



European Monitoring Centre  
for Drugs and Drug Addiction



# **Belgian National Report on drugs 2014**

## **New Developments and Trends**

**Scientific Institute Public Health (WIV-ISP)**

Operational Directorate Public Health and Surveillance

Service Surveys, Lifestyle and Chronic Diseases

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## General introduction

The Programme Drugs is located within the Scientific Institute of Public Health and is the national partner of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). As National Focal Point, the Programme Drugs (also known as BMCDDA) aims to provide a better understanding of the impact of illegal drugs and drug addiction in Belgium through this annual report.

The structure and the content of this report are pre-determined by the EMCDDA to facilitate the comparison with similar reports published by other European member states, Turkey or Norway. Each chapter of this report documents the latest developments that have not been included in previous annual reports. In general, assembled data of 2013 or the first half of 2014 and observed trends over the past years are described. Within this report, *illegal drugs* are considered as substances which are controlled by VN, EU or national legislation and which can only be used in specific circumstances. As tobacco and alcohol are not part of our mission, these substances are not systematically reported.

Since health policy is a federate jurisdiction in Belgium, the focus and actions concerning illegal drugs might differ among the Belgian Communities and regions. Therefore, the cooperation with regional partner organisations - the sub-focal points Eurotox, SPZ, VAD and PFCSM-OPGG - of respectively the French, German and Flemish Community as well as the Brussels-Capital Region, is a vital element in the collection of national drug-related data. These regional partners guarantee the assembly of information in their respective Community or region. Nevertheless, each of them has a different background. Consequently, the Programme Drugs clusters all drug-related information and initiatives in order to reach a national overview of the illegal drug situation in Belgium.

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## **Summary**

### **Drug policy: legislation, strategies and economic analysis**

In the framework of the further development of a global and integrated drug policy, the Belgian drug law of 1921 was adapted aiming to counter the rapid development of new psychoactive substances (NPS). Moreover, drug users are identified as one of the target groups for the national HIV-plan 2014-2019. The federal science policy supported amongst others 1) the development of specific guidelines for drug prevention and treatment for children and youngsters and 2) the improvement of the effectiveness and efficiency of the drug treatment court in Ghent. In addition, an ad hoc working group was established by the General Cell Drug Policy, comprising different experts involved in the field in order to make a global evaluation of the Belgian cannabis policy.

### **Drug use in the general population and specific targeted groups**

Drug use in specific targeted populations such as students, youth and partygoers is described in chapter 2. As different studies use different designs, the results are distinct as well and not always comparable. In general, cannabis remains the most popular drug. However, a declining trend in cannabis use is observed since 2006. The use of psychoactive substances other than cannabis was mentioned mostly by older users and was much more limited. In general, the use of NPS remains low.

### **Prevention**

Drug prevention targets the general population, schools, families, at-risk groups and partygoers. As the Federal Government does not bear responsibility for the prevention policy of drugs, chapter 3 describes the different initiatives in the Flemish Community, the Wallonia-Brussels region and the German Speaking Community. Alcohol and illegal drugs remains by far the most common items in the prevention of addictions. Most prevention initiatives are implemented for several years and are prolonged every year. Nevertheless, a new prevention project oriented towards parents of ethnic minorities started in 2013. The main goal of this project is to improve parental skills concerning tobacco, alcohol and drugs.

## **High risk drug users**

High risk drug use is by the current EMCDDA definition defined as 'recurrent drug use that is causing actual harm to the person or is placing the person at a high probability or risk of suffering such harms'. Based on the HIV-multiplier method it was estimated that 3.4 on 1,000 adults in 2012 had ever injected drugs. This prevalence estimation has been stable since 2004. Chapter 4 focuses on 1) the estimation of ever-injecting drug use in Belgium, 2) problematic drug use among students in higher education and 3) polydrug and injecting drug use among partygoers. The most worrisome finding is the revealed very young starting age of injecting: half of the injecting drug users started before the age of 21 and even 15% of the participants was younger than 15 years. Among the current injecting drug users in the Flemish and French community, opiates and cocaine were still the most popular injecting drugs. The use of drug cocktails and the injection of methadone has increased compared to 2012.

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

In terms of diversity of treatment facilities, Belgium has different types of outpatient programmes ranging from low threshold initiatives for marginalized people to general mental health care and specialised day centres. Inpatient programmes are categorized into hospital (psychiatric or general)-based programmes, crisis centres that are more dedicated to detoxification and long-term residential treatment. In addition, different treatment modalities are dedicated to some specific groups of drug users, such as patients with dual diagnosis and emergency situations. In 2013, a total of 9,192 patients entered treatment for illicit substances, with an equal proportion for opiate use and cannabis use as a main reason for treatment. In the past two years, a steep increase is observed in the proportion of patients entering treatment for cannabis abuse while a decrease is seen for opiate users. The characteristics of patients between these different groups of users are very different though on socio-economic level as well as concerning the risk behaviour related to their consumption. The number of clients receiving methadone or buprenorphine in Belgium is relatively stable over time and even a slight decrease in the proportion of methadone treatments was observed. Finally, this chapter also discusses several pilot projects that were performed to formulate recommendations on further specialised treatment development.

## **Health-correlates and consequences**

Health correlates and consequences of substance use is described in chapter 6. The most relevant infectious diseases are monitored, such as HIV, hepatitis B and C, syphilis and tuberculosis. The transmission of infectious diseases is most often linked to risky injecting behaviour. Based on diagnostic serological testing of ever-injecting drug users in treatment and other diagnostic settings, the prevalence of these infectious diseases seems to stabilise over the last decade. Although needle exchange programmes have contributed to the reduction of the number of people reporting to share needles or syringes, many injecting drug users still share other injecting equipment such as spoons, filters and water. This might explain why a decrease in the prevalence of hepatitis C is not achieved. Additionally, although stable in the past years, the prevalence of psychiatric comorbidity among illicit substance users is still very common. Finally, a reduction of drug-induced deaths in Belgium was observed in 2010, especially in the Walloon region, which is a trend in line with other European countries.

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

Several services to treat acute drug-related harms and health concerns are available in Belgium. In 2013, 916 patients were admitted to the crisis intervention centres, hosted by specialised drug treatment centres. Most of the patients experiencing a crisis are regular polydrug users. Opiate use is the second most mentioned reason. In addition, highly dosed ecstasy tablets were reported. MDMA levels in ecstasy tablets have nearly doubled during the last few years, leading to an alarming, increased risk for toxicity symptoms and even deaths. Consequently, drug prevention and harm reduction services remain important approaches for raising public awareness about potential dangerous compositions of illegal drugs and NPS. The number of recovered syringes by needle exchange programmes was stable to slightly decreasing. In relation to these findings, treatment uptake for infectious diseases remained low in injecting drug users.

## **Social correlates and social reintegration**

Many problem drug users in Europe have unmet social needs related to their housing situation, educational level or employment status. The proportion of persons with a lower education level and the proportion of unemployment are much higher in the population of drug users in treatment compared to the general population. Therefore, social reintegration is a key aspect of full recovery from drug dependency.

Most of the reintegration initiatives in Belgium aim to improve the housing situation, as one in ten drug users in treatment is living in an unstable accommodation. Housing projects, such as Housing First, aim at arranging temporary housing accommodations for (ex-)drug users

without any requirements for sobriety, treatment attendance and other barriers to housing entrance. Furthermore, social reintegration is supported by creating new perspectives with regard to the working situation of this target group. Finally, organised and guided leisure activities provide opportunities to recreate social interactions and a social network.

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

Based on the analysis of law enforcement data, the vast majority of drug law offences is related to the demand side. An increased prevalence of amphetamine use in combination with cocaine, cannabis or opiates is found among drivers. The analysis of the interventions in the criminal justice system indicate that more drug-related sentences are imported at court level and the drug-related suspensions are slightly decreasing. Moreover, the total number of alternative sanctions is declining again. Although prisons are confronted with an overpopulation, more and more drug-related detentions are registered in the past years. Nevertheless, health care (specialised drug treatment in particular) is limited in prison and due to the economic crisis and the associated savings, the capacity of drug-related treatment services in prisons also decreased.

### **Drug markets**

Although Belgium is a small country, it plays an important role as a production country for cannabis and synthetic drugs (mostly amphetamine and MDMA). The last two years, Belgium has also begun to play a role in the production and distribution of NPS. Due to the large port of Antwerp and the national airports, cocaine is imported and exported from Belgium. Drug seizures, both number and quantity, have increased in 2013. The number of dismantled synthetic drug production laboratories reached an all-time record. For the first time, considerable amounts of methamphetamine were seized (38kg versus 3kg in 2012). Due to the high availability and high drug production capacity, drug prices in Belgium tend to be low compared to other EU member states. Nevertheless, significant changes in price compared to previous years were not observed. Another consequence of this production capacity remains the high purity and quality of drugs found in Belgium. This is especially true for ecstasy tablets.

## Chapter 1. Drug policy: legislation, strategies and economic analysis

*Plettinckx E., Blanckaert P. and Gremeaux L.*

- *The law of February 7<sup>th</sup> 2014 adapts the Belgian drug law of 1921 by defining a generic classification to control psychoactive substances, criminalising preparatory actions and enabling the instant destruction of seized drugs and materials.*
- *The national action plan for an integrated HIV policy consists of clear actions related to (intravenous) drug use. This plan might be a trigger to the further development of an integrated policy involving policy makers, professionals and patients concerned.*
- *New best practice guidelines are available for the detection, prevention and treatment of substance abuse in children and youngsters, validated by the Belgian centre for evidence-based medicine.*
- *Due to the sixth state reform transferring important drug treatment facilities to the communities and regions, the addiction fund is to become a federate project. The Institute of Public Health remains provisionally responsible for the TDI project in order to guarantee national and European comparable data.*

### 1. Introduction

The implementation of the Common Declaration of January 25<sup>th</sup> of 2010 of the Inter-ministerial Conference Drugs (B.S./M.B. 15.04.2010) continued in 2013-2014. This implementation occurred in line with international and European policies and in close collaboration with the working field and concerned citizens. The Common Declaration is based on the Federal Drug Note of 2001 which constituted a global and integrated drug policy in Belgium (B.S./M.B. 15.04.2010).

This Federal Drug Note focussed particularly on illicit drugs. Nevertheless, the fast increase of newly detected new psychoactive substances (NPS) necessitated the adaptation of the Belgian Drug law of 1921 (section 2.1). Besides the illegal drugs and NPS, the Belgian drug policy deals also with alcohol use. As a result of the call of the World Health Organization (WHO) to reduce the harmful use of alcohol, attention was given to this topic in Europe and Belgium. A common declaration of the Ministers of Public Health on the alcohol policy in Belgium was approved in 2008. However, the persistent harmful use of alcohol, necessitated a National Alcohol Plan (NAP) 2014-2018. A draft version of a more global approach, including other areas than public health, was set up in 2013 (section 3.1.1). Nevertheless, this NAP 2014-2018 was rejected later on. In 2013, the development of a national action



plan 2014-2019 for an integrated HIV policy (section 3.1.2) and the security and prevention plans 2014-2017 (section 3.1.3) were finalised.

The Federal Drug Note emphasized the importance of both the effectiveness and efficiency of drug treatment. As a result, the research programme on drugs of the Belgian federal science policy office (BELSPO) annually supports funding for several projects that contribute to the evaluation of the global and integrated Belgian drug policy. In 2013, among others, two evaluation studies were finished (section 3.2.1). The ADAPT-YOUTH project described adaptations of best practice guidelines for the detection, prevention and treatment of substance abuse in children and adolescents (Hannes et al., 2011). A second project resulted in a qualitative outcome evaluation of the drug treatment court in Ghent (QUALECT) (Vander Laenen et al., 2013).

Also, a working group on the evaluation of the Belgian cannabis policy was set up at the request of the Minister of Public Health (section 3.2.2).

As different ministries and facilities are involved in the organization of drug treatment in Belgium, different initiatives are defined by the Common Declaration of January 25<sup>th</sup> of 2010 to be important for the Belgian Drug Policy. Amongst them, two initiatives were specifically mentioned to stimulate and ensure the follow-up on the Belgian drug treatment (section 3.3). As a first, the Addiction Fund was appointed for financing innovative pilot projects to stimulate the development of a broad range of treatment facilities. Second, a uniform registration system for the Treatment Demand Indicator (TDI) was enforced in cooperation with the treatment centres in Belgium. TDI estimates the incidence of drug users in treatment in Belgium to allow adjusting treatment to the needs of the clients. This TDI register (discussed in chapter 5) is active in all European member states. Final coordination of adjustments to the TDI register is taking place at the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) to assure the comparability of treatment data in Europe (EMCDDA, 2014).

Finally, a reflection is provided on the challenges and opportunities implied by the mentioned developments on the drug policy. To this end, external expert Prof. dr. Freya Vander Laenen of the institute of International Research on Criminal Policy (IRCP) at the Ghent University was invited to cover section 4.

## 2. Legal framework

Similar to other EU member states, NPS - also known as 'legal highs' - are increasingly becoming an issue in Belgium. In 2013, a total of 81 new NPS were reported in Belgium. These substances mimic the effects of controlled substances, however they are not internationally controlled (UNODC, 2013). The fast increase of detected NPS in the last years, outruns current (setup of) legislation. Consequently, an adaption of the Belgian drug legislation was required.

### 2.1. Adaptation of the Belgian Drug law of 1921

The law of February 7<sup>th</sup> 2014 adapts the Belgian drug law of 1921 (B.S./M.B. 10.03.2014) and aims at improving the efficiency and flexibility of the law regarding the rapid development of NPS. The Royal Decrees of 31.12.1930 (B.S./M.B. 10.01.1931) and 22.01.1998 (B.S./M.B. 14.01.1999), derived from the Belgian drug law of 1921, provide a list of controlled substances that can only be used, produced, imported, exported or sold when having a license. The disadvantage of this set-up is the limited option to action upon the event, as changing this legislation by adding substances to the list takes about six months. As such, producers can slightly modify the molecular structure of the substance to outrun the legislation. In order to anticipate to this problem, the law of February 2014 includes a fourfold change.

First, the Belgian legislator has opted to foresee the possibility to control some of the substances by their common chemical structure. In addition to the internationally recognized list of controlled substances (further in this report referred to as 'illegal or illicit drugs'), a generic definition could cover practically all existing and future - even currently still unknown - NPS derivatives. This definition is similar to the analogue drug laws currently in effect in the USA, Hungary and the UK. To this end, a proposal was drafted for a new Royal Decree which includes a generic classification. Several categories of NPS are defined, including synthetic cannabinoids, synthetic cathinones, tryptamines, phenethylamines, piperazines and a category covering all the opioid fentanyl derivatives. In this proposal, a "base/core structure" for each category is included.

Secondly, the Belgian legislator decided to criminalize preparatory actions. Firm action is taken against preparatory actions of illegal drug production and trafficking, i.e. the materials and techniques used. In the past, it was not always possible to prosecute these actions nor to seize the used material. Next to synthetic drugs, the law also targets cannabis and drug precursors. A description of preparatory actions is also included.

Third, this law enables the instant destruction of seized drugs and materials. Because of logistic limitations when seizures have to be stored during the whole procedure, the Belgian legislator judged that samples and visual material provide sufficient evidence in trial. The physical destruction is mandatory in case of confiscation.

Fourth, the law includes a profound regulation of information exchange regarding laboratory results through the Belgian Early Warning System on Drugs (BEWSD). Laboratories and experts are obliged to transfer their information (anonymous data regarding the composition and the use of classic illegal drugs and NPS) to the BEWSD, which is hosted by the Scientific Institute of Public Health (WIV-ISP). The latter regulation was already included earlier in the Royal Decree of 29 June 2003 (B.S./M.B. 14.07.2003). However, laboratories rarely complied due to contradictory legislation. To overcome this ambiguity, the Belgian legislator added the obligation in the law of 7 February 2014 (B.S./M.B. 10.03.2014). Moreover, since judicial investigations can easily take months to complete, an exception on the secrecy of the judicial investigation was made to report the results of laboratory analysis immediately to the BEWSD. This exception enables the prevention of public health risks by interventions and rapid reporting of dangerous drug phenomena. The performance of these four principles is proposed in a Royal Decree.

### **3. National action plan, strategy, evaluation and coordination**

#### **3.1. National action plan and/or strategy**

##### **3.2.1. Rejection of the National Alcohol Plan**

In June of 2013, a draft version of the NAP 2014-2018 was written to further develop a global and integrated drug policy. This draft aimed at preventing the harmful use of alcohol by 1) reducing the availability of alcohol, 2) limit alcohol use at work and in traffic and 3) improving prevention, early intervention, treatment and scientific research.

A review of the draft NAP was performed by three academic international experts (Dr. Lars Møller, WHO; Prof. Dr. Jürgen Rehm, Centre for Addiction and Mental Health; Prof. Dr. Peter Anderson, Institute of Health and Society, Newcastle University). Different stakeholders as well as the general public had one month to comment on the outlined measures in order to broaden the (community) support for the policy of the draft NAP.

The measures related to prevention, treatment and monitoring of the harmful use of alcohol in Belgium were supported by all stakeholders. Nevertheless, there was no agreement on a variety of proposals related to the availability of alcohol, such as the prohibition of happy hours or temporary price promotions. The amendments weakened the content of the NAP. In

the end, no political consensus was found concerning a ban on alcohol sales in vending machines and a revision of the regulation regarding the minimum age to buy alcoholic beverages. Consequently, the NAP could not be approved by the Inter-ministerial Conference Drugs in December 2013. However, the proposed health-related measures are largely included in other action plans and continue to be applied.

### 3.2.2.A national action plan for an integrated HIV policy

A protocol agreement 'HIV-plan 2014-2019' was signed by the federal and federate ministers of health policy and social affairs in 2013. Next to the distribution of the HIV-plan and set priorities, the ministers also committed to propose a specific implementation plan of the actions that falls within their competences (B.S./M.B. 21.11.2013).

The aim of the HIV-plan is a) to increase prevention of HIV transmission by information, education and raising awareness, b) to increase screening of HIV in an early stage, c) to increase treatment of persons living with HIV, d) to improve the quality of life of persons living with HIV and e) to reduce stigmatisation and discrimination (B.S./M.B. 21.11.2013).

The recent national HIV-plan gives the opportunity to further develop an integrated policy. Throughout the report, (intravenous) drug users are identified as one of the target groups for the national HIV-policy. Moreover, harm reduction strategies for drug users are identified as one of the most important strategies to limit the risks associated with drug use. For instance, action 22 of the plan stresses the need for improving access to needles and prevention material and the establishment of drug consumption rooms. Action 24 aims at the development of a comprehensive legal framework with regard to public health and risk reduction for drug users (Belgian Research Aids&HIV Consortium, 2013). The actions 27 to 31 discuss several measures towards people in detention mentioning specifically (in action 29) the aim to reduce the stigmatisation of drug using prisoners (Belgian Research Aids&HIV Consortium, 2013).

