment, but at the same time they are confronted with difficulties to do so (De Maeyer et al. 2011b). They are having often substantial debts and cannot afford to rent a more expensive house or apartment (De Maeyer et al. 2011c).

2.1.2 Education

A research conducted among drug using youth (between 18 and 25 years old) in Antwerp indicates that drug use is often accompanied with truancy (Tieberghien and Decorte 2010;Tieberghien and Decorte 2011;Decorte and Nachtergale 2012). As consequence, drug using youth often finish their school too early (Tieberghien and Decorte 2010). Although, some of the drug users who do not have a degree are thinking about going to second change education for adults, a substantial part of the drug users do not have a degree (Tieberghien and Decorte 2010;Decorte and Janssen 2011;Decorte and Nachtergale 2012).

The TDI data indicates that 28% (see table 8.2) of the new clients entering treatment in 2011 did not have an eduction or did only have a primary level of education. The proportion of clients with no or only primary education is significantly higher for men (29.6%) than for women (22.7%). 40.5% of the youngest age group (< 24) have low education. This percentage decreases until 18.2% for the oldest age group (55+). Opiates and cocaine users are having the lowest education level (38.0% and 39.6%, respectively) followed by stimulant (20.5%) and cannabis users (20.3%).

Table 8. 2: Incidence of people low educated among drug users in demand for treatment, by gender, age and primary drug (Belgium, 2011)

Category	%	95% CI	N*
Gender			
Men	29.6	27.9-31.3	2732
Women	22.7	19.9-25.5	868
Age			
<24	40.5	35.5-45.5	373
25-34	29.1	26.3-31.9	1021

35-44	28.9	26.3-31.5	1159
45-54	22.8	19.7-25.9	712
55+	18.2	14.1-22.3	335
Substance			
Opiates	38.0	28.1-28.6	1212
Cocaine	39.6	33.6-45.6	255
Stimulants	20.5	13.5-27.5	127
Cannabis	20.3	18.4-22.3	1632
Total	**27.9**	**26.4-29.4**	**3600**

*Total TDI population
Source: Treatment Demand Indicator, Belgium, 2012

2.1.3 Work and financial situation

The research done by daily drug users in Antwerp indicates that most of the respondents do not have a degree (see 2.1.2), this makes them very vulnerable on the labour market (Decorte and Janssen 2011;Decorte and Nachtergale 2012). They do not meet the work rhythm of the regular labour market and don't have a work attitude, because of the few work experiences they have (Decorte and Janssen 2011;Decorte and Nachtergale 2012). The research about methadone treatment among heroin users indicates that most of these drug users really want to work though. Having a job gives them the feeling they are contributing to society (De Maeyer et al. 2011a). Nevertheless, drug users and especially heroin users are often unemployed (De Ruyver et al. 2008;Decorte and Janssen 2011).

Young and long-term drug users struggle often with mental and psychiatric problems (Decorte and Janssen 2011;Decorte and Nachtergale 2012). The study of De Maeyer et al. (2011c) showed that 87.9% of the respondents complained about psychological distress and 54.1% of them scored above the clinical cut-off score of overall psychopathology. The results of an evaluation of a labour market programme especially for women with mental health problems in a social workplace in East Flanders indicated that the tasks are not adapted to the interests, capacities and strengths of these women. The activities were designed to be typically male and too havy for the physical abilities of these women. Moreover, the workplace was characterised by a lack of flexibility in case of pregnancy or taking individual responsibilities in the household. Also certain needs such as special sanitary provision were denied. Moreover, the low compensation of the work could not cover the additional costs of childcare (Vandekinder et al. 2012). A respondent of the research about methadone treatment among heroin users explained that all jobs he got were below his standard and that he could not use his capacities (De Maeyer et al. 2011a). Both researches indicates that

even labour programmes meant for people with certain disabilities and problems of substance use are too standardised and are lacking flexibility (Vandekinder et al. 2012).

The TDI data shows that around 18% of the clients entering the registration system are unemployed (see table 8.3). Less women (15.1%) are unemployed than men (18.5%). The figures indicate that drug users younger than 24 years old are having more problems to find or keep a job in comparison with people of an older age. People who use cocaine seem to have the most difficulties. 20.4% of the cocaine users do not have a job at the moment of entering treatment, in comparison with 17.9% of the opiate users, 17.0% of the cannabis users and 10.2% of the stimulant users.

Table 8. 3: Incidence of people with working problems among drug users in demand for treatment, by gender, age and primary drug (Belgium, 2011)

Category	%	95% CI	N*
Gender			
Men	18.5	17.0-20.0	2732
Women	15.1	12.7-17.5	868
Age			
<24	22.5	18.3-26.7	373
25-34	20.1	17.6-22.6	1021
35-44	18.3	16.1-20.5	1159
45-54	14.2	11.6-16.8	712
55+	9.9	6.7-13.1	335
Substance			
Opiates	17.9	15.7-20.1	1212
Cocaine	20.4	15.4-25.4	255
Stimulants	10.2	4.9-15.5	127
Cannabis	17.0	15.2-18.8	1632
Total	**17.6**	**16.4-18.8**	**3600**

*Total TDI population
Source: Treatment Demand Indicator, Belgium, 2012

The research conducted among daily drug users in Antwerp indicates that most of them receive unemployment and healthcare benefits. Nevertheless, some drug users do not even get these benefits (Decorte and Janssen 2011). These drug users often have debts as well (see also 2.1.1) (Decorte and Janssen 2011;Decorte and Nachtergale 2012). Especially heroin use is related to high costs of supporting drug consumption habits (De Maeyer et al. 2011a;De Maeyer et al. 2011b;De Maeyer et al. 2011c). Due to the poor education and the

unemployment, the legal financial sources of most of the drug users are scarce (Decorte and Janssen 2011;De Maeyer et al. 2011c). Daily users decide often to earn money through moonlighting, theft, prostitution, dealing and begging as survival strategy (Tieberghien and Decorte 2010;Decorte and Janssen 2011;Decorte and Nachtergale 2012).

2.1.4 Social networks

The research among daily drug users in Antwerp shows that loneliness is a big problem for most daily drug users (Decorte and Janssen 2011). Although a good friend, children or a supportive and caring partner are very important for them. A good conversation with these people gives them the feeling of acceptance and being supported by society (De Maeyer et al. 2011a;De Maeyer et al. 2012). Nevertheless, most of them lost contact with family and friends (Decorte and Janssen 2011). Young drug users, for example, have often a difficult relationship with their family. On the one hand, the drug use of the children may affect the relationship. In this case, parents are worried about their children and at the same time they are desperate about the problems of their children. These families are often confronted with a difficult education. Nevertheless, it rarely happens that children are rejected by their parents. On the other hand, it happens often that one of the parents or both parents are absent, due to a divorce, dependency or financial, mental or psychiatric problems (Tieberghien and Decorte 2010;Decorte and Nachtergale 2012). In these cases the family does not manage to have a good and balanced conversation (Decorte and Nachtergale 2012). The relationship with friends is also often affected by discussions about drug use (and money). As consequence, daily drug users often have only social contacts with other users. These drug users do not have a social network supporting them. The longer they wait to get in contact again with their family and former friends, the more difficult it is to get support and respect of them (Decorte and Janssen 2011).

The TDI registry shows that 43% of the clients who entered treatment in 2011 are living alone or living alone with a child. Although, this percentage does not reflect all social contacts they have, this gives at least a partial picture of the daily contacts among drug users in treatment. 48% of the women are living alone or with a child, in comparison with 42% of the men. Clients of a younger age group are fewer living alone or with a child in comparison with older clients. Only 23.6% of the youngest age group (<24) are living alone or with a child. This percentage is increasing with each age group until 56.4% for the oldest age group (>55). Clients in treatment for cannabis (50.4%) and for stimulants (48.8%) are more often living alone or with their children than clients in treatment for cocaine and opiates users (32.5% and 40.6%, respectively).

Table 8. 4: Incidence of people with restricted social networks among drug users in demand for treatment, by gender, age and primary drug (Belgium, 2011)

Category	%	95% CI	N*
Gender			
Men	42.0	40.1-43.9	2732
Women	47.6	44.3-50.9	868
Age			
<24	23.6	19.3-27.9	373
25-34	34.7	31.8-37.6	1021
35-44	46.9	44.0-49.8	1159
45-54	54.2	50.5-57.9	712
55+	56.4	51.1-61.7	335
Substance			
Opiates	40.6	37.8-43.4	1212
Cocaine	32.5	26.8-38.3	255
Stimulants	48.8	40.1-57.5	127
Cannabis	50.4	48.0-52.8	1632
Total	**43.4**	**41.8-45.0**	**3600**

*Total TDI population
Source: Treatment Demand Indicator, Belgium, 2012

2.2 Drug use among socially excluded groups

The drug use patterns of different groups of socially excluded or vulnerable groups will be addressed in this section. Five groups will be discussed separately, namely homeless people, migrants, sex workers, persons with mental disabilities and minors who committed a crime.

2.2.1 Drug use among homelessness youth

The studies among young drug users between the age of 18 and 25 in Antwerp indicates that most of those people have already a long tradition of drug use. Most of them started at the age of 12-13 years using only cannabis. After a few years they came in contact with other drugs such as ecstasy, cocaine, hallucinogens and amphetamine (Tieberghien and Decorte 2010;Decorte and Nachtergale 2012). Some of the people who came in contact with the *special youth care* are using also GHB (Decorte and Nachtergale 2012). These substances are often used in combination with each other. Only at the moment they became homeless they were introduced (often by older drug users) to heroin and benzodiazepine. Most of them

start to inject speed, cocaine or heroin pretty early (around the age of 20). Most of those people became daily users because they try to avoid the reality (they do not want to think about their problems), to prostitute themselves or to avoid being 'sick' (Tieberghien and Decorte 2010;Decorte and Nachtergale 2012). The fact that they have most of the time only contact with other users, reinforce their user pattern. When they are trying to use less illegal substances, it is noticed that they are going to drink more alcohol (Decorte and Nachtergale 2012).

For 2011, only figures are available from Relais Social Urbain Namurois. They indicated that 61% out of the 361 homeless people who had contact with social workers had an addiction problem in 2011. Among these people, drug use is mostly related to alcohol, followed by cannabis and heroin (Relais social urbain namurois 2012).

2.2.2 Drug use among migrants

Migrants are not a homogenous group. The study about daily drug users in Antwerp indicates that poverty is an important factor related to drug use among migrants. Some migrants are problematic users, others are recreational users. Migrants who did not use drugs before they arrived in Belgium are using because of work problems and the clandestine life. It is known that illegal migrants change to more risk behaviour, because they have the feeling not loosing anything. Some Nord African migrants living in Antwerp use cannabis, cocaine and/or heroin (Decorte and Janssen 2011). The study about young drug users in Antwerp indicates that Moroccan minors are often for the first time confronted with ecstasy at parties. Cocaine is more often used by Moroccan female minors and Turkish minors (Decorte and Nachtergale 2012).

2.2.3 Drug use among sex workers

Drug use among sex workers is often related to the specific environment they are confronted with. The threshold for using drugs become lower among sex workers. Drug use is often functional for sex workers. Drug use facilitates prostitution and prostitution generates money in order to finance their drug use. In these cases, sex work is a survival strategy. Drugs make it easier to relax and stay awake.(Decorte and Janssen 2011;Decorte and Nachtergale 2012). The studies among daily and young drug users in the city of Antwerp states that a high percentage of the street workers are using drugs (Tieberghien and Decorte 2010;Decorte and Janssen 2011;ASBL Icar-Wallonie 2012). For example, the association ICAR in Liège argue that 80% of the street sex workers are using drugs (Tieberghien and Decorte 2010;ASBL Icar-Wallonie 2012). Among them a considerable amount of the street sex workers are excessive and injecting drug users who use cocaine and heroin (Decorte

and Janssen 2011). Nevertheless, alcohol stays the most used drug among young sex workers. ‘poppers’ are often used among young male sex workers. Young female sex workers instead are using often benzodiazepines. Heroin, ecstasy and speed are less used. Cannabis is especially used in order to ‘forget’ (Decorte and Nachtergale 2012).

2.2.4 Drug use among persons with mental disabilities

The authors of the Antwerp Drug and Alcohol Monitor indicate an increase of drug users in treatment with a mental disability. The fact that the drug market is more visible and accessible for people can be one possible explanation for this increase. It is possible that nowadays persons with mental disabilities have easier access to the drug market than before (Decorte and Janssen 2011).

2.2.5 Drug use among minors who committed a ‘crime’

The study of the characteristics and the lifestyle of vulnerable youngsters indicates that most of the drug using minors who committed a ‘crime’ are using cannabis, speed, cocaine and ecstasy. The use of mephedrone, GHB and LSD is more occasionally. They start to use these substances because they are bored and do not know how to spend their spare time. It happens as well that these minors start using because of relational problems with their parents. Due to the lack of a listening ear, daily activities and future perspectives, the risk is higher they start to experiment with drugs. Most of these minors are starting to use cannabis at the age of 14 or 15 years old. Most of them are more problematic users. Heroin use among this target group is considered as problematic as well by the community workers. Recreational use of amphetamines and LSD is related to the nightlife scene. Recreational cocaine is more used together with friends (Decorte and Nachtergale 2012).

3. Social reintegration

The studies about social exclusion among drug users and drug use among social excluded groups of 2010 and 2011 (described above) indicates that drug users are dealing with different social problems during their life. These problems can change from time to time. The research about methadone treatment among heroin users indicates that most of the drug users consult treatment services to tackle non-health-related problems (De Maeyer et al. 2011a).

Drug users have the possibility to appeal to general social services such as Psychiatric hospitals, the employment agency, VDAB, ACTIRIS, FOREM, OCMW, CPAS, CAW, CASG. Although drug use is often inherently related to the social problems they are confronted with,

drug use is often used as exclusion criteria in these social services (Decorte and Janssen 2011).

Moreover, the problems described in this chapter prove the importance to focus on the personal life goals. This shows that policies and programmes relating to housing, income, employment, education and social networks are themselves disabling to the people they intend to serve (Vandekinder et al. 2012). The support offered by social services has to start from an individual and person centred approach. It is important that people have the feeling having a meaningful life. Improving client's perceptions about themselves by increasing their personal control over their lives is very important (De Maeyer et al. 2011a;De Maeyer et al. 2011b;De Maeyer et al. 2011c). As consequence, more effort is needed in order to reintegrate drug users into society (Vandekinder et al. 2012). In order to do so, a long-term integrated and holistic treatment approach with attention to all issues of housing, vocational support, education and work is required (De Maeyer et al. 2011b). Case management is for example an intervention that acknowledges the unicity and multiplicity of clients (De Maeyer et al. 2011a). There is a need for more differentiation and flexibility in the initiatives for active drug users (Decorte and Janssen 2011;Vandekinder et al. 2012).

In the next sections different local projects will be described about reintegration of drug users at different domains such as housing, education, work, finances and social relations.

3.1. Housing

Housing is a very important issue in treatment (De Maeyer et al. 2011a;De Maeyer et al. 2011b;De Maeyer et al. 2011c). Therefore, different housing projects are introduced in Antwerp, Brussels, Charleroi and Liège. ADIC is offering 6 beds to homelessness drug users in order to give them some rest for maximum 7 days. The project 'Reception homelessness drug users' aims accompanying drug users in order to negotiate with landlords about, for example, the price of a house. Drug users who are living in Antwerp have the possibility to find some rest, to have contact with a social worker and to wash their clothes in two 'walk-in centres'. A related project was introduced especially for polish homelessness drug users at the end of 2010 (Decorte and Janssen 2011). The city of Antwerp, together with the OCMW and three CAW's negotiated with the social housing companies in order to dispose 50 apartments to homeless people. CAW 'De Terp' focuses on adult homeless men, with special attention to chronic problems such as addiction. Besides these initiatives, homeless drug users can find a place to stay at the homeless cel of Antwerp as well (Decorte and Nachtergale 2012). ADIC offers as well ambulant housing support for 50 (ex) drug users in Antwerp (De Sociale Kaart [online] 2012). Besides this project, CAW Metropool is offering

individual support to homelessness drug users. Those people can ask for medical and financial support as well (OCMW Antwerpen 2008).

Transit Brussels is providing 2 formulas of housing projects for drug users. First, the crisis centre is offering (for free) 21 beds to drug users for a short duration of stay (average length of stay is 13 days). The aim is to offer a safe and friendly resting place. Second, Transit is offering eight supervised flats that can be used for one month, renewable two times. It's conceived to support self-sufficiency among drug users who are searching for a house.

In Wallonia a few initiatives were organised the last years. Thaïs asbl in Liege offers 9 individual housings for drug users or sex workers with a focus on parents with their children. In case of refusal, a follow-up is foreseen in order to find alternatives. The price is limited to 40% of the incomes of the family. In Charleroi, Autrement asbl has a supervised housing project for drug users since 2010. They can house 7 people who will have to pay a low rent.

What stands out is the limited number of places and the lack of specific initiatives for minors (Decorte and Nachtergale 2012).

3.2 Education

The value of training projects for drug users should not be underestimated, since many drug users have a learning deficit (Decorte and Nachtergale 2012). In Charleroi, Ghent and Antwerp education projects are introduced.

The asbl Autrement located in Charleroi give drug users the possibility to follow different trainings and upgrade courses in French and in mathematics. *De Sleutel* in Ghent introduced education and social employment especially for (ex) drug users and people with a psychiatric disorder (De Sociale Kaart [online] 2012). In Antwerp, low educated people have the possibility to follow a training car mechanics (Decorte and Nachtergale 2012).

3.3 Work and finances

Unemployment increases the risk of relapse after drug treatment. Moreover, employment increases the willingness to seek treatment (Sumnall and Brotherhood 2012). Although, research among heroin users indicates that traditional treatment such as methadone treatment may help users to keep their job, a lot of the users in treatment are unemployed (De Maeyer et al. 2011a;De Maeyer et al. 2012). These findings illustrate that vocational support is very important in treatment. The research about methadone treatment among heroin users indicates that most of the drug users consult treatment services to tackle non-

health-related problems, in order to reach more future perspectives (De Maeyer et al. 2011b).

In general, the OCMW has the possibility to be a low-threshold employer. In this way the OCMW can train the employee in order to improve the basic skills and to integrate them in the normal working circuit (Decorte and Nachtergale 2012). Besides this special low threshold initiatives are organised in a few cities.

De Sleutel in Ghent introduced education and social employment especially for (ex) drug users and people with a psychiatric disorder. The work project is developed in collaboration with the OCMW/OTC Ghent and offers intensive individual support during the work process (De Sociale Kaart [online] 2012). In Antwerp a similar project is organised especially for minors. *Buro Aktief* tries to give excessive drug users positive work experiences through little employment projects. The employees get a little fee and there are possibilities to be referred to other workplaces (Decorte and Nachtergale 2012). Phénix asbl in Namur has also an insertion service where drug users can follow stages on different topics. The stage is paid 1€ per hour.

Specific for heroin users can methadone treatment have a positive impact on the financial sources of drug users, because methadone is much cheaper than heroin. Moreover, methadone is quite easy to obtain. Nevertheless, as far as known, special projects to increase the financial independency of (heroin) drug users have not been introduced the last few years (De Maeyer et al. 2011a;De Maeyer et al. 2012).

3.4 Social relations

Although, traditional treatment has a positive influence on the fulfilment of responsibilities, drug users are often confronted with stigmatisation (De Maeyer et al. 2011a). This hinders their functioning in daily life and the reintegration in the society (De Maeyer et al. 2011a;De Maeyer et al. 2012). Moreover, excessive and long-lasting drug users are losing a lot of skills. Therefore, the city of Antwerp is investing in an activation project in order to ‘teach’ drug users social and practical skills through different social activities such as sport, cooking, creative workshops, etc. In La Louvière (Wallonia), a project from the asbl Ellipse was introduced in order to support around 50 current or ex-drug users at home. Daily support is offered on a social, education and psychological point of view (Ellipse asbl 2010).

Both in Flanders and Wallonia, projects are introduced especially to support drug using parents and their children. In Vlaams Brabant, a special living room is created for children from parents in treatment. Different activities are organised in order to strengthen the

relationship of the children with their parents (Tieberghien and Decorte 2010). In Charleroi, a project is introduced in order to develop the education skills of drug using parents. Trempoline is offering drug using parents who are living in the therapeutic community individual social, educational and relational support.

Migrants, for example, are confronted with language problems, psychological traumas, distrust among other drug users, etc. Specific for this group, Antwerp started in 2010 a project concerning the integration of migrants in the treatment services (Decorte and Janssen 2011). Through two projects Antwerp is trying to increase the discus ability of drug use in the Muslim community (Decorte and Nachtergale 2012).

Acknowledgements chapter 8:

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Chapter 9.

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

Van Malderen S. and Plettinckx E.