As the actions of this national HIV-plan are divided among the assigned competences of different Belgian ministries, each minister gave order to an execution plan to implement the national HIV plan. These execution plans describe the priority actions for each minister, as well as the financial implications. The Inter-ministerial Conference Public Health appointed a Monitoring Committee consisting of health care workers, associations fighting against HIV/AIDS, the WIV-ISP and representatives of the governments concerned. A council of people with HIV was composed as well (Belgian Research Aids&HIV Consortium, 2013;Roegiers, 2014).

The Monitoring Committee should a) identify bad practices, b) formulate advice and recommendations, c) centralise all relevant information, d) stimulate scientific research and consultation, e) support federal authorities and f) provide a yearly report about the implementation of the HIV plan (Belgian Research Aids&HIV Consortium, 2013). In addition, the mission of the council is to involve people with HIV in the execution of the HIV plan in order to improve prevention, care and quality of life (Belgian Research Aids&HIV Consortium, 2013).

### 3.2.3. The development of strategic security and prevention plans 2014-2017

Strategic security and prevention plans were introduced in Belgium in 2002 to replace the previous security and prevention contracts and drug plans. Two years later, the strategic security and prevention plans became part of a local integrated security policy (VandeWalle et al., 2010). These plans give responsibility to cities and municipalities in order to develop and coordinate a local security policy regarding crime prevention. In exchange, cities and municipalities receive a financial contribution from the Federal Government (B.S./M.B. 22.12.2006). As the drug plans were replaced by the strategic security and prevention plans, the cities and municipalities were stimulated to develop a local drug policy by receiving subsidies for drug prevention, (low threshold) drug treatment services and harm reduction. Approval of the security and prevention plans 2014-2017 by the Minister of Internal Affairs requires cities and communities to comply with the defined conditions of 2013. The objective of the security and prevention plans is to stimulate, at local level, the prevention or reduction of nuisance and certain crimes exceeding the local context. It is the responsibility of the cities and municipalities to prioritise only those crimes that cause problems within the local context (B.S./M.B. 31.12.2013).

The prevention of drug-related crime such as production, trade and sale of synthetic drugs and cannabis as well as drug-related nuisance is one of the categories for which security and prevention plans can be developed. Unfortunately, primary drug prevention initiatives and medical-therapeutic care are no longer included. In this perspective, street corner work can contribute to the prevention of drug-related nuisance and crime (B.S./M.B. 31.12.2013).

### 3.2. Evaluation of the federal drug policy

#### 3.2.1. Research programme of the Federal science policy office to support the federal drug policy

BELSPO invests in the research projects that contribute to the support and improvement of the efficiency of the Belgian drug policy. Four new projects related to social costs, quality standards for the reduction of drug demand, illicit cannabis cultivation and alcohol use disorders were started during 2013-2014. In 2013, two projects with a focus on the evaluation of Belgian drug treatment initiatives were completed. Two other projects were finalized in 2013 as well; one related to supply indicators of illicit drugs and the other to cannabis production (described in chapter 9 and 10). Additionally an evaluation of the Belgian cannabis policy was started at the beginning of 2014.

*Adapting best practice guidelines for the prevention, detection and treatment of substance abuse in children and youngsters to a local Belgian context (ADAPT-YOUTH)*

In Belgium, drug prevention and youth care as well as ambulatory treatment are decentralised authorities. Until recently, specific guidelines for drug prevention and treatment for children and youngsters were lacking. For this reason, research on adapting best practice guidelines using the ADAPTE process was introduced. This process adapts existing, international guidelines to a local, Belgian context (Bekkering et al., 2014). This methodology gives the opportunity to involve relevant stakeholders in the process to ensure maximum relevance to their particular settings (Hannes et al., 2013).

A systematic review of existing guidelines was conducted (Bekkering et al., 2014). The researchers applied focuses on the assessment of the quality, consistency, applicability and appropriateness of existing guidelines for a Belgian context by using a step-by-step approach (Hannes et al., 2011). In conclusion, three guidelines were drafted and piloted in a potential user group. The final best practice guidelines for the prevention, detection and treatment of substance abuse in children and youngsters were validated by CEBAM (Belgian Centre for Evidence-Based Medicine) at the beginning of 2014. Two of them are related to the use of illegal drugs. The first guideline concerns the prevention of alcohol and drug misuse among adolescents. The second concerns the screening, assessment and treatment of youngsters who misuse drugs (Wilms, 2014).

*Drug treatment Court Ghent, qualitative outcome evaluation (QUALECT)*

The drug treatment court (DTC) Ghent is one of the alternative sanctions that can be imposed by the criminal justice system in the judicial district Ghent since 2008. The DTC Ghent focuses on persons who committed crimes because of their drug use (organised drug-related crime is excluded) in order to redirect them to treatment. Drug using offenders are supported and supervised intensively by a judge, prosecutor and liaison. The latter serves as a vital link between justice, treatment and the client. In consultation with the liaison, the client formulates a treatment plan which has to be approved by the DTC Ghent. During the treatment, several follow-up sessions are organised by the DTC Ghent (Colman et al., 2011; Wittouck et al., 2013).

The qualitative outcome evaluation of the DTC Ghent is a continuation of previous research projects in this area. In 2007, a first study was finalised on alternative sanctions to divert drug dependent offenders to treatment. This Belgian effect study showed that the levels of offending and drug use decreased and that drug-related life domains improved after an alternative sanction (De Ruyver et al., 2007). Between May 2008 and May 2009, a process evaluation study was conducted by Ghent University and the Service on Criminal Policy. Although some weaknesses were addressed, the overall evaluation was positive. The DTC Ghent provides the opportunity to address problems in different life domains (Colman et al., 2011).

The outcome evaluation compares the outcomes of the DTC Ghent with those of a sample of probation clients in Hasselt (Wittouck et al., 2013). However, the size of the sample survey was limited and information was not registered in a systematic way. The analysis indicated that 1) referral to drug treatment and financial counselling was realised, 2) respondents went more often in substitution treatment without additional drug use and 3) respondents were more often employed at the end of the DTC trajectory. The DTC faces the deficits of probation. First of all, the time lapse between the committed crime and the start of the trajectory is much smaller in DTC (6 months compared to 22 months for the probation clients). Secondly, DTC is more flexible and gives the opportunity to work result-oriented. DTC stakeholders are not committed to a mandate (which is the case for probation). As such, all problematic life domains can be included. Moreover, upcoming issues can be treated during the trajectory. This individual approach oriented to different life domains give the possibility to work to reintegration. In contrary to probation, DTC gives attention to 'persons with a drug issue' rather than to focus on the 'offender'. Despite these advantages, these treatments are not always continued once the DTC trajectory has been completed. Additionally, continuity of the counselling and support of DTC clients is limited.

Consequently, structural succession of the clients after DTC is lacking (Vander Laenen et al., 2013).

These results show an indication of the added value of the DTC in comparison with probation. The treatment of problematic drug use and the support of drug-related life domains decrease drug use and crime (for the results of the analysis of recidivism, please refer to chapter 9) which then results in less costs related to health care and the criminal justice system. The intensity of the supervision has to be tailored to the drug treatment and criminal justice history of the DTC client. Depending on the individual needs and the progress of the trajectory, extinguished follow-up sessions can promote the pursue of treatment. A cautious accomplishment of the DTC trajectory is important in order to decrease the risk of relapse. Consequently, the DTC project can also be extended to other judicial districts. The implementation requires 1) a clear distinction between the roles and tasks of the criminal justice system and mental health care providers, 2) written engagements and 3) a sufficient diverse and dispersed (drug) treatment offer. Moreover, the liaison and the financing of a DTC coordinator are essential criteria to guarantee an optimal functioning of the DTC (Vander Laenen et al., 2013).

### 3.2.2. On-going evaluation of the Belgian cannabis policy

In compliance with international treaty obligations, the Belgian law states unequivocally that the possession of cannabis is illegal. The most recent adaption to the Belgian drug law of 1921 with regard to the possession of cannabis dates back almost ten years: the cannabis policy approach was differentiated from other illicit substances, determined by a change in the law in 2003 which also introduced an outline of problem drug use and public nuisance. The Constitutional Court found these concepts to be insufficiently defined and part of the law was rescinded. A temporary solution to this annulment was issued by a new ministerial directive in February 2005, which called for full prosecution for possession in cases where the 'user amount' (3 grams or one cannabis plant) is exceeded, public order is disturbed or aggravating circumstances are identified. Still, as the current legislation is often interpreted differently in the working field, the cannabis policy requires renewed attention.

In the past years, the public debate on the regulation of possession and use of cannabis has been vividly fed; among others by the recent changing policies towards legislation in several other countries such as Uruguay, Colorado and Washington, USA (Pardo, 2014), but also by the discussed changes towards a more restricted cannabis policy in our neighbouring country The Netherlands.



In this light, by the end of 2013, the Minister of Public Health requested a global evaluation of the Belgian cannabis policy. To this end, an ad hoc working group was established by the General Cell Drug Policy, comprising different experts involved in the field. The main aim of the group is to offer a state of affairs on the current cannabis policy, by indicating deficiencies and to provide recommendations on the feasibility of alternatives to the enforced cannabis prohibition. The conclusions of this assessment will serve as a basis for further political consultation.

Currently, approved cannabis-related drugs for medical purpose cannot be delivered to patients by Belgian pharmacies (B.S./M.B. 19.07.2001). A joint working group of the 'Commission for Herbal Medicinal Products for Human Use' and the 'Commission for Medicinal Products for Human Use' of the federal agency for medicines and health products (FAMHP) was appointed to formulate a scientific opinion on this subject. This subject matter is to be integrated into the activities of the working group on the evaluation of the cannabis policy as well.

The outcome and recommendations will be discussed by the General Cell Drug Policy and presented to the next Inter-ministerial Conference Drugs; the ad hoc working group report is expected by December 2014.

### 3.3. Coordination arrangements

A bottom-up approach is at the heart of the Belgian drug policy. Different actors and authorities are involved in the daily organization and practice of this global and integrated drug policy. In order to coordinate the different drug treatment initiatives in Belgium, the Federal Government developed two projects. Both the addiction fund and the TDI registration were implemented to gear the availability of drug treatment to the treatment needs of persons.

As a consequence of the sixth state reform, important initiatives related to the specialised drug treatment field become the authority of the federate levels. A steering group guided the compilation of a draft (Green paper) for the organization of an alcohol and drug (A&D) policy in the Flemish Community. During a first phase, an overview of the current situation was written. In a second phase, two options for a future integrated A&D policy were described. On the one hand, an integration of the addiction field in the mental health sector was proposed. On the other hand, a description of the addiction field as a separate entity that cooperates with many different fields in society, was given. The Green paper A&D was integrated in a global proposal (Green book) that outlines the options and priorities for a state reform in 2014.

The Brussels and Walloon Federation of Institutions for Drug addiction (Fedito Bruxelles – Fedito Wallonne), the Federation of the Employers of the Ambulatory Institutions for Drug addiction (FEIAT) and the Local Coordination of drugs in Brussels (CLDB) proposed a series of recommendations as well within a sectorial memorandum. The objective was to establish an enhanced Drug Policy in Brussels. These recommendations have to strengthen 1) different action plans, 2) the consolidation and expansion of the network of prevention, support and specialised drug care, 3) the legal framework regulating illegal drug use and 4) stimulate prevention, harm reduction, support and specialised drug care (Fedito Bruxelles et al., 2014). Additionally, Fedito Wallonne published a memorandum concerning the quality of the services specialised in drug use. This memorandum highlight the necessity to appropriately respond to the variable needs and expectations of drug users and their family. In order to reach this objective, Fedito Wallonne advocates 1) the improvement of the accessibility of existing services and their adaptation to the new challenges (new products and consumption patterns), 2) the development of new programmes, 3) the development of a coherent policy, which include a role for the Fedito Wallonne in the different levels of consultation and review committees, 4) appropriate funding and 5) adequate trainings for professionals who work with drug users and their families (Luisetto and Hensgens, 2014).

The most important drug treatment facilities involved in the sixth state reform are the low threshold medical social treatment centres, day care centres, crisis intervention centres and therapeutic communities. The transfer of competences from the federal level to the federate levels also has an impact on the addiction fund and the TDI project.

In 2013, the addiction fund still financed 35 projects (Table 1.1). Seven projects initiated in 2012 were no longer prolonged, instead one new project was financed. Most of the projects (70%) are related to addiction in general or to illegal substances. The remaining 30% is related to abuse of medicines or alcohol. The addiction fund was a federal initiative until the 1<sup>st</sup> of July of 2014. After a transitional period of six months, the addiction fund will be transferred to the Communities.

The transition period for the transmission of the TDI project to the Communities is defined from the 1<sup>st</sup> of July of 2014 until the 31<sup>th</sup> of December 2017. Due to the importance of national and European comparable data, the WIV-ISP will still guarantee the TDI registration and the analysis of the results during this transition period. Moreover, this uniform registration system is applied to support drug policy makers. As such, the contract with the WIV-ISP concerning the TDI registration is automatically renewed each year, also after the transition period. The Inter-ministerial Conference Public Health, however, still has the possibility to decide whether the Communities should guarantee the TDI registration instead

of the WIV-ISP. In case this decision should be made, similar as for the projects of the addiction fund, the systematic financing and course of registration of TDI may be hampered.

Table 1.1. Financed projects of the addiction fund in 2013

<b>Title of the project</b>	<b>Organization</b>	<b>Main objective</b>
Project to support drug using parents considering their children	Bogolan	Support future of young addicted parents and their children younger than three years old.
Evaluation and support of adolescents who are confronted with problems of cannabis use	Hospital University centre Brugmann	A multi-dimensional-family therapy is implemented for adolescents experiencing problems due to cannabis use and their environment
Alcoholhulp.be – Cannabishulp.be – Drughulp.be	CAD Limburg	Online support and distribution of information through the internet of problems related to alcohol, cannabis and other drugs
Project of withdrawal of alcohol dependence at home	La Caho asbl	Implementation of an outreach project to encourage withdrawal of alcohol dependence in a familiar environment
Mighties	Centre for mental health Eclips	Development of psycho-educative material and a specific methodology for youngsters who aren't qualified for classic treatment projects because of reasons of motivation, language or mental limitations
Network Recovery Antwerp	CISO	Evaluation with patients and their network in order to determine an individual treatment trajectory
Free medical consultations and nursing care for drug users	Comptoir	Medical consultation and nursing for somatic problems
Reinforcement of the syringe exchange programme and street corner work in Brussels-Capital	DUNE	Reinforcing syringe exchange programme, street corner work, nursing care on the street and try to direct people to treatment
DocA-Project youth Antwerp	Free clinic	Specific project for vulnerable youth age 15-25yrs who have been admitted to the residential sector of youth assistance and will not accept treatment. Development of a brief intervention to work on motivation and stimulate the organization of free medical consultations.
Specific intervention for alcohol problems in emergency services	IDA	The development of a specific intervention model for emergency services to handle alcohol-related problems
National information and raise awareness project: no alcohol below the age of 16	IDA	Project to improve the knowledge in the sales sector about the change in the law which forbids selling alcohol to youngster under the age of 16

## Chapter 1. Drug policy: legalization, strategies and economic analysis

Raising awareness and give information to pharmacists on the consumption of alcohol and medicines to encourage discussions with patients	IPSA-APB-SSPF	Education of pharmacists to create a state of awareness for patients who are combining medicines and alcohol
Education within the specialised network Bruxelles-cannabis	Interstices Bruxelles	Education of professionals to tackle problems related to the consumption of cannabis use
Project Liaison alcohol	Interstices Hospital University centre St. Pierre	Raising awareness and education of professionals working at hospitals to give information and to offer guidelines about alcohol-related problems. Also support is offered for the most difficult situations
Outreach work in crisis situations	Kompas	Support in crisis situations towards minors and their family. An intensive follow up is offered at home during 6 weeks. The main objective is to stabilize the patient, search for the most appropriate orientation and evaluate thoroughly the familial context
Clinical case management and interventions to health care providers of pregnant drug users or drug using parents with young children	MSCC Ghent	Raise awareness to professionals Guide and support pregnant drug users or women with young children.
Assertive community treatment	MSCC Ostend	Outreach project to support drug using parents, drug using pregnant women and their children up to 12 years old in an intensive and integrated way.
Education project of drug using parents and promotion of expertise of help	MSCC Flemish Brabant	Project related to parenthood to support parents using drugs and their children. The objective is to decrease the risk of drug consumption and the negligence of the children
Development of a nursing and medical team within syringe exchange programmes	Namur Entraide Sida	The objective is to grant first care related to problems of injecting drug use
Online help for people facing problems with alcohol and their environment	Pelican	French version of the website alcohol.be in order to provide information and therapeutic counselling
Outreaching psychiatric counselling for youngsters (16-35yrs)	Psychiatric centre OLV	which are confronted with a psychiatric problem combined consumption of drugs (alcohol or illegal drugs)
Synersanté	Les petits riens	Creation of a mobile health cell to support persons with a drug problem and coordination of intervention of different organizations

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Improvement of care for persons having a mental handicap in combination with drug problems	PopovGGZ	The main objective is to improve the collaboration with specialised drug treatment centres, services for persons with a mental handicap and sheltered workplaces
Intensive outreach project to follow-up for persons with a alcohol dependence	Psychiatric Hospital St. Camillus	In three hospitals a case manager is assigned in order to decrease the duration period of hospitalisation and to improve the quality of life of persons with an alcohol problem
Social counsellor for the réseau HCV Buxelles	Réseau HCV	Individual counselling for patients in HCV treatment
Global and integrated support to reintegrate young adults with a dual diagnosis	Neuro-Psychiatric Hospital St. Martin	Project for young adults with a drug problem and psychiatric co morbidity. Global and integrated support which involves different sectors and the environment of the youngsters
Training of general practitioners and other health care services about benzodiazepines	ULB & collaborators	Training and raising awareness of doctors and pharmacists to promote the rational use of benzodiazepines
Implementation of guidelines	VAD	Guidelines in order to support patients with ADHD and addiction
Equipment in order to develop an modular offer of motivational interviewing	VAD	Optimization of training on the motivational interviewing (specificity addiction) and development of didactic and audio-visual material
Implementation of guidelines related to the already developed ASSIST screening instrument	VAD	Support the implementation of the ASSIST instrument and a short term counselling intervention
Quality promotion of drug treatment	VAD	Development of methods to evaluate the efficiency of different services?
Implementation of a specific treatment programme for cocaine use: CRA+ vouchers	De Kiem	Specific programme to treat problems of cocaine use through the method of Community Reinforcement Approach
Promotion of a more efficient and effective use of psychotropic substances for persons living in a rest and care home	Residential treatment centre Leiehome	Raise awareness to support rational use of psychotropic substances
TADAM project	Liège	Pilot project heroin (diacetylmorphine) assisted treatment
CASA: Outreach counselling project for (ex) addicts	Ellipse	Personal and individualised counselling at home for (ex-)alcohol and drug users

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

#### 4. Challenges and opportunities

*Reflection by Vander Laenen F., IRCP Ghent University*

In Belgium, efforts have been made to develop an integrated, balanced and evidence-based drug policy, in line with the requirements of the EU drug strategy and the consecutive EU Action plans. Indeed, the 'EU Drugs Strategy 2013-2020' explicitly refers to the need for scientific studies to evaluate interventions. Drug policies and actions based on these policies should be underpinned with the scientific results of these studies: "*Actions must be evidence-based, scientifically sound and cost-effective, and aim for realistic and measurable results that can be evaluated*" (Commission of the European Union, 2012). The new law on NPS and the current evaluation of the Belgian cannabis policy illustrate the resolve to adapt Belgian drug policy to new - international - developments. Next, since the Federal policy Note on Drugs of 2001, BELSPO funded over 60 scientific research projects to support the implementation of an integrated drug policy. For instance, during the ADAPTE-youth study three existing evidence-based practice guidelines for adolescent substance misuse were evaluated and adapted to the Belgian context (one on the treatment of alcohol misuse, one on the treatment of drug misuse and one on the prevention of alcohol and drug misuse). The study applied a specific methodology to adapt existing, international guidelines to a local, Belgian context (Bekkering et al., 2014). The qualitative research part of the study showed that the most commonly mentioned barriers regarding the use of guidelines are the lack of applicability of guidelines to the specific target population or organization and the lack of knowledge about implementing evidence-based practices. Various strategies to facilitate the implementation of (evidence-based) guidelines are suggested. Respondents recommend to facilitate access to guidelines by providing the guidelines through the internet, the network of the Belgian focal point (BMCDDA) or conferences and seminars. Also, advice and training is required during the implementation process (Hannes et al., 2013). A second example is the outcome evaluation of the Drug treatment Court in Ghent (Vander Laenen et al., 2013). The aim of this study was to identify the prerequisites to allow for an expansion of the DTC project to other judicial jurisdictions in Belgium. One important prerequisite is a systematic, structured and continued registration of data regarding DTC clients allowing for a systematic outcome evaluation. Another condition is the presence of a liaison in the drug court, a counsellor who holds professional confidentiality and acts as an intermediary between the DTC client, the criminal justice system and (drug) treatment services. Currently, the drug treatment court is implemented in two other judicial jurisdictions, though without a liaison person due to a lack of resources.

Since 2012, the Inter-ministerial Conference Drugs agreed to make the Federal Public Service Health, Food chain safety and Environment responsible for the collection of the public expenditure data and its analysis. This collection and analysis is based upon a manual developed in the research project 'Drugs in figures III' (Vander Laenen et al., 2011). In September of 2014, the analysis of the data for 2012 and 2013 are not available yet in particular due to a backdrop in data delivery from some departments. Based upon an assessment of the data collection and the analysis by the researchers from the Drugs in figures III project, the Federal Public Service is currently optimizing the data collection and is collecting the Belgian public expenditure data for 2012 and 2013.

These three examples illustrate that the implementation of an evidence-based drug policy is complex and requires sufficient investment from the academic community as well from governmental agencies (Uchtenhagen, 2010).

A driving force behind the Belgian national drug policy is the General Drugs Policy Cell. Next, as one of the characteristics of the Belgian drug policy is the bottom-up approach, the development of the Belgian drug policy is executed in close cooperation with the people in the working field (De Ruyver, B., Vander Laneen, F., and Eelen, S., 2012). For over a decade, the security and prevention plans provided a financial stimulus for the development of a local integrated security policy. The plans stimulated the development of a local drug policy by providing subsidies for among other things drug prevention, (low) threshold drug treatment services and harm reduction. Since 2007 however, the focus of the plan shifted towards the prevention of crime and nuisance, so that primary drug prevention initiatives could no longer apply for these subsidies. Since the first of January of 2014, a new ministerial decree clearly states that the focus of local initiatives should be on crime and nuisance prevention if they want to be subsidized. As a result, drug treatment services and harm reduction no longer can apply for subsidies as part of the security and prevention plan. Linked to this is the state reform in Belgium, as a result of which the specialised drug treatment services and the accompanying subsidies will become a competency of the federate levels.

The latter brings us to important challenges and at the same time opportunities lie ahead for the Belgian drug policy in the year(s) to come. Three of these challenges and opportunities are discussed in detail.

First, the 6<sup>th</sup> state reform in Belgium, which is in preparation since 2012 and in full operation in 2014 and beyond, will impact in particular on the specialised drug treatment field in Belgium. This shift in drug-related competences not only defers new political and policy initiatives by the federate levels. It also leads to unrest in people in the drug treatment work

field. To these professionals it is not clear yet what the drug policy priorities of the federate governments will be and whether or not they will be able to at least continue the current treatment offer for problem drug users. Moreover, unrest is augmented since public expenditures are increasingly a subject of discussion in view of the economic crisis and austerity. The anticipated cuts in government spending may affect substance abuse treatment (Lievens et al., 2014), particularly at times of transfer of competencies. However, the transfer of competencies also provides an opportunity for the federate governments to develop a fully integrated drug policy that is based on the analysis and the monitoring of problems at federate level and that can be adjusted if an evolution in these problems occurs.

Second, it is laudable that the draft of 2014-2018 National Alcohol Plan was reviewed by three academic international experts. This stimulated the development of an evidence-based alcohol policy, addressing not only the demand side but also the availability and the marketing of alcohol (Anderson et al., 2012). However, no political consensus was found with regard to the proposed measures related to the supply side of alcohol. As is the case in the UK (McCambridge et al., 2014) corporate lobbying had an important impact on the failure to the Alcohol plan politically approved. In this respect, McCambridge, Hawkins & Holden (2014) provide us with the following advice: *“Transparency in all aspects of lobbying, including money spent on it, should be a key issue for alcohol policy reform.”*

Finally, the national HIV-plan by the different competent ministers in Belgium shows an integrated policy plan can be indeed developed. It is positive to see that in this HIV-plan the link with (intravenous) drug use is clearly made throughout the plan (WHO et al., 2012). It is also positive to see that currently execution plans are being developed to implement the national HIV plan. These execution plans describe the priority actions for each minister, as well as the financial implications. For the coming year(s), it will be important to systematically monitor the implementation, the execution and the results of the priority actions by means of both process and outcome evaluations (Vander Laenen et al., 2010). This will strengthen the evidence base of policies and actions as put forward by the EU Drugs Strategy (2013-2020).

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## Chapter 2. Drug use in the general population and specific targeted groups

*De Ridder K.*

- *Cannabis is by far the most common used illicit substance in all described settings, followed by amphetamines, ecstasy and cocaine.*
- *The prevalence of cannabis use among students in secondary and higher education has been stable since 2006.*
- *The prevalence of other illicit psychoactive substance use among students in secondary and higher education is limited and stable, if not slightly decreasing.*

### 1. Introduction

In Belgium, there is no recurring general population survey specifically on drugs and drug addiction. 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. The BHIS covers a broad range of health topics such as health status, life style, prevention, and medical consumption (Demarest et al., 2001; Van der Heyden et al., 2010; Van der Heyden et al., 2010). Due to limitations in the length and duration of the questionnaire, only a few questions on substance use are included in the BHIS.

As policy on education, youth and culture are competences of the Communities in Belgium, population surveys about drug use in schools and nightlife are supported by the competent administrations and our regional focal points. Sometimes, more local large-scale surveys are administered with the support of the competent city administration.

This chapter describes the Belgian Health Interview Survey (section 2), the results of the VAD School Survey ('Leerlingenbevraging') among high school pupils in combination with the results of the Belgian Health behaviour in School-aged Children (HBSC) Survey (section 3.1), the 'Head in the clouds?' survey among university and university college students in Flanders ("In hogere sferen?") (section 3.2), the Flash Eurobarometer 2014 (an ad hoc survey on behalf of the European Commission) (section 3.3), and some results of two surveys in the party scene, namely 'Drugs Risk Less' ('Drogues Risquer Moins') and the Belgian part of the Global Drug Survey (section 4).

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

The most recent published results of the BHIS on psychoactive substance use date from 2008 (Gisle, L., 2010;Gisle, L., 2010;Van der Heyden et al., 2010;Van der Heyden et al., 2010). The results of this national general population survey (N= 11,026 for the drugs section; 15-64y) are described in detail in the 2011 Belgian Annual Report (Deprez et al., 2012). In 2013, the Surveys, Lifestyle and Chronic Diseases (SLCD) research group of the Scientific Institute of Public Health (WIV-ISP) performed the data collection of a new BHIS. Different from previous waves, the 2013 BHIS used the computer-assisted personal interviewing (CAPI) method for the face-to-face part of the questionnaire, although drug use is still surveyed by the use of a self-completion part. The researchers maintained the same substance-related items of the 2008 survey, being the lifetime, last year and last month cannabis use; frequency of last month cannabis use; the age of first time cannabis use and the last year use of cocaine, amphetamines, ecstasy, LSD, heroin, methadone and buprenorphine. New for the 2013 BHIS is the inclusion of information on 'legal highs'. Results for the 2013 BHIS are expected by the end of 2014.

However, it is worth noting that the prevalence for illicit substance use (15-64 years old persons) found in general surveys, such as the BHIS, are probably underestimated, especially for drugs other than cannabis. Marginalized people (homeless, prisoners, institutionalized persons) are excluded from the sample because invitations to participate to this study are sent only to households after a prior phone contact. The self-completion questionnaire related to substance use is only filled out after having received the visit of the interviewer (Van der Heyden et al., 2010;Van der Heyden et al., 2010). It is highly likely that "hard" or "severe" users do not accept to receive the interviewer at home and/or do not take the time to complete the questionnaire (Demarest et al., 2012).

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

### **3.1. Drug use among Belgian secondary school students**

In Belgium, several large-scale surveys (using self-completion questionnaires) are conducted among school students of both the Flemish and French Community. First, the HBSC survey is conducted every 4/5 years (1985/86, 1989/90, 1993/94, 1997/98, 2001/02, 2005/06, 2009/10) (Favresse and de Smet, 2008;Godin et al., 2008;Hublet et al., 2006). Second, the European School Survey Project on Alcohol and other Drugs (ESPAD) was conducted in Belgium in 2003 and repeated in the Flemish Community in 2007 and 2010 as the Flemish School Survey Project on Alcohol and other Drugs (VLASPAD) (Lambrecht et

al., 2004; Lambrecht and Andries, 2013). Third, the School survey of the VAD is conducted on an annual basis among Flemish school students since 2000/01 (Kinable, 2011).

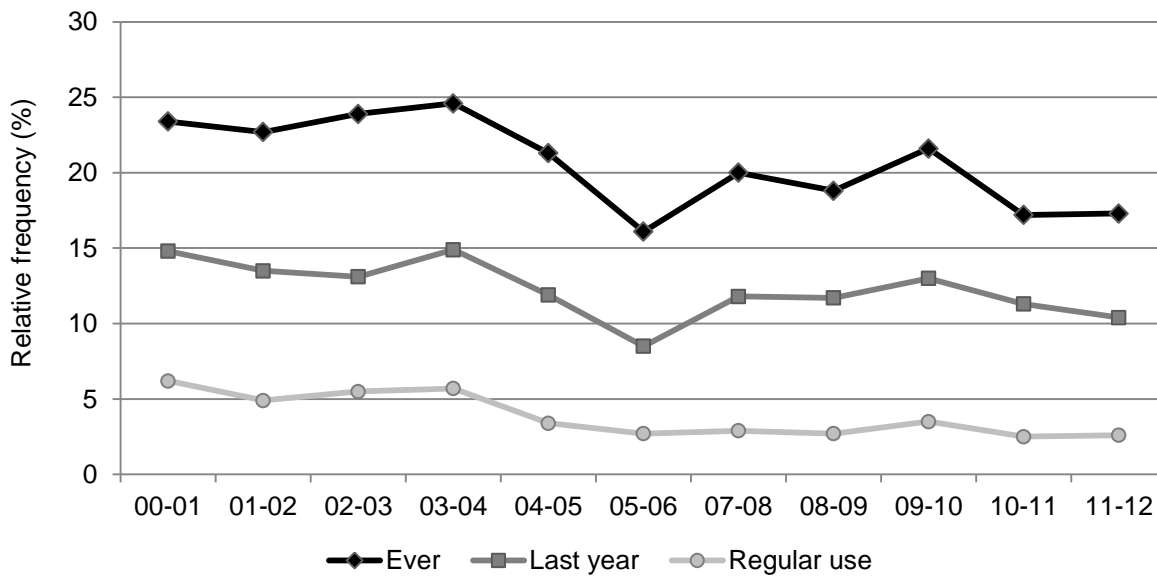
As for the most recent school year 2011-2012, only the VAD School Survey was conducted (Melis, 2013). In total, 39,999 students (12-18 years of age) from 68 Flemish schools participated in this survey. Based on sex, grade and type of education, a representative sample of 6,083 students was selected. In the 2011-2012 survey, 17.3% of the 12-18 year old students had ever used illicit psychoactive substances and 10.4% had used them the last year. In the following sections, the use of cannabis and other illicit psychoactive substances in this population are described.

### 3.1.1. Cannabis

The prevalence found for cannabis use in the 2011-2012 VAD School Survey confirm the trend found in previous Belgian studies (Godin et al., 2011; Kinable, 2011; Lambrecht and Andries, 2013; Lombaert, 2011; Melis, 2013). The study shows that about one fifth (20.9%) of the 15-16 year old and one third (36.6%) of the oldest school students (17-18y) used cannabis at least once in their lives. About one fifth (21.1%) of the oldest age group also used cannabis during the last 12 months prior to the survey. Both the lifetime and the last year prevalence of the oldest students were about 10 times higher compared to those found in the youngest age group (12-13y: respectively 4.4% and 2.4%). There is a stabilisation of regular use to around 3% since the 2005-06 survey (see Figure 2.1). "Regular use" was defined as use of cannabis "once a week", "more times a week" or "daily". The prevalence of regular cannabis use was 2.6% for all students (12-18 years of age) with 1.2% of the girls and 3.9% for the boys. Of the 15-16 year old students, 3.1% used cannabis on a regular basis compared to 5.4% of the oldest age group. A small but not trivial group of 12-14 year old students (0.7%) reported the regular use of cannabis.

The mean age at which school students used cannabis for the first time was 15.4 years. Higher prevalence of ever, last year and regular cannabis use were found in students following technical or vocational educational programmes compared to students of general programmes. The most frequently reported reasons to use cannabis were "sociability", "relaxation", and "curiosity". Important reasons not to use cannabis were: "they don't need it", "cannabis is dangerous", "it's unhealthy" (Melis, 2013).

Figure 2. 1. Relative frequency (%) of ever, last year and regular use of cannabis in Flemish Community school students (12-18 years of age) between 2000 and 2012



Source: Melis, 2013a

In the cross-national HBSC study of 2009/2010, 17% of the 15 year old girls and 23% of the boys had ever used cannabis. In the Flemish Community, respectively 7% and 11% of the girls and boys had reported cannabis use the last 30 days compared to 9% and 14% in the French Community (WHO, 2012). The prevalence of frequent use of cannabis (>40 times) in life-time among 15 year old Belgian girls and boys was estimated to be respectively 2.0% and 4.9% in 2010 (ter Bogt et al., 2014). Compared to the HBSC study of 2002, a decline in frequent use occurred for both the girls and boys. However, the prevalence of frequent use of cannabis in 2010 has been stable compared to the prevalence of 2006. This trend is in accordance with the trend in the VAD School Survey.

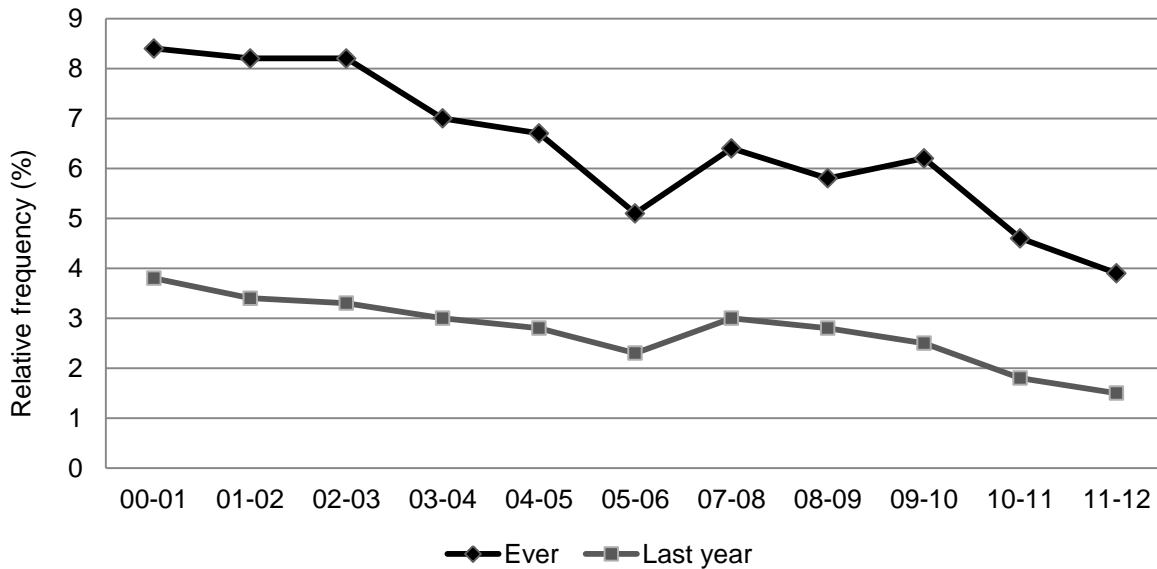
### 3.1.2. Other illicit psychoactive substances

Results of the VAD school survey 2011-2012 show that the use of illicit psychoactive substances other than cannabis was rather limited in the population of school students (Melis, 2013). In the whole school population, only the older students mentioned ever use of these substances: 4.4% of the 15-16 year old students and 7.7% of the 17-18 year old students. The highest lifetime prevalence among the oldest school students (17-18y) of the Flemish Community were reported for ecstasy (3.8%), hallucinogens (3.5%), amphetamines (3.4%) and cocaine (2.5%). A lifetime prevalence of heroin use was found to be about only 0.4% among the oldest school students (Melis, 2013).

For the school years 2007-2008 until 2009-2010, a stable prevalence of lifetime and last year use of psychoactive substance other than cannabis was found (Kinable, 2011).

Compared to this, a gradual decrease was found in the school surveys of 2010-2011 and 2011-2012 (see Figure 2.2) (Melis, 2013).

Figure 2. 2. Relative frequency (%) of ever and last year use of illicit psychoactive substances other than cannabis in Flemish community school students (12-18 years of age) between 2000 and 2012



Source: Melis, 2013a

### 3.2. Drug use among Flemish university and university college students

The survey “Head in the clouds?” (“In hogere sferen?”) is based on the collaboration of the research group “Medical Sociology and Health Policy” of the University of Antwerp, the research group “Health promotion” of the University of Ghent, the Catholic University Leuven, Catholic University College Limburg and the VAD. The third version of “Head in the clouds?” surveyed the use of psychoactive substances in students of the universities and university colleges in Antwerp, Ghent, Leuven and Limburg in 2013 (Rosiers et al., 2014). These participating institutions represent 46.7% (N=107,126) of the total Flemish student population and 18.5% of the eligible students (n=19,822) participated in the survey. With a stratified sampling based on institution and sex, a representative sample of 2,375 students was selected. Of the representative sample, 55.0% was female, which is in concordance with the gender balance of the studied student population. The students’ mean age was 21.2 years. Similar to the surveys performed in 2005 and 2009, the 2013 survey was a web-based questionnaire on the use of (legal and illegal) psychoactive substances, motives and consequences of substance use, mental health, and contextual aspects of substance use (Rosiers et al., 2011; Van Hal et al., 2007).