1. Introduction

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

Data on drug law offences are provided through the federal (highway) police. These figures will be compared with a trend analysis of drug offences in Belgium between 1998 and 2006. This study, conducted by Grunzczska and Heinskanan (2012), is based on data of the European Sourcebook wich was initiated in the Council of Europe in 1993 by a group of researchers. The results are based on police data. Various types of offences are described over a time period of ten years by standardising the methodology and the definitions of the offences. Moreover, a description is given in this section of the onset, duration and desistance of drug-related crime. Between 2006 and 2008 a research project (DRUGCRIM), commissioned by the Belgian science policy office, was conducted. This research project had the objective to find a method to measure drug-related crime. The first part of this research is related to a quantitative document analyses. 1435 police files, spread over 10 research locations, were analysed in order to get information about the current nature and extent of drug-related crime in Belgium. Secondly, additional information about the context of these crimes was collected through a qualitative survey. 204 drugusers and 127 criminal justice clients were asked about their commitment in drug-related crime. The 204 drug users were selected through a snowball sampling. These respondents were asked if they committed a (drug-related) crime in the past 12 months. The 127 criminal justice clients were selected through random sampling. During these interviews the criminal justice clients were asked if they had used illicit substances the day they committed a crime. Besides drug law offences, this research focuses on four main drug-related offences namely property crime, violence, sexual offences and driving under the influence of drugs (De Ruyver et al. 2008). Addittional information on drug-related crime among youth was collected through the study AMJAD I. This study aims to meet the lack of reliable and relevant local level data for the purpose of an evidence-based local drug policy. The design of the study consisted of qualitative methods (like in-depth interviews with key informants and ethnographic fieldwork) based on national and international youth drug monitoring systems (Tieberghien and Decorte 2010). Specific data about driving under the influence of drugs were provided by NICC.
In 2009, Colman C. started her PhD on turning points in the criminal careers of drug-using offenders. In this study the researcher is interested in the recovery and desistence processes of drug-using offenders. The subjective experiences of regular drug users who had a criminal career in the past are very important in this study. Therefore, a qualitative research design was chosen. The research design comprised of semi-structured interviews, which lasted

between one and three hours. The study makes use of gatekeepers in order to identify suitable respondents. The researcher searched for gatekeepers in treatment services and in social work services (so-called 'street corner services'), rather than in prison. Only drug users who used/ are using illicit drugs at least three times a week during 1 year (regular drug users) and who committed at least five offences (property, violent, sexual or consensual crimes ...) during a period of five years (criminal career) were selected for this study. The interviews were recorded, after the consent of the interviewee. The analyses of these interviews were made by using specific qualitative software (NVivo) (Colman and Vander Laenen 2012).

Although prevention of drug-related crime is not a general priority for the interministerial conference of drugs, some prevention projects concerning drug-related crime are conducted in 2011.

According to the update of the drug note in 2010, different projects were introduced as an alternative to prison for drug-related crime in the framework of probation and mediation. Mediation is one of the responsabilities of the houses of justice in Belgium. The prosecutor has the possibility to propose in certain cicumstances (1) a treatment of maximum 6 months, (2) a treaining or (3) service of maximum 120 hour and (4) mediation between offender and victim (B.S.27.04.1994). When the offender agrees (voluntarily) with one of these proposals, the offender will be refered to a justice assistant who works in one of the 28 houses of justice in Belgium. The justice assistant is responsible for the guidance and supervision of the offender during the mediation period. Every offence (not offender) which is subject of mediation has to be registered in the SIPAR database (general database of the houses of justice). In 2011, a study has been published which describes the number of offences and clients who were in mediation in 2007. The researchers made different data-extractions of the database. After different preparatory stages, the researchers analysed the data using different quantitative methods (such as logistic regression and crosstables) (Vanneste and Burssens 2011). Judicial referral (at court level) of problem users to the (drug) treatment is the last years strongly encouraged in Belgium as well. Following the research project JUSTHULP commissioned by the Belgian science policy office, Colman et al. (2010) conducted a literature review about the effectiveness of drug treatment and the differences between voluntary referral and judicial referral. This information is supplemented with an evaluation study of the drug court in Ghent (Colman et al. 2010;Colman et al. 2011;Vander Laenen and De Keulenaer 2012).

Prosecution data is provided by the College of the General Prosecutor. The statistical service of the Public Prosecutor collects data on the number of drug-related cases entering and

leaving the first line court system. In this section, the number of drug-related cases entering the level of the youth prosecutor is taken into account as well. This information is collected by the statistical service of the Public Prosecutor through the consultation of the PJP-system. The PJP-system collects all the information registered in the administrative PJP-database of each judicial district. Nevertheless, the use of these administrative databases implicates some limitations. These limitations are related to the lack of uniformity of the registration of the data in the different judicial districts. Additionally, this registration system is not systematically adapted to the changes in the youth protection law (Statistische analisten van het Openbaar Ministerie 2012). Besides this, an overview of the closing decisions of drug-related cases at the level of the public prosecutor is given. The number of new drug law offence cases entering the Court of Appeal, is at the moment of writing this report not available. The number of convictions and suspensions for drug law offences are gathered by the Service of Criminal Policy based on data coming from all Belgian courts. Finally, the regional drug coordinator of the general directorate for prisons, Van Malderen S., provides information about drug use and drug-related health consequences in prisons.

2. Drug-related crime

Drug-related crime is a complex phenomenon and the relationship between drugs and crime is neither simple nor linear. Although defining drug-related crime is a reductive exercise that cannot account for the whole complexity of the drug–crime nexus, four types of drug-related crime were defined by the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction 2007), namely (1) psychopharmacological crimes: crimes committed under the influence of a psychoactive substance, as a result of its acute or chronic use (e.g. violence); (2) economic-compulsive crimes: crimes committed in order to obtain money to support drug use (e.g. robbery, prostitution, etc); (3) systemic crimes: crimes committed within the functioning of illicit drug markets, as part of the business of drug supply, distribution and use (e.g. assaults, homicides) and (4) drug law offences: crimes committed in violation of drug (and other related) legislations (e.g. possession, cultivation, production, importation and trafficking). The drug law offences will be described in section 2.1. These data were collected by the federal police. Data about self reported crime in 2011 are not available because the surveys from the ‘jeugdonderzoeksplatform’ were not conducted.The other three offence categories will be addressed in section 2.2.

2.1. Drug law offences

Possession, cultivation, production, importation and trafficking of illicit drugs are considered as drug law offences by the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction 2007). Last year we described the evolution of the total drug law offences in Belgium, compared to the total number of law offences (Deprez et al. 2012). These statistics are not available at the moment of writing this report. Therefore, we are only describing the drug law offences as main offence (one person arrested for drugs possession and drug dealing is for example only counted for dealing drugs) registered by the Belgian federal police in table 9.1. The federal police registered 35,765 drug law offences in 2011. This is a decrease of 9% in comparison with 2010 (39,307 drug law offences and a decrease of 14% in comparison with 2009 (41,525 drug law offences). Apparently, this is not an isolated case. According to Gruszcynska & Heiskanen (Grunzczynska and Heiskanan 2012), Belgium experienced already a negative annual growth rate of drug offences between 1998 and 2006.

Table 9. 1: Drug law offences as main offence registered by the federal police in Belgium

Year		
	2011	
Type of offence	N	%
Drug-related use/possession	22,791	63.72
Drug-related dealing/trafficking/production	10,965	30.66
Other types of offences (Aiding with use, other, misuse by pharmacist etc).	2,009	5.62
Total	**35,765**	**100**

Source: Federal police: ST11_2012_BE_01

Concerning the 35,765 drug law offences registered by the federal police in 2011, table 9.1 indicates that 64% is related to use and/ or possession of illicit drugs. 31% of the total drug law offences is related to dealing, trafficking or/and production of illicit drugs and almost 6% is classified as ‘other’.

This is a decrease of 11.41% in comparison with 2008. In 2008 40,370 drug law offences were registered by the federal police. 33.68% of the total drug law offences were related to dealing, trafficking or/and production of illicit drugs. This percentage is a little bit higher than reported in the study of De Ruyver et al. (2008). In this study drug users were asked about their commitment in drug-related crime. 31.3% of the respondents have sold drugs the past 12 months (De Ruyver et al. 2008). The survey indicates that the majority (81%) of them had the age between 18 and 30 and 84% were male (De Ruyver et al. 2008).

Since the federal police do not always register what kind of illicit drug is involved, table 9.2 does only describe the number of illicit substances involved in 93% (33,276) of the drug law offences for the year 2011. The federal police reported that almost 73% of these drug law offences are related to cannabis. 7% of the drug law offences are related to (meth)amphetamine, 2% to ecstasy, 7% to heroin, 8% to cocaine or crack and 3% to 'other' drugs (benzodiazepine, captagon, codeïne, GHB, ketamine, khat, methadone, morfine, opium and mushrooms).

Table 9. 2: Drug law offences as main offence in Belgium, by type of drug, 2006-2011

	Year											
	2006		2007		2008		2009		2010		2011	
Drug type	N	%	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	24,211	72.76
(Meth)amphetamine	2,862	8.1	2,800	7.3	3,275	8.1	2,580	6.7	2,830	7.8	2,323	6.98
Ecstasy	1,921	5.4	1,796	4.7	1,607	4.0	798	2.1	593	1.6	738	2.22
Heroin	3,301	9.3	3,897	10.2	3,706	9.2	2,997	7.8	3,145	8.6	2,186	6.57
Cocaine/crack	3,569	10.1	3,683	9.6	4,042	10.0	3,879	10.1	3,234	8.9	2,819	8.47
Other	1,165	3.3	1,166	3.0	1,392	3.4	963	2.5	991	2.7	999	3.00
Total	**35,458**	**100**	**38,386**	**100**	**40,370**	**100**	**38,561**	**100**	**36,504**	**100**	**33,276**	**100**

Source: Federal police: ST11_2012_BE_01 / ST11_2008_BE_01

These figures indicate the increase of drug law offences related to cannabis over the years. The drug law offences related to (meth)amphetamine are fluctuating over the years, the same trend is visible for heroin related law offences. In comparison with last years, ecstasy related law offences increased in 2011. Cocaine related law offences, instead, are decreasing since 2009. Nevertheless, the drug related law offences classified as 'other' are increasing since 2009. A possible explanation for the increasing trend of the category 'other' is the increase of new psychoactive drugs discovered through the BEWSD system (see Chapter 7, section 2.2.1).

2.2. Other drug-related crime

In the next two paragraphs, an overview is given of the most recent literature about drug-related crime such as robbery, violence and driving under the influence of drugs. The first paragraph describes the onset, duration and desistance of drug-related crime among drug users. The second paragraph gives a description of the profile of drug users who commit crimes and describe different types of drug related crime.

2.2.1 Onset, duration and desistance of drug-related crime

The DRUGCRIM research of De Ruyver et al (2008), describes the reasons of committing drug-related crimes. This research, commissioned by the Belgian science policy office, shows that drug users start committing crimes for different reasons such as, earning money (e.g. to buy food and pay the bills), getting attention, enforcing respect and thrill seeking. This last reason is also mentioned for drug-related crime among drug using youth (Tieberghien and Decorte 2010). Drug users often persist to commit crimes because of their lifestyle, their addiction to drugs, weak family bonds, homelessness or unemployment. Nevertheless, certain circumstances, such as stability, daily activities, etc. facilitate the desistance of drug-related crime (De Ruyver et al. 2008). Since 2009, a PhD-study by Colman (Ghent University, 2012) is focussing on the 'Turning points in the criminal career of drug using delinquents'. Colman & Vander Laenen argue that external factors such as family, employment, marrying, age, etc. are not the most important elements to stop with drug-related crime. Although they might have an influence, the intrinsic motivation of somebody is much more important in the desistance process. Unfortunately, the desistance process of drug using offenders is complex. This process does not evolve in the same way for every drug user who commits crimes. The offences of some drug users are directly related to the use of drugs (e.g. robbery because of financing their drug use). In this case, a recovery from drug use would lead to stop offending. Other drug users often realize the need to change after a difficult period in their life (e.g. after several overdoseses) or a period of heavy drug-related crime. These persons have often the feeling not being themselves anymore. Although these persons are willing to change, most of the respondents are confronted with the difficulty that also society, such as family, friends and colleagues, needs to accept the new roles they want to take (Colman and Vander Laenen 2012).

2.2.2 Drug users who commit different kind of offences

According to the quantitative document analyses of the DRUGCRIM research of De Ruyver et al (2008), 13.6% of the suspects committed at least one drug-related offence in their life. The average age is 29.5, which is a little bit younger than suspects in non drug-related cases.

Among the 204 drug users who where interviewed in this study, 60.2% confirmed having committed a (drug-related) crime during the last 12 months. Although all age groups are represented, drug users between the age of 18 and 30 committed drug-related crimes the most. The majority of these drug users did not have a stable life situation and are not highly educated. The study shows that drug users without a stable family life or education are

committing more offences in comparison to drug users having a stable family life or having had an education. The income of a drug user is also very important. De Ruyver et al describe a negative correlation between income and committing crimes among drug users. Moreover, the percentage of drug-related crimes in a certain region increased with the level of urbanisation in this study. Nevertheless, this does not imply a causal relationship between these factors and offending a crime (De Ruyver et al. 2008).

The majority of these offences are classified as psychopharmacological crimes. Cannabis and heroin, followed by amphetamine, cocaine and hallucinogens are the illicit drugs most cited in relation to drug-related crime (De Ruyver et al. 2008;Decorte and Nachtergale 2012). Nevertheless, benzodiazepines are often mentioned as well among drug using youth (Tieberghien and Decorte 2010). Below, a more detailed description is given of four types of drug-related crimes, namely property offences, violence, sexual offences and driving under the influence of drugs.

Property offences

Among all property offences analysed in 2008, 19.9% of the cases were related to illicit drugs. 21.5% of these cases were committed in big cities.The suspects involved in these crimes are younger than suspects of non drug-related property offences. One third of drug-related property offences are crimes committed in order to obtain money to support drug use (De Ruyver et al. 2008). Property offences are also committed as part of the business of drug supply such as theft of electricity in order to cultivate cannabis plants or theft to be able to refund their dealers. Although, the drug most associated to this kind of offences is heroin (De Ruyver et al. 2008).

Violence

The analysis of police data shows that 7.3% of all violent cases were related to illicit drugs. 10.8% of these cases were committed in big cities. The suspects of drug related violence are younger than suspects of violence in general. More women are involved in drug-related violence in comparison with non drug-related violence. Drug-related violence is often (in 9 of the 30 cases) related to psychopharmacological crime. Another part of the drug-related violence can be categorised as systemic crime. Assault and battery are often described in DRUGCRIM (both police data as self reporting data) as a result of a failure of a deal or as result of a discussion about price and purity of the drugs. In comparison with property offences, violent drug-related crimes are not only associated with heroin use, but also with frequent cocaine use and the use of amphetamines (De Ruyver et al. 2008).

Sexual offences

Among all sexual offences analysed in 2008, 19.9% of the cases were related to illicit drugs. 33.3 % of these cases were committed in big cities. The cases where the victims were under the influence of illicit drugs (18) are higher than the cases where the suspects were under the influence of illicit drugs (11). The drug most associated to this kind of offences is cannabis, followed by cocaine, ecstasy, heroin and amphetamine (De Ruyver et al. 2008).

Driving under the influence of drugs

Between January 2008 and September 2009 a voluntary roadside survey was organised, in the framework of the DRUID (DRiving Under the Influence of Drugs, alcohol and medicines) project, in order to compare the number of drivers in Belgium who have drug concentrations above the legal cutoffs for driving under the influence of illicit substances in blood and oral fluid. Drivers where asked to give both a blood sample and an oral fluid sample. The toxicological laboratory of the department of clinical chemistry, microbiology and immunology of the University of Ghent analysed the blood and oral fluid samples for eleven illicit psychoactive substances. The Act of July the 31th 2009 (B.S. 15.09.2009) which introduces the oral fluid drug testing in traffic was taken into account in order to interpret the results of these analyses as positive or negative based on the confirmation cutoffs for oral fluid and plasma. The results show that 1.0% of the drivers in Belgium would be punishable for driving under the influence of illicit drugs based on the analysis of blood and 2.9% based on the analysis of oral fluid. These percentages are similar to the average 1.90% of drivers under the influence of illicit drugs on European level (Van der Linden et al. 2012).

In the framework of the Road Safety Action Plan, the Federal Highway Police are organising controls in order to screen drivers for their drug use. Since 2011, the Federal Highway Police only uses oral fluid screenings tests. About 51% of these controls are taking place during the weekends and about 50 % of them are taking place during the night and early morning (Ricour, Personal communication, 2011). In 2011, 1020 drivers were tested by the Federal Highway Police through this selective screening method. 17.9% of them tested positive for THC, cocaine, morfine, amphetamine and/or MDMA (B.S.15/09/2009).

Table 9. 3: Drug controls by the Federal Highway Police, oral fluid screening, Belgium, 2011

	2011
Number of controls	*
Screenings	
N	1020
% positive	17.9
refusals	1
Blood tests	183

* Since the introduction of on oral fluids screening device, the first step of the drugs procedure is a visual checklist. In case of positive sign we go to the second step: the oral fluid screening device. If that is positive a doctor will take a blood sample that is analysed in a laboratory. Since the first step is a visual checklist, we don't count the number. However we ask our personnel in the federal highway police to have a quick visual check with every alcohol breath test. We conducted in 2011 263.268 breath tests.

Source: Ricour, personal communication, 2012.

After a positive oral fluid screening test, a blood sample is taken in order to confirm what substances were used. The National Institute for Criminology and Criminalistics (NICC) analyses the majority of these blood samples. The blood samples analysed by the NICC are related both to controls of the Federal highway police and the Local police. In 2011 1,384 blood samples (see table 9.4) were analysed by NICC. 8.3% of these samples were related to false positive oral fluid screening tests. According to the analysis of the NICC, 52.5 % of the blood samples were only related to cannabis. 14.6 % of drivers used amphetamine as only substance, 9% were under the influence of cocaine and 2.3% were only related to opioids.

Table 9. 4: Substances detected in blood sample test after positive oral fluid screening, 2010-2011, NICC

	2011	
Substances detected in blood	N	%
Amphetamine	202	14.6
Amphetamine + cannabis	73	5.3
Amphetamine + cannabis + cocaine	7	0.5
Amphetamine + cannabis + cocaine + opiates	0	0
Amphetamine + cannabis + opiates	0	0
Amphetamine + cocaine	19	1.4
Amphetamine + cocaine + opiates	0	0
Amphetamine + opiates	1	0.1
Cannabis	726	52.5
Cannabis + cocaine	70	5.1

Cannabis + cocaine + opiates	2	0.1
Cannabis + opiates	3	0.2
Cocaine	124	9.0
Cocaine + opiates	11	0.8
Opiates	31	2.3
Below legal cut-off value	115	8.3
Total blood tests	**1,384**	**100**

Source: NICC, Personal communication, 2012.

Specific data about driving under the influence of illicit drugs among drug users were reported by the DRUGCRIM study through self-reported data. 65.8% of the respondents had driven already once in their life time under the influence of illicit drugs. If we have a look into these data, we see that 40.3% of the respondents drove under the influence of illicit drugs during the last 12 months. Most of them (46,4%) are male and are in possession of a university (college) degree (De Ruyver et al. 2008).

3. Prevention of drug-related crime

According to the update of the drug note of 2001 in 2010, prevention of drug-related crime in general is not one of the priorities in order to reach a global and integrated drug policy. Nevertheless, two initiatives related to drug-related crime are mentioned in this document.

The first one concerns the prevention of driving under the influence of drugs. In order to prevent people to drive under the influence of drugs BIVV has developed different prevention campaigns. In 2012 BIVV introduced the Festival Hero, the MNM zero car and the BOB campaign (as every year). Since the introduction of the oral fluid tests several studies have suggested that random roadside drug screening can have a deterrent effect and might prevent driving under the influence of drugs (Interministeriële Conferentie Drugs 2010;Blencowe et al. 2011).

Although drug-related nuisance is not drug-related crime in strict terms, it is worth mentioning that this is also one of the policy priorities of the Interministerial conference on drugs (Interministeriële Conferentie Drugs 2010).

4. Interventions in the criminal justice system

The parliamentary workgroup drugs stressed already in 1996-1997 the importance of alternatives for drug users (Interministeriële Conferentie Drugs 2010). In 2011 different pilot projects were operational in Belgium. These projects will be described in 4.1. In 4.2 a description is given about the reaction of the prosecution system and courts regarding drug-related crime.

4.1. Alternatives to prison

Traditional criminal justice interventions do not have a big influence on the behaviour of drug users. Drug use and drug related crime are often related to other life domains, such as housing, education, work, finances and social networks. Therefore, treatment is often a crucial factor for drug users and has to be integrated also in the criminal justice system in order to influence their behaviour. As such, most drug users confronted with the criminal justice system are convinced of the opportunities alternatives give them to change (Colman et al. 2010).

Firstly, different efforts are made at prosecution level to avoid custody for drug-related crime. The study of 2011 about mediation in criminal matters in 2007 indicates that big efforts are made to convince suspects (and victims) to agree with a mediation proposal. People who committed a drug-related crime (defined in this study as use, possession or dealing) have a bigger change to achieve an agreement in comparison with crimes against persons and offences in family context. In 73.1 % of the drug-related cases involved in a mediation procedure, an agreement was achieved (Vanneste and Burssens 2011). The prosecutor in Liège and Ghent, for example, has the possibility to refer drug users to treatment. These referral-to-treatment projects have both an analogue working procedure, but are still pilot projects (Interministeriële Conferentie Drugs 2010). The procedure of the pilot project in Ghent was described in detail last year (Deprez and Van Malderen 2012). Nevertheless, treatment as modality of the mediation agreement reduces the change of a successful conclusion of the procedure (Vanneste and Burssens 2011).