3.2.1. Cannabis

Four out of ten students reported ever cannabis use (39.6%; n=940) and one in five had used cannabis in the last 12 months (22.0%; n=519). These results are of the same size as the values reported in the previous survey (2009) (43.0% ever cannabis users and 22.9% last year cannabis users) and as the results of the VAD School Survey of 2011-2012 among the 17-18 year old school students (36.6% ever cannabis users and 22.9% last year cannabis users). Male students had more often used cannabis than female students (49.4% versus 31.6% respectively). Among the ever cannabis users, 31.0% of the male students had used cannabis the last 12 months compared to 14.7% female students.

Among the students who had used cannabis the last 12 months, about half of them used it once a month or less during the academic year. One in five used it at least once a week (for more details see Table 2.1) and one in 20 used it every day. During the holidays the frequency of daily use was slightly higher (6.3%) than during the academic year (5.3%) or the examination period (4.2%). Although nearly all of the ‘last 12 months’ cannabis users confirmed the use during the holidays, almost half of them did not use cannabis during the exam period. Regular users of cannabis were more often male than female. The survey also showed associations between age and cannabis use: a higher proportion of ‘last year use’ is found among the younger students. In addition, a younger age of first time cannabis use was associated with more frequent use during the academic year and the holiday period.

Table 2.1. Frequency of cannabis use (%) among students in the ‘last 12 months’ cannabis users in the Flemish Community, 2011/2012

Cannabis Use									
Time framework	Total (N=519)			Men (N=327)			Women (N=192)		
	not	<1x/ week	≥1x/ week	not	<1x/ week	≥1x/ week	not	<1x/ week	≥1x/ week
Academic year	10.5	68.8	20.7	7.8	64.6	27.6	15.0	75.7	9.3
Examination period	45.3	42.3	12.4	39.0	45.4	15.6	55.5	37.2	7.3
Holiday period	4.3	72.2	23.5	3.2	66.2	30.6	6.2	81.9	11.9

Source: Rosiers et al., 2014

### 3.2.2. Other illicit psychoactive substances

Next to cannabis use, the third wave of “Head in the clouds?” also assessed the use of amphetamines, ecstasy and cocaine. The proportion of students that used one of these substances is substantially lower than the proportions of cannabis users: about 5% ever users and 2.5% last 12 months users for each of these substances (Rosiers et al., 2014). These proportions are of the same size as the proportions in the second survey in 2009 (Rosiers et al., 2011) and the proportions are of the same size as in the 17-18 years old high school students of the VAD School Survey (Melis, 2013). Among the last 12 months users, amphetamines, ecstasy or cocaine were seldom used on a regular basis (once a week or more frequent) during the academic year or examination period. However, during holidays, they reported more often the use of these substances on regular basis (amphetamines 15.4%; ecstasy 10.1%; cocaine 6.9%). Of the last 12 months users, 3.8% of the amphetamines users and also 1.5% of the ecstasy users reported daily use in the examination period. No one reported daily use during the academic year or holidays. On the contrary, daily use among the last 12 months users of cocaine was only reported during the summer holidays (2.3%). Male students reported more ever use and last 12 months use of amphetamines, ecstasy and cocaine than female students. Older students reported less ecstasy use in the last 12 months.

### 3.2.3. Mental well-being and illicit substance use

Well-being was measured with the General Health Questionnaire (GHQ-12) with four questions related to anxiety and depression symptoms, two questions related to self-confidence and six questions related to social functioning (Vanheule and Bogaerts, 2005). A higher GHQ-12 score (more psychological problems) was associated with a higher DAST-10 score (problems related to illicit substance use other than cannabis). Consequently, anxiety and depression symptoms were associated with more problems related to cannabis use and other illicit substance use. Less self-confidence was associated with problems related to illicit substance use other than cannabis.

### 3.2.4. Contextual factors of illicit psychoactive substance use

In the third wave of “Head in the clouds?” survey, half of the students lived in a student room, 40% lived at their parental home and 10% were living independently. The latter group reported more cannabis use (54.7%) compared to students living in rooms (39.5%) or at home (36.6%). The same pattern of more substance use among independently living students was observed for the other illicit psychoactive substances. However, the living

condition had no association with the frequency of substance use or problems related to illicit psychoactive substance use.

In addition, the survey did not report any association between the frequency in use of illicit psychoactive substances and the membership or management in an association for students or a sport club.

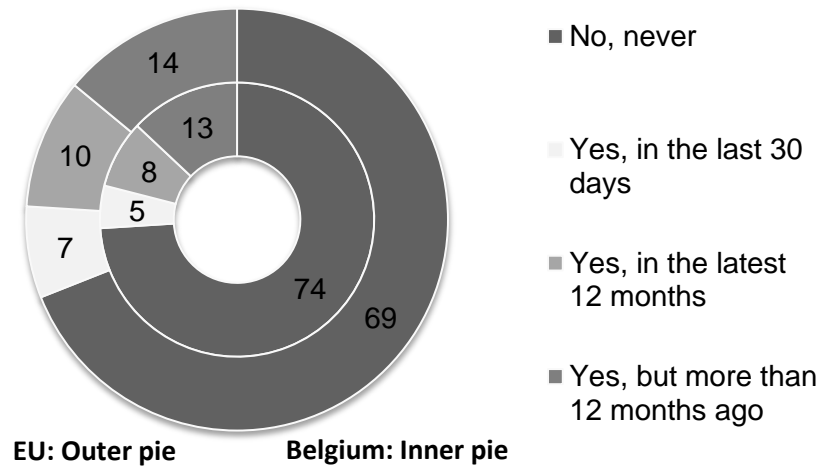
### 3.3. European study on young people and drugs

In June 2014, the TNS Political and Social Network (Tayler Nelson Sofres) of the European Union carried out the Flash Eurobarometer Survey “Young people and drugs” in the 28 Member States on behalf of the European Commission, Directorate-General for Justice. This thematic Flash Eurobarometer has also been performed in 2002, 2004, 2008 and 2011 (TNS Political and social, 2014). About 13,000 respondents aged 15-24 from different social and demographic groups were interviewed by telephone (landline and mobile phone) in their mother tongue. The basic design applied in all countries is a multi-stage random method taking into account region and urbanisation. In Belgium, 500 young respondents were interviewed.

Overall, 13% of the participants in Belgium reported that they had used cannabis the last 12 months (Figure 2.3) compared to 17% in the EU. 28.5% of the Belgian participants reported the use of cannabis during the last 30 days (EU: 7%). Going against the overall EU trend, the respondents in Belgium were more likely to say they never tried cannabis (74%) compared to the Flash Eurobarometer 2011 (Belgium: 71%). The proportion of cannabis users in this survey is substantially lower than the results from the presented school and student surveys. This may be a reflection of the different designs and selection biases. In Belgium, 59% reported that it would be “easy” to obtain cannabis within 24 hours (EU: 58%) and about 61% said that cannabis should continue to be banned (EU: 53%) (TNS Political and social, 2014).



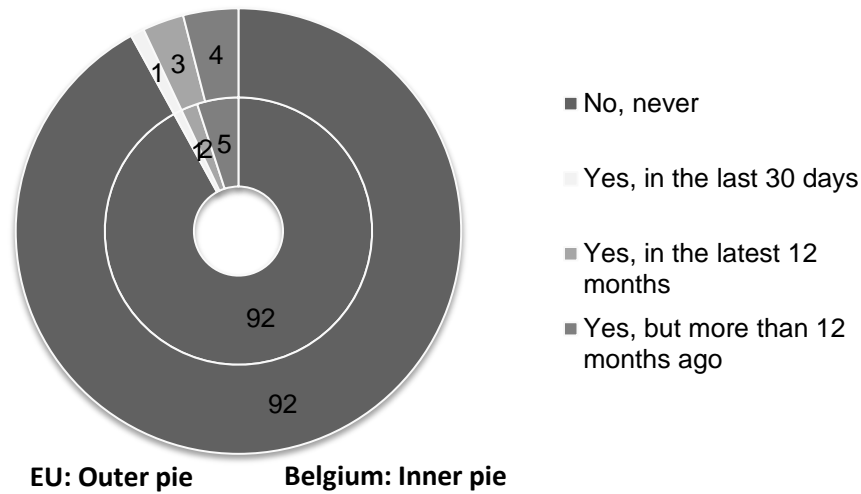
Figure 2.3. Proportion (%) of youth aged 15-24 reporting the use of cannabis, 2014



Source: Flash Eurobarometer (TNS Political and social, 2014)

The large majority (92%) of the respondents in Belgium has never tried new psychoactive substances (NPS), which is similar to the mean in the EU (92%). Only 1% had used NPS the last 30 days, 2% the last 12 months and 5% more than 12 months ago (Figure 2.4). However, the number of ever-users has risen with 4% in Belgium compared to the Flash Barometer 2011. Of the last 12 month users, 87% was given or had bought NPS by a friend, while respectively 35% and 30% reported to have bought them from a drug dealer or in a specialised shop. Only 3% reported to have bought the substances online. All of the last 12 months users reported that they used the NPS with their friends, and 76% used it during a party or event. Of all respondents, 34% reported to have received information on the effects and risks of NPS through the media, while 36% found this information on the Internet. Respectively 29% and 21% reported to have received information through a school prevention programme or from friends and 19% said that they have not been informed at all. A large majority considers regular use of NPS to carry a high health risk (87%).

Figure 2.4. Proportion (%) of youth aged 15-24 reporting the use of NPS, 2014



Source: Flash Eurobarometer (TNS Political and social, 2014)

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

##### 4.1. Drug use in recreational settings in Belgium

Several recent reports of Belgian student surveys (Kinable, 2010; Lombaert, 2011; Rosiers et al., 2011) highlighted the fact that recreational and nightlife settings (e.g. pubs, clubs, parties) are preferred settings for the use of illicit substances. Although the gap in drug use habits between music lovers and non-lovers has narrowed, dance music lovers are still more likely to (frequently) use illicit drugs (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 Community by the VAD research in nightlife settings and the risk reduction project “Drugs risk less” (“Drogues Risquer Moins”) coordinated by Modus Vivendi (Hogge and Denoiseux, 2014) respectively. The methodological approaches of these monitors are significantly different and were described in detail in previous Belgian Annual Reports on Drugs (van Bussel, J. C. H. and Antoine, J., 2012). In preceding years, the prevalence of substance use in both Communities fluctuated to some extent. Changes in the coverage of number, type and location of recruitment settings could have contributed to this fluctuation, especially in the French Community (Rwubu and Hogge, 2013).

For 2013, data were available through the “Drugs risk less” project in the French Community. The next VAD research in night life settings is scheduled for the year 2015. “Drugs risk less”

is a joint action of more than 30 harm reduction and prevention organizations active in recreational settings (Hogge and Denoiseux, 2014). Professionals and peers provide information and advice to users and those who are interested. The primary objective of the accompanying survey (paper questionnaire; in 2013 N=1,653, mean age is 23.1 years old) is to verify whether the harm reduction activities are well matching the targeted audience. Therefore, the survey is not representative to the whole party scene and, hence not interpretable as prevalence data because there is no sampling method (Hogge and Denoiseux, 2014). The results can be interpreted as a first indication of specific (new) issues of substance use among the targeted group. Because of changes in the questions in the 2013 survey, results on last month and last year use of illicit substances are no longer available. Instead, the participants were questioned about their usual substance use during nightlife.

Cannabis is by far the most used illicit psychoactive substance in the recreational settings in the French Community. In 2013, 66% of the partygoers has sometimes or often used an illegal drugs during nightlife events; more specifically, 53.3% had sometimes or often used cannabis, followed by amphetamines (27.1%), cocaine (24.2%), hallucinogenic mushrooms (23.5%) and ecstasy (23.5%). Additionally, 13.7% and 11.4% of the respondents reported sometimes or often use of respectively ketamine and NPS (in this questionnaire referred to as 'research chemicals') during nightlife events (Hogge and Denoiseux, 2014). Of all night life event visitors, 44.1% reported the use of any illegal drugs during the event. 36.0% of the respondents had used cannabis during the event, followed by amphetamines (12.5%), ecstasy (8.5%) and cocaine (6.8%) (Hogge and Denoiseux, 2014). Additionally, 4.2% of the visitors reported the use of ketamine during the event and 2.5% had used NPS.

Finally, the 2014 Global Drug Survey has launched its yearly drug research in November 2013, in which Belgium participated. This was coordinated by the Association of University and University Colleges of Ghent (Vanderplasschen, 2014). Globally, 80,000 people participated in 18 different countries. In Belgium, about 2,670 persons completed the online survey on drug use. It is important to emphasize that such kind of survey is not representative for the Belgian population, as it has shown to comprise an overrepresentation of drug users because respondents are self-selected (no sampling method). Two-thirds of the Belgian participants were men and the mean age was about 27 years. Three-quarters currently had a job or was still a student, 23% was unemployed. Two-thirds visited at least once a month a club or disco. Also, two-thirds had used at least one illicit substance during the last year, while 52% had used a substance during the last month. Cannabis was the most often used substance (42%). Among the cannabis users, half of them used it more than 50 times during the last 12 months. About 30% of the cannabis users would like to use

less cannabis. Other drugs regularly used are ecstasy (23.5%) and cocaine (20%). Speed (8%) and ketamine (6.5%) were less prevalent. About 4.5% of the Belgian respondent reported to have used NPS in the last 12 months compared to 5.3% of all the Global Drug Survey respondents. Buying drugs over the internet is not yet as common (done by 7% of the Belgian participants) when compared to other countries (e.g. 22% in the UK), but the number has been increasing during the last years (Winstock, 2014). It should be noted that the samples from the different countries vary significantly in a number of ways including mean age and involvement in clubbing. Therefore, caution is needed when comparing the data between countries.

## **5. Conclusions**

For this report, the results of the latest general population survey (BHIS 2013) were not yet available and will be presented in the Belgian national drug report of 2015. In general, we remark that population and/or school surveys usually will have difficulties to reach marginalized people, and as such, “hard” or “severe” drug users will often not be included. These surveys will give us some information on more common forms of substance use, but are not suitable to study high risk substance use such as injecting drug use (for a description of high risk drug use please refer to chapter 4) or the use of less common substances in the general population (e.g. heroin).

The regional based surveys among students of secondary and higher education in the Flemish region suggested that the use of cannabis has declined in 2006 and remained stable since then. About one fifth of the 17-18 years old (21.1%) and of the university (college) students (22.0%) used cannabis during the last 12 months prior to the survey. “Regular use” of cannabis among 12-18 years old school students was limited to 2.6% of the study population. The use of cannabis among university and university college students is very time dependent. About half of the last 12 months cannabis users did not use cannabis during the exam period, but almost all students of the last 12 months user group used cannabis during the holidays.

The decreasing trend in the prevalence of cannabis use among youngsters since 2006 has also been observed in other European countries, such as Germany, France, UK and Spain (EMCDDA, 2014). The results of the Flash Eurobarometer 2014 also showed a slight decrease in the prevalence of cannabis use compared to 2011. Therefore, the results of the latest HBSC study 2013/14, the future VLASPAD 2015 and their conclusions on spotted cannabis trends are expected with great interest. On the latest General Population Survey (GPS) expert meeting organised by the EMCDDA (June 2014), an oral presentation from the

Spanish national focal point (GPS expert Alvarez Elena) suggested a correlation between the risk perception of cannabis use and the prevalence of cannabis use among youth. In periods of higher risk perception the prevalence of cannabis use decreased and vice versa. Additionally, the oral presentation of the French national focal point (GPS expert Spilka Stanislas) suggested a correlation between the age of onset of tobacco and of cannabis. In France, there have been no major legislative modifications concerning the use of cannabis, but when the anti-tobacco efforts increased, the age of onset of tobacco increased and so did the age of onset of cannabis. The VAD school survey also describes a gradual decrease in smoking among adolescents during the last 10 years, however more profound research on the mechanisms of onset of drug use is currently not available in Belgium.

The school and university (college) based surveys also suggested that the use of other illicit psychoactive substances than cannabis is limited (about 1.5 to 2.5% last 12 months users of amphetamines, ecstasy and cocaine). A minor group of students in higher education reported the daily use of amphetamines and ecstasy during the examination period. Especially the latter is rather surprising as it not only has a central stimulating effect similar to amphetamines, but also a hallucinogen effect that might become more and more reinforced with repeated and long-term use. Although the use of NPS in Belgium still seems to be limited, based on the results of the Flash Eurobarometer 2014 and the Global Drug Survey, vigilance is needed as an increased use of these substances is reported over the last 3 years.

Observational data from the party scene (French Community) suggest that illicit substance use is much more common in this setting. Partygoers most often reported the use of cannabis during the event (33%), followed by amphetamines (12.5%), ecstasy (8.5%) and cocaine (6.8%). We also notice that 4.2% and 2.5% of the respondents reported the use of respectively ketamine and NPS during the event. As ketamine and other NPS are gaining popularity among partygoers, it should be considered in all kind of substance-related surveys to add these substances in the questionnaires in order to better monitor this phenomenon

As no recurring general population survey specifically on drugs and drug addiction exists in Belgium, all data are cross-sectional using different samples and methodology. Therefore these data are difficult to compare and formulating general conclusions isn't easy. Because of different time and priority schedules in the different Communities, it is also difficult to give a good national overview at all times. In a European context, Belgium is one of the few countries that is not yet systematically collecting national prevalence data on all forms of drug use (Decorte et al., 2009). As such, this research should be prioritized as it is the basic information for other research and policy actions within the field of drugs and drug addiction.

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## Chapter 3. Prevention

*Laudens F. & Casero L.*

- *A large scale cannabis prevention campaign was launched in the Flemish Community, combining a mass media approach with promotion of didactic materials through professionals.*
- *In 2013, the specialised addiction sector and the harm reduction actors developed a “Harm Reduction Plan” in the Brussels Region. The implementation of the plan will be one of the priorities for the next years.*
- *Most of the prevention and harm reduction actions organised in the Wallonia-Brussels Federation are marked by the changeable institutional context of the sixth state reform.*

### 1. Introduction

In Belgium, the Federal Government does not bear responsibility for the prevention policy of drugs. Specific drug prevention in the general population is a competence of the Communities and Regional governments. Each specific Community and Regional government is authorized to implement an own prevention policy in order to respond to the specific needs of the region. Nevertheless, prevention initiatives with regard to general hospitals, medicines, hepatitis C and drug use within the army, have a Belgian coverage and national impact. Therefore, the Federal Government is thus still involved in the implementation of drug-related prevention activities.

The Association for alcohol and other drug problems (Vereniging voor Alcohol- en andere Drugproblemen, VAD) and the Association for Addiction Prevention and Coping with life (Arbeitsgemeinschaft für Suchtvorbeugung und Lebensbewältigung, ASL) are the co-coordinating structures in the Flemish and German Community respectively. The socio-epidemiological observatory for alcohol and drugs in the Federation Wallonia-Brussels (EUROTOX) is the monitoring centre for alcohol and drugs in the French community (Wallonia-Brussels federation).

Prevention in the Flemish Community is regulated by a Flemish Action Plan on tobacco, alcohol and drugs (TAD) 2009-2015. Within this framework, attention is mainly given towards actors in the health and educational sector. Each year, different aspects of the action plan are implemented.

Although several prevention activities are organised within local communities and with police services, regional mental health centres received an additional structural funding in 2013 in order to target companies and local governments. As most of the private companies in

Flanders and Brussels - surveyed in the framework of the action plan TAD - do not use an active policy for alcohol and drugs yet, improvements are highly required in these sectors.

The policy framework for alcohol and tobacco in the educational sector is better developed. A lot of secondary schools carry out a structural policy framework of good quality for alcohol and tobacco. Nevertheless, the action plan TAD is less implemented in primary schools. The topic of alcohol is only present in the curriculum of 58% of the primary schools. Moreover, in only one primary school in three attention is given to rules and clear standards for pupils. Schools also lack a specific legal framework for alcohol and drugs used by employees, given that the Collective Employment Agreement regarding 'the preventive alcohol and drug policy in enterprises' (CAO 100) doesn't involve public institutions (Larmuseau et al., 2013).

Next to these general objectives in the health and educational sector, the Flemish TAD action plan identified secondary schools and public centres for social welfare as the two priority sectors for targeting people with a low socio-economic status.

Alcohol and drug prevention activities in the Flemish Community are monitored by the Ginger programme, which is coordinated by VAD (Rosiers et al., 2014). In 2013, 83 prevention workers took part in this annual registration. In total 6.065 valid alcohol and drug prevention activities were registered.

Prevention actions in the Wallonia-Brussels Federation are performed with a focus on the concept of "health promotion" (WHO, 1986). The main objective is to improve the quality of life and the health of citizens. Due to reform of the federal state, the competence of "health promotion" is transferred to the responsibility of the Walloon Region and the Brussels Region (Commission of the French Community, COCOF) since July 1<sup>st</sup>, 2014. Most of the prevention and harm reduction actions organised in the Wallonia-Brussels Federation during 2013-2014 were marked by this changing institutional context.

During 2013 and 2014, efforts were made in the Wallonia-Brussels Federation to strengthen existing initiatives regarding help, care and harm reduction for injecting drug users by the mobilization of diverse actors.

Since 2013, a 'French-speaking Health Addictions Cell' is operational. This cell consists of representatives of Ministers for Health of the governments of the French Community (Wallonia-Brussels Federation), the Walloon Region and the COCOF. The cell works towards three main objectives: 1) to spread a common political framework to favour the health of citizens and the integration of everyone in society, 2) to facilitate the integration of health policies, 3) to formalize functional political collaborations.



In 2014, three organizations, including the Brussels federation of Institutions for Drug addiction (Fedito Bruxelloise), the Local Coordination of Drugs in Brussels (CLDB) and Modus Vivendi, started to develop a joint harm reduction plan for Brussels. This plan will give a more formal framework to harm reduction strategies in the Brussels region in different environments such as care, prison, party and sport environments (Van Huyck et al., 2014).

Prevention activities in the German speaking Community are set up by ASL. This organization has the objective to prevent addiction and to stimulate a healthy life without drugs. Both legal and illegal drugs are addressed. Nevertheless, this report includes only prevention projects related to illegal drug use. ASL offers amongst others information, lectures, trainings, activities and counselling. In 2013, ASL reached a total of 6,740 people, of which 3,985 students (ASL, 2014).

In the following paragraphs an overview is given of a broad range of universal, selective and indicative prevention activities implemented in the Flemish and German speaking Community and the Walloon-Brussels Federation. Efforts are made to improve and enlarge prevention initiatives towards schools (section 2.1), families (section 2.2 and 3.2) and specific at-risk groups and settings (section 3.1 and 3.3). Citizens who have questions about drug use in general, have the possibility to consult a helpline. Helplines in the Flemish Community and in the Walloon-Brussels Federation provide online counselling as well (section 2.3.1 for more detail). Additionally, a framework to stimulate the implementation of a local drug policy in cities and communities is conducted (section 2.3.2). Moreover, the communities show an increasing interest in screening, detection and intervention of hazardous substance misuse at an early stage (see 4.1 - 4.3). During 2013 also several media campaigns were set up or prolonged (see section 5 for the description).

## **2. Universal prevention**

### **2.1. School**

#### **2.1.1. Universal prevention in primary schools**

Although the number of requests for prevention interventions in primary schools is less numerous than in secondary schools, a number of successful initiatives focussed on this audience.

VAD and VIGeZ developed a guideline for primary schools concerning TAD. This instrument helps to decide which topic (tobacco, alcohol and/or illegal drugs) can be tackled at what age (grade 1, 2 or 3) and which didactic material can be used.

In the last few years, more activities with a main focus on the delay of onset of drinking are introduced in Flemish primary schools. For example 'Fun without alcohol' is an intervention for youngsters aged 10-12 years to promote the non-use of alcohol and delay the age of onset. The intervention consists of 8 lessons to be integrated in the normal curriculum of 3<sup>rd</sup> grade primary school pupils. Pupils as well as their parents can find more information on the website (VAD, 2010).

Teachers can appeal on trainings organised by 'De Sleutel', which provides support in improving so-called 'general life skills' of pupils by using age appropriate materials. Improving life skills is one of the end terms in primary schools that are set by the Flemish government.

In the Wallonia-Brussels Federation, actions are based on the following five principles: 1) analyse the demand and clarify the situation, 2) adapt the action to the educational project and to the institution's resources, 3) recognize the role of prevention to the adults in connection with the young people, 4) act together and create dynamics of participation and 5) guarantee the respect for confidentiality.

In 2011, a pilot project called 'Well-being Cells' ('Cellules bien-être') was implemented in schools. This project combines the philosophic and theoretical continuity of the integrated approaches usually used in health promotion at school. Internal and external participants of the same school (directors, teachers, educators, members of the promotion teams, the pupils, etc.) are regularly consulted to support the director in defining the guidelines regarding well-being applied to an individual school.

### 2.1.2. Universal prevention in secondary schools

Secondary schools in the Flemish Community, the Wallonia-Brussels Federation and the German speaking Community are developing projects concerning the consumption of alcohol and drugs.

There is a strong tradition in universal prevention in secondary schools in the Flemish Community. For many years, a structural policy framework for drug prevention in secondary schools is developed and has a very wide uptake. Each school develops its own global and structural framework, tailored to each individual school setting.

Flemish secondary schools have the opportunity since 1999 to evaluate their drug policy according to the input of their pupils. The school survey ('Leerlingenbevraging'; see also chapter 2 and 4) collects data of all the pupils of a school and renders a report with tips and tools to improve the school's drug policy. Since the beginning of the project, 951 schools and more than 502,651 pupils were involved in this evaluation.

Within the framework of the drug policy at school, there is a wide range of universal prevention programmes that are being used in secondary education, in principal by the teachers themselves. They receive support from prevention workers and prevention organizations, mainly through training and consultation. 'De Sleutel' trains teachers in implementing drug prevention programmes, such as the European programme 'Unplugged', in their classrooms. This approach on education of life skills and social influences has shown effective outcomes in the delay of the onset of drug use in the age range of 12 to 14 years (first grade). 'De Sleutel' also developed a follow-up programme for the second (14 to 16 years) and third grade (16 to 18 years).

VAD created 'Crush', a didactic package for 3<sup>rd</sup> grade pupils on the topic of alcohol and cannabis, associated to relationships. The package uses five methodologies that focus on information concerning alcohol and cannabis, norms and values, coping with social pressure and setting boundaries (Baeten et al., 2013).

Specific support points are operational in the Wallonia-Brussels Federation to strengthen links between the specialised network regarding prevention of addictions on one hand and the school environment on the other hand.

In line with the school survey in the Flemish Community, a survey called "And the young people, what do they think of it?" was elaborated in 2013 in the schools of the Wallonia-Brussels Federation. The results were communicated in all schools. In addition, teachers are offered trainings as well in the framework of "Prevention of addiction and health promotion". These trainings ought to offer schools a common language to discuss the subject addiction with the pupils.

In the French Community, thirteen partners of the health, education and youth sector are involved in the project called "Young people, alcohol and society". The project aimed at promoting less risky and more responsible consumption among young people.

The exhibition "Hooked, not me either" is an interactive exhibition about addiction addressing young people and is developed by Young Latitudes (a service developing several actions of prevention and sensitization). In order to animate the debates with the young people that participated in the exhibition, the NGO "Prospective Jeunesse" organised six debates with pupils and one with social speakers who discovered the exhibition. Next to this, the "Prospective Jeunesse" also created the project "Art and Prevention" in 2013 to support schools in using an artistic practice to approach the questions of consumption. This approach has the advantage to enable the debate with young people without posing questions about addiction too directly. The "Art and Prevention" project also proposes a

health promotion training of the adults relay. In 2013, the initiative concerned five interventions (three in schools and two in municipal departments).

The following additional trainings are organised within schools in the French Community:

- Basic training: prevention of the addictions and health promotion,
- Training in the use of educational tools,
- An educational approach about how to prevent risks connected to addiction (drugs, alcohol, internet, video games, etc.),
- The education on how schools can stimulate the well-being of pupils.

In the German speaking Community a global approach is used to discuss drug use with school students. Together with police agents, ASL give lectures in secondary schools about rights, duties and risks in society. Several topics such as violence, vandalism, theft, etc. are discussed during these information sessions. Legal drugs are attended in the first secondary school year, while illegal drugs are only discussed in the secondary school year. After the session, students are asked to participate to a quiz (ASL, 2014). Another project is introduced in the first year of secondary school, making the subject addiction discussable. Students are asked to sort cards on which words are written such as smoking, relax, dependency, etc. On the basis of the classification of the words the students made, the prevention worker starts a discussion. ASL also organised EuPrevent, a two-days adventure at the sports centre of Eupen. This project gives students the opportunity to experience a 'kick' without using a drug. Besides these adventurous activities, information was given about cannabis and the risks related to cannabis use (ASL, 2014).

### 2.1.3. Universal prevention in higher education

In Flanders, the DrugLijn-website has a dedicated section for university (college) students (De druglijn, 2014). The highlighted topic changes during the course of the academic year. At the start of the academic year, alcohol or cannabis are the main focus. At the end of the academic year, the use of medication (in relation to exams) is highlighted.

Since 2010, the NGO 'Univers Santé' has developed an action plan for 10 years at UCL, in association with the Students Help Service and the Housing Department and targeting the alcohol problem in the student environment. In September 2013, five groups - consisting of students, academic authorities, departments and institutions - were created to develop different priority axes of the operational plan.

Several actions on responsible behaviour concerning drinking alcohol, such as a preventive plan of 24 hours bike, a new campaign "Alcohol" and a Facebook page, are organised during the academic year.

Another project on alcohol use among students in Brussels was developed in 2013 by Modus Vivendi. The experimental project “Alcohol Harm Reduction in student environment” is subsidised by the COCOF for the academic year 2013-2014. The project intends to study the drinking situation in 2 campuses in Brussels, namely the Lucia de Brouckère College and the Saint-Louis University. By testing and estimating certain tools, concrete harm reduction actions will be developed.

## 2.2. Family

### 2.2.1. Improving parental skills

Universal prevention initiatives for parents are mainly integrated in programmes of adult education organizations and at a local level. Several programmes are open to all parents (meaning not only parents with drug using children) and have a broad objective to develop ‘life skills’.

Starting from December 2011, VAD developed an interactive one-session family-based prevention programme for parents of teenagers (10 to 15 years) in the Flemish Community. This prevention programme intends to improve parenting skills linked to the use of tobacco, alcohol and other drugs by teenagers. After a pilot project and a controlled pretest-posttest evaluation, the implementation of the programme started in September 2013. Five trainer sessions (with a total of 71 participants) were organised aiming at both professionals in the alcohol or drug sector and professionals active in parenting support. The complete package (trainer manual, interactive material such as films, leaflets, postcards) is available online (VAD, 2014).

This approach is also implemented in the German speaking Community. For several years, ASL is organising education trainings for the general population. Several gatherings were arranged during 2013 concerning themes chosen by interested parents. In total, 16 evenings with 201 participants were organised. Additionally, one gathering for families about ‘fit children’ was organised (ASL, 2014).

A specific Flemish website on e-learning for parents of teenagers was launched by the end of 2013 after executing a product- and effect evaluation. This universal prevention project, developed by VAD and VIGeZ, focuses on five health themes in parenting namely alcohol, tobacco, cannabis, motion and nutrition (Vigez, 2014). In order to promote the implementation, the site was announced through channels of diverse public health organizations and made subject to training of professionals active in parenting support.

Parents who have questions about possible drug use of their children, can consult online information. A separate page on the website of the Flemish helpline the DrugLijn is paying special attention to parents and parental skills. Also the frequently asked questions on the website of the French helpline 'Infor-Drogues' are dealing with this topic (See also 2.3.1).

## 2.3. Community

### 2.3.1. Helplines

'Infor-Drogues' and 'the DrugLijn' are the drug help lines for respectively the French and Flemish Community. These services do not only operate a telephone helpline. Since a few years, online counselling is also provided through their website.

The annual figures for 'the DrugLijn' in 2013 (N=6,197) are presented in Table 3.1 and show a decrease of 364 contacts or 6% as compared to 2012 (Evenepoel, 2014). These contacts consisted of telephone calls and online enquiries via e-mail, Skype and chat service. However, there are differences in the way the number of contacts per medium evolve. The number of telephone calls (N=3,124) decreased similarly to previous years (-5%). The number of e-mail enquiries (N=2,523) saw its first substantial decrease since the e-mail service was launched in 2004 (-19%). This was however for a large part compensated by the online chat service which was launched in the fall of 2012 and had its first full operational year in 2013. The number of online chat contacts (N=385) is expected to rise further in the future. Despite the increases and decreases in the different 'channels' offered by the helpline, the overall balance between telephone calls and online enquiries remains at an approximate 50/50-ratio.

'The DrugLijn' is not an emergency helpline and therefore not operational 24 hours per day. Outside staffed hours (Mon-Fri 10 am to 8 pm), 1,942 callers reached the 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 601 hoax calls.

Cannabis is the drug which has always been the most mentioned substance at 'the DrugLijn', however the proportion of enquiries on cannabis remains stable (see Table 3.1). The figures on alcohol show a decrease in 2013 after a remarkable increase in 2012. The number of questions concerning cocaine remained fairly stable as they have done for years. The number of enquiries about psychoactive medicines continues to decline. The proportion of enquiries remained stable for Ecstasy and showed a small increase for LSD. The number of contacts related to amphetamines also increased in 2013, whereas those related to heroin or methadone show a decrease. For other drugs that are not mentioned in Table 3.1. like GHB, ketamine or other new psychoactive substances, the numbers remain low.

Nevertheless, taking several years into account, the number of questions concerning GHB seem to increase.

Table 3.1. Number (N) and prevalence (%) of calls by gender and substance in 2013, DrugLijn and Infor-drogues

Characteristics	Infor-Drogues		Druglijn*	
	N	%	N	%
Total number of contacts	2,539	100.0	6,197	100.0
Involved substance				
Cannabis	1,008	40.3	1,935	35.4
Cocaine	431	17.2	792	14.5
Ecstasy	49	1.9	297	5.4
Heroin	142	5.7	156	2.9
Alcohol	327	13.1	1,475	27.0
Psychoactive medicines	204	8.1	492	9.0
Crack	48	1.9	N/A	N/A
Methadone	109	4.3	73	1.3
LSD	29	1.1	97	1.8
Amphetamine	61	2.4	460	8.4

\*Figures include telephone calls & enquiries by e-mail. Percentages for 'involved substances' are calculated on total number of persons that mention at least 1 drug (5,486 persons)

Source: Infordrogue, 2012; DrugLijn 2013

The figures for 2012 already indicated that the 'DrugLijn' reaches more young people now than a few years ago. This evolution is confirmed in 2013 and is due to the success of the online services the helpline is providing. The telephone service traditionally reaches older age groups and also more women. Often this involves partners and even more mothers of drug users. The online services - especially the chat service - seem to appeal to young people: 64% of them is younger than 25 years. The chat service also reaches somewhat more men and more drug users than the telephone or e-mail service. The combination of those findings lead to the conclusion that the chat service succeeds in reaching young male drug users, who are a valuable target group for self-tests, self-care and early interventions (see 4.2 and 4.3 for a detailed description).

It is noted with caution (because of the high percentage of unknown data), that 'Infor-drogues' reaches less young people in comparison with the 'Druglijn'.

In the Wallonia-Brussels Federation, the Infor-Drogue helpline received 2,539 calls during 2013. This figure represents a strong decrease as compared to previous years (3,422 calls for 2012 and 4,347 calls for 2011). Doubtless, phones are replaced by other types of information and communication channels (such as internet and chat services). Since 2005,

Infor-Drogues has an “e-permanence” service. The “e-permanence” service allows users to ask their questions and to consult the answers from the web site in a confidential way. The team receives the message and indicates among its two members who will handle this question and will answer it within a maximum of 72 hours. In 2013, the “e-permanence” service received 190 mails. 59% of mails are made by women. 60% of mails are sent by users. 61% of questions concern cannabis and a quarter of the people contacting the e-service is less than 25 years old.

The decrease of calls can also find complementary explanation in longer processing durations of calls, caused by the increasing complexity of the approached situations. Among the total number of received calls, it is important to distinguish the notion of “call” and “request”. Indeed, every received call is not generally limited to a single request. So, it is common that a single caller asks for several things during the same call (e.g. the information about a product, the explanations on the functioning of detoxification centres, councils, etc.). In 2013, ‘Infor-Drogues’ still had only one unique connection for all incoming calls, which makes double or triple calls impossible. The average duration of phone calls has been 13 minutes (one minute more than 2012 and three minutes more than in 2011). In addition, since July 2013, the telephone line of Infor-drogues is no longer available 24 hours a day and 7/7 days. There is an interruption of the line from 10 pm till 8 am as well as during the weekend (a single time slot on Saturdays from 10 am till 2 pm remains available). This decrease had an impact on the number of received calls as well.

Three target groups contacted the ‘Infor-drogues’ helpline: users, relatives and professionals. The percentage of callers categorized as “users” was 36% in 2013 compared to 37.3% in 2012. Therefore, a constancy in the user calls is observed in spite of the difficulties described above. Users are essentially men from 26 to 50 years old. Calls made by relatives are lower in number than those of the last year (47% of the total calls for 2013 and 52.2% for 2012). Mothers of users represent a little less than 50% of these calls. This proportion remains stable over the years. 16% of the total calls are made in a professional framework. The following professions are included into the professional category: health care professionals (46.6%), the educational sector (27.4%), professionals of the justice sector (5.3%), journalists (18.7%) and public authorities (1.9%).