Secondly, Ghent launched a pilot project at the sentencing level named as the ‘Drugbehandelingskamer’ (DBK). Although we do not know whether this pilot project is effective or not, the qualitative evaluation of this project stresses the attention to different advantages. First of all, the liaison is a very important actor. The liaison does not pay attention only to the drug problem, but also to other different problems the drug user might have difficulties with. Moreover, there is a better relationship between the professional

actors. Justice and treatment know each other better than in the traditional justice procedure and have respect for each other. Nevertheless, there are still a few bottlenecks that need improvement. The DBK procedure implies a higher work load for both the judge and the liaison. They are confronted with capacity problems within (drug)treatment services. As consequence, there is a risk that justice clients get precedence over non-justice clients. Besides this, there is a need for a better description of the assignments of all actors (Vander Laenen and De Keulenaer 2012).

Thirdly, a special pilot project is available for adolescents from 12 to 23 year. This project was launched especially for minor drug users who are not motivated to stop using drugs. The liaison has also in this project, an interfering role. In this pilot project, the clients have the possibility to follow a special treatment of 9 months (Interministeriële Conferentie Drugs 2010).

Although alternatives have more advantages for drug users in comparison with the traditional sentences, the subjective interpretation of the alternative by the drug user is still decisive for the effect (Colman et al. 2010).

4.2. Other interventions in the criminal justice system

In 2011, 5.2% (37,952) of the cases related to drugs or doping entered the prosecution system of first line courts. In comparison with the total amount of cases entering the prosecution system the figures in table 9.5 show an increase in drugs and doping related cases from 2006 until 2008. From 2008 until 2010 the amount of drug related cases decreased and in 2011 the percentage drug and doping related cases remained stable in comparison with 2010.

Table 9. 5: Drug/doping related cases entering the prosecution system of first line court, Belgium, 2006-2011

	Year*					
	2006	**2007**	**2008**	**2009**	**2010**	**2011**
Drug/doping related (N)	33,874	39,058	40,843	40,695	37,835	37,952
% drug/doping-related	4.6	5.6	5.7	5.6	5.2	5.2
Total	**741,436**	**703,341**	**712,329**	**724,422**	**729,354**	**731,007**

* both new and reopened cases

Source: College of the Procurator General (College van procureurs-generaal: Statistisch analiste 2012)

In comparison with the prosecution system of first line court, more drug and doping related cases (%) are entering the youth prosecution system (see table 9.6). In 2010, 7.9% of all cases entering the youth prosecution were related to drugs and doping. The majority of these cases were related to drugs, though. More male (83.3%) than female (16.2%) minors are involved in drugs and doping related cases. Drugs and doping related cases are ranked at the fourth place among male minors, whereas, at the fifth place among female minors. 67.57% of all drugs and doping related cases are committed by the age group of 16 to 18 years old. In 2006, the percentage of drug and doping related cases entering the youth prosecution system was the highest. This percentaged decreased in 2007, but increased again in 2008. From 2009 on, the drug and doping related cases remained stable (Statistische analisten van het Openbaar Ministerie 2012).

Table 9. 6: Drug/doping related cases entering the youth prosecution system, Belgium, 2006-2010

	Year*				
	2006	**2007**	**2008**	**2009**	**2010**
Drug/doping related (N)	6,265	5,850	6,207	6,364	6,547
% drug/doping-related	8.4	7.1	7.4	7.9	7.9
Total (N)	**74,500**	**82,301**	**83,850**	**80,170**	**82,757**

* both new and reopened cases

Source: College of the Procurator General (Statistische analisten van het Openbaar Ministerie 2012)

The global picture regarding the settlement of these drug-doping related cases at prosecution level remains the same as in recent years (table 9.7). Most of them (56.5%) left the prosecution system without consequence in 2011. 15.9% of the drug/doping related cases were handed over. 12% of these cases are related to ‘joinder’, 6.1% to ‘immediate summons’, 7.1% is related to the pre-trial chamber, 3% to ‘out-of-court settlement’ and only 0.3% of the cases completed the mediation. The current data do not allow to make a more detailed subdivision of the drug-related cases (e.g. ‘possession of cannabis’, ‘dealing narcotics’, etc.), as not all prosecutor’s offices are using these subdivisions systematically (Van Dael, personal communication).

Table 9. 7: Closing decision for drug/doping related cases at prosecution system of first line court, Belgium, 2006-2011

	Year											
	2006		2007		2008		2009		2010		2011	
	N	%	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	20,917	56.5
Handed over	5,058	14.8	5,983	15.6	7,217	18.3	5,877	14.7	5,303	14.2	5,879	15.9
Joinder	4,412	12.9	4,869	12.7	5,097	12.9	4,950	12.4	4,478	12.0	4,301	11.6
Out-of-court settlement	763	2.2	891	2.3	932	2.4	1,356	3.4	1,115	3.0	1,00	2.7
Mediation completed	97	0.3	116	0.3	114	0.3	113	0.3	123	0.3	100	0.3
Immediate summons	1,767	5.2	1,930	5.0	2,102	5.3	2,322	5.8	2,289	6.1	2,243	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	2,616	7.1
Total	**34,117**	**100**	**38,283**	**100**	**39,428**	**100**	**39,888**	**100**	**37,334**	**100**	**37,056**	**100**

Source: College of the Procurator General
(College van procureurs-generaal: Statistisch analiste 2012)

The Service for Criminal Policy collects the information about the final judgements in all Belgian courts. In comparison with last year, figures are available until 2010. Additionally, the Service for Criminal Policy made an update of the previous years. The incompleteness of the figures for 2000 until 2004 was the result of either a delay in sending the 'judgement extractions' from the courts to the Central Criminal Registry or a delay in the registry in the Central Criminal Registry itself (Elke Devroe, personal communication). As consequence, table 9.8 shows the figures of drug/medication-related sentences and suspensions in relation to the total numbers of registered sentences and suspensions for the years 2000 until 2010.

Table 9. 8: Sentences and suspensions of drug-related cases, Belgium, 2000 – 2010

	Year										
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Sentences											
All (N)	240,179	254,082	253,597	271,774	288,503	329,920	298,904	237,608	251,195	263,397	250,908
Drug-related (N)	5,080	4,833	5,049	5,200	4,830	5,142	5,439	5,354	5,420	5,226	5,572
% drug-related	2.12	1.90	1.99	1.91	1.67	1.56	1.82	2.25	2.16	1.98	2.22
Suspension											
All (N)	12,766	16,026	16,578	12,547	11,084	13,473	14,726	11,651	9,925	9,487	9,302
Drug-related (N)	1,489	1,450	1,288	971	934	1,016	1,036	839	634	555	568
% drug-related	11.66	9.05	7.77	7.74	8.43	7.54	7.04	7.20	6.39	5.85	6.11

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

The drug-related sentences and suspensions are fluctuating over time. Nevertheless, in global terms, the drug-related sentences have increased from 2.12% in 2000 to 2.22 in 2010. The drug-related suspensions, in contrary, have decreased over the last 10 years from 11.6% to 6.11%

5. Drug use and problem drug use in prisons

Drug testing does not serve as data source in order 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 systematic 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. The instrument used 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 information source to monitor drug use and risk behaviours in the prison population (cf. Todts et al, 2007; Todts et al, 2009). It is used as a tool for policy making. It is the Regional Coordinator of Drug Policy, of the Directorate-general of Prisons of the Federal Department of Justice who is responsible for this information gathering and manages the organisation of the survey.

The latest available data on drug use in Belgian prisons stem from the third edition of the monitoring organised in 2010 (Van Malderen 2012). The results are presented in the annual report of 2011.

The data collection for the fourth edition of this monitoring is organised between July and September 2012.

5.1 Drug use in Belgian prisons: Monitoring of health risks

Offering care starts with a good screening and assessment of prisoners needs. The developed instrument of screening- and assessment of drug use and psychopathological disorders in prison is essential in identifying those needs and referring prisoners to the most suitable treatment program.

5.1.1. Scope and methodology

The monitoring focuses mainly on the epidemiological side of drugs in prison and, to a lesser extent, on health responses. Illicit drugs as well as alcohol are taken into account in this monitoring, although the use of alcohol is prohibited in the prison rules and regulations (Federale overheid justitie 2011). 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 abuse of these drugs is included in the survey.

With the fourth edition this year the questionnaire is reviewed in terms of policy needs. Questions concerning the use of tobacco and anabolic steroids are integrated since it is an explicit objective to include these products in the process of prison policy making. Since the revised methodology in 2010, no changes are made concerning the coverage and sampling procedure and the organisation of the data-collection.

5.1.2 Results

Since the data collection of 2012 is organised between July and September 2012 one has to consult the annual report of 2011 for the latest available data on drug use in Belgian prisons, presenting the results of 2010 (Van Malderen 2012).

6. Responses to drug-related health issues in prisons

The prison 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. This paragraph describes the prevention, treatment and harm reduction initiatives to drug-related health issues in the Belgian prisons.

6.1. Drug treatment

Drug policy in Belgian is gradually put into practice. Different drug-related health services, such as Cognitive-behavioural interventions, OST, TC and drug free programs are available.

6.1.1. Cognitive-behavioural interventions

In 2012 the first ‘Short Duration Drug Program’ (“Kortdurend Drugprogramma”) of six weeks is installed in the prison of Bruges. This cognitive-behavioural program is based on the Transtheoretical Model of change of Prochaska and DiClemente. An existing manual is used as reference in order to develop a prison-oriented, standardised manual based on practical experience with running the program.

6.1.2. 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 prisons 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 was involved.

On 13 of April 2011 again 3% of the total prison population received OST. Methadone is used for 80% of those treated with OST and buprenorfine is prescribed in 20% of the cases.

6.1.3. 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, in 2011, the Nimby-effect has lead to a disapproval of this location.

6.1.4. Continuity of drug free programs

In 2009 a new drug free wing 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 60 prisoners) is used to treat sentenced prisoners for whom drug addiction has lead to their offending. A high intensity, cognitive behavioural programme of 8 months is offered as a 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.

6.2. Prevention and reduction of drug-related harm

The two yearly monitoring of drug use and health risks in prisons clearly demonstrate-s that risk behaviour in Belgian prison population is not negligible. In every prison, information leaflets on the effects of drugs, developed by non profit organisations, are distributed.

6.3. Prevention, treatment and care of infectious diseases

In order to prevent the dispersion of infectious diseases among prisoners, condoms are provided in the Belgian prisons. In addition, prisoners have the possibility for testing of hepatitis and HIV on a voluntary basis in Belgium.

6.3.1. 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. 2012). Therefore, the availability and low threshold accessibility to condoms by implementing a condom distribution method in Belgian prisons is included in the Action Plan 2011 on Drug policy in Belgian Prisons. As a result, a distributing device, based on the principal of a small vending machine, to adjust to the wall, to distribute the package, is created. In every prison, a need assessment is executed examining the number of distributing devices needed to enable a low threshold accessibility to condoms.

6.3.2. Infectious diseases

Access to provider initiated voluntary testing of hepatitis and HIV in prison is available to prisoners. For the latest available data concerning the degree in which prisoners make use of this service, one has to consult the annual report of 2011 drug use in Belgian prisons, presenting the results of 2010 (Van Malderen 2012).

6.4. Prevention of overdose-risk upon prison release

In every prison, the information booklet on health in prison is distributed through internal and external collaborators in their contacts with prisoners. A range of health and drug-related topics are discussed, as well as information on what to do in case of an overdose with a fellow prisoner.

7. Reintegration of drug users after release from prison

In 2011 a central intake unit for drug using prisoners is installed in every prison.

The objective of such 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 unit. The prisons 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, upon which a referral to health care and treatment services outside is realised.

Since prison health care and drug policy is a competence of the Federal department of Justice, 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.

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Chapter 10.
Drug markets

Blanckaert, P.

1. Introduction

Estimations of the drug market in Belgium stem from several different sources. Questionnaires among youth or drug users are used, as well as police reports and lab data. As for the first, the European School Survey Project on Alcohol and other Drugs (ESPAD), Vlaams schoolonderzoeksproject naar alcohol en andere drugs (VLASPAD) (Lambrecht and Andries 2008;2011) and the VAD Leerlingenbevraging (Kinable 2011) provide regularly valuable information about the perceived availability of illicit substances in school students. Results of the most recent wave of these surveys were summarized in last year's Belgian Annual Report (Deprez and Van der Linden 2012). In 2011, a survey on Youth attitudes on drugs was conducted among young people of all EU Member States, at the request of the Directorate-General Justice and Home Affairs of the European Commission (The Gallup Organisation 2011; See also Chapter 2). Noteworthy are the reported results on the perceived ease of access to cannabis, cocaine, ecstasy, heroin, and the places where so-called "legal highs" are offered to young people.

Information regarding drug seizures and the seized illicit laboratories are provided by the General Directorate of the Judicial Police, Direction of Crime against Persons (DGJ-DJP), Drug Programme, and are based on data from the General National Database (GND). This GND gathers all police reports in Belgium, both for local and federal law enforcement services. Information on drug origin and trafficking is provided by the federal police services as well.

Information on drug precursors in Belgium is obtained from the Precursor Unit from the Federal Agency for Medicines and Health Products (FAMHP).

With regard to prices of drugs at street level, this information is obtained from two sources: the Observatoire Socio-epidemiologique Alcool-Drogues (Eurotox asbl, the regional focal point in the Walloon region) and data from the DGJ-DJP.

The results on purity and composition of illicit drugs were obtained from the 2011 database of the Belgian Early Warning System on Drugs (BEWSD). This database includes all notifications of new and high-risk psychoactive substances in Belgium. The analysis results of "classic" illicit drugs are also reported to the BEWSD on a regular basis by the forensic toxicological laboratories in Belgium. A comprehensive overview of the functioning of the BEWSD can be found in chapter 7. An analysis of the composition of known illicit drugs is made. Also, for each substance, the contaminants and cutting agents are listed and

discussed, with a comprehensive analysis of drug composition. A comparison of these data with data obtained from analyzed drug samples submitted by users is also made.

Finally, an update is provided of academic research with regard to the drug market in Belgium.

2. Availability and supply

2.1. Perceived availability of drugs, exposure, access to drugs

According to the “Youth attitudes on drugs” study, Belgian young people (between 15 and 24 years of age) think that they easily (Fairly or very easy: 62.2%) could obtain cannabis within 24 hours if they wanted this substance (The Gallup Organisation 2011). This result is slightly higher with the perceived access to cannabis by all EU respondents fairly or very easy (57.0%). The perceived access to cocaine, ecstasy, and heroin was found to be more difficult, respectively 74.6%, 76.7%, and 82.1% (from “fairly difficult” to “impossible”). These perceptions are more or less in line with the total EU response: 73.1%, 72.8% and 81.5% respectively.

In addition to the perceived availability of the more classic substances, the researchers of the “Youth attitudes on drugs” study also surveyed the use and place of access of new substances that imitate the effects of illicit drugs (“legal highs”). Of the 4.0% youngsters that used such a substance at least once in their lives, the majority (73.3%) received this type of substance of a friend (The Gallup Organisation 2011). This clearly contrasts with the overall EU response, where 54.2% of the users were offered such a substance by a friend. Interestingly, no Belgian respondent bought such substances over the internet (0.0%) whereas the overall EU response was 7.3%. In Sweden, with a comparable life time prevalence of 3.3%, the internet was even for more than a quarter (26.5%) of the respondents the retail channel. The Belgian result somehow surprises given the fact that, for Belgian young people, the internet was found to be the most important information source (63.1%) about illicit drugs and drug use in general.

The final Gallup report does not provide detailed information on the socio-demographic background of the Belgian youngsters that found illicit drugs easily accessible if desired. Based on the responses of the total European sample, the researchers found no gender difference in the perceive access to heroin, cocaine or ecstasy, whereas young women (28.0%), compared to young men (20.0%), found cannabis more difficult to obtain (The Gallup Organisation 2011).

2.2. Drugs origin: national production versus imported

In Belgium, most cannabis seizures originated from The Netherlands or Belgium itself. The most frequent country of origin for seized cannabis resin was Morocco. Significantly less heroin was seized compared to previous years; this heroin was, as in previous years, mostly imported from Turkey. The predominant country of origin for cocaine was Colombia, although seizures from the Dominican Republic were also significant. As in previous years, amphetamines and ecstasy were mostly produced in Belgium or imported from The Netherlands (Dommicent, personal communication).

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

The Belgian federal police provided information about the trafficking patterns for drugs in Belgium. For cannabis plantations, the increasing seizure trend, observed in the previous years, continued in 2011, with a record number of 1070 cannabis plantations seized in 2011 (table 10.1 and 10.5). Most of the production is destined for export to The Netherlands, where the cannabis products are sold in coffee shops. Also, Belgium remains a trafficking country for cannabis resin.

Belgium is a transit country to traffic cocaine from South-America to Europe; this is also reflected in the record amount of cocaine seized in 2011 (table 10.1). The most important points-of-entry remain the sea ports (port of Antwerp) and the Brussels airport. At Brussels airport, less body packers (people swallowing balloons filled with cocaine to escape detection) were observed; on the other hand, more people concealing packages of cocaine on their body or luggage were observed in 2011 (Dommicent, personal communication). As in previous years, again in 2011 a number of ecstasy and amphetamine labs were dismantled. For the first time in Belgium, a methamphetamine lab was dismantled in 2011. However, this concerned a small-scale laboratory, presumably in a test setting, where pseudoephedrine was used as the precursor, using the red phosphorus/iodine route to synthesize methamphetamine (Dommicent, personal communication).
Of note is that in 2011, a large-scale production/packaging facility for synthetic cannabinoids was seized and dismantled in Belgium. The packages of spices mixed with synthetic cannabinoids were destined for export, mostly to Germany, UK and other EU countries. It seems that, for the distribution and manufacturing of synthetic cannabinoid mixtures, Belgium is starting to play a pivotal role.

3. Seizures

3.1. Quantities and numbers of seizures of all illicit drugs

The numbers (table 10.1) and quantities (table 10.2) of seizures for illicit drugs are data obtained from the Belgian federal police (GND, General National Database). As in previous years, the majority of seizures comprise seizures related to cannabis (herbs, plants and resin). In 2011, 75.4% of seizures involved cannabis, confirming the increasing trend in the proportion of seizures related to cannabis of the previous years. Most prevalent in Belgium are cannabis herbs (“weed”).

The number of cocaine seizures in Belgium continues to decline (8.8% of seizures in 2011). However, it has to be noted that the total quantity of cocaine seized in 2011 is markedly increased compared to previous years (a 16.8% increase of seized cocaine quantity was observed in 2011, compared to 2010). Thus, there are less seizures of cocaine, but they are larger in size. Specifically, in 2011, several large seizures (> 500 kg) were made from sea ports in Belgium.

A sharp decline was observed in 2011 in the quantity of heroin seized by federal police services. Only 36% of the quantity seized in 2010 was seized in 2011 (140.3 kg). Also, the number of heroin seizures decreased markedly (2,176 seizures in 2011 compared to 3,433 seizures in 2010, table 10.1).

Table 10. 1: Number of drug seizures by substance, Belgium, 2006-2011

	Year											
	2006		2007		2008		2009		2010		2011	
Drug type	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Cannabis												
Resin	5,546	16.2	5,87	16.0	4,921	15.3	6,206	15.5	5,048	13.3	5,156	13.9
Herbal	17,668	51.5	19,196	52.4	16,831	52.3	22,274	55.5	21,485	56.4	21,784	58.6
Plants*	73	0.2	466	1.3	666	2.1	732	1.8	979	2.6	1,070	2.9
(All)	(23287)	(67.9)	(25532)	(69.6)	(22418)	(69.7)	(29212)	(72.8)	(27512)	(72.3)	(28,010)	(75.4)
Heroin	2,341	6.8	2,85	7.8	2,307	7.2	3,054	7.6	3,433	9.0	2,176	5.9
Cocaine	3,708	10.8	3,656	10.0	3,345	10.4	4,021	10.1	3,448	9.1	3,263	8.8
Amphetamine	2,933	8.6	2,767	7.6	2,646	8.2	2,944	7.3	2,912	7.6	2,699	7.3
Methamphetamine	.	.	.	.	.	.	.	.	64	0.2	91	0.2
Ecstasy-type	2,009	5.9	1,798	4.9	1,412	4.4	921	2.3	650	1.7	838	2.3
LSD	1	0.0	1	0.0	.	.	.	.	59	0.2	78	0.2
Total	**34,279**	**100**	**36,604**	**100**	**32,128**	**100**	**40,152**	**100**	**38,078**	**100**	**37,155**	**100**

Source: Federal police: ST13_2009_BE_01; ST13_2012_BE_01

Table 10. 2: Total quantities of seized drugs by substance, Belgium, 2006 – 2011

	Year					
Drug type	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Cannabis resin (kg)	8,054	58,544	1,529	18,659	3,153	5,019
Herbal cannabis (kg)	4,563	12,732	4,891	4,486	5,207	5,094
Cannabis plants (units)*	110,368	148,251	177,190	272,714	312,528	337,955
Heroin (kg)	154	548	63	275	386	140
Cocaine (kg)	3,946	2,470	3,851	4,605	6,844	7,999
Amphetamine (kg)	119	483	411	49	362	111.5
Methamphetamine (kg)	.	.	.	.	39	2
Ecstasy-type substances (tablets)	482,904	541,245	162,821	31,025	32,954	64,384
LSD (units)	120	1	.	.	3,924	838

Source: Federal police: ST13_2009_BE_01; ST13_2012_BE_01.