Regarding the age of users that are contacting Infor-drogues, the group of 26-35 year continues to be the most presented (31.5%) followed by the 36-50 year old group (21.1%) and by the 18-25 year old group (13.7%). Among all age groups, males are overrepresented. This observation is a continuing trend from previous years.



Concerning the geographical origin of call, the statistics showed that the origin of most calls are Brussels (1,247), the Walloon region (741), Flanders (19) or elsewhere (34).

Cannabis (40.3%), cocaine (17.2%) and alcohol (13.1%) are the most often evoked products during calls in the Wallonia-Brussels Federation.

### 2.3.2. Other forms of community based prevention

Belgian citizens can attend lectures about illegal drugs in order to know more about these substances. ASL e.g. organises lectures about cannabis, heroin and co-addiction. Another project gives the opportunity to experience how it feels to be under the influence of drugs by wearing special glasses. This project intends to improve the self-awareness of children and adolescents and to prevent driving under the influence in the future (ASL, 2014).

### 2.3.3. Local alcohol and drug policy

With the objective to stimulate an integral and inter-sectoral-based policy of alcohol and drugs in Flemish communities and cities, VAD updated in 2013 the stepping-stone method which was launched in 2011. This method uses the local network and partners and consists of seven steps (VAD, 2014). A local analysis has to allow the communities and cities to implement actions concerning 1) rules and regulation; 2) structural measures; 3) raising awareness and early intervention and 4) access to primary healthcare and welfare services. Next to this theoretic stepping-stone method, an online, interactive exchange platform for regional and local prevention workers was launched in 2014. On this platform, prevention workers can exchange information on new, locally developed campaigns or policy initiatives. They can also communicate with each other and post questions on things they are struggling with in developing a local alcohol and drug policy. Currently, 72 prevention workers are registered for this platform.

Local prevention workers can also use a protocol to perform test purchasing in order to investigate whether or not sellers of alcoholic beverages cling up to the legislation on selling alcohol to minors. The monitor can be used to check if sellers of alcoholic beverages are familiar with the legislation or whether they need more information on the legislation on selling alcohol to minors. It can also be used to evaluate the effects of preventive actions on this theme. VAD prepares a tailored made report for each city in which the test purchasing took place.

Since 2014, all Belgian cities have to work within a new framework of rules to compose their policy plans for the coming legislature (the so-called policy and management cycle for cities and social welfare organizations). In order to stimulate and assist cities to include the topic of

alcohol and drugs in these plans, VAD developed three information sheets: one on alcohol, one on cannabis and one on other illegal drugs.

### **3. Selective prevention in at-risks groups and setting**

The Flemish Community disposes of a specific action plan on TAD, while the Wallonia-Brussels Federation works within the concept of 'Health promotion'. Therefore, the selective prevention approaches in both regions differ from each other.

#### **3.1. At-risk groups**

The focus in the Flemish Community regarding selective prevention activities towards at-risk groups is directed to people with special needs and ethnic minorities. The Wallonia-Brussels Federation, in its turn, has a broader scope and is investing more in peer prevention towards people with an unstable living situation.

##### **3.1.1. Selective prevention for people with special needs**

Two Flemish prevention programmes are targeting youngsters with special needs. The first didactic package 'Alcohol and cannabis, no nonsense' ('Alcohol en cannabis zonder boe of bah') is a package tailored to young people with a mild mental disability. It offers an effective way to make them more aware of the effects, risks and consequences of alcohol and or cannabis use. The second programme is developed by CAD Limburg, which operates exclusively in the province of Limburg. 'Hard steps' ('straffe stappen') is a programme targeting youngsters in special needs education. CAD has also a programme for people with a mental disability.

##### **3.1.2. Selective prevention for ethnic minorities**

Specific actions for ethnic groups are mainly implemented in the Flemish Community. Until January 2013, VAD coordinated a pilot project 'drug prevention for ethnic minorities' (Laudens, 2013). The general objective was to develop a methodology to set up future preventive actions towards ethnic minority youth. Youngsters with a Turkish background were chosen 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 were carried out after a Rapid Assessment and Response (RAR) was undertaken. In the three regions together 13 preventive actions were carried out.

In December 2013, VAD started with a new prevention project oriented towards parents of ethnic minorities. The main goal of this project is to improve parental skills concerning tobacco, alcohol and drugs. VAD coordinates this project while VIGeZ is the partner

organization bringing in expertise on tobacco. The project is carried out with the help of six pilot regions. In each region, an existing intervention for autochthonous parents is adapted to be used with parents of ethnic minorities or a completely new intervention is developed. The local development of each intervention is carried out by a prevention worker and a professional working with ethnic minorities. Testing and evaluation of the interventions is foreseen from April till September 2014. Implementation of the final versions of the six interventions will take place early 2015.

### 3.1.3. Drug prevention for people with unstable living situation

The Wallonia-Brussels Federation take great pains to stimulate citizens to participate actively in prevention and harm reduction activities. A specific strategy, called “snowball operations”, is a peer prevention programme to spread prevention and harm reduction related information about AIDS, hepatitis and other risks linked to drug use. The non-profit association Modus Vivendi coordinates these snowball operations.

This project has the objective to reach drug users and prevent them from risk behaviour through the environment where they are living. As drug use is more common among homeless people and prisoners in comparison with the general population, snowball operations are conducted on the street and in prison. The main goal is to spread harm reduction messages through people who might have experience with drug use and know other drug users. This method allows to inform people who are not reached by general prevention initiatives (“hidden population”). Specifically for the snowball operations within prisons, this project intends to make professionals aware of the need for harm reduction projects in prisons.

During the last year, six snowball operations have been organised on the street: 2 operations were made in Charleroi, 1 in Liège, 1 in Brussels, 1 in Namur and 1 in Luxembourg (Modus Vivendi, 2014). One out of the six operations was specifically organised for women (in Liège, with the cooperation of a local partner: SpaceP). Additionally, two exploratory snowball operations were organised in Arlon and Sambreville. The operation in Arlon aimed to enhance the name of the needle exchange site. The operation in Sambreville intended to measure the behaviour of injecting drug users who are living far from needle exchange sites. In 2013, also two snowball operations were done in prison. One in the prison of Berkendael in Brussels (women prison) and the other one in the prison in Luxembourg (men prison).

During a snowball operation a questionnaire is conducted; which is at the same time a tool of contact and information. The anonymous questionnaire is composed of about fifty questions

(mostly multiple choice) and approaches a variety of themes such as the consumption of psychotropic products, risk behaviour and screening of infectious diseases. This survey is administered by peers (so-called 'jobistes').

In total, 428 questionnaires were collected during street snowball operations in 2013. The quantitative analysis of the questionnaires confirms that the snowball operations reach the target group. In particular, a consumer public who uses substances by injecting and sniffing (during the last 6 months) was contacted. Although this group mostly lives in precarious conditions and are socio-economically vulnerable, the results show that they have contact with psychological, medical and social professionals.

Finally, the project "Synersanté" in Brussels, aims to create a mobile health unit to follow homeless people with problems of substance use. This unit has the objective to coordinate non-specialised prevention, medical and social interventions as this desolated group is often locked out of these services. One of the reasons is that this group are often confronted with multiple problems.

### 3.2. At-risk families

Prevention initiatives pay also attention to at-risk families giving them extra support to prevent (extra) harm to (ex) drug dependent families (both children and parents).

#### 3.2.1. Selective prevention for drug using parents and their children

"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. The project provides case management to clients. The case manager assists families in identifying their needs, obtaining these services and developing their goals.

In a number of low threshold services for drug users in the Flemish Community the KIDO-projects provide support in developing the parental skills of drug-using parents.

Within the Flemish Community, VAD coordinated trainings in 2013 for professionals who often are in contact with children of substance abusing parents. During this project, collaborators working for 'The DrugLijn' and the 'Children and Youth telephone' ('Kinderen en Jongeren Telefoon') were trained, as well as professionals working in low threshold youth welfare organizations.

Also in the Wallonia-Brussels federation, attention is given to establish a harmonious relationship between drug using parents and their children in order to prevent harm. The "Parenthood" Service of the non-profit association ALFA (based in Liège province) presents

on the one hand a global and integrated care for drug using parents and on the other hand an innovative therapeutic care for a young public. The objective of this project is to strengthen the parents' role and to give children a psychological follow-up. In 2013, 126 patients were followed by the service (66% women, 24% men and 10% children). An increase in the number of followed patients was noticed with regard to the previous years. The majority of the patients are between 26 and 44 years. 30% of the persons return voluntarily to the service during a new pregnancy or during a new stage of their parenthood.

The non-profit association NADJA (based in the province of Liège) closely followed 34 relatives of young people in 2013. These relatives made use of the so-called 'welcome point of relatives' because their children often present a problematic consumption combined with alarming risk behaviours. Symptoms such as absenteeism and unhooking (68%), degradation of the relation with the parents (60%), isolation, withdrawal (58%) and small criminal behaviour (fights 18%, dealing 12%, harassment, verbal threats 12%, and violence 12%) are mentioned by parents as a motivation for a request. Besides this 'welcome point of relatives', NADJA is offering parental coaching as well, through an open group which meets once a month. These coaching sessions intend to provide parental guidance and have both an informative and therapeutic aim.

The drug addiction department of the mental health of Charleroi developed a parenthood-addictions project. This project aims at allowing (ex-)drug using parents to take care of the well-being of their child(ren). Social, educational and psychological support is offered as well in order to improve the reintegration with the social network.

The "Parenthood-Addiction" ("Parentalité-Addiction") project of the public hospital of the Public Centre of Welfare, Saint-Pierre in Brussels, specifically targets pregnant women who are using drugs, future addicted parents and other members of the parenthood. A multidisciplinary team offers a coherent and reassuring framework for the future drug using mother. Care and postnatal follow-up is given to the family. A separate environment "the Alizes" has to allow families to meet each other. It gives an opportunity to parents and children to get used to the new composition of the family. In 2013, the Parenthood-addiction team followed 71 families which represent 187 people and accompanied a total of 17 births.

Drug using parents living in the German speaking Community can consult ASL that offers two programmes to drug using parents with young children. The first programme is oriented towards parents with young children up to 3 years old and supports parents during three months in order to increase the confidence of the parents in nursing their children. In 2013, three sessions of the parent-child programme took place. The second programme offers a short (four days) family holiday which is based on pedagogic principles. The objective of this

type of holiday is to improve the parental skills and to create a pleasant family event. Additionally, it gives the opportunity to children and youngsters to escape the daily grind (ASL, 2014).

### 3.3. Recreational settings

As opposed to other settings described in this chapter, the activities and projects in the recreational setting show quite some collaboration and exchange of expertise between the different Regions and Communities in Belgium or even between different countries.

#### 3.3.1. Quality Nights

The Belgian Label “Quality Nights” aims at reducing the risks (health, addictions, return at home, conflict/violence, noise pollutions, sexually transmitted infections, etc.) related to recreational settings by collaborating with the evening organizers, the owners and their staff in the party environment. The project was implemented in 2007 in Brussels. Since 2009 it was gradually dispersed to the Walloon Region, where the label works in association with seven local operators. Following this expansion, the label (called ‘charter’ in Flanders) was adapted to the specificities and habits of the Flemish party scene in 2012. In October 2012, the Quality Nights Charter was officially launched in Antwerp starting with nine new clubs. From 2013 on, the Quality Nights charter was implemented in an increasing amount of venues and festivals. By the end of the year a cooperation with 15 club owners and 10 event promoters was established in the Flemish Community.

Quality Nights intends, among others, to boost the information and prevention activities in recreational settings in order to make young people aware of the risks related to drug use. Club owners or event promoters are supported to make several services available in order to facilitate safe night life. When the services described below are met, the club or event receives the Quality Night label.

At present, the following six compulsory services are identified:

1. The availability of free water,
2. The availability of condoms at reasonable prices,
3. The availability of ear plugs at reasonable prices,
4. The distribution of alerts (early warnings – in collaboration with the BEWSD),
5. The staff training (addictions, first aids, management of conflicts, noise pollutions and Quality Nights),

6. The distribution of information about health, including information on the risks connected to the consumption of certain drugs, to the excessive consumption of alcohol, etc.

To guarantee the coherence of Quality Nights, a global plan of evaluation was developed and set up in association with the local operators in Walloon region. It allows the collaborative settings to access all important information, such as the contacted and certified places, the implementation of the compulsory and optional criteria, and the dates and results of controls.

In order to estimate the knowledge, the perception and the use of the Quality Nights label (or its services) by the festive public, an evaluation was realized by the CBPS NGO and Eurotox in November 2013. 601 questionnaires were collected in 14 certified places. The evaluation underlines the usefulness of the label for the festive public. Additionally, it results in recommendations to strengthen this label in the future, such as increasing the visibility of the label and the services, improving accessibility of these services so that the beneficiaries do not have to look for them, improving the explanation on the harm reduction policy of the label via the internet site, etc. (Centre bruxellois de promotion de la santé, 2013).

### 3.3.2. Peer support in recreational settings

Peer support was introduced in Flanders in the mid 2000 as a promising new method to work on risk minimization in the nightlife in Flanders, first by Breakline and later by Vitalsounds. During the years both projects became stronger, more experienced, better equipped and they managed to develop a crew of experienced and motivated peers. In 2010, Vitalsounds and Spiritek (Lille, France) 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. In 2011, both Breakline and Vitalsounds developed a new website to inform party people on health risks in nightlife settings. Both project are also active via social media such as Facebook and cooperate closely with Quality Nights (see 3.3.1) to create a healthy and safer nightlife in Flanders. By the end of 2013, the funding of the city services ceased which lead to a shutdown of the interregional cooperation between Vitalsounds and Spiritek. However, new funding was applied with the Flemish government and granted for one year (until the end of 2014).

Peer support in recreational settings in the Wallonia-Brussels Federation are performed by two types of projects, namely “Mobile Team” and “Drugs, taking less risks” (“Drogues Risquer moins”).

The Mobile Team gets in touch with young people using psychotropic products, including alcohol. This population has little contact with the socio-sanitary sector. A mobile team is constituted of both professionals and peers. This last group are often users themselves and receive two trainings beforehand (a first training to become jobiste and a second training on the specificities of the festival job). The activities of the Mobile Team took place in 2013 at five festivals: Couleur Café, Tribe Gathering, Dour, 'Espéranzah and Doudou. During these festivals, a mobile team was working in the relax zones and gave advice to people in case of bad consumption experiences. More than 80% of the people welcomed in a relax zone (N=235) in 2013, declared to have consumed at least one psychotropic substance (and more than a third even two products or more). Alcohol was the product most frequently declared (60.5%), followed by ecstasy (39.5%) and cannabis (28.1%). 47.9% of the people went to the relax zone by themselves. A third of the people was sent by Red Cross (32.7%) and only a small minority arrived through a friend (8.1%) or through a peer (4.2%). The average age of the party goers taken care in the relax zones is 21.5 years (min. 15 years - Max. 50 years). By comparing the results of previous years, the average age was 23.5 year old in 2012, 22 year old in 2011 and 2010 and 21 year old in 2009. These results confirm the presence of problems for a relatively young public, who are often less used at managing their consumption. The majority of the public welcomed in relax zones are men. The women's proportion reached 27%, almost identical to previous years. The reasons for admission are rather similar in proportion to those in 2012: for the majority of the people (83 %) fatigue is the reason to come to the relax zone.

"Drugs, taking less risks" is a harm reduction information project at festive places which is set up by peers as well as professionals coming from the psychological, medical and social sector. It is implemented in the Wallonia-Brussels Federation since 2001. Information about all types of products (legal and illegal) and different consumption habits (occasional, entertaining, regular, problematic, compulsive, etc.) is spread to the general public via a desk at the festival, discotheque, bar or concert hall (specific results about substance use of respondents participating this project are described in chapter 2 and 4 of this report). In total, 118 interventions (excluding the interventions in Liège) were realized in 2013. Particular attention was paid to the development of the project in the Walloon Brabant province (a few interventions are developed on this territory).



## 4. Indicated prevention

### 4.1. 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 is more likely to show symptoms of harmful substance use than the general population (WHO, 2010). However, hazardous and problematic use is often not detected in primary health care and welfare services.

To facilitate screening and early intervention the online toolbox 'me-assist' was developed in the Flemish Community. This toolbox provides general practitioners with a web-based instrument that consists of a screening tool (modified electronic ASSIST), help with a brief intervention based on FRAMES, referral guides on alcohol, tobacco and other drugs, patient leaflets, guidelines, scientific reports and information for relatives (children, partners or parents from users). This web-based instrument is free of charge for all general practitioners and social workers that want to use it.

Additionally, staff of emergency departments (ED) were provided with (new) tools to deliver the 'Screening, Brief Intervention and Referral to Treatment' (SBIRT) for clients whose alcohol use may put them at risk of health problems. After evaluating the former SBIRT intervention on acceptability and usability, the intervention was changed to a brief feedback and the provision of a patient leaflet. The literature review and the results of the pre-test stage were disclosed to ED. Furthermore, a guide was made on how ED can implement SBIRT.

Within the framework of Saint Pierre public hospital in Brussels, the Interstice NGO has a project called "Emergencies-drug addiction". A psychologist of the association is closely involved in the service of the psychiatric emergencies. This allows the awareness raising of and informing the medical teams. These teams feel indeed often deprived and/or exhausted in front of drug using patients. Another project called "Connection-drug addiction" aims to make doctors and nurses qualified in the treatment and care of mainly opiate users.

### 4.2. Early intervention

In the Flemish Community there's an increasing interest in indicated prevention and detection of, and intervention with hazardous substance misuse at an early stage.

Youngsters are more sensitive to the risks of substance use and more vulnerable to develop drug problems. They are often not motivated to receive any kind of help because they don't

determine 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.

The screening instrument SEM-J allows organizations in contact with young people to assess the risk level of drug use and the need for referral to treatment of youngsters (Baeten et al., 2009). Next to schools and juvenile care communities, drug prevention workers are also important in providing early interventions for substance use. A training programme was developed and successfully implemented.

In addition to the screening instrument, also an interactive psycho-education tool 'Mighties' was developed. With this tool, professionals in drug treatment and early intervention are able to analyse experiences and behaviour in different situations together with their young clients. This will visualize how behaviour (drug use) results from a competition between rational and conscious considerations as well as automatic, greatly unconscious processes in the brain. The tool was tested and the implementation was initiated. In a next phase the tool will also be used in drug prevention.

In 2013, a short research on best practices showed the feasibility to develop a two session intervention for juvenile care. This intervention has the objective to target personality specific risks of youngsters with early onset alcohol or cannabis use.

#### 4.3. Self-care and self-help

Nowadays, youngsters are easily reached through social media and online services. Bearing this in mind, the help line 'The DrugLijn' (See also 2.3.1) contains a section with a number of online assessment-tests and online self-help programmes on their website (De druglijn, 2014). This section contains nine online assessment tests (on cannabis, cocaine, ecstasy, amphetamines, alcohol, gambling, benzodiazepines, gaming and internet) for adults and three similar test (on cannabis, alcohol, gaming ) for minors. In addition, six knowledge tests are available online. In 2013, 42,827 self-assessment test and 13,984 knowledge tests were filled out on the website. Finally, 365 persons (+12% compared to 2012) registered for the online self-help programmes for cannabis and cocaine users at the helpline's website. In total, the website had 476,101 visitors (+56% compared to 2012) resulting in a total of 1,567,534 page views.

The centres for alcohol and drug problems (CAD) and Drug aid Kempen (Drughulp Kempen) run an online treatment programme specifically for cannabis, ecstasy, speed, cocaine and GHB. In 2013, the website counted 78,993 visitors (of which 49,058 were unique visitors). This resulted in 126 persons that registered for treatment. This website counted 34,936

visitors (of which 24,844 were unique visitors) which resulted in 44 registrations for treatment.

A specific website for alcohol-related problems was implemented in both parts of the country. The Flemish and the French websites are designed for both persons who are developing problematic alcohol use as well as their family and friends. The online programme allows people to set their own goals and provides the necessary tools to reach those goals.

The website guarantees anonymity and consists of 3 parts:

- Information (for users and relatives),
- Support for self-help,
- On-line support with a therapist.

The German speaking Community organises self-help groups in order to exchange experiences and getting support to take further steps in treatment (ASL, 2014).

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

As human behaviour is a very complex thing, a mass media campaign will not necessarily result in changed behaviour. A recent review of mass media campaigns of illicit drug use could not affirmatively conclude on the effectiveness of reducing (the intention to) the use of illicit drugs amongst young people (Ferri et al., 2013).

Though, campaigns can attract attention and encourage the development of a critical attitude. In order to make mass media campaigns effective, they have to be conducted in parallel with other preventive actions. Consequently, more intensive prevention initiatives have to be encouraged.

The development of a mass media campaign is not an easy task. A recent PhD dissertation at the Ghent university concluded that the use of two-sided messages, which recognize both the perceived advantages and disadvantages of a health issue, is not always sufficient to obtain an effect (Cornelis, 2013). The effect depends on the processing level. When the target audience is expected to process the message in a profound way more attention is to go to the message content. On the other hand, when the target audience is expected to process the message in a peripheral way, the framing of the message in particular becomes more important.

The cell 'General health policy drugs' of the Federal Public Service Health, Food chain safety and Environment is involved in awareness campaigns related to sedatives, Hepatitis C patients and alcohol use in hospitals. The cell 'Addictions' of the Federal Public Service

Defence and Security is regularly organising awareness campaigns for illegal drug use among soldiers.

On November 5<sup>th</sup> 2013, the Flemish Minister for Welfare, Public Health and Family launched a large cannabis campaign. Target groups were parents and youngsters aged 14 till 25 years. The main aim was to reinforce and encourage the non-use of cannabis. The campaign message “don’t fool yourself” (‘Laat je niet vangen’) was spread using a variety of communication channels. The campaign website, built around a quiz and a referral tool, was advertised using Facebook, print ads, online banners, posters, internet, radio- and TV-commercials.

The public campaign ran until April 2014 and was heavily supported by professionals working in the alcohol and drugs-field. During the campaign a large number of existing didactic materials for targeting youngsters and parents was distributed for free. In order to promote the campaign among professionals and to present all these materials, VAD organised a kick-off event for prevention workers and local health promotion. An independent evaluation of the campaign revealed a high penetration among the target groups. The appreciation was considerable higher among non-users of cannabis than among youngsters who already use cannabis.

In the Walloon-Brussels region an alcohol campaign was implemented for the same age group (15 to 25 years old). The brochure "The effectomètre: alcohol or not, how to make a success of the evening" has the objective to raise awareness towards the consumption of alcohol. This brochure includes advice to reduce the risks of alcohol use and pays attention to the responsibility of young people for their own alcohol use.

Additionally, the “-16 no alcohol, -18 no liquor” campaign is a national initiative to inform retail, youngsters and parents concerning the new law and to instruct retail personnel how to enforce the new law. In 2013, 65,000 stickers with the message “-16 no alcohol, -18 no liquor” were distributed in retail shops. 10 mobile booths delivering the campaign message on events were used for a total of 142 days in 2013. During 2013, the information campaign “-16, no alcohol” was re-launched in Brussels. A postal package was sent to the state employee of prevention of the municipalities, containing an explanatory mail, stickers “-16 years no alcohol; -18 years no liquor”, a poster and a card of instruction.

## 6. Conclusion

In Flanders the Ginger registration sheds light on the relative importance of the different prevention settings and activities. Prevention is mainly oriented towards actors in the health and educational sector. In the educational sector, secondary schools participate in three-quarters of the activities. In the health sector, more than half of the prevention activities take place in the regional mental health centres. Two third of the prevention activities aim at intermediary target groups, such as professional prevention workers, health experts or teachers. One in four prevention activities are 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.

Alcohol and illegal drugs are by far the most common items in prevention activities, although ICT-related addiction (e.g. internet addiction, video game addiction) is becoming increasingly popular as a topic in prevention.

In 2013, a number of activities (compilation of memorandum by VAD and Fedito's (Brussels and Wallonia) and compilation of the Green book in Flanders) were linked to the elections of May 2014 and especially the sixth state reform which is in effect from July 1<sup>st</sup> 2014 (see also chapter 1). The transfer of the Health Promotion sector (which includes a big part of the addictions projects in Federation Wallonia-Brussels) to the Walloon Region and the COCOF is one of the most important stakes for 2014. An important part of the activities realized during 2013 were intended to raise awareness of the government on the importance of keeping the concept of "Health promotion".

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## Chapter 4. High risk drug users

*De Ridder K.*

- *The prevalence of estimated ever-injecting drug use in Belgium has remained stable between 2002-2012 (3.4 per 1000 inhabitants).*
- *More than half of the injecting drug users was initiated to injecting drug use before the age of 21 and 14% was even younger than 15 years of age at the time of first injection.*

### 1. Introduction

In this chapter, aspects of high risk drug use are presented following EMCDDA's current definition being 'recurrent drug use that is causing actual harm to the person or is placing the person at a high probability/risk of suffering such harms' (Thanki and Vincente, 2013).

Hence, high risk drug use (defined by EMCDDA) can be measured as the use of psychoactive substances by high risk patterns and/or by high risk routes of administration in the last 12 months. As consequence, prevalence data of daily substance use, polydrug use (patterns) and injecting drug use (route of administration) can be considered as an indication of high risk drug use. Polydrug use in particular is increasing the risk of overdose due to the synergistic effects of the different types of drugs combined. For the description of frequent or daily substance use please refer to chapter 2.

As the prevalence of injecting drug use (IDU) in Belgium is currently estimated by the use of the HIV multiplier method (combining data from the national HIV/AIDS register with estimates of the HIV-prevalence rate among injecting drug users), the presented prevalence is related to *ever*-injecting drug use.

The policies on prevention and harm reductions are competences of the Communities in Belgium. Activities in this framework are supported by the competent administrations and our regional focal points. As results are therefore not comparable, they are reported separately. Characteristics of the injecting population are investigated through a yearly survey by the needle exchange programme in the Flemish Community. Indications of high risk drug use, of which some do not strictly follow the EMCDDA case definition of high risk drug use, among persons visiting recreational settings within the French Community were obtained through the survey 'Drugs risk less' ('Drogues Risquer Moins' of Modus Vivendi).

## 2. Prevalence of and trends in high risk drug users

### 2.1. Estimation of high risk drug use prevalence

#### 2.1.1. National prevalence estimation of injecting drug use

##### *Research strategy: 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-behavioural study among injecting drug users (IDUs) (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 a benchmark. To overcome these limitations, statistical corrections were required, which allow avoiding seriously biased estimates of the size of the injecting drug using population. In particular, imputation by chained equations (van Buuren 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 mortality. Monte Carlo confidence intervals were obtained properly reflecting the uncertainty resulting from the statistical corrections. For a thorough overview on the methodology, the reader is referred to Bollaerts et al. (Bollaerts et al., 2013).

##### *Data sources*

- *National HIV/AIDS register*

In Belgium, HIV-screening is widely used with an average of 56 screening tests per 1,000 inhabitants per year during the period 2000-2010 (National Institute for Health and Disability Insurance (NIHDI)). All serums for which the screening test results were 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 which exists since 1985-86 and is hosted by the Scientific Institute of Public Health (WIV-ISP). 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, through IDU 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 subjects for follow-up; each year, data is collected on last consultation and possible death. The non-AIDS cases are no subject for further follow-up.

- *Sero-behavioral prevalence study*

In Belgium, a sero-behavioural study was carried out in 2004-05 among drug users in contact with drug treatment facilities or users who were imprisoned (Plasschaert et al., 2005). In total, 1,005 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. 57% (n=573) and 68% (n=80) of the drug users in treatment and in prison respectively, 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: [1.8;4.6]) and 5% (95%CI:[2.0;12.2]), respectively. These prevalence's were not significantly different (p-value= 0.30), yielding an overall estimated prevalence of 3.1% (95%CI: [1.8;4.8]).

In addition to serological studies, the HIV prevalence rate among IDUs can be obtained from routine diagnostic testing. As these results are yearly available, this allows for the investigation of time trends. However, concerns remain regarding the (geographical) representativeness of the data. Similar to other observed (Western) European trends (EMCDDA, 2010), no significant time trends in HIV prevalence rates among IDUs were observed during the past 10 years in Belgium based on the results from routine diagnostic testing (Deprez et al., 2012). Therefore, the HIV prevalence rate from the sero-behavioural study conducted in 2004-2005 is assumed to apply to the entire period 2002-2012.

### *Results*

Because of an update of the file from the national HIV/AIDS register, the estimates before 2012 are slightly different from the estimates in the previous editions of the Belgian Annual Report on Drugs (Table 4.1).

In 2012, the prevalence of ever-IDU (per 1000 inhabitants, aged 15-64 years) was estimated to be 3.5 (95% CI: [2.4;4.7]) and the total number of ever-IDUs in Belgium to be 25,132 (95% CI: [17,352;33,959]). The estimated prevalence for 2013 was 3.5/1,000 inhabitants (95% CI: [2.5;4.8]) and the estimated total number of ever-IDUs was 25,673 (95% CI: [18,135;34,987]). No significant time trends were recorded. Complementary information related to IDU is described in chapter 5.



Table 4. 1. Estimated number and prevalence of ever-injecting drug use (15-64 years) between 2002 and 2012

Year	Ever- IDUs alive		Prevalence ever-IDU	
	N	95% CI	n/1,000	95% CI
2002	21,200	[15,165;29,933]	3.1	[2.2;4.4]
2003	21,866	[15,539;30,101]	3.2	[2.3;4.4]
2004	23,175	[16,352;32,345]	3.4	[2.4;4.7]
2005	23,189	[16,067;32,886]	3.4	[2.3;4.8]
2006	23,237	[16,453;31,904]	3.4	[2.4;4.6]
2007	24,044	[17,146;33,603]	3.4	[2.5;4.8]
2008	24,525	[17,453;34,409]	3.5	[2.5;4.9]
2009	24,743	[16,975;34,026]	3.5	[2.4;4.8]
2010	24,869	[17,398;34,251]	3.5	[2.4;4.8]
2011	25,160	[17,577;34,528]	3.5	[2.4;4.8]
2012	25,132	[17,352;33,959]	3.5	[2.4;4.7]
2013	25,673	[18,135;34,987]	3.5	[2.5;4.8]

CI: Confidence Interval

Source: national HIV/AIDS register, WIV-ISP

### 2.1.2. High risk substance use among students

The 2011-2012 VAD School Survey assessed polydrug use among Flemish students in secondary education (Melis, 2013). Although an interesting aspect of multiple drug use, note that this report does not put a focus on concomitant use with tobacco or alcohol as they are not defined as illicit drugs and not part of our surveillance tasks (EMCDDA). Of the Flemish school students who had ever used cannabis, 20.6% had also used another illicit psychoactive substance (Melis, 2013). 45.1% of the regular cannabis users had ever used another illicit drug.

Problematic use of cannabis and other psychoactive substances among Flemish students in higher education was assessed in the third wave of “Head in the clouds?” survey (Rosiers et al., 2014). Problematic cannabis use was examined through six questions which were based on criteria for cannabis dependency of the diagnostic and statistical manual on mental health (DSM-IV) (Decorte et al., 2003). The questions were related to

- the use of cannabis longer than planned,
- feeling the need to reduce or stop cannabis use,
- not being able to keep up work or study obligations,
- the reduction or suspension of social activities because of cannabis use,
- sustained use of cannabis despite relational problems, psychological or somatic problems caused or worsened by cannabis use.

Only respondents with reported cannabis use the last 12 months were requested to answer the yes/no-questions. 15.8% did use cannabis more or longer than planned and 10.0% did feel the need to reduce or stop cannabis use. Three-quarter of the last 12 months users had never experienced one of the six expressions of problematic cannabis use. A higher risk for problematic use is correlated with more frequent use and a younger starting age of use. 90.6% of the female students reported no expressions of problematic cannabis use compared to 70.2% of the male students.

Problematic use of amphetamines, ecstasy and cocaine was assessed with the DAST-10 screening instrument (McCabe et al., 2006). The questionnaire is based on ten yes/no-questions related to possible experienced negative consequences of substance use the past year and breaks users down into three different categories: limited risk, increased risk and strongly increased risk of problematic drug use. In the survey, the number of respondents for DAST-10 was limited (N=138), so cautious interpretation of the results is required. Less than half of the respondents reported increased risk (34.1%) and strongly increased risk (11.6%) for problematic substance use. Certain symptoms were more frequently reported: using substances for non-medical reasons, polydrug use, involvement in illegal activity to obtain the substances, feeling bad or guilty about substance use, and having blackouts or flashbacks because of substance use. At the same time, nine in ten respondents of this user group reported that they expect to be able to stop using these substances if wanted. The report postulates that this observation could suggest two things: either it could confirm a difference between problematic drug use and dependency, or perhaps these substance users underestimate the difficulty to stop their substance use. Similar as the results on cannabis use, male students reported more problems related to these substances than female students.

### 2.1.3. High risk drug use within the party scene

In the French Community, indications regarding IDU and polydrug use can be obtained based on the annual survey within the party scene (“Drug risk less”, Modus Vivendi, see also Chapter 2). 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. In 2013, the survey questions related to last month and lifetime drug use (in recreational settings and other) have been changed into the terminology “usual drug use in recreational settings”. Of all questioned visitors, 4.3% (n=61) reported lifetime IDU *in recreational settings*. The mean age of those reporting IDU was 24.9 years. Of the 1,418 visitors, 1.0% (n=14) reported IDU during the event (see Table 4.2). 1.5% and 1.0% of the visitors reported respectively ‘sometimes’ and ‘often’ injecting drugs in nightlife, while 1.6% reported IDU

outside nightlife. Polydrug use was reported much more in 2013 than in previous years. However, it is uncertain whether this is a true increase or rather a selection bias.

Table 4. 2. Prevalence (%) of injecting drug use and polydrug use within nightlife settings in the French Community between 2006 and 2013

Drug use pattern	Year							
	2006	2007	2008	2009	2010	2011	2012	2013
<b>Injecting (N)</b>	2,402	2,618	3,917	2,969	2,111	2,778	3,155	1,418
Lifetime (%)	2.7	3.2	3.2	3.5	4.6	4.4	3.8	-
Last month (%)	1.7	1.3	1.1	1.5	2.1	1.7	1.8	-
During event (%)	-	0.6	0.7	1.1	1.2	0.9	0.9	1.0
<b>Polydrug use* (N)</b>	2,402	2,618	3,917	2,969	2,111	2,778	3,155	1,653
2 products (%)	18.6	16.9	23.0	18.7	17.3	17.0	13.2	22.2
≥3 products (%)	13.2	11.5	12.9	10.1	12.7	9.3	7.2	19.7

\* not part of problematic drug use definition by EMCDDA, alcohol is taken into account when used together with an illegal substance

Source: Drogues Risquer Moins, Modus Vivendi

## 2.2. Observed trends

The estimated prevalence of ever-IDU in Belgium for the period 2002-2013 (see Table 4.1) and the observed prevalence of IDU during events within nightlife settings in the French Community for the period 2006-2013 (see Table 4.2) suggest a stable trend in the area of injecting drug use.

## 3. Characteristics of high risk drug users

### 3.1. Injecting drug users in contact with needles exchange programmes in the Flemish Community

Data on IDUs frequenting the needles exchange programmes (NEP) located in the Flemish Community are collected through a structured, voluntary, anonymous questionnaire since 2001 (Windelinckx, 2013; Windelinckx, 2014). Yearly, a sample of IDUs contacting one of the NEP is asked to fill out 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 questionnaire is used. In 2009, 2010 and 2013, additional questions such as recent and ever used injection places, injection site abscesses, first product injected were added to the questionnaire. The results described below are self-reported and are not considered to be representative for all IDUs in the Flemish Community, as the number of IDUs not in contact with these programmes is

believed to be substantial. 64% of the participants (N=264) to the study in 2013 indicated to know at least one injecting drug user not in contact with the syringe exchange programmes.

The age of the participants ranged from <20 to 50 years, with an average age of 35.2 years. The majority of the participants were male (79.6%). About 50% of the IDUs lived in an unstable environment (homeless or living with others). The vast majority of the participants reported non-concurrent polydrug use (on average 2.4 different types of drugs injected, on average 4 different types of drugs used). Opiates (80.8%) were the primary injected drug of choice, a substantial increase compared to last year (2012: 67.9%). Injecting opiates are followed by injecting cocaine (58.9%) and amphetamines (39.2%) which remained stable compared to 2012 (respectively 58.0% and 40.1% in 2012). Drug cocktails were more frequently injected (2013: 37.5%, 2012: 26.9%), and similar to previous year, injecting methadone has also again increased (2013: 11.7%, 2012: 8.0 %, 2011: 8.7%, 2010: 4.6%).

Up to 54% of the participants reported to be initiated into IDU before the age of 21 years, which is an increase of 3.5% in comparison with last year. The mean age for starting with IDU is 21.8 years. 65% reported to be injected by someone else during first injection. Similar as previous years, the main concern of the researchers was the young age at initiation into IDU, with 14.3% of the participants being even younger than 15 years when injecting the first time. The age of the IDUs frequenting the NEP 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. Of the respondents, 76.6% is currently in treatment, but 18.7% (compared to 15.7% in 2012) reported never to have been in treatment.

### 3.2. Drug users recruited at the street in the French Community

Data on risk behaviour among IDU in the French Community is collected by the use of 'snowball operations' ("Opérations Boule de Neige"), which have been organised by Modus Vivendi since 1993. The primary objective of these snowball operations is peer prevention and targeting hard-to-reach subpopulations. To this end, volunteering IDUs ('jobistes') receive a 15-hours training and are paid to disseminate information on AIDS and hepatitis prevention as well as other information on harm reduction among their peers. These results are not fully representative for IDUs on the street in the French Community, as the results are not corrected for dependence on the social network of the jobistes. Additionally, the questionnaire is mainly used as 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.