The amount of seized amphetamine was significantly less compared to previous years, even approaching the lowest amount in the last six years (111.5 kg in 2011). Methamphetamine remains a relatively rare drug in Belgium, both in number of seizures as in the total quantity of seized methamphetamine (total quantity seized in 2011 was 2 kg). However, one methamphetamine lab was seized (table 10.4). Around double the amount of ecstasy-tablets were seized in 2011 compared to the previous year. Also, smaller amounts of LSD were seized in 2011 compared to 2010. Of interest is that drug smuggling organizations become more and more inventive in disguising their contraband. For example, in 2011 a mail parcel containing a dance pad was seized by the Customs Department at Brussels Airport. After investigation, the inside of the dance pad was found to contain a thick polymer testing positive for cocaine. Laboratory analysis revealed the polymer to contain 18% cocaine, mixed with polyvinyl alcohol (van Nuijs et al. 2012b).

3.2. Quantities and numbers of precursor chemicals used in the manufacture of illicit drugs

The Precursor Unit from the Federal Agency for Medicines and Health Products (FAMHP) collects and reports data on the drug precursors found in Belgium. An overview of drug precursors seized in 2010 and 2011 in Belgium is provided in table 10.3. In 2010, large quantities of 1-phenyl-2-propanon (benzylmethylketon, BMK) were seized, the direct precursor for synthesis of (meth)amphetamine. However, methamphetamine is rarely found in Belgium: the illicit synthesis of amphetamine is more popular.

Table 10. 3: Precursors found in Belgium in 2010 and 2011

Substance	Amount		Location of detection
	2010	2011	
1-phenyl-2-propanon (BMK)	5000 l	/	Bulk Container
1-phenyl-2-propanon (BMK)	50 l	/	Belgian lab
Hydrochloric acid	1016 l	839 l	Belgian lab
Sulphuric acid	100 l	3733 l	Belgian lab
Methanol	70 l	40 l	Belgian lab
Formamide	650 l	15 l	Belgian lab
Formic Acid	300 l	265 l	Belgian lab
Sodium hydroxide	987 kg	896.5 kg	Belgian lab
Sassafras oil		1 l	Belgian lab
Gamma-butyro-lactone (GBL)		30 l	Belgian lab
Alphaphenylacetoacetonitrile (APAAN)		10 kg	Belgian lab

Source: FAMPH, data 2010 and 2011.

In 2011, the only controlled (non-solvent) drug precursor seized was a small amount of sassafras oil, used for the illicit synthesis of MDMA. Also, larger quantities of GBL (the precursor for GHB) and APAAN (a pre-precursor, used to synthesise BMK *in situ*, which in turn is used in the illicit synthesis of amphetamine) were seized, but these are not on the list of internationally controlled precursors.

3.3. Number of illicit laboratories and other production sites dismantled; and precise type of illicit drugs manufactured there

Since Belgium and The Netherlands are known countries of origin for amphetamine and MDMA, it shouldn't come as a surprise that each year a number of illicit drug laboratories are dismantled (table 10.4). The number of seized ecstasy labs has remained stable over the years (with one lab dismantled in 2011). Compared to previous years, a low number of amphetamine labs was dismantled in 2011 (only one, compared to 4 in 2010).

Remarkable in 2011 was the seizure of a methamphetamine-producing lab in Belgium, especially since the use of methamphetamine is low in abundance compared to the use of amphetamine (termed 'speed' in Belgium). However, this seizure concerned a small-scale home laboratory, presumably in a test setting, using (pseudo)ephedrine and red phosphorus/iodine to produce relatively small amounts of methamphetamine (Dommicent, personal communication).

Table 10. 4: Number and type of labs dismantled by Belgian police services, 2006-2011

Lab type	Year					
	2006	2007	2008	2009	2010	2011
Labs for synthetic drugs						
Ecstasy	1		1			1
Amphetamines		3	3	1	4	1
Methamphetamine						1
GHB			1		2	
LSD		1		1		
Ecstasy + amphetamine	1					
Unknown/unspecified combinations		4				
Other						
Creation of tablets			1			
Total	**2**	**8**	**6**	**2**	**6**	**3**

Source: Dommicent, personal communication, 2012.

Regarding the discovery and seizure of cannabis plantations in Belgium, 2011 was again a record year (table 10.5): 1070 plantations were seized, a 9.3% increase compared to 2010. This confirms the increasing trend of numbers of cannabis plantations seized in the period 2007-2011. The largest increase was observed in the number of so-called “mini plantations” (plantations comprising between 6 and 49 cannabis plants): 376 were seized in 2011, compared to 312 in 2010. These mini-plantations also encompass the largest proportion of plantation seizures in 2011 (35.4% of all plantations). The proportion of seized big and industrial scale cannabis plantations remained relatively stable.

Table 10. 5: Number of seized cannabis plantations in Belgium, by plantation size, 2007-2011

	Year									
	2007		2008		2009		2010		2011	
Plantation size*	**N**	**%****	**N**	**%****	**N**	**%****	**N**	**%****	**N**	**%****
Micro	66	16.8	136	21.1	138	18.7	211	21.8	190	17.9
Mini	130	33.1	219	33.9	227	30.8	312	32.2	376	35.4
Small	62	15.8	125	19.3	161	21.8	165	17.0	187	17.6
Middle sized	40	10.2	58	9.0	73	9.9	94	9.7	101	9.5
Big	44	11.2	63	9.8	67	9.1	104	10.7	119	11.2
Industrial	51	13.0	45	7.0	71	9.6	82	8.5	88	8.3
Total with info on size	**393**	**100**	**646**	**100**	**737**	**100**	**968**	**100**	**1061**	**100**
No info***	73		20		1		11		9	
Total	**466**		**666**		**738**		**979**		**1070**	

* 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.

4. Price/purity

4.1. Price of illicit drugs a retail level

Drug street price information for Belgium is collected by the federal police services. For the French community in Belgium, price data are also available from Eurotox. Eurotox collects information on street prices by questioning drug users in contact with prevention services, while federal police data on street drug prices is obtained during interrogation of suspected drug dealers and users. An overview of the reported mean, minimum and maximum drug prices by drug type and region is provided in table 10.6 until 10.10.

For 2011, the average price for 1 gram of herbal cannabis varied between 6.9 and 8.1 €, depending on the region and source of the information. Comparable prices for cannabis resin were observed (between 6.7 and 8 €). Prices remained stable over the years.

Table 10. 6: Cannabis prices in euro at street level, Belgium, 2006-2011

Drug type	Year																	
	2006			2007			2008			2009			2010			2011		
	Mean	min	max	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	8	2	25
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	6.7	2	25
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	7.4	2	25
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	8.1	2	25
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	8	2.5	16.7
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	6.9	2.5	16.7

Source: Federal police: Dommicent, personal communication (ST16_2008_BE_03; ST16_2012_BE_01); Eurotox (ST16_2008_BE_02 – ST16_2012_BE_02).

In 2011, a significant increase in the street price of heroin was observed, reaching the highest level in the past six years (average price varied around 30 € per gram, compared to ~ 25 € per gram in the previous years). This is not surprising considering the decreased availability of heroin, which is in turn reflected by the smaller amounts of seized heroin.

Table 10. 7: Heroin prices in euro at street level, Belgium, 2006-2011

	Year																	
	2006			2007			2008			2009			2010			2011		
Drug type	Mean	min	max	mean	min	max	mean	min	max	mean	min	max	mean	min	max	mean	min	max
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	29.7	7	100
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	30	7	100
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	24.5	6	75
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	.	.	.	.	.	.

Source: Federal police: Dommicent, personal communication (ST16_2008_BE_03; ST16_2012_BE_01); Eurotox (ST16_2008_BE_02 – ST16_2012_BE_02).

Prices of cocaine remain relatively stable over the years. For 2011, average street prices for cocaine of 49.9 to 56 € per gram were reported.

Table 10. 8: Cocaine and crack prices in euro at street level, Belgium, 2006-2011

	Year																	
	2006			2007			2008			2009			2010			2011		
Drug type	Mean	min	max	mean	min	max	mean	min	max	mean	min	max	mean	min	max	mean	min	max
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	49.9	20	100
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	51.8	20	100
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	56	20	100
Crack per gram																		
Eurotox, French community	.	.	.	30.90	5.00	60.00	45.00	5.00	70.00	55.00	40.00	60.00	.	.	.	.	.	.

Source: Federal police: Dommicent, personal communication (ST16_2008_BE_03; ST16_2012_BE_01); Eurotox (ST16_2008_BE_02 – ST16_2012_BE_02).

Reported street prices for amphetamine have slightly decreased from previous years: in 2011, average prices for 1 gram of ‘speed’ varied between 7.53 and 8.35 €. Since methamphetamine use is not prevalent in Belgium, no price data are available.

Table 10. 9: Amphetamine prices in euro at street level, Belgium, 2006-2011

	Year																	
	2006			2007			2008			2009			2010			2011		
Drug type	Mean	min	max	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	8.2	2	25

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	8.35	3	16.7
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	7.53	3	16.7

Source: Federal police: Dommicent, personal communication (ST16_2008_BE_03; ST16_2012_BE_01); Eurotox (ST16_2008_BE_02 – ST16_2012_BE_02).

The average price of an ecstasy-tablet varied between 4.5 and 5.1 €, while reported average prices for 1 dose of LSD varied between 8 and 11.8 €, depending on the region and the source of the information.

Table 10. 10: Ecstasy and LSD prices in euro at street level, Belgium, 2006-2011

	Year																	
	2006			2007			2008			2009			2010			2011		
Drug type	**Mean**	**min**	**max**	**mean**	**min**	**max**	**mean**	**min**	**max**	**mean**	**min**	**max**	**mean**	**min**	**max**	**mean**	**min**	**max**
Ecstasy 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	5.1	1	15
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	4.6	2	10
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	4.5	2	10
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	8	2	18
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	11.8	7	15

* French community data from federal police include Brussels

Source: Federal police: Dommicent, personal communication (ST16_2008_BE_03; ST16_2012_BE_01); Eurotox (ST16_2008_BE_02 – ST16_2012_BE_02).

4.2. Purity/potency of illicit drugs

For calculation of the purity of illicit drugs, the results of analyses performed on substances seized by police and customs services and reported to the BEWSD were used. This concerns both small (at the consumer or small dealer level) and large (for example, a large shipment of cocaine) seizures in Belgium. Mean, minimum and maximum concentrations in seized illicit drug samples are indicated in figure 10.1 for the time period 2002-2011.

Figure 10. 1: Substance concentration in seized drug samples, Belgium, 2002-2011

Source: Database of the Belgian Early Warning System on drugs, ST14_2012_BE_01.

THC concentration in herbal cannabis showed a slight decrease in 2011 (10.72% versus 11.1% in 2010). The maximum observed concentrations also decreased slightly. The same trend was observed in the THC concentration in cannabis resin (mean concentration in 2011 was 11.79%). The maximum THC concentration in cannabis resin was significantly lower in 2011: 22.4% versus 29.0% and 30.2% in 2010 and 2009 respectively (figure 10.1).

After a temporary spike in purity of seized amphetamine powders in 2010, the mean amphetamine purity in seized samples decreased to 22.19%. The observed maximum concentration in 2011 was high, due to the seizure of an amphetamine lab where high-purity amphetamine was seized.

After a period of relatively low mean amounts of MDMA per ecstasy tablet during 2002-2009, the amounts of MDMA per tablet increased in 2010 to a mean value of 92.3 mg of MDMA base per tablet. This trend is confirmed in 2011, although a slightly lower mean value of 85.32 mg of MDMA base per tablet was observed. Perhaps more importantly, the maximum amount of MDMA base found in one ecstasy tablet in 2011 was 150.51 mg, which is a sharp decrease compared to 2010 (198.2 mg) and 2009 (169.5). The number of analysed samples containing MDMA (n=32) was comparable to the previous year.

For cocaine, both the mean and maximum concentrations were similar to previous years (respectively 56.11% and 98.19% in 2011). Except for an increase in 2004 and 2006, mean concentrations in seized heroin samples are relatively stable. The maximum concentration increased from 55.5% to 65.5% in 2011.

4.3. Composition of illicit drugs and drug tablets

Information on the composition of seized drug samples (tablets, powders and liquids) is available from the database of the Belgian Early Warning System on Drugs (BEWSD).

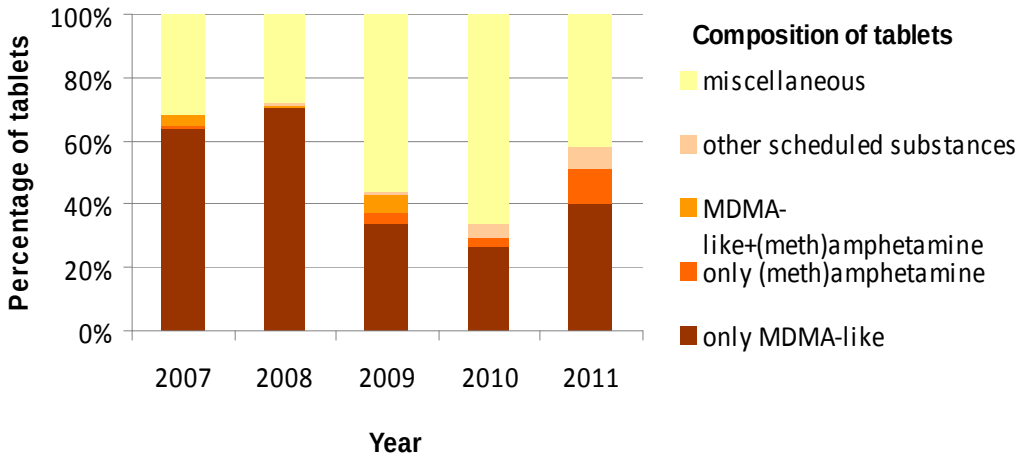
4.3.1. Tablets

A summary of the composition of seized drug tablets is provided in figure 10.2 for the 2007-2011 time period. Compared to previous years, in 2011, an increasing proportion of analysed seized drug tablets contained only MDMA or MDMA-like substances as psychoactive substance. Most of these tablets only contained MDMA. One tablet contained MDMA and MDA, and one tablet MDMA and butylone.

No tablet combinations containing both MDMA and (meth)amphetamine were seized and analysed in 2011. In contrast to the previous years, considerably more tablets containing only (meth)amphetamine as controlled substance were seized. The category “other scheduled substances” includes 3 tablets containing 2-CB and 2 tablets containing MDMA and (trace amounts) of PMMA.

Tablets seized as illicit drugs but containing no scheduled or unscheduled psychotropic substances (for example, tablets containing only lactose, n = 6) were not included in these calculations.

Figure 10. 2: Composition of illicit drug tablets



[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).

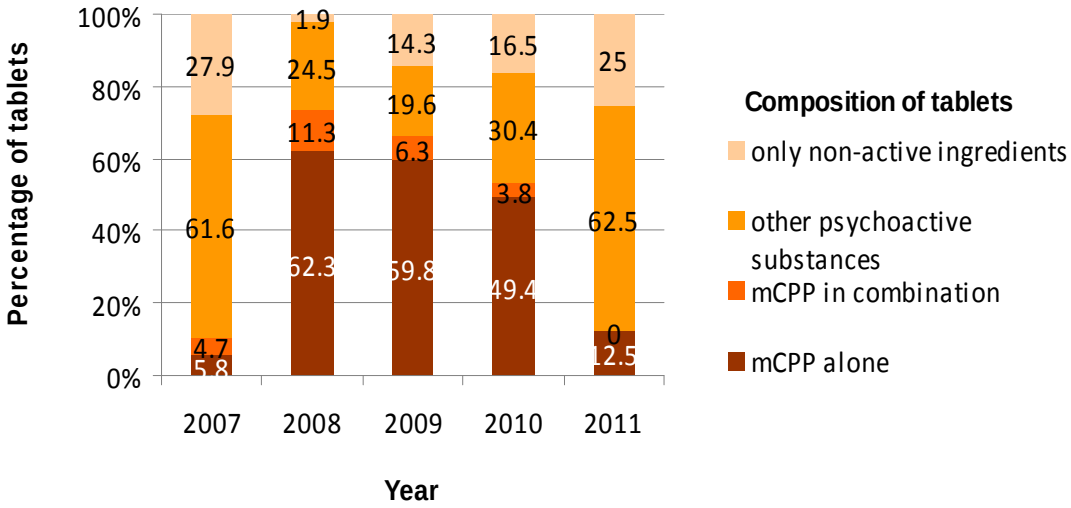
[4] The category 'MDMA-like substances and (meth)amphetamine (as the only scheduled substances) ' refers to tablets containing only MDMA-like substances and amphetamine and/or methamphetamine, together with or without non-scheduled substances (e.g. mCPP, caffeine).

[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_2012_BE_01.

Figure 10. 3: Description of tablets category 'miscellaneous'



Source: BEWSD database, 2011.

An overview of the composition of the drug tablets in the category "miscellaneous" is provided in figure 10.3.

Evident from figure 10.3 is the sharp decrease in the proportion (and number) of mCPP containing tablets. This should come as no surprise, considering the increase in number of drug tablets containing only MDMA or MDMA-like substances, as can be deduced from figure 10.2. However, it has to be noted that in the category "other psychoactive substances", samples submitted as seized drug samples but – after analysis – containing legal psychoactive substances (such as benzodiazepines, ephedrine) are included as well. Also, in several tablets, hormones or other pharmaceuticals were found. In 2011, 3 tablets were analyzed containing only fluoromethamphetamine; also, 1 tablet was analysed containing both fluoromethamphetamine and 3,4-dimethoxy-methamfetamine. The group "only non-active ingredients" includes tablets that only contained substances like ibuprofen, vitamins or lactose.

4.3.2. Other product types

An overview of the adulterants/cutting agents in amphetamine, cocaine and heroin powders can be found in table 10.7. The mean concentration of the adulterant/cutting agent is also provided in table 10.7. (Meth)amphetamine purity is relatively low in Belgium (figure 10.1). For seized (meth)amphetamine powders, caffeine was the most prevalent adulterant, found in 60% of samples in 2011. The mean caffeine concentration in (meth)amphetamine powders was also high: 49.82%.

An important contaminant found in Belgium in amphetamine samples is 4-methylamphetamine, which was present in 6.11% of analysed seized samples, in a mean concentration of 12.58%.

4-Methylamphetamine was responsible for or contributed to the deaths of 3 persons in Belgium in 2011; its presence in amphetamine samples is more than likely the consequence of a contamination with 4-methyl-BMK of the precursor used for amphetamine synthesis (BMK). Currently, it is unclear whether illicit amphetamine manufacturers are aware of this contamination.

Table 10. 11: Adulterants/cutting agents found in seized drug powders

Drug type	Adulterants	Samples (N)	% of samples	Mean adulterant concentration (%)
Amphetamine	4-methylamphetamine	11	6.11	12.58
	Caffeine	108	60	49.82
	Phenacetine	3	1.67	39.25
	Pseudo-ephedrine	1	0.56	1
	Fluoro-amphetamine	6	3.34	3.38
Cocaine	Caffeine	79	15.16	6.34
	Diltiazem	4	0.77	4.86
	Hydroxyzine	35	6.72	5.28
	Levamisole	290	55.67	9.29
	Lidocaine	37	7.11	7.60
	Paracetamol	2	0.39	27.25
	Phenacetine	102	19.58	23.67
	Procaine	2	0.39	5.465
Heroin	Caffeine	97	70.29	20.7
	MAM	100	72.46	2.64
	Noscapine	97	70.29	11.01
	Papaverine	64	46.37	1.21
	Paracetamol	95	68.84	41.31

Source: BEWSD database, 2011.

Cocaine purity is relatively high in Belgium (average purity was 56.11% in 2011, figure 10.1). The most prevalent adulterant in cocaine powder was levamisole: it was present in more than half of cocaine samples (55.67%) in a mean concentration of 9.29%. This trend is worrisome, since levamisole can have immunosuppressive effects in humans and can lead to potentially fatal agranulocytosis (Brabant et al. 2012;Caldwell et al. 2012;Wolford et al. 2012). Moreover, there is a potential for levamisole to be metabolised to 4-methylaminorex,

which can lead to serious health hazards (Barker 2009). Another major adulterant was phenacetine, present in 19.58% of samples in a relatively high concentration (23.67%). Furthermore, caffeine was present in 15.16% of cocaine samples in a mean concentration of 6.34%. Lidocaine and procaine, local anaesthetics used to mimic the local effects of cocaine, were also found frequently. Hydroxyzine, an anti-histaminic, was found in 6.72% of analysed cocaine samples. In a limited amount of samples, diltiazem and paracetamol were present.

However, it has to be noted that the vast majority of analysed cocaine samples were obtained from (large) seizures. Hence, the high observed purity of analyzed cocaine samples is not surprising, considering the position of Belgium as a transit country for cocaine. Since pure cocaine is "cut" further down the line, these purity levels don't necessarily reflect the purity of cocaine at the (street) user level.

Most impurities found in heroin samples (table 10.7) are not added deliberately, but stem from the illicit synthesis of heroin. Also, a lot of alkaloids are present most of the time in heroin produced using opium poppies. Examples of such impurities include mono-acetyl-morphine (MAM, present in 72.46% of samples in low concentrations), noscapine (present in 70.29% of samples in a mean concentration of 11%) and papaverine (present in 46.37% of samples). Adulterants that were deliberately added to heroin (to increase profit) are caffeine (present in 70.29% of samples in high concentrations, 20.7% on average in 2011) and paracetamol (present in 68.84% of samples in high concentrations: mean value was 41.31% in 2011).

From the above results, we can conclude that the least "pure" drug in Belgium is amphetamine, followed by heroin. In amphetamine samples, some common adulterants are found (caffeine, phenacetine). However, it has to be noted that potentially dangerous and even life-threatening substances were also present (mainly 4-methylamphetamine and fluoro-amphetamine). The origin of these adulterants/contaminants remains unclear.

The observed impurities in heroin are mostly alkaloids derived from the opium poppies. However, cutting agents to increase dealer profit (caffeine and paracetamol) are also present. Cocaine is frequently cut with phenacetine, caffeine, hydroxyzine and lidocaine, to increase profit. Levamisole (and in some cases hydroxyzine and diltiazem) is added in the producing country (mostly South-American countries) to increase weight and improve the appearance of the cut cocaine. Also, it adds to the weight of freebase cocaine, since levamisole cannot be removed using an acid/base reaction to produce smokable cocaine or crack.

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 – little information is available on purity. Since they are mostly legal substances, most laboratories do not perform quantitative analyses on these substances.

4.3.3. Analysis of user-submitted drug samples

In Belgium, a small proportion of the analysed drug samples are submitted by users through the Modus Vivendi project. This small-scale project allows users to submit their drug samples for testing in an anonymous way in the Brussels region.

For amphetamine powder, 10 user-submitted samples were analysed. Average concentration of amphetamine base in these samples was 55.20% (median 59.85%, min 4.3%, max 90.2%).

For cocaine, 7 samples were analysed, with an average concentration of 57.39% (median 64.4%, min 25.43%, max 95.5%).

Thirteen tablets or tablet fragments were submitted for analysis in 2011. Of these, 5 contained mCPP; 1 tablet contained amphetamine, 1 tablet contained 2-CB. The remaining 6 tablets contained MDMA. Mostly, tablet fragments are submitted through Modus, which, contrary to drugs in powder form, prohibits calculation of purity or the amount of drugs per tablet.

For cocaine, no differences in average concentration were observed between the user submitted samples and the police seizure data. For amphetamine however, significantly higher average concentrations were observed in the user submitted samples. Also, a larger number of the tablets submitted by users contained other psychoactive substances than MDMA (cfr supra). Especially mCPP was prevalent in these tablets. Since users tend to submit tablets for analysis after feeling no effects, or experiencing adverse effects, this bias shouldn’t come as a surprise.

However, due to the limited size of the user-submitted sample set, these results have to be interpreted with caution.

5. Other research

5.1. Local drug markets

Some cities in Belgium have a local drug and/or alcohol monitoring program.
For example, the city of Antwerp published a report of the local drug-scene in 2007 and 2011 (Decorte and Janssen 2011). The most prevalent drugs of abuse in Antwerp are cannabis, heroin, cocaine, crack and amphetamines.

The most prevalent drug in Antwerp is cannabis, as in most Western countries. Use and possession of small quantities of cannabis, although still illegal, have the lowest priority in the Belgian justice system; in practice, this implies that in most cases, users in possession of small amounts of cannabis (< 3 grams) are not prosecuted.

Heroin use is the most popular drug of abuse amongst marginalised users in Antwerp. This in contrast to socially integrated drug users, who's main drug of abuse is cocaine. Marginalised users in Antwerp seem to prefer the use of smokable (base) cocaine or crack.

Until a couple of years ago, smokable cocaine (in base form or as crack) was not available for sale on the street in Belgium. Recently, the availability of a stable supply of crack on the streets in Antwerp has been reported (Tieberghien and Decorte 2010). Nevertheless, the availability of crack in Antwerp remains limited especially compared to other large European cities such as Amsterdam or Paris.

Amphetamines are less easily obtained in Antwerp, compared to cocaine and heroin.

The use of GHB is increasing in Antwerp, although it is usually not offered for sale on the street (Decorte and Janssen 2011). In most cases, users prepare the GHB themselves.

Ketamine and khat are used sporadically. Also, mephedrone and other new synthetic psychoactive substances are used on a limited scale in Antwerp.

Street drug prices in Antwerp are comparable to the prices in other parts of the country (table 10.6)

5.2. Alternative sampling methods

5.2.1. Waste water analysis

Official figures for the prevalence of illicit drugs in different countries were obtained solely from socio-epidemiological studies, including direct (general population surveys) and indirect (extrapolation from specific populations) methods. Estimates of illicit drug consumption rates and prevalence calculated by such studies may have several limitations, including substantial time lag, self-report bias (intentional and accidental) and limited population coverage that impact negatively the reliability and validity of such data. As recommended by the Commission on Narcotic Drugs of the United Nations and the European Monitoring Centre for Drugs and Drug Addiction, the development of novel approaches is needed not only to provide more realistic, objective and comparable estimates of illicit drug consumption in different communities, but also to rapidly detect changes in the patterns and trends of illicit drug use (van Nuijs et al. 2011).

Dr. Alexander van Nuys (Toxicology Department, University of Antwerp) recently finished a PhD thesis on wastewater analysis (sewage epidemiology) of illicit drugs. The results will be presented briefly here. 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 sewage systems. If an excretion product is stable in wastewater and efficiently transported to a wastewater treatment plant (WWTP), it is reasonable to assume that the amount collectively excreted in a given time period is reflected by the amount reaching the WWTP in the corresponding time interval. This can provide evidence of the amount and types of illicit drugs that are consumed by a certain population (Thomas et al. 2012); (van Nuijs 2011); (van Nuijs et al. 2011).

Partial results of this research were already reported in the Belgian Annual Report 2011 (Deprez and Van der Linden 2012). New results include the data from collaboration with other European research groups to bring the sewage epidemiology approach in a transnational context (Thomas et al. 2012).

It was decided to collect 24-hour composite influent wastewater samples for 7 consecutive days at the same time in 19 locations spread over 11 countries in Europe in March 2011 (being Belgium, Croatia, Czech Republic, Finland, France, Italy, Norway, Sweden, Spain, The Netherlands, United Kingdom). Wastewater samples were analyzed for cocaine, benzoylecgonine, amphetamine, ecstasy, 11-nor-9-carboxytetrahydrocannabinol, and the resulting wastewater loads were normalized for the amount of inhabitants living in the

catchment area of each WWTP. In this way, it was possible to compare the consumption of illicit drugs in Europe in a relatively easy way, in a short time frame and following the same approach. To assure the quality and comparability of the results, an interlaboratory exercise was organized for the first time.

Cocaine use as determined by sewage epidemiology was the highest in Belgium (especially in Antwerp), the Netherlands (Amsterdam) and Spain (Valencia).

For methamphetamine, a regional effect was observed with high use in Scandinavia and the Czech Republic. The other countries showed very low methamphetamine use, and almost no use was observed in Belgium.

Amphetamine and ecstasy consumption was the highest in the Netherlands and Belgium. Moreover, an inverse relationship between methamphetamine and amphetamine/ecstasy use could be found.

For cannabis, no large differences in consumption rates were observed.

The evaluation of weekly patterns showed a significant increased use of cocaine and ecstasy during the weekend compared to weekdays, confirming the recreational character of the consumption of these substances.

All data were generally in agreement with officially reported prevalence data, and thus, sewage epidemiology seems a promising approach to gain knowledge about the consumption of illicit drugs, complementary to the conventional socio-epidemiology (van Nuijs et al. 2012a); (Thomas et al. 2012). Advantages of this approach include low-cost, short time frame of obtaining results and high objectivity of the data, without bias.

5.2.2. CANMARKT cannabis grower survey

To assess and map the production market of cannabis in Belgium, a joint study (CANMARKT) was launched between the Ghent University (Prof. Dr. Tom Decorte, Institute for Social Drug Research) and the Catholic University of Leuven (Prof. Dr. Letizia Paoli, Leuven Institute of Criminology).

Over the last 30 years major changes on the supply side of cannabis have occurred. The shift to (inter)regional production, trade and domestic production of cannabis has become an irreversible international trend. Belgium has been catching up with this trend: the number of plantations that have been dismantled by the authorities has increased sharply in recent years (as is evident in table 10.5). Many of them are indoor operations, located near the Dutch border, set up for commercial purposes. These changes in the organization of the cannabis market raise important questions, in terms of estimating the size of the domestic cultivation industry, in terms of opportunities for new and existing offenders to enter the illegal trade, etc. Furthermore, the rise of domestic or regional cannabis cultivation is associated with heightened levels of criminal organization, involvement of 'gangs' and higher levels of violence (Decorte et al. 2004).

Typologies of cannabis cultivators always include large-scale (commercially oriented) growers on the one hand, and small scale cultivators ('home growers') on the other, and a grey zone in between ('social-commercial cultivators'). Little is known about the exact market share and role of these different types of cannabis producers. Perhaps the most pressing policy issues relate to the differential harmfulness of activities within each type of cannabis producers, and the differential impact of the Belgian drug policy on different segments and networks of the cannabis production market (Decorte 2010).

Therefore, the CANMARKT study aims to describe the organization of cannabis production in Belgium; to create typologies of different types of cannabis producers in Belgium and identify their modi operandi and aims; to assess the market significance of different types of cannabis producers in Belgium (i.e. market segments); and to estimate the harms associated with different types of producers and to evaluate the impact of the Belgian drug policy strategies on them. To this end, two main sets of data collection methods will be used:

- A large-scale anonymous, quantitative web survey among Flemish and Walloon small-scale cannabis producers. The basic module of the web survey questionnaire is developed on the basis of earlier exploratory studies on small scale cannabis cultivation, and will simultaneously be used in (independent en nationally funded) web surveys set

up in the US, Canada, Australia and a few European countries in 2011 and 2012, thus allowing for international comparisons.

- The analysis of min. 40 criminal proceedings, at least 20 qualitative interviews with law enforcement officers and other experts and 15 qualitative interviews with imprisoned cannabis producers.

In particular, the two sets of data will serve to identify the modus operandi of different cannabis producers: patterns and careers of cultivation, technical aspects of growing operations, supply channels for seeds or cuttings, average yields per plant, size of growing operations, number of harvests, destination of harvest, motives for growing, contacts with other growers, labour division and specialisation, financial turn-over, etc. The data will also enable to identify "accompanying activities", such as the use and threat of violence and corruption. Typologies of the different producers and their profiles and aims will be created.
Any effort or activity to reduce cannabis supply must be well-structured, which means the whole criminal drug supply chain needs to be charted, including the origin of the cannabis, the organizers and commissioners of the cannabis production, and the market outlets and the criminal profits.

Special attention must be given to adequate description and representation of the phenomenon and transfer of useful information. The analysis of the organization and structure of the supply side of the cannabis market in Belgium will provide evidence for strategic, operational and tactical priority setting: they will allow to compare the harmfulness of criminal activities within different segments of the cannabis market, to identify the most harmful perpetrators, and to identify and to compare the impact of current and proposed policies in Belgium. This knowledge will be useful for policy-makers, including law enforcement strategic planning advisers.

Also, a study, published by Vanhove et al (Vanhove et al. 2012) and funded by the Belgian Science Policy Office (BELSPO), investigated the yield and turnover of illicit indoor cannabis plantations in Belgium. The Belgian judiciary currently uses outdated yield figures (28.1 g per plant) for fining illicit indoor cannabis plantations. The investigators used state-of-the-art cultivation techniques to simulate the illicit production of cannabis, and concluded that yield is better expressed in g/m^2 cultivated surface area rather than in gram per plant, and that yield significantly varies between different cannabis strains (lower limits of indoor cannabis plantations amounted to 575 gram/m^2).

Acknowledgements chapter 10:

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Part B
Selected issue

Chapter 11.

Residential treatment for drug users in Belgium

Verstuyf G.

1. Introduction

In this chapter an overview of residential treatment in Belgium is presented. A describtion is given about the history, policy frameworks and availability and characteristics of residential treatment. Finally we look at the quality management in residential treatment and discuss trends in demand for residential treatment over the past decade.
In the context of this Selected issue “residential treatment” is defined as a range of treatment delivery models or programmes of therapeutic and other activities for drug users, including mid- and long-term medical- psychosocial interventions within the context of residential accommodation. One defining characteristic of such programmes is that they address multiple treatment needs, including but not limited to the following domains: drug use, health, quality of life and wider social functioning. This definition leaves out: residential detoxification only, programmes dedicated to the provision solely of social support (e.g. shelters,…) to drug users, and drug treatment provision in prison.

2. History and policy frameworks

2.1 History of residential treatment

The first specialized residential centres for drug addicts in Belgium arose from youth organizations and a psychiatric hospital. These centres were created in the middle of the seventies as therapeutic communities.

The two oldest therapeutic communities for drug users, De Sleutel and De Kiem, were created respectively in 1974 and 1977 in Flanders. These residential centres were the first being recognized and officially financed. In 1980, the Belgian National Health Insurance Institute (RIZIV-INAMI) launched the convention “rehabilitation for addicts” allowing new therapeutic centres to be created in the whole country. The absence of juridical definition of a rehabilitation program for drug users allowed these new centres to easily adopt new therapeutic programs and to respond to regional discrepancies. Even if the functioning of the centre is not set by the convention, the therapeutic program of each centre has to be described in the convention.

Only since the eighties some psychiatric hospitals included drug addicts into their addiction units and units were created that had a specialized therapeutic offer for drug addicts, in addition to the existing services for alcohol and medication addicts.

For decades residential care was the norm but under the influence of scientific, social and economic arguments this dominant position clearly shifted toward outpatient care.

In addition, the objectives of treatment for drug users has changed. Where once the emphasis was on abstinence only, nowadays in some residential centres the drug free principle is not so absolute anymore and clients can have prolonged substitution medication if indicated.

Substitution therapy in recent years became the standard treatment for heroin addicts.

As a result of more community-based care there is an enhanced cooperation with neighboring areas (welfare, justice, general practitioners, employment and housing organizations). The last decade there is also a trend towards more coordination and networking.

Innovative projects in residential care that have been positively evaluated recently are: units for mothers with children, integrated treatment programs for dual diagnosis clients, implementation of evidence based practice.

The trend in Mental Health Care towards a more community-based care will also affect substance abuse care.

2.2 Strategy and policy frameworks for residential treatment

2.2.1 Current policy frameworks for provision of residential treatment

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 Inter-ministerial Conference on Drugs approved the Communal Declaration, which was an update of the Federal Drug Policy Note and was prepared by the General Drugs Policy Cell (Van Malderen 2012;Interministeriële Conferentie Drugs 2012a).

On the subject of ‘Treatment’, the Communal Declaration supports 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 optimization 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.

In the Joint statement of the inter-ministerial Conference on Drugs named “A global and integrated drug policy in Belgium” from January 2010 some recommendations are made concerning treatment assistance strategy for drug users. It is stated that a global assistance strategy, starting from a health approach and integrating other dimensions (well-being, social integration…) is necessary. It also indicates that assistance for drug users must be developed and diversified to provide treatment as well as care and caring. To achieve this objective, a large choice of facilities is recommended, i.e. facilities specifically dedicated to drug users or global health care and well-being settings. The geographic repartition of these settings must also be balanced based on an estimation of the needs. The statement defines also what kind of treatment has to be available: non pharmacological treatment, withdrawal treatment, maintenance treatment, harm reduction, reintegration and post cure. Complementary, other problems have to be taken into account when treating those clients: dual diagnosis, employment, housing, psychosocial problems. Another important point to be improved is the consultation and the collaboration between all levels of collaborators. This must lead to the development of networks offering general and specific treatment approach. Waiting lists of clients 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 an individualized assistance for an improved follow-up and a complete approach must be spurred, particularly in specific groups.

2.2.2 Financing models and main funders of residential treatment

Due to the political structure different types of statutory regulations and financial rules co-exist. Several authorities are often involved at the same time and this leads sometimes to a lack of clarity in terms of one’s authority.

In Belgium, residential care is primarily a federal responsibility and residential care facilities analyzed in this report are those that are solely financed by RIZIV-INAMI or the Federal department of Public Health (for hospitals). However, some residential care facilities may be financed by other means. Thus, in Brussels, there is another structure financed by the Federal Department of Justice. Moreover, it is important to note that residential care is articulated with other types of ambulatory accompaniments (and medical) who are numerous in the territory.

The RIZIV-INAMI subsidizes institutions active in the field of rehabilitation, therefore the RIZIV-INAMI has agreements with different sectors. Within the sector of mental and neurological disorders RIZIV-INAMI provides funds for ‘rehabilitation for addicts’. The grants are distributed to crisis intervention centres (CIC), therapeutic communities (TC), day centres

(DC) and medical-social care centres (MSOC-MASS). Each setting has a convention concluded with the RIZIV-INAMI for the reimbursement of medical services. The funding is based on the number of treated clients who meet the conditions of reimbursement.

The table below shows the public expenditure of the RIZIV-INAMI for conventions 'rehabilitation for addicts' for residential institutions divided by region. This is an estimate on the basis of the theoretical ‘annual budget envelopes’ that are linked to an occupancy rate of 90%. In practice, the occupancy is sometimes not reached and sometimes exceeded. The theoretical annual envelope of a rehabilitation centre for addicts includes the full annual cost of the staff and the operating costs.

The bulk of this ‘annual budget envelope’ is paid by the RIZIV-INAMI, and a small share is paid by the clients through co-payments.

Table 11. 1: Government spending (in €) of RIZIV-INAMI Conventions for 'Rehabilitation for addicts in residential institutions per region’ in 2008

	Flanders	Wallonia	Brussels	Total
Residential Centres: CIC and TC	13,945,842.15	9,220,915.86	4,298,769.96	27,465,527.97

Source: (Vander Laenen et al. 2011)

RIZIV-INAMI and the Federal Department of Health are jointly responsible for the expenses of psychiatric hospitals (PZ-HP) and psychiatric service in general hospitals (PAAZ-SPHG).

These institutions are given a budget with a flat rate to cover costs. The budget of the Health and Disability Insurance pays 75% of this budget and the remaining 25% is financed by the Federal Department of Health.

Since the hospitals are obliged to register MZG/RHM (Minimum Hospital data), it is possible to multiply the average daycare-price with the number of hospitalization days 'substance abuse'. This can also be used in the context of a House for psychiatric care (PVT-MSP), Initiative of sheltered housing for psychiatric clients (IBW-IHP) or Psychiatric hospital (PZ-HP), and this with the help of the Minimum Psychiatric Data registration (MPD-RPM). The expenditure arising from this methodology is more accurate. Therefore this methodology is only applied.

On the basis of this formula there are two types of estimates, a minimum and maximum (see table 6). The minimum estimate uses the primary diagnoses abuse / dependence on illegal drugs, alcohol and psychoactive medication. The maximum estimate takes into account the

primary and / or secondary diagnose by this route, the drug-related costs measured for instance among persons with dual diagnosis.

It should be noted that this is an overestimation since the full daycare price is included, even though the primary diagnosis is drug related. The tables below show the data including the number of hospitalization days for PZ-HP, PAAZ-SPHG, IBW-IHP and PVT-MSP that are available for the year 2008. The MZG-RHM registration produces the same data for general hospitals (AZ-HG), but for the year 2007.

Table 11. 2: Number of hospitalization days for primary and / or secondary diagnosis of abuse / dependence of illicit drugs

Type of institution	Number of hospitalization days
PZ-HP	228,055
PAAZ-SPHG	26,845
PVT-MSP	1,188
IBW-IHP	29,376
AZ-HG	105,807
Total	**391,271**

Note: We take into account the 'primary and / or secondary diagnoses because in this way overlaps are excluded. If the criteria 'primary and secondary diagnosis example is used for admissions of people who have a primary diagnosis of illegal drugs and also for admissions of people with a secondary diagnosis of alcohol, this would be charged twice.

Source: Vander Laenen, F.et al (2011)

Table 11. 3: Average daycare-price 2008 per type of institution

Type of institution	Average daycare-price (€)
PZ-HP	242.04
PAAZ-SPHG	348.21
PVT-MSP	102.10
IBW-IHP	40.46
AZ-HG	348.21

Source: Vander Laenen, F.et al (2011)

Table 11. 4: Minimum estimate of government expenditure on the basis of hospitalization days and the average daycare-price (illicit drugs)

Type of institution	Government expenditure
PZ	28,263,494.88
PAAZ	4,917,073.41
PVT	79,944.30
IBW	612,443.02
AZ	2,142,884.34
Total	**36,015,839.95**

Source: Vander Laenen, F.et al (2011)

Table 11. 5: Maximal estimate of government expenditure on the basis of hospitalization days and the average daycare-price (illicit drugs)

Type of institution	Government expenditure
PZ	55,198,423.20
PAAZ	9,347,697.45
PVT	121,294.80
IBW	1,188,552.96
AZ	36,843,055.47
Total	**102,699,032.9**

Source: Vander Laenen, F.et al (2011)

Table 11. 6: Minimum and maximum estimates of government expenditure on the basis of hospitalisation days and the average day-care price of illicit drugs

Type of institution	Minimum hospitalization days	maximum hospitalization days	Average daycare-price (€)	Minimum Government expenditure	Maximum Government expenditure
PZ-HP	116,772	228,055	242.04	28,263,494.88	55,198,423.20
PAAZ-SPHG	14,121	26,845	348.21	4,917,073.41	9,347,697.45
PVT-MSP	783	1,188	102.10	79,944.30	121,294.80
IBW-IHP	15,137	29,376	40.46	612,443.02	1,188,552.96
AZ-HG	6,154	105,807	348.21	2,142,884.34	36,843,055.47
Total	**152,967**	**391,271**		**36,015,839.95**	**102,699,032.9**

Source: Vander Laenen, F.et al (2011)

After these calculations, the drug-related public expenditure for the hospital sector is not yet fully clear since the budget funding is only a part of the government expenditure. In addition there are costs for honoraria of medical staff and pharmaceutical specialties ... (Sermeus 2006). The technical unit of the RIZIV-INAMI provides financial feedback on general hospitals and in the example of alcohol and drug use, the daycare price is 74.8% of the total

amount that is reimbursed by the health services under the mandatory health insurance. In other words, a correction for drug-related spending in general hospitals increases the cost by 33.69%. For psychiatric institutions the average daycare-price is 91% of total government expenditure and the average daycare-price is thus increased by 9.89%.

3. Availability and characteristics

3.1 National (overall) availability

3.1.1 Availability

In Belgium, a large diversity of treatment settings related to psychoactive substances and addiction exist. They try to help people who cannot deal with their addiction and prevent harmful consumptions by informing them on the effects and risks related to 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 (VAD 2012).

As the drug problem is very complex, there is no quick and final solution available to help drug users. It is often a long process with different phases, different from one patient to another. There is no standard treatment available. During a treatment, there are several possible interventions offered by different organizations. Next to specialized or categorical drug centres, informal care and self care as well as primary care play an important role in early detection, care and orientation of people with a drug problem.

Psychiatric hospitals and psychiatric services in general hospitals are most involved in the residential care of drug addicts.

Most of the psychiatric hospitals have a specific section for treatment of people who are using drugs. It is traditionally more oriented towards alcohol and psychotropic drug addicts but more and more of these centres are also treating people addicted to illegal drugs. With medical and psychiatric personnel and a personal approach, they offer a global package of services such as crisis care, screening, detoxification, treatment, social reintegration and after care. Most of the time, clients are encouraged to stop using drugs, this is also a condition during treatment.

In Wallonia and Brussels there are four psychiatric hospitals with a separate unit to provide a specialized program for drug users. There are also specialized units open to alcohol and drug users except “heavy” users such as those addicted to opiates and cocaine. Finally, many hospitals are catering for these clients with helpers specialized in addiction but without

separate treatment services.

In Flanders among the 40 psychiatric hospitals and the 38 psychiatric services in general hospitals, 13 have a specialized unit for drug users.

Since 1980 the RIZIV-INAMI convention ‘rehabilitation for drug addicts’ has been launched. It finances the following treatment programs:

Therapeutic communities are specialized services with a multidisciplinary team oriented to a pedagogic and a group dynamic type of treatment for drug users. The objective of these settings is to detoxificate drug users and to reintegrate them in society. The program is long term oriented. Next to separate units for crisis stay and detoxification, there are also short term therapeutic programs. The reintegration phase often takes place in a separate living situation.

There are 4 therapeutic communities in Wallonia (121 beds), 3 in the Brussels region (50 beds) and 7 in Flanders (135 beds).

Crisis Centres aim to intervene in a crisis situation. These centres try to take care rapidly of the client but also to achieve a detoxification and to prepare and motivate the client for a complementary treatment. There are 2 crisis centres in Wallonia (20 beds), 1 in Brussels (8 beds) and 5 in Flanders (57 beds). Note that crisis units in psychiatric hospitals may also open their door to drug users.

The number of residential clients treated in Belgium can be estimated through different sources, such as TDI and psychiatric hospitals or psychiatric services.

The treatment demand indicator (TDI) gives information about new clients entering specialized treatment centres for their drug problems. Control for doubles can currently only be partially done at the centre or group of centres’ level. The indicator does not reflect the total number of clients in treatment but only the new admissions. The coverage of the centres registering this indicator is high and it concerns for 2010, 11 residential units in Flanders, 7 in the Walloon region and 6 in Brussels region.

Table 11. 7: Number of new treatments by primary drug in residential treatment centres in 2010 registered via the Belgian TDI register

Substance	2010			
Primary drug	Men (N)	Women (N)	Total (N)	Proportion (%)
Opiates	667	92	759	52,9
Cocaine	180	42	222	15,5
Stimulants	108	20	128	8,9
Hypnotics and Sedatives	73	24	97	6,8
Cannabis	142	17	159	11,1
Other primary drug or unknown	57	12	69	4,8
Total	**1227**	**207**	**1434**	**100**

Source: Treatment Demand Indicator, Belgium, 2011

In psychiatric hospitals or psychiatric service in general hospitals, the minimal psychiatric register is recording all admissions. For drug problems the DSM-IV codes were used as main diagnosis.

Table 11. 8: Number of clients with a drug related disorder (main diagnosis on As1 DSM IV) in psychiatric facilities in Belgium, by sex, 2008[1]

Substances	Men (N)	Women (N)	Total	
			(N)	(%)
Amphetamine abuse	103	42	145	1.7
Amphetamine dependence	171	80	251	2.9
Cannabis abuse	219	65	284	3.3
Cannabis dependence	435	103	538	6.3
Cocaine abuse	107	41	148	1.7
Cocaine dependence	351	143	494	5.8
Hallucinogen abuse	4	5	9	0.1
Hallucinogen dependence	13	4	17	0.2
Inhalant dependence	6	5	11	0.1
Opioid abuse	63	26	89	1.0
Opioid dependence	1244	414	1658	19.4
Sedative, hypnotic or anxiolytic abuse	95	213	305	3.6
Sedative, hypnotic or anxiolytic dependence	297	489	786	9.2
Other (or unknown) substance abuse[2]	84	47	131	1.5
Other (or unknown) substance dependence	67	64	131	1.5
Polysubstance dependence	1546	613	2159	25.3
Substance induced disorders[3]	314	601	915	10.7
Substance induced mood disorders	19	8	27	0.3
Substance induced persisting amnestic disorders	6	6	12	0.1
Substance induced persisting dementia	3	5	8	0.1
Substance induced psychotic disorders + delusions	136	31	167	2.0
Substance induced psychotic disorders + hallucinations	50	12	62	0.7
Substance intoxicatie delirium	19	24	43	0.5
Substance withdrawal	67	44	111	1.3
Substance induced disorders nos	24	10	34	0.4
Total	**5443**	**3095**	**8535**	**100**

Source: FOD Volksgezondheid, Veiligheid van de Voedselketen en Leefmilieu, Minimum Psychiatric Data registration (MPD)

[1]Psychiatric facilities are psychiatric hospitals (PZ), psychiatric services in general hospitals (PAAZ), initiatives of sheltered housing for psychiatric clients (IBW) and houses for psychiatric care (PVT).

[2]Other substance abuse (DSM code 305.90) is other (or unknown) substance abuse, caffeine intoxication, inhalant abuse, other (or unknown) substance abuse or phencyclidine abuse.

[3] Substance induced disorder (DSM code 292.89) are substance induced anxiety disorders, substance induced sleep disorder, substance induced seksual dysfunction or substance intoxication.

3.1.2 Referral pathways

The referral pathways to specialized residential treatment can be evaluated by the TDI where a question concerns the source of referral of each patient entering treatment in 2010.

Table 11. 9: Referral pathways to residential treatment

Referral pathway	
Self-referred	38,7%
General practitioner, another drug treatment centre, hospital, medical source	37,7%
Justice	10,4%
Friends or family	6,3%
Social services	5,5%

Source: Treatment Demand Indicator, Belgium, 2011

More than one third (38,7%) are self-referred, 37,7% are sent by their general practitioner, another drug treatment centre, an hospital or another medical source, 10,4% are sent to treatment on juridical decision. Friends or family represent 6,3% of the referrals and social services 5,5%.

In order to process applications, most of the residential treatment centres have established application procedures organizing the reception of clients. In general the centres provide a pre-admission interview (or more) to analyze the request of the person and set up a hospitalization if necessary. There is no general assessment or triage procedure.

In some regions there is network/circuit meetings where admission requests are discussed and the client is given advice for referral.

3.2 Types and characteristics of residential treatment

3.2.1 Common approaches

The following treatment elements are usually (in a greater or lesser extent) part of a residential treatment program, whether or not in certain combinations:

- Pharmacotherapy withdrawal management: usually a gradual cessation of an opioid agonist (methadone) or a short-term use of a partial agonist (buprenorphine).
- Pharmacotherapy maintenance treatment: opioid maintenance treatment is the administration of thoroughly evaluated opioid agonists by accredited professionals in the framework of recognized medical practice to people with opioid dependence for achieving defined treatment aims (World Health Organisation 2009).

- Pharmacotherapy relapse prevention.
- Motivational interviewing: a collaborative, person-centreed form of guiding to elicit and strengthen motivation for change (Miller and Rollnick 2009). Motivation interviewing is usually part of a broader approach in which one tries to motivate the person to seek help or strengthen its reasons for its drug use to reduce or discontinue (Rigter et al. 2004).
- Cognitive behavioral therapy and variants (including skills training, relapse prevention) is a collective term for an intervention carried out in different ways. Usually starts with motivation increase. The client is trained to resist and to guard against cues/triggers. He learns to say no and in more comprehensive approaches to expand his social network to undertake activities other than drug use. The emphasis is on teaching skills to avoid or reduce relapse (relapse prevention). If one cognitive component - 'learning to think differently' – lacks, we speak of behavioral therapy (Rigter et al. 2004). Relapse prevention is a cognitive-behavioral approach in the treatment of addictive behavior specific to the nature of the relapse process approach and suggests coping strategies useful in the maintenance of change (Marlatt and Gordon 1985).
- Group-oriented psychotherapy: a form of therapy in which 2 or more clients participate under the supervision of one or more psychotherapists with the aim of treating emotional disorders, social maladjustment and increased psychotic modes (MeSH 2006).
- Family-work as a continuum of interventions: from increasing family involvement in treatment to family therapy.
- Psycho-education: education about addiction using video, film, lectures, brochures (Rigter et al. 2004).
- Activities aimed at social integration: housing, employment, daytime activation, leisure, budget and so on.
- Relaxation: activity that reduces stress (MeSH 2006).
- Non-verbal forms of therapy: for example, creative-, occupational-, music- and movement therapy.
- Case management: a form of individualized counseling where one pays attention to different life areas with focus on the coordination and continuity of care.
- Aftercare: ambulatory/polyclinical management of clients / clients after they have completed residential treatment.

3.2.2 Examples of typical mix/integration of services

- Inpatient treatment programs for dually diagnosed clients: a long-term residential integrated treatment program that can be seen as a combination of a specialised assessment, outreaching work, motivational interviewing, individual and group counseling, a pharmacological treatment, psycho education and broadening of the social network.
- Residential treatment with a social workplace to train and integrate low-skilled, unemployed inactive people into employment.
- Residential programs with a structural cooperation with selfhelp-groups.

3.2.3 Integration of OST in residential treatment

As mentioned in 1.1 there is a minor trend that in some psychiatric hospitals the drug-free principle is not so absolute anymore and clients can have prolonged substitution medication if indicated. In other words the application requirements to follow the therapeutic program are not so rigid (drug-free) anymore. This is not the case in TC's, though they sometimes accept clients ending an OST treatment.

3.2.4 Typical levels of collaboration and networking

At the national level

There is a federal pilot project with the aim to implement the function of coordinator of care in the platforms of consultation in mental health care for the treatment of people with substance abuse.

The provincial platforms of consultation should investigate regional mental health needs, as well as describe the programs and channels of care. These platforms should also detect missing features in the provision of care through local consultation. Overlap in the provision of care should also be investigated and remedied.

The task of the care coordinator for each of the platforms of consultation is to facilitate dialogue in a circuit of care for people with a problem related to substances and strive for a maximum participation of stakeholders, so that this consultation leads to creation of cooperative agreements from at least three different types of relevant actors.

The situation of collaboration and networking is very different from one province to another and from one region to another so it is very difficult to make an overall assessment. The number of relevant actors varies from province to province. Moreover, in some provinces the

number of specific "drugs" actors is limited because it is principally of general structures (Luxembourg, Brabant, ...).

Some provinces have a tradition of collaboration while others are in the initiation of the process of networking. The level of cooperation between the various services is ranging from consultation and network meetings to a structured formal cooperation agreement.

At the regional level

Since 2007 in French Community, there is a networking project called “Réseau WAB” (shrinking of Bruxelles-Wallonia network) aiming to help clients in difficulties. This network is composed of different stakeholders (psychologist, social worker, nurse…) from residential and outpatient services of Wallonia and Bruxelles helping drug users. Members of the WAB network meet once a month to discuss and elaborate a care pathway for users whom previous treatment trials failed. More generally, they meet to exchange good practices and to elaborate tools to promote networking and facilitate the clinical support to clients. The topic of this network is of course not limited to residential care.

Also, the Walloon government promotes networking between services helping drug users with a recent decree allowing a subvention to create and promote local networks through the whole region. In 2012, 8 local networks can be identified, regrouping mostly services proposing residential and/or outpatient treatment for drug users, but also of services only involved in prevention and harm reduction. The aims of these networks are: 1) to identify the existing ‘help and care’ supply and demand in collaboration with the platforms of consultation in mental health care; 2) to promote institutional consultation to insure a coherent and complete help and care supply at local level; 3) to help each services at a methodological level to improve their actions (information and harm reduction, psychosocial support, and treatments); 4) to collaborate with the platforms of consultation in mental health care; 5) and to initiate and organize intervision if necessary.

At the international level

Several outpatient and residential services in Belgium participate to the addiction network of the European Companionship in Education (ECEtt-addiction), which regroup more than 700 partners across Europe. The principle of this network is to exchange practice and knowledge of workers during training sessions of several days in another service in Europe. Each institution participating to the network also agrees to host workers from another service.

4. Quality management

4.1 Availability of guidelines and service standards for residential treatment

4.1.1 Clinical guidelines

In Belgium, the implementation of evidence-based practice and guidelines is becoming an important issue for policy makers, researchers and practitioners in substance abuse treatment (Autrique et al., 2007, 2009). Despite this rising interest, almost no guidelines for substance abuse treatment have been developed at a national level and working with evidence-based guidelines is not imposed by the government.

However, some treatment services are using of international guidelines, adapting them to their specific context. This is congruent with the suggestion of some authors that investing in the adaptation of existing evidence-based guidelines and even the development of shareable guidelines at a European level might be preferable over the development of guidelines at a national level, since the evidence underlying guideline recommendations is usually of an international nature (Stiegler et al., 2005). So far, in Belgium no international evidence-based guidelines for substance abuse treatment have been adapted at a national level.

Examples of substance abuse treatment guidelines developed in the Flemish Community:

- Guideline for prescribing benzodiazepines to illicit drug users (2008).
- Guideline for the clinical use of buprenorphine – high dosage – in the treatment of opiate dependency (2005).
- Development of Good Clinical Practice in the assessment and treatment of ADHD in (young) adults with addiction problems (2010).

In 2009, different initiatives were taken within the project ‘Quality improvement in substance abuse treatment’ to inform and sensitize substance abuse treatment practitioners in the Flemish Community concerning the importance of evidence-based guidelines, and to increase the expertise of professionals in substance abuse treatment. An overview of existing evidence-based guidelines was developed and disclosed; it concerns general guidelines for substance related problems, as well as guidelines for specific interventions in substance abuse treatment. Dual diagnosis and HIV related to substance abuse are also included. The quality of the guidelines has been assessed by means of indicators derived from the AGREE instrument (the AGREE Collaboration, 2001) and the GLIA instrument (Shiffman et al., 2005). Based on the results of the needs assessment, one international evidence-based guideline is translated each year. All this information can be found on the VAD website.

Training is an important way to enhance the knowledge, skills and attitudes of the drug care professional in quality improvement in residential care.
In Flanders the VAD (Dutch acronym for Association for Alcohol- and other Drugproblems) has an extensive training program for professionals in the area of residential treatment. There's an offer of basic and specialized education and training by Werkwijze® (Work director).

Training was developed on evidence-based practice/evidence-based guidelines and is organised annually. By means of a digital newsletter, substance abuse treatment services are informed of interesting weblinks, new initiatives, evidence-based guidelines. For these trainings, VAD can count on a large group of experts.

In 2010, a manual for quality improvement in substance abuse treatment was developed, focusing on the implementation of evidence-based guidelines and outcome management.
In Flanders about half of the residential facilities use a form of outcome management. For this purpose residential centres usually use self-developed or adapted instruments. The focus of the questionnaires is not always on clinical outcomes but also on clients satisfaction, quality of life and other issues.
There is some resistance by health care professionals towards the type of measurements that link results in an economic principle and resistance to measuring devices that interfere in the therapeutic process. A change of mindset is needed before the addiction outcome management will be supported by all drug care professionals, this will be a lengthy process.
In Belgium, standard and formal systems of quality assurance aren't used by common consensus in the field of treatment.
A major opportunity for quality improvement is the start of the process to general application of TDI. As of Jan. 1st 2011, about 750 treatment programs (or more than 300 treatment centres) in Belgium will register the TDI variables for every new patient. The substantial increase of the number of participating programs is due to the first-time registration by the hospitals (general and psychiatric) and in the regular centres for mental health care in the Walloon Region. The raw data will be merged in a "Master TDI database" that will be used for the EMCDDA standard tables in 2012 and for further epidemiological research by the Drugs and Illegal Substances Program and its partners (van Bussel and Antoine 2011).
Recent examples of practice supporting research commissioned by Belgian Federal Science Policy Office that can improve the quality of residential treatment:

- Effectiveness of inpatient treatment programs for dually diagnosted clients.
- Implementation of casemanagement in the substance abuse treatment system, taking into account regional differences (Flanders, Brussels and the Walloon provinces in

Belgium) and existing practices.

- Treatment trajectories of drug users from ethnic minority groups
- Evidence-based practice in substance abuse treatment in Belgium: a state of the art

5. Discussion and outlook

Challenges

- There is a lack of crisis beds for illicit-drug users. The existing crisis beds are almost only available for alcohol abusers.
- Pilot projects such as dual diagnosis project, care coordination, case management, crisis centres, which have been favorably evaluated several times, are still waiting for a structural embedding/funding.
- The target groups with poly-drug use and associated psychiatric problems have high drop-out rates and more requests for help come in/after crises. For those target groups, a specific and customized offer should be expanded. There is a need for structured cooperation with other sectors that work with these target groups like social services, outreach, etc. Further implementation and adequate financing of long-term counseling for this group is needed.
- There is a need for Belgian clinical guidelines for substitution treatment and more educational initiatives for physicians who want to work with substitution treatment. Treatment centres that offer training/supervision should have financial compensations.
- The treatment capacity for minors is insufficient for both outpatient and residential care. The environment / context is essential in working with young people. That makes the approach complex and time intensive.
- The guidance and influx of ethnic minorities into care remain a problem, partly because of lack of information about the assistance available, the experience of high-threshold of some categorical services and the different way of dealing with health, illness, request for help, treatment and social and family networks. Language and cultural differences especially complicate the counselor-client relationship. Indigenous workers are educated and trained from 'Western' concepts that are sometimes different to the world of ethnic and cultural minorities. Not all native workers are aware of or manage the gap. There is a need-oriented training of indigenous workers to work with clients from ethnic cultural minorities.
- In both outpatient and residential treatment centres we see a slight downward trend in the number of women in treatment. Some methods are insufficiently geared towards women while newer methods such as online assistance and treatment reach a higher percentage of women than the regular assistance.

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Chapter 12.

Recent trends of drug-related public expenditures and drug services

Vander Laenen F.

1. Introduction

For several years, a clear choice at both national and international level for an evidence-based policy can be noticed (Wyatt 2002;Leeuw 2005). For several reasons, the “public expenditure-research” is an integral part of this evidence-based-policy. Firstly, it is impossible to execute a policy evaluation without having insight into the expenditures of the several authorities for the realization of their policy goals (Single 2003). Secondly, the inventory of public expenditures is part of the social cost-research of the drug phenomenon (Moore 2005;De Ruyver et al. 2007;Reuter et al. 2012). Thirdly, a clear view on the outline of the costs is necessary to conduct a cost-effectiveness study. In this respect, since 2001 the EMCDDA underlines the importance of studies on public expenditures on drug policy in the EU member states.

In Belgium, the importance of research into public expenditure is emphasised in the federal policy document on drugs of 2001. The Federal drug note (2001) indicates that, in the framework of an integrated and comprehensive approach, it is indispensable to map the public expenditures of the several policy levels and sectors. To this end, the research ‘Drug policy in Figures I’ was carried out between 2001 and 2003 under Prof. dr. Brice De Ruyver as the promoter (De Ruyver et al. 2004). From 2005 until 2006, ‘Drug policy in figures II’ performed a new measurement using a refined and updated methodology, to gain insight into the evolutions in public expenditure concerning the approach to the drug problem in Belgium (De Ruyver et al. 2007).

In the present research ‘Drug policy in figures III’, the method is refined again and extended to estimate legal drugs (tobacco, alcohol and psychoactive medication) (Vander Laenen et al. 2011). This extension allows - in line with the Joint Declaration of the Interministerial Conference on Drugs (2010) which do not make a distinction between legal and illegal drugs - to obtain a full insight into all public expenditures with regard to an integrated and comprehensive drug policy. Each of the drug policy in figures studies were funded by the Belgian Federal Science Policy.

The biggest part o this contribution is based on the most recent study, “drug policy in figures III” and, as for the part on the evolution in expenditures, on the results of the “drug policy in figures II” study as well.

The results section of this contribution will be focussed on the evolution of the total drug-related expenditure in Belgium and its main components. Because of the complexity of the

public expenditure methodology, the methods used to obtain the results will be discussed in detail, preceding the results.

2. Methodology

2.1. Conceptual framework

The Drugs in Figures III study used the same definition for public expenditure as the two previous studies: "*the composition of the drug budget as an estimation of public authorities' expenditures on the drug policy*" (De Ruyver et al. 2007). The drug budget of the public authorities is analysed at each level of competency (national, regional, provincial and local) for the different policy domains (prevention, treatment, harm reduction and law enforcement).

The study focuses on the direct nature of the public expenditure: "*investments or budget lines of public authorities for actions expressly and directly aimed at implementing drug policy"* (Vander Laenen et al. 2008). Consequently, external expenditures related to the consequences of drug use are not included in the public expenditure analysis. Examples of excluded expenditures are policing expenditures for property and violent crimes resulting from drug use or expenditures for treatment of lung cancer due to smoking. Furthermore, the definition of public expenditure already indicates that private expenditures are excluded. This means that the spending of persons and private organisations such as the expenditure of drug users and expenditure of charity funds is not measured. A corollary merits stating explicitly. Under this conceptual framework, the total social cost is not measured; the public expenditure is one element of the social cost of the drug problem, but it is not the entirety of social costs (Lievens et al. 2012).

2.2. Methodological framework

The drugs in figures III study refined the methodology of 'Drugs in figures I and II' (De Ruyver et al. 2004;De Ruyver et al. 2007) in order to carry out a new estimation of public expenditures (anno 2008: Since there was a 2-year backlog in the data from the hospitals we had to study the data for 2008 for all policy domains) on illegal drugs and a first estimation for legal drugs (tobacco, alcohol and psychoactive medication). For alcohol and psychoactive medication this was limited to the expenditures for a policy with regard to potential misuse and dependence.

The methodology consists of three phases: data collection, data processing and data classification.

2.2.1. Data collection: top-down and check on top-down

In order to collect data, both a top-down and bottom-up approach are applied. The “top-down approach” is a method that starts from the resources made available by the different public authorities involved in drug policy. First, the public authorities are identified (De Ruyver et al. 2004;De Ruyver et al. 2007). Afterwards, the public authorities’ drug budgets are collected and analysed. This top-down approach starts with an analysis of the budget lines of the public administrations. The bottom-up approach is an approach that starts from the activities in the field and traces the money flow back to the public authorities funding.

In Drug policy in figures III study, 98.45% of the identified expenditures came through the top-down approach. Top-down data, that come from official accounting documents such as national budgets, may be more valid for the study, since these data are audited by the Court of Audit and therefore are partially protected from political pressure. Uncertainty arises about the data available from the bottom-up approach, although their impact on the results (1.55%) was limited. These public expenditures come from organisations that depend on the government for most of their funding.

2.2.2. Classification

The classification of public expenditure allows expenditures to be classified according to their goal, and this allows an insight into the ‘policy mix’ of the drug policy. The classification system of Reuter (2004) was applied: prevention, treatment, harm reduction and enforcement. These four conventional categories were also used in the studies of Ramstedt (Ramstedt 2006), Righter (Rigter 2006) and Moore (Moore 2008). The addition of a fifth category “other” in the study was required because some of the expenditures could not be assigned to one of the four pillars of drug policy. The following expenditures were added, amongst others, to the category “other”: European School Survey Project on Alcohol and Other Drugs and contribution to Pompidou Group.

2.2.3. Data processing: Drug specific expenditure, Proration technique & Unit expenditure

The rough financial data are collected during the first phase, followed by the process of data processing. For the three ‘Drugs in Figures’ studies, three methods were distinguished: drug specific data (labeled expenditures), proration technique (non-labeled expenditures), and unit expenditure (non-labeled expenditures).

These methods have several advantages, but also a couple of disadvantages that are discussed below.

For the labeled expenditures, no further calculations are necessary, because the expenditures are exclusively used for drug policy (Prieto 2010).

The other methods are used for drug programmes that are embedded within broader budget categories. This means that a process must be followed to ascribe a portion of that broader budget category to the drug programme. Typical approaches are the proration technique or unit expenditure calculations (Van Malderen et al. 2009). The proration technique is for example used for estimating the expenditure on enforcement by police, judicial authorities and customs. The expenditures of the local police are calculated by multiplying the total local police budget by the fraction of all offences that are offences concerning violations of drug laws. In some cases the methodology of unit expenditure is preferred, because it simplifies the calculation. The proportion of drugs is taken into account for a repartition key and therefore the quantity of 'drugs' is divided by the total amount. For an unit expenditure less data are required because only the quantity 'drugs' (for example, number of hospitalisation days drugs) is necessary to estimate the drug related public expenditure. For example, the public drug expenditures on hospitalisation are estimated by multiplying the average expenditure for hospitalisation per day by the average number of days that drug users are hospitalised.

The main disadvantage of the proration method is that it can lead to distorted figures, because this methodology assumes that, for example in the case of law enforcement, all criminal activity has the same unit cost. However, a number of studies (e.g.(AOS 2006;Moolenaar 2009) have documented the common sense notion that the cost per arrest varies widely across offence types. The difference in the cost of arrest by offense is not taken into account in the proration method and consequently the amount of drug expenditures could be exaggerated. They are likewise exaggerated to the extent that the police do things other than arrest criminals. Presumably some portion of policing expenditures are better thought of as allocated to traffic control, order maintenance, and emergency response, not to arresting people. Therefore, they do belong in the aggregate pool that is prorated by the relative number of arrests by crime type. The results should also be taken with caution since for the underlying aggregate expenditure data were provided by interested institutions/actors, leading to a possible contestation of the reliability of those data (Lievens et al. 2012).

All in all, these examples show that the drug budget is a fragile construction. The results of the public expenditure studies can only be estimations, and the quality of the studies is only as good as the quality and timeliness of the available data (Vander Laenen et al. 2008).

In the Drug policy in figures III study, 75.85% of the identified expenditures were processed by the unit expenditure calculations, 15.48% by proration technique and only 8.67% were labelled expenditures.

In table 12.1, a distinction is made between the labelled and the non-labelled expenditures for the expenditures of 2008. Unfortunately, for the Drug policy in figures II study, it is not possible to present the distinction between labelled and non-labelled expenditures because this distinction was not made during the study.

From table 12.1 it becomes clear that for the categories prevention, harm reduction and 'other', most expenditures are labelled. From our analysis, it became clear that most of the budget for prevention was spent on preventing illicit drugs use, while labeled expenditures for the prevention of alcohol is limited to less than 5 % of the prevention budget. In the pillar harm reduction the entire budget is dedicated to illegal drugs, for the most part for needle exchange and to a small extent for pill testing.The opposite is the case for the categories treatment and enforcement where most of the expenditures are non-labelled and these expenditures had to be calculated by means of proration techniques and unit expenditures.

Table 12. 1: Methodology for data processing for alcohol, illicit drugs and psycho-active medication

	Labelled expenditure		Non-labelled expenditure			
			Proration technique		Unit expenditure	
Category	N	%	N	%	N	%
Prevention	9,049,603	75.91	2,872,543	24.09	/	/
Treatment	61,994,146	8.41	6,803,006	0.92	668,288,246	90.67
Harm reduction	2,256,345	96.85	73,406	3.15	/	/
Enforcement	4,994,941	2.8	134,011,327	63.73	71,278,975	33.90
Other	1,988,213	100	/	/	/	/

3. Results: Comparison of Belgian public expenditures between 2004 and 2008

3.1. Overall evolution

For the national comparison over time, the expenditures of 2008 were compared to the ones of 2004, derived from 'Drugs in figures II' (De Ruyver et al. 2007). The research scope of the drugs in figures II study was limited to illegal drugs therefore we have to limit the comparison over time to illegal drugs as well. The drugs in figures II study found that over 50% of the public expenditures dealing with illegal drugs went to enforcement, approximately 40% to the treatment sector (harm reduction included), and the share of prevention amounted to just under 4%. It was difficult to make a comparison with the 2004 estimate, because of differences in research scope and methods of performing the calculations. The methodology in the drug in figures III study was more refined than the methodology used for the drugs in figures II study (for the hospitals, the ambulant mental health care, the police, the public prosecutor, the detention centres, ...). To give one example, in 2008, we included in the drug budget of the police the expenditures for traffic offences. To allow for a comparison over time though, the 2004 methods have been applied for this contribution. To allow for a comparison over time though, the 2004 methods have been applied for this contribution. Therefore, a new calculation was made for the year 2008 using the same proration techniques as in 2004. This provides a consistent comparison across years, allowing for direct comparisons between past and future budgets produced with the same methods (see table 12.2).

Table 12. 2: Estimated drug policy expenditures (illegal drugs), Belgium, 2004 versus 2008

	Expenditures of 2004 expressed in 2008 monetary units (*)		Expenditures of 2008	
Category	N	%	N	%
Prevention	12.294.733	3,72	11.412.257	2,91
Treatment	130.909.594	39,58	133.557.858	34,05
Harm reduction	min. 340.628 (**)	0,10	2.329.752	0,59
Enforcement	186.038.337	56,24	243.000.490	61,96
Other	1.190.329	0,36	1.890.813	0,48
Total	**330.773.622**	**100**	**392.191.170**	**100**

(*) The expenditures mentioned in the 2004 study are expressed in terms of their real value in 2008. Inflation is taken in account (general index= 111,32 base 2004, year 2008)

(**) In the Drugs in Figures III study, the Flemish expenditure for syringe exchange programmes were no longer listed as prevention; it was considered as the minimum amount for harm reduction.

Between 2004 and 2008, the government expenditures for drug policy have increased quite substantially by more than 61 million Euros (18.57%), with 92.75% of this increase going to supply reduction programmes. Only small changes in expenditures are noticed for demand reduction. In the following paragraphs we will discuss the evolution for the categories prevention, treatment, harm reduction, enforcement and 'other' more in detail.

3.2. Evolution for prevention

From table 12.3 it becomes clear that the total public expenditures for prevention decreased with 7,18% between 2004 and 2008. This decline took place on the level of regions and communities (French community and the 'Commission Communautaire Française' (Cocof)). The subsidies 'prevention des assuétudes' from the French community decreased with 10%. In Brussels Capital-region a decline of expenditures is localised for the 'Commission Communautaire Française' due to changes in content of the activities of 14 subsidized organisations (with more focus on treatment instead of prevention: although the global budget of CoCoF for the 14 organisations increased, in 2004 36.6 % of the expenditures went to prevention while this was 27.3% in 2008).

Table 12. 3: Expenditures prevention (illegal drugs), Belgium, 2004 versus 2008

	2004		2008	
Level	**N**	**%**	**N**	**%**
Federal government	1.820.224	14,80	2.304.105	20,19
Flemish government	3.333.784	27,12	3.060.618	26,82
Wallonia	3.773.711	30,69	3.212.533	28,15
Brussels Capital-region	1.499.838	12,20	1.038.397	9,10
Provinces	596.859	4,85	740.347	6,49
Towns and municipalities	1.270.316	10,33	1.056.256	9,26
Total	**12.294.733**	**100**	**11.412.257**	**100**

3.3. Evolution for treatment

A small increase in expenditure between 2004 and 2008 was observed for the pillar treatment. An analysis of the different competence levels provides more information. At federal level changes were noticed for the specialised drug treatment services with a convention with the National Institute for Health and Disability Insurance (RIZIV/INAMI), namely an increase of approximately 37% in comparison with 2004. On the other hand, the number of hospitalization days in 2008 slightly declined in comparison with 2004. The main

reason for the increase nonetheless was the rising hospital costs per day. For example, the average daily cost in psychiatric hospitals went from 178.76 Euros to 242.04 Euros, while the number of drug dependence diagnoses declined.

Table 12. 4: Expenditures treatment (illegal drugs), Belgium, 2004 versus 2008

	2004		2008	
Level	**N**	**%**	**N**	**%**
Federal government	120.004.951	91,67	123.119.383	92,18
Flemish government	5.312.146	4,06	4.615.193	3,46
Wallonia	2.189.531	1,67	1.604.195	1,20
Brussels Capital-region	2.546.546	1,95	2.894.997	2,17
Provinces	303.558	0,23	430.745	0,32
Towns and municipalities	552.861	0,42	893.345	0,67
Total	**130.909.594**	**100**	**133.557.858**	**100**

Flanders and Wallonia both spent less on drug treatment in 2008. The Walloon region allocated less subsidies to mental health care centres. The Flemish government has increased expenditures for the mental health care centres (CGG), social service centres (CAW) and the helpline (tele onthaal). An increase of the global budget and activities ‘drugs’ for these services are responsible for the increases. The expenditure for the specialised drug treatment centre ‘De Sleutel’ declined though, leading to an overall decrease in expenditure.
We observed an increase of provincial and local expenditures. On the one hand a methodological shift is responsible for this increase, on the other hand large cities invested more in drug treatment.

3.4. Evolution for harm reduction

Harm reduction was not considered as a separate pillar in the 2004 study, it belonged to the pillars prevention and treatment. It is therefore not possible to determine the exact amount of the harm reduction expenditures in 2004. Despite this, the evolution of the Flemish program ‘needle exchange’ could be studied. In 2004 the expenditure for this program is 305,990 Euros and it rises in 2008 to 461,203 Euros. If inflation is taken in account, it still increased with approximately 120.000 Euros.

3.5. Evolution for Law enforcement

In table 12.5 the expenditures for supply reduction are analysed for each level of the criminal justice system.

Table 12. 5: Expenditures enforcement (illegal drugs), Belgium, 2004 versus 2008

	Expenditures 2004 (*)		Expenditures 2008	
Category	N	%	N	%
Detection	152.318.468	81,87	168.989.940	69,54
Prosecution	3.832.648	2,06	6.799.870	2,80
Sentencing	3.883.307	2,09	6.229.902	2,56
Sentence execution	21.836.579	11,74	5.743.379 (**)	23,63
Indefinable level of the criminal justice system	4.167.335	2,24	3.550.399	1,46
Total	**186.038.337**	**100**	**243.000.490**	**100**

(*)Inflation is taken in account (general index= 111,32 base 2004, year 2008)

(**) The methodology of Drugs in Figures II could not be used for the penitentiary, because the necessary information for the proration technique was not available. A great share of the expenditures was measured with unit expenditure or proration technique and this must be regarded as approximations as they are built mainly on various assumptions. Therefore in the Drugs in figures III study, intervals were presented: a low end estimate and a high-end estimate augment the baseline or best point estimates (which is the average between low and high estimate).The minimal estimation of Drugs in Figures III was therefore taken into account.

Increasing expenditures were observed for each level of the criminal justice system. Two factors influenced this evolution. First, the general budget on each level increased more than one would expect on the basis of inflation. Secondly, an upward trend in the number of recorded drug crimes was noticed: on the level of detection the number 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% to 2.99%.

If we take a closer look at the different levels of the criminal justice system, we can study the reasons for this increase in detail. Firstly, on the level of detection, the general national database (ANG) of the police registered 20.64% more drug crimes. Secondly, the expenditures for prosecution and sentencing increased. In comparison with 2004, the number of drug records increased on the level of the public prosecutor with 18.84%, furthermore 26.03% more drug convictions are registered. The evolution on the sentence of execution level was studied by looking at the houses of justice and penitentiary. The

proportion of new mandates ‘drugs’ in houses of Justice increased from 13,12% to 17,20%. The population in the penitentiary for a drug offence increased with 9.78% (minimum estimate) and with 15.45% in the case of drug offences in combination with other offences (maximum estimate).

3.6. Evolution of the category ‘Other’

Between 2004 and 2008 the expenditures for the category ‘other’ show a slight increase (table 12.6). The federal expenditures increased due to methodological changes: a bigger part of the strategic security and prevention plans (SVPP) was considered to fall within the category ‘other’ in 2008 because the expenditures could not be assigned to one of the four pillars of drug policy. The expenditures in the pillar ‘other’ did not change on the local level.

Table 12. 6: Expenditures other (illegal drugs), Belgium, 2004 versus 2008

	2004	2008
Level	N	N
Federal government	927.875	1.588.563
Flemish government	-	38.250
Towns and municipalities	262.452	264.000
Total	**1.190.329**	**1.890.813**

4. Discussion and conclusions

A comparison of the evolution of the public expenditures for illicit drugs between 2004 and 2008 showed that the expenditures for enforcement increased with 30,62 %, while the expenditures for treatment remain stable and the expenditures for prevention even decreased with 7,18 % (Lievens et al. 2012).

The Belgian comparison over time shows changes in the drug budget, especially in the field of enforcement. This could indicate that drug policy has influenced the public expenditures. This is probably not the case since the Belgian federal drug policy note of 2001 remained applicable during the years 2004-2008, and no important changes were made in the national drug policy. A sequence of small decisions on several levels is responsible for the decreasing prevention expenditures and increasing treatment and enforcement expenditures. For example, the police reports on the offence ‘drug possession’ and ‘import/export drugs’ increased between 2004 and 2008. It is possible that the focus on drug tourism has enhanced the enforcement expenditures (Vander Laenen et al. 2011). Another explanation

could be an increase in the fight against public drugs nuisance (Ward 2011). Finally, there may have been no change in enforcement policy per se, but an increase in arrests because of an increase in the level of the underlying criminal activity.

The Belgian public expenditure study of 2004 warned that prevention is underfinanced. The 2004 study was used as an argument by the prevention sector to ask the government for more funding, a request that was not granted, as the 2008 study shows. The comparison over time shows that resources for prevention programmes did not grow; they actually decline, while resources for enforcement increase (by 29.01%). It seems that it was not possible or desirable for Belgium to change the (historical) drug policy mix and enlarge the pillar prevention over this period of four years. Furthermore, the drug expenditures are always after-the-fact calculations based on decisions made by those competent public authorities and therefore they use data collected from budgets and/or accounting statement. The results of a public expenditure study may be useful for guiding future decisions, but it is not a decision forcing instrument (Reuter 2006).

A public expenditure study can be an instrument for guiding the drug policy toward a balanced resource allocation. Moreover, the public expenditure studies can fulfil an important role by serving as the first step for economic evaluation of drug policy interventions, where a cost analysis and social cost study are the next steps. The ultimate goal of public expenditure studies is to derive important information for policy makers and to improve policy making. However, caution must be applied when using the results of a public expenditure study for policy (decision making) purposes only.

Firstly, a full policy evaluation can only be completed by combining information about public expenditures with a range of other types of information/studies. This means basing it upon epidemiological data about new trends in drug use and groups of (problem) drug users, on data about reached target groups (in prevention, early intervention and treatment) and on evaluation and effectiveness studies. A public expenditure study identifies facts that are worth looking into more deeply, but only further research can detect for example a lack of performance. Ideally, this leads to an evidence-based policy, where the financial resources are assigned to the implementation and evaluation of evidence-based prevention, regulatory, treatment, and harm-reduction interventions (Wood et al. 2010).

Secondly, through a public expenditure study the resource allocation and balance in the various drugs and implementation sectors becomes clear. The EU Strategy 2005-2012, states that "*The present integrated, multidisciplinary and balanced approach of combining demand and supply reduction will remain the basis of the Union's approach to the drugs*

problem in the future" (Council of the European Union 2004). It is not clear how demand and supply reduction will be 'combined' to reach this balance. In general, what is an 'appropriate' or desired balance in resource allocation will depend on the criteria deemed to be essential in (drug) policy decision making. It could mean that the resources need to be allocated in accordance with the relative burden that a type of drugs imposes on society. To others, it means allocating the public expenditures to cost-effectiveness programmes (McDonald 2011). Others still mainly follow the historical allocation and want to comply with the prevailing standards (Lee et al. 2010). Although a tension might exist between the scientific and political worlds on which criteria should dominate decision making, both parties have one thing in common: they want to reduce drug-related harm.

Part C
Bibliografie

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Alphabetic list of relevant databases available on internet

This alphabetic list contains only specific drug-related databases (accessed on 11/09/2012). More general databases are provided on the BMCDDA-webite.

Belgian Health Interview Survey (BHIS) interactive analysis module
http://www.iph.fgov.be/epidemio/hisia/index.htm

Federal Research Actions (FEDRA)
http://www.belspo.be/belspo/fedra/prog.asp?l=nl&COD=DR

Ginger
http://www.vadginger.be

IDA-web
http://www.ida-fr.be
http://www.ida-nl.be

Alphabetic list of relevant internet addresses

This alphabetic list contains only specific drug-related websites (accessed on 11/09/2012). More general websites are provided on the BMCDDA-webite.

Algemene cel drugs
https://www.drugbeleid.be

Antwerp drugs intervention centre
http://www.adicvzw.be

Belgian Early Warning System on Drugs
http://ewsd.wiv-isp.be

Belgian Health Interview Survey
http://www.iph.fgov.be/epidemio/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

Cannabis clinic
http://www.chu-brugmann.be/fr/med/psy/cannabis.asp

Centre L'oree
http://www.centreloree.be/index.htm

Centrum voor alcohol en andere drugproblemen Limburg
http://www.cadlimburg.be/index.html

Centrum voor geestelijke gezondheidszorg
http://www.vggz.be

De Druglijn
http://www.druglijn.be

De Sleutel (Flanders and Brussels)
http://www.desleutel.be

De Spiegel (Asse en Leuven)

http://drugshulpverlening.despiegel.org

Driving under the Influence of Drugs, Alcohol and Medicines (**DRUID)**
http://www.druid-project.eu

EUROTOX
http://www.eurotox.org

Free Clinic
http://www.free-clinic.be

Gezondheidsenquête
https://www.wiv-isp.be/epidemio/epinl/index4.htm

Go for zero
http://www.goforzero.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

Kompas VZW (West Flanders)
http://www.kompasvzw.be

Modus Vivendi:
http://www.modusvivendi-be.org

Narcotics anonymous
http://www.na-belgium.org

Plate-forme de Concertation pour la Santé Mentale en Région de Bruxelles-Capitale - Overlegplatform Geestelijke Gezondheidszorg Gebied Brussel-Hoofdstad
http://www.pfcsm-opgg.be

Service de prévention Schaerbeekois aux usagers des drogues:
http://sepsud.irisnet.be

Sozial-Psychologisches Zentrum (SPZ)
http://www.spz.be

Stedelijk overleg drugs Antwerpen
http://ocmw.antwerpen.be/Overig-OCMW/Publicatiekanalen/Overig/Overig-OCMW/Website-OCMW/OCMW-Hoofdnavigatie/OCMW-Hoofdnavigatie-Partners/Stedelijk-Overleg-Drugs-Antwerpen.htmlS

Therapeutisch programma voor druggebruikers en hun omgeving De Kiem (Gent, Ronse/Geraartsberge, Gavere)
http://www.dekiem.be

Trempoline: prevention et traitement des assuetudes
http://www.trempoline.be

Universitair Wetenschappelijk instituut voor Drugsproblemen
http://www.uwid.be

Vereniging voor Alcohol en andere drugproblemen (VAD)
http://www.vad.be

Vlaamse schoolonderzoeksproject naar alcohol en andere drugs (**VLASPAD)**
http://www.vlaspad.be/vlaspad/vlaspad.php

List of Standard Tables submitted in 2012*:

ST/SQ	Full title	Submitted by	Data provider	BAR chapter(s)
ST 5	ST5_2012_BE_01: Drug-related Deaths/Drug-induced deaths, Belgium, 2006. ST5_2012_BE_02: Drug-related Deaths/Drug-induced deaths, Belgium, 2008.	BMCDDA	General mortality Register	6
ST 6	ST6_2012_BE_01: Evolution of Acute/direct related Deaths, Belgium, 2006-2008.	BMCDDA	General mortality Register	6
ST 7&8	ST7_2012_BE_01: National/local prevalence estimates on problem drug use, Ever IDU, Belgium, 2011.	BMCDDA	HIV/AIDS register + Survey	4
ST 9 Part 1	ST9_2012_BE_01: Methods prevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs), French Community, 2011. ST9_2012_BE_02: Methods prevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs), Flemish Community, 2011. ST9_2012_BE_03: Methods prevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs), Antwerp, 2011.	Eurotox VAD VAD	Treatment centres De Sleutel Free Clinic	6
ST 9 Part 2	ST9P2_2012_BE_01: Serology prevalencePrevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs)_HIV Self-reported, Walloon region, 2011. ST9P2_2012_BE_02: Serology prevalencePrevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs)_HCV AB, Flemish Community, 2011.	Eurotox VAD	Treatment centres De Sleutel	6

	ST9P2_2012_BE_03: Serology prevalencePrevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs)_HIV AB, Flemish Community, 2011.	VAD	De Sleutel	
	ST9P2_2012_BE_04: Serology prevalencePrevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs)_antiHBs, Flemish Community, 2011.	VAD	De Sleutel	
	ST9P2_2012_BE_05: Serology prevalencePrevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs)_antiHBc, Flemish Community, 2011.	VAD	De Sleutel	
	ST9P2_2012_BE_06: Serology prevalencePrevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs)_HBsAG, Flemish Community, 2011.	VAD	De Sleutel	
	ST9P2_2012_BE_07: Serology prevalencePrevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs)_TPHA, Antwerp, 2011.	VAD	Free Clinic	
	ST9P2_2012_BE_08: Serology prevalencePrevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs)_antiHBs, Antwerp, 2011.	VAD	Free Clinic	
	ST9P2_2012_BE_09: Serology prevalencePrevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs)_antiHBc, Antwerp, 2011.	VAD	Free Clinic	
	ST9P2_2012_BE_10: Serology prevalencePrevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs)_antiHAV, Antwerp, 2011.	VAD	Free Clinic	
	ST9P2_2012_BE_11: Serology prevalencePrevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs)_HCV Ab, Antwerp, 2011.	VAD	Free Clinic	
	ST9P2_2012_BE_12: Serology prevalencePrevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs)_HbsAg, Antwerp, 2011.	VAD	Free Clinic	
	ST9P2_2012_BE_13: Serology prevalencePrevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs)_HIV Ab, Antwerp, 2011.	VAD	Free Clinic	
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TDI_2012_BE_03: Characteristics of persons starting treatment for drugs in low-threshold agencies, Belgium, 2011.

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Annexes

Annex 1:

List of abbreviations

Abbreviations	Explanation
2-CB	4-bromo-2,5-dimethoxyphenethylamine
ACHG	Academisch centrum voor huisartsgeneeskunde *(Academic Center for family medicine)*
ADAM	Antwerp Drug and Alcohol Monitor
ADAPT-YOUTH	Adapting best practice guidelines for the detection, prevention and treatment of substance abuse in children and youngsters to a local Belgian context
ADHD	Attention Deficit Hyperactivity Disorder
AIDS	Acquired Immune Deficiency Syndrome
Aids	Acquired Immune Deficiency Syndrome
ALFA	Aide Liégeoise aux Alcooliques et à leur Famille *(Help Liege to Alcoholics and their families)*
ALTO	Alternative aux Toxicomanies *(Alternative to drug addiction)*
AMJAD	Antwerpse Monitor Jongeren, Alcohol en Drugs *(Antwerp Monitor on Youth, Alcohol and Drugs)*
ANG	Algemene nationale gegevensbank *(General national database)*
anti HBc	Hepatitis B core antigen
anti HBs	Hepatitis B surface antigen
APAAN	Alphaphenylacetoacetonitrile
ASBL	Association sans but lucratif *(Non-profit association)*
ASL	Arbeitsgemeinschaft für Suchtvorbeugung und Lebensbewältigung *(Association for addiction prevention and life management)*
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
AZ-HG	Algemeen ziekenhuis *(General hospital)*
BAC	Blood Alcohol Content
BDN	Boule de Neige *(Snowball)*
BELSPO	Belgian Science Policy
BELTA	Belgian Lung and Tuberculois Association
BEWSD	Belgian Early Warning System on Drugs
BHIS	Belgian Health Interview Survey
BIVV	Belgisch Instituut voor de VerkeersVeiligheid *(Belgian Institute for Traffic Safety)*
BMCDDA	Belgian Monitoring Centre for Drugs and Drug Addiction

Abbreviations	Explanation
BMK	Benzylmethylketon
BTDIR	Belgian Treatment Demand Indicator Register
CAD	Centra voor Alcohol en andere Drugproblemen *(Centres for Alcohol and other Drug problems)*
CANMARKT	Cannabis production in Belgium: assessment of the nature and harms, and implications for priority setting
CAP	Centraal aanmeldingspunt voor druggebruikers *(Central Intake Unit for drug using prisoners)*
CASG	Centres d'Action Sociale Globale *(Global Social Action centres)*
CAW	Centrum Algemeen Welzijnswerk *(Centre General Social Work)*
CD4	Cluster of differentiation 4
CEV	Centre for evaluation of vaccinations
CFWB	Communauté Française Wallonie – Bruxelles *(French Community Wallonia – Brussels)*
CGG	Centra Geestelijke gezondheidszorg *(Mental health centres)*
CHU	Centre Hospitalier Universitair *(Hospital university centre)*
CI	Confidence interval
CIC	Crisis Intervention Centres
CLICK	CompuLsIve Computer use and Knowledge needs in Belgium: A multimethod approach
CLPS	Centre local de promotion de la santé *(Local health promotion centre)*
COCOM	Commission Communautaire Commune *(Common Community Commission)*
CPAS	Centre Public d'Aide Sociale *(Public Center of social assistance)*
CRA	Community Reinforcement Approach
CSPS	Conseil Supérieur de Promotion de la Santé *(Superior Council of Health Promotion)*
DBK	Drugbehandelingskamer *(Drug Treatment Court)*
DC	Day Centre
DGJ-DJP	General Directorate of Judicial Police - Direction of crime against persons
DICIII	Drugs In Figures III
DR-	Drogues Risquer moins *(Drug risk less)*
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

Abbreviations	Explanation
DSM IV	Diagnostic and Statistical Manual of mental disorders, fourth edition
DU	Drug users
DUI	Driving Under the Influence
ED	Emergency Departement
EDDRA	Exchange on Drug Demand Reduction Action
EHIS	European Health Interview survey initiative
EMCDDA	European Monitoring Centre for Drugs and Drug Addictions
ESPAD	European School Survey Project on Alcohol and Other Drugs
EU	European Union
EuropASI	European addiction severity index
EUROTOX	Observatoire Socio-Épidemiologique Alcool-Drogues
EWS	Early warning System
FAMHP	Federal Agency for Medicines and Health Products
FARES	Fonds des Affections Respiratoires *(Fund of respiratory diseases)*
FESAT	European Foundation of Drug Helplines
FOREM	le service public wallon de l'emploi et de la formation.
FPS	Federal Public Service
GBL	Gamma-butyro-lactone
GHB	Gamma-hydroxybutyrate
GMR	General Mortality Record
GND	General National Database
GP	General Practionners
GPS	General Population Survey
HAV	Hepatitis A virus
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
HIV	Human Immunodeficiency Virus
HIV Ab	Human Immunodeficiency Virus Antibody
IBW-IHP	Initiative of sheltered housing for psychiatric patients
ICD-9-CM	International classification of diseases - version 9 - clinical modification
ICPC	International Classification of Primary Care
IDA	Information about drugs and alcohol
IDU	Injecting Drug use

Abbreviations	Explanation
IFEB-IPhEB	Belgian institute for pharmaco-epidemiology
INCANT	International Cannabis Need of Treatment project
IRQ	Injecting Risk Questionnaire
IUFC	Institut universitaire de formation continue
IVR	Interactive voice response system
JAC	Jongeren Advies Centra *(Youth Advice Centres)*
JUSTHULP	Essential and supplementary preconditions for the interaction of justice and drug treatment services
JWH-019	1-hexyl-3-(1-naphthoyl)indole
LOGO	Lokaal GezondheidsOverleg *(Local health consultation)*
LSD	Lysergide / Lysergic acid diethylamide / 9,10-didehydro-N,N-diethyl-6-methylergoline-8β-carboxamide
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-Methylenedioxymethamphetine
MHD	Minimum Hospital Data
MPD	Minimum Psychiatric Data
MSOC-MASS	Maison d'Accueil Socio-Sanitaire - Medisch sociaal opvangcentrum *(Medical social care centre)*
NAAP	National Alcohol Action Plan
NEP	Needle exchange project
NEWIP	Nightlife Empowerment & Well-being Implementation Project
NGO	Non-governmental organisation
NICC	National Institute for Criminalistics and Criminology
NIHDI	National Institute for Health and Disability Insurance
NSTR/NRST	National Substitution Treatments Register
OCMW	Openbare Centrum voor Maatschappelijk Welzijn *(Public centre for social welfare)*
OIP	Organization of Public Interest
OIVO	Onderzoeks- en Inforatiecentrum van de verbruikersorganisaties *(Research and Inforation centre for consumer organisations)*
OP	Occupational physiciens
OST	Opiate Substitution Therapy
OTC	Opleidings en tewerkstellings centrum *(Training and employment centre)*

Abbreviations	Explanation
PAA	Points d'appui assuétudes *(Addiction support points)*
PAAZ-SPHG	Psychiatrische afdeling van algemeen ziekenhuis – Service Psychiatrique de l'Hôpital Général *(Psychiatric service in general hospitals)*
PCO	Plan Communautaire Opérationnel *(Operational community plan)*
PCS	Plans de cohésion sociale *(Social cohesion plans)*
PDU	Problem Drug Use
PFCSM - OPGG	Plate-forme de Concertation pour la Santé Mentale en Région de Bruxelles-Capitale - Overlegplatform Geestelijke Gezondheidszorg Gebied Brussel-Hoofdstad
PHDC	Policy Health Drugs Cell
PMMA	Polymethyl Methacrylate
PMS	Centre Psycho-Médico-Social
PSE	Service de promotion de la santé à l'école *(The school health promotion service)*
PSSP	Plans stratégiques de sécurité et de prevention *(Safety and prevention strategic plans)*
PVT-MSP	Psychiatrisch verzorgingstehuis - Maison de soins infirmiers psychiatrique *(House for psychiatric care)*
PZ-HP	Pschychiatrisch ziekenhuis – Hôpital Psychiatrique *(Psychiatric hospital)*
QoL	Quality of life
RAR	Rapid Assessment and Response
RdR	Reduction des Risks *(Risk reduction)*
REES	Réseau des Écoles en Santé *(Network of Schools in Health)*
SAP	Service Aide et Prévention *(Help and Prevention Service)*
SBIRT	Screening Brief Interventions and Referral to Treatment
SEM-J	Screeningsinstrument Ervaringen met Middelengebruik – Jongeren *(Screening instrument experience with substance use – youth)*
SIPAR	Système Informatique PARajudiciaire
SLCD	Surveys, Lifestyle and Chronic Diseases
SLN	Sentinel Laboratory Network
SODA	Sociaal overleg drugs Antwerpen *(Social consultation drugs Antwerp)*
SPZ	Sozial-Psychologisches Zentrum
SQ	Standard Questionnaire
SSM	Service de Santé Mentale *(Mental health service)*
ST	Standard Table
STI	Sexual transmittable infection
SVPP	Strategische veiligheids en preventie plannen *(Strategic safety and prevention plans)*

Abbreviations	Explanation
TAD	Tobacco, Alcohol and Drugs
TADAM	Treatment Assisted by DiAcetylMorphine
TC	Therapeutic Community
TDI	Treatment Demand Indicator
THC	Δ^9-tetrahydrocannabinol
UK	United Kingdom
ULB	Université Libre de Bruxelles
UP TO DATE	Use of alcohol, illegal drugs, hypnotics and tranquilizers in the Belgian population
UWiD	Universiteir wetenschappelijk Instituut voor Drugsproblemen *(University Scientific Institute for Drugproblems)*
VAD	Vereniging voor Alcohol- en andere Drugproblemen *(Association for Alcohol and other Drug problems)*
VAD-LLB	Leerlingenbevraging van de Vereniging voor Alcohol en andere drugproblemen *(Pupils survey of Association for Alcohol and other drug problems)*
VAT	Value-added tax
VDAB	Vlaamse Dienst voor Arbeidsbemiddeling en Beroepsopleiding *(Flemish service for employment mediation and vocational training)*
VIGEZ	Vlaams instituut voor gezondheidspromotie en ziektepreventie *(Flemish Institute for health promotion and disease prevention)*
VLASPAD	Vlaams schoolonderzoeksproject naar alcohol en andere drugs *(Flemish school research project on alcohol and other drugs)*
VRGT	Vlaamse Vereniging voor Respiratoire Gezondheidszorg en Tuberculosebestrijding *(Flemish Association for respiratory health and Tuberculosis control)*
WHO	World Health Organisation
WIV-ISP	Wetenschappelijk instituut voor de volksgezondheid – Institut de la santé publique *(Scientific Institute for Public Health)*
WWTP	WasteWater Treatment Plant

(Italics) : English translation

Annex 2.

List of tables

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Annex 4.

List of full references of laws in original language

Belgian legislation texts

French

28 decembre 1983 - Loi sur la patente pour le débit de boissons spiritueuses (M.B. 30.12.1983).

10 février 1994 - Loi organisant une procédure de médiation pénale (M.B. 24.04.1994).

10 decembre 1997 - Loi interdisant la publicité pour les produits du tabac (M.B. 11.02.1998).

20 decembre 2001 - Décret concernant la promotion de la santé à l'école (M.B. 17.01.2002).

16 mai 2002 - Décret relatif à la promotion de la santé dans l'enseignement supérieur hors universités (M.B. 07-06-2002).

19 juillet 2004 - Loi modifiant la loi du 24 janvier 1977 relative à la protection de la santé des consommateurs en ce qui concerne les denrées alimentaires et autres produits (M.B. 10-11-2004).

10 aout 2005 - Arrêté royal modifiant la loi du 7 janvier 1998 concernant la structure et les taux des droits d'accise sur l'alcool et les boissons alcoolisées (M.B. 22.08.2005).

5 mai 2006 - Décret relatif à la prévention du tabagisme et l'interdiction de fumer à l'école (M.B. 21.06.2006).

6 juin 2008 - Décret instituant une interdiction de fumer dans les établissements d'enseignement et les centres d'encadrement des élèves (M.B. 18.07.2008).

28 mai 2009 - Arrêté ministériel dêterminant les avertissements combinés pour toutes les unités de conditionnement de cigarettes mises dans le commerce (M.B. 02.07.2009).

31 juillet 2009 - Loi relative à l'introduction des tests salivaires en matière de drogues dans la circulation (M.B. 15.09.2009).

10 decembre 2009 - Loi portant des dispositions diverses en matière de santé (M.B. 31.12.2009).

22 decembre 2009 - Loi instaurant une réglementation générale relative à l'interdiction de fumer dans les lieux fermés accessibles au public et à la protection des travailleurs contre la fumée du tabac (M.B. 29.12.2009).

25 janvier 2010 - Une politique globale et intégrée en matière de drogues pour la Belgique: Déclaration Conjointe de la Conférence Interministérielle Drogues (M.B. 15.04.2010).

Dutch

28 december 1983 - Wet betreffende de vergunning voor het verstrekken van sterke drank (B.S. 30.12.1983).

10 februari 1994 - Wet houdende regeling van een procedure voor de bemiddeling in strafzaken.(B.S. 27.04.1994)

18 janvier 1995 - Arrêté du Gouvernement de la Communauté française relatif à la diffusion de campagnes d'éducation pour la santé par les organismes de radiodiffusion (B.S. 19.04.1995).

10 december 1997 - Wet houdende verbod op de reclame voor tabaksproducten (B.S. 11.02.1998).

19 juli 2004 - Wet tot wijziging van de wet van 24 januari 1977 betreffende de bescherming van de gezondheid van de verbruikers op het stuk van de voedingsmiddelen en andere producten (B.S. 10-11-2004).

27 maart 2009 - Decreet betreffende radio-omroep en televisie (B.S.30.04.2009).

10 augustus 2005 - Koninklijk besluit tot wijziging van de wet van 7 januari 1998 betreffende de structuur en de accijnstarieven op alcohol en alcoholhoudende dranken (B.S. 22.08.2005).

6 juni 2008 - Decreet houdende het instellen van een rookverbod in onderwijsinstellingen en centra voor leerlingenbegeleiding (B.S. 18.07.2008).

28 mei 2009 - Ministerieel besluit tot vastlegging van gecombineerde waarschuwingen voor alle in de handel gebrachte verpakkingseenheden van sigaretten (B.S. 02.07.2009).

31 juli 2009 - Wet tot invoering van speekseltesten op drugs in het verkeer (B.S. 15.09.2009).

10 december 2009 - Wet houdende diverse bepalingen inzake gezondheid (B.S.

31.12.2009).

22 december 2009 - Wet betreffende een algemene regeling voor rookvrije gesloten plaatsen toegankelijk voor het publiek en ter bescherming van werknemers tegen tabaksrook (B.S. 29.12.2009).

25 januari 2010 - Een globaal en geïntegreerd drugsbeleid voor België: Gemeenschappelijke Verklaring van de Interministeriële Conferentie Drugs (B.S. 15.04.2010).

International legislation texts

Februari 1971, United Nations convenrtion on psychotropic substances.

Annex 5.

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