Of the 313 contacted drug users on the street in the 2013 survey, 279 persons (89.1%) reported to be a “current” drug user (defined as “having used drugs during the last month”) (Hogge and Denoiseux, 2014). In total, 166 respondents reported lifetime IDU, which was 53% of all drug users or 59.5% of the “current” drug users (Table 4.3). Of the lifetime IDUs, 65.7% reported current IDU. Of the “current” drug users, 15.1% (n=42) reported current use of more than two products and 81.7% (n=228) reported the current use of three products or more. Among the current IDUs, the most popular injection drugs were heroin and cocaine, respectively 76.1% (n=83) and 73.4% (n=80). 11.9% reported the injection of methadone.

Table 4. 3. Lifetime injecting drug use and polydrug use among people recruited at the street in the French Community

Consumption profile	All drug users (N=313)	“Current” drug user (N=279)
	%	%
Lifetime IDUs	53.0	59.5
Current IDUs	34.8	39.1
Polydrug use		
2 products	.	15.1
3 products or more	.	81.7

Source: Opérations Boule de Neige, Modus Vivendi, 2013

#### 4. Conclusions

The current available national data on high risk drug use is limited and therefore only an estimated prevalence of ever-IDUs in Belgium can be reported instead of last 12 months users. The additional reported results are geographically or situational limited (school populations, recreational settings and NEP in either Flemish or French Community) and are rather indicative than conclusive.

In general, the key indicator ‘high risk drug use’ has been revised during the last years. In an effort to support the development of theoretical definitions of subcategories in the revised key indicator, a literature study on the patterns of use and their relation to harm in users of opioids, cocaine and amphetamines was performed (Skafupova et al., 2014). The literature study pointed out some patterns that were more strongly associated with harms:

1. Route of administration: *injecting drug use* was the most risky route of administration, followed by smoking and inhaling. Although snorting and oral use were less risky routes, they could not be considered to be risk-free behaviours.
2. *Polydrug use* was an extremely significant confounding factor of any harm, as it indicates a particular level of compulsivity and is associated with higher levels of dependence and overdose risk.

3. Frequency: for cocaine and amphetamines, it appeared that *weekly and higher frequency of use*, and patterns of heavy periods of continuous use (bingeing) were related to higher risks of harm. It was less clear to define a cut off for opioid use as most studies were only based on heavy, dependent, daily users. Based on clinical experience that opioid use is not less harmful than the use of stimulants, a cut off on weekly (and more frequent) use of opioids seems reasonable.

Trends in injecting drug use both on a national level and in recreational settings suggest that the prevalence of IDUs has been stable during the last decade. The most alarming observation is the young age at which current IDUs were initiated to injecting drug use; more than half of the users were initiated under the age of 21 and even 15% was initiated under the age of 15 years. Additionally, the time lapse between initiating injecting drug use and frequenting needle exchange programmes is probably several years, which increases the risk of developing unsafely injecting habits and the associated risk for infectious diseases and other health problems. This young age of onset certainly supports the further development of selective prevention measures (EMCDDA, 2014).

Among the students in higher education, about one in five 'last 12 months' users of cannabis reported expressions of problematic cannabis use (DSM-IV), while more than half of the 'last 12 months' users of other psychoactive substances expressed (strongly) increased risk for problematic use (DAST-10). Because of the low prevalence of illicit substances other than cannabis, these problems related to illicit drug use occur rather exceptional. Although clear indications of problematic use in the latter group, most of them assume that they would be able to stop using without any problems. Further longitudinal research with comprehensive questionnaires and interviews is needed to define whether these findings reflect the difference between dependency and drug abuse, or whether a part of the drug users underestimates the difficulty of ending the use of illicit substances. Although the prevalence of high frequent use of stimulants is rather rare in the examined school and student populations, any health care, pedagogic or judicial contact revealing this pattern of drug use should be handled with care. The assessment of relevance of a sudden increase in prevalence of polydrug use in recreational settings (French Community) requires follow-up data during the next years.

Another noticeable fact is that about one in ten IDUs in the NEP of the Flemish Community and on the streets in the French Community ('snowball operations') reported injection of methadone. In Belgium, heroin is still the most common opioid used for injection, but the gradual increase in prevalence of methadone injection should be followed carefully as is already the case in some other European countries (e.g. Estonia, Finland) alternatives such

as illegal fentanyl or buprenorphine have become the most common injected opioids (EMCDDA, 2014).

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## Chapter 5. Drug-related treatment: treatment demand and treatment availability

*Antoine J.*

- *Since 2011, the number of treatment demands for cannabis as primary drug shows a steep increase and a decrease for opiates. In 2013, patients most commonly reported the use of cannabis (33.5%) for entering treatment.*
- *A first pilot project on assisted treatment with diacetylmorphine in Belgium recommends to extent diacetylmorphine treatment as a second-line treatment for patients who continue to use street heroin despite treatment with methadone.*

### 1. Introduction

Due to the sixth state reform, the Communities are to become more competent in political and policy initiatives, which will radically change the drug treatment sector in Belgium. This evolution in the institutional status of the country leads currently to a transitory situation (see chapter 1). This chapter comments on the most recent situation on drug-related treatment in Belgium. First, the common declaration on drug policy is screened regarding treatment information (section 1.1) and organizations working on drug-related treatment field (section 1.2) are presented. Key figures, based on treatment demand indicator data from 2013 (section 1.3) and a description on the different treatment modalities (section 1.4) are described. Trends on the number of treatment demands and on people following a substitution treatment are presented (section 2). Finally, a review of the most recent developments in the field of drug-related treatment (section 3) concludes this chapter.

### 2. Drug-related treatment in Belgium

#### 2.1. Policies and coordination

An efficient drug policy requires a global and integrated approach. In 2010, the representatives of all governments in Belgium (Federal Government, Walloon region, Flemish region, French Community, Brussels-Capital Region, German-speaking Community, the French-speaking authorities in the Brussels-Capital Region and the Common authorities in the Brussels-Capital Region) have signed a common declaration entitled “A global and integrated drug policy in Belgium”. The main treatment-related objectives mentioned in this document are:



- 1) promoting a global and collaborative strategy for help, starting from an approach on health and integrating other dimensions (such as well-being and social integration),
- 2) providing cure/treatment as well as care and support,
- 3) providing a large choice of facilities, specifically dedicated to drug users or global health care and services related to well-being,
- 4) creating a balanced geographic spread of the settings based on the evaluation of needs,
- 5) guaranteeing the availability of various treatment programmes, including drug-free treatment, withdrawal treatment, substitution treatment, harm reduction initiatives, reintegration and aftercare,
- 6) promoting integrative treatment with a focus on dual diagnosis, employment, housing, and psychosocial problems,
- 7) developing a collaborative care/treatment network offering general and specific approaches,
- 8) training of new health care workers in order to ward off waiting lists,
- 9) promoting case management focused on individualized support in specific groups.

In the light of this common declaration, a general drug policy cell was created in which 17 representatives of the Federal Government and 18 representatives of the Regional Governments, a national drug coordinator and a vice-coordinator participate. Its main purpose is to formulate well-elaborated recommendations in order to synchronize drug policies.

## 2.2. Organization and availability of drug treatment

In Belgium, there is a large variety of treatment or help facilities for persons with drug-related disorders. The main objective of these services for drug-users is the promotion of quality of life in terms of global health (physical and psychological) and in terms of welfare and respect of the autonomy of the client.

The primary care network is the first, low-threshold step for organised help. These facilities are the best to detect a substance related problem, to evaluate and eventually to redirect if more specialised help is needed. This network is composed with general practitioners, centres for general welfare, services of domiciliary care, youth advice centres and public centre for social welfare.

Next to primary care, ambulatory or residential specialised treatment are also available and will be described in detail in the following sections.

The federal state is responsible for health care insurance and for defining the basic principles for inpatient treatment (hospitals).

In the health policy sector, the Communities have responsibilities in administrating in- and outpatient care as well as in the field of health education and preventive health care. This implies that the Communities are responsible for laying down rules for institutions that fall under their jurisdiction and for implementing federal regulations. On a regional level, centres for mental health in the Flemish region are coordinated by the Flemish Agency for Care and Health. For their part, the Walloon region (General Directorate Social Action and Health) subsidized specialised addiction centres respecting the recommendations of the addiction decree (B.S./M.B. 25.06.2009). In Brussels, the French Community Commission funds specific projects on treatment, prevention, support and (social) reintegration.

Since the 80's, conventions are concluded between specialised centres for the treatment of addictions and the National Institute for Health and Disability Insurance (NIHDI) in order to stimulate new initiatives in this field. In 2013, 29 conventions were signed with ambulant or residential centres working on specific medical and psychosocial treatment. These centres represent a large (but not exhaustive) and diversified part of the treatment offer for drug users in Belgium. Conventions with revalidation centres for drug users financed by the NIHDI will be transferred to the Communities in the near future.

### 2.2.1. Outpatient network

An overview of the available outpatient treatment facilities is presented in Table 5.1 and 5.2 , describing a definition of the different types of centres and their importance in terms of number of illicit drug treated patients respectively. General practitioners may play an important role in the treatment of drug users, however these are not mentioned in the tables because of the current lack of this information.

Table 5. 1. Network of outpatient treatment facilities (total number of units)

Type of centre	Total number	National definition
Specialised drug treatment centres	34	Day care centres are specialised centres that reach a large group of people with drug-related problems (ranging from new users to persons with severe substance-related disorders) and their relatives or friends. Psychosocial, administrative, judicial support is offered on an individual basis or as part of group therapy. During these programmes, total abstinence is not mandatory, however clients cannot be under the influence during the activities. Substitution treatment (e.g. methadone or buprenorphine) is also available in these centres. The emphasis is put on the guiding process during the transition towards a better structured life. Day care centres are present in the Flemish region (6), in the Brussels-Capital region (9) and in the Walloon region (19).
Low-threshold agencies	9	Medical and Social Care Centres (MSCC) are low-threshold agencies that offer social, psychological and health care services to persons with a substance-related disorder. Their main objective is to get into contact with people normally excluded from the standard treatment facilities. A large part of their daily work comprises medical and social care, harm-reduction and substitution treatment. Some of them also offer a needle exchange programme. In the Flemish region, there are 5 centres (known as 'Medisch en Sociaal Opvangcentrum', MSOC)). In the Walloon and Brussels-Capital regions, there are 3 and 1 centre(s) respectively (known as 'Maison d'Accueil Socio-Sanitaire', MASS).
Mental health care	31	Some mental health centres are also specialised in the treatment of substance-related disorders with the reduction of consumption or even total abstinence as the ultimate goal of their services. A variety of treatments is available within these centres: from an individual approach to group, relational and family therapy. Clients that present more complex problems - such as dual diagnosis of substance use - are admitted to an adapted, specific treatment offer. In the Flemish region there are 20 centres (known as 'Centra voor Geestelijke Gezondheidszorg', CGG). In the Walloon and Brussels-Capital region there are respectively 8 and 3 centres specialised in addiction (known as 'Service de Santé Mentale', SSM).

Source: Standard table 24

Table 5.2. Total outpatient treatment provision for illicit drug treatment demand (number of clients) in 2013

Type of centre	Total number of clients entering treatment	Coverage of monitored treatment facilities
Specialised drug treatment centres	2,975	24 centres / 34 in total
Low-threshold agencies	1,795	9 centres / 9 in total
Mental health care	1,073	21 centres / 31 in total

Source: Standard table 24; BTDIR, 2014

## 2.2.2. Inpatient network

Inpatient treatment structures are mostly represented by hospitals. Besides these general structures, there are also specialised centres for drug users in crisis situations (crisis intervention centres) or in a more stabilized phase (long-term residential centres, including therapeutic communities). An overview of the available inpatient treatment facilities (Table 5.3) and provision (Table 5.4) is presented below.

Table 5.3. Network of inpatient treatment facilities (total number of units)

Type of centre	Total number of centres	National definition
Hospital-based residential drug treatment	120	Among all hospitals in Belgium, psychiatric hospitals as well as psychiatric units in general hospitals have a limited capacity to treat patients with substance use. In some hospitals, there's a special programme for drug users. The range of care options can be very extended in hospitals. In order to evaluate the number of hospitals where drug users can be treated, the number of hospitals with specific psychiatric beds were considered (Classified as beds A, T, K). There are 67 hospitals in the Flemish region, 16 in the Brussels-Capital region and 37 in the Walloon region. Nevertheless, not all psychiatric beds are used to treat substance users.
Crisis intervention centre	8	Crisis intervention centres are short-term residential treatment centres that guarantee the unconditional and rapid support in case of a crisis situation. They promote a physical detoxification and motivate for further abstinence or guide patients towards the best fitted treatment programme. There are 5 crisis centres in the Flemish region, 1 in the Brussels-Capital region and 2 in the Walloon region.
Therapeutic communities or other long-term residential centres	15	Therapeutic communities were the first treatment initiatives for drug users in Belgium. Other long-term residential centres are also presented here. They are drug-free environments with a strong focus on self-help and peer support. A hierarchical community structure and group therapy sessions are the key lead to detox and to reintegrate patients into the society. There are 8 therapeutic communities in Belgium: 5 in the Flemish region and 3 in the Walloon region. A recent European publication gives a more detailed picture of therapeutic communities in Belgium and more generally in Europe (Vanderplasschen et al., 2014).

Source: Standard table 24

Table 5.4. Total inpatient treatment provision for illicit drug treatment demand (number of clients) in 2013

Type of centre	Total number of clients	Coverage of monitored treatment facilities
Hospital-based residential drug treatment	2,119	42 hospitals / 120 in total
Crisis intervention centre	727	8 centres / 8 in total
Therapeutic communities	380	15 centres /15 in total

Source: Standard table 24; BTDIR, 2014

### 2.3. Treatment demand data

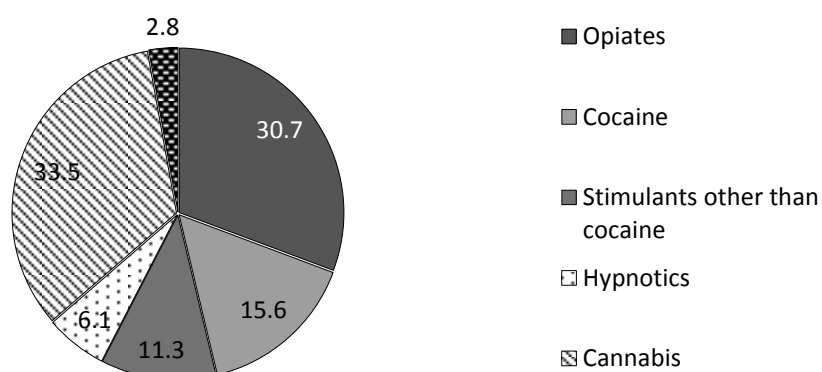
The Treatment Demand Indicator (TDI) registration in Belgium was officially approved by the Inter-ministerial conference on Public Health in 2006 (B.S./M.B. 03.05.2006). Consequently, a national TDI protocol was adopted in 2010 based on the EMCDDA Protocol version 2.0. On this basis, the TDI registration was launched at national level in specialised centres in 2011. Prisons and general practitioners are currently not part of the registration. This system registers both patients entering treatment for illegal drugs as well as alcohol as a primary substance. A new European protocol was adopted in 2012 and had to be implemented in EU member states. At national level, a new protocol was adopted in September 2013 and will be the basis for the TDI registration from 2015 onwards.

The specialised residential and ambulatory centres are using an online application since 2011 to encode their clients or are sending their data through a repository module. In 2013, around 100 specialised centres participated in this TDI registration.

In 2013, a total of 9,192 drug users entered treatment in the centres that report data. Around 73% and 45% of the specialised out- and inpatient centres in Belgium are reporting data. More or less 2 patients out of 3 (64.0%) were registered in outpatient centres and 36.0% in inpatient centres.

In all types of centres, patients most commonly reported the use of cannabis (33.5%) for entering treatment (see Figure 5.1), next to opiates (30.7%), cocaine (15.6%), stimulants other than cocaine (11.3%) and misuse of hypnotics and sedatives (6.1%). Characteristics of patients and addiction profile of patients entering treatment for the different substances are described in Table 5.5.

Figure 5.1. Proportion (%) of treatment demands by primary drug in 2013



Source : BTDIR, 2014

Table 5.5. Characteristics of patients entering treatment in 2013 by type of primary drug

Characteristics of patients	Type of primary drug mentioned for entering treatment				
	Opiates	Cocaine	Stimulants	Hypnotics	Cannabis
Women (%)	19.6	18.8	24.9	50.9	14.8
Mean age (years)	34.7	30.8	28.6	38.9	23.5
Ever injected (%)	41.5	13.7	18.9	7.6	3.9
Daily users (%)	58.6	30.9	30.9	76.3	48.2
Use of only one substance (%)	18.0	22.1	30.7	41.7	49.0
First time in treatment (%)	16.0	36.4	34.2	27.0	58.5
Mean age at time of first use (years)	21.2	20.4	18.1	25.9	15.4

Source : BTDIR, 2014

Remarkably, the majority of the group of persons in treatment for hypnotics are women. On the opposite, women are the least represented in the group of cannabis users in treatment. The mean age of patients in treatment is higher for people in treatment for hypnotics and opiates than in the group in treatment for cannabis and stimulants. The proportion of people that ever injected a substance is the highest in the group of people in treatment for opiates. Patients in treatment for hypnotics or cannabis are using less other substances (alcohol

included). The registration shows that most patients using opiates already went into treatment in the past. The mean age of first time use is the lowest for cannabis users.

## 2.4. Treatment modalities

### 2.4.1. Opioid substitution treatment

In Belgium, methadone and buprenorphine are the two substances authorized for opioid substitution treatment (OST). The provision is organised by both specialised centres and general practitioners. Since April 2009, prescriptions for methadone and buprenorphine are registered in the Pharmanet-system of the NIHDI. The objective of this registration is to avoid multiple prescriptions and allow warnings among involved practitioners as requested by the Royal Decree of March 19<sup>th</sup> 2004 (B.S./M.B. 30.04.2004). This database contains information from public pharmacies, hospital pharmacies and specialised centres. Substitution treatments provided in prisons are not included in this database.

Currently, there are big regional differences concerning the administration: in the Flemish Community, substitution treatment is often prescribed by specialised centres whereas in the French Community, general practitioners are more involved. A daily delivery of the treatment can be arranged in specialised centres or alternatively, in a pharmacy under the supervision of a pharmacist.

In 2013 there were 17,482 persons registered in the Pharmanet register (see Table 5.6). Among them, only 13.5% were in treatment with buprenorphine. The patients were mainly men (77.0%) and had a mean age of 39.3 years. Methadone and buprenorphine are more often prescribed in the French Community (2/3 when counted together) than in the Flemish Community (1/3).

Table 5.6. Characteristics of patients receiving methadone or buprenorphine in 2013 by type of substance

	<b>Methadone</b>	<b>Buprenorphine</b>	<b>Total</b>
Total amount (N)	15,112	2,370	17,482
women (%)	22.9	23.5	23.0
Mean age	39.5	37.9	39.3
Region (%)			
Flemish	29.9	49.4	32.6
Brussels-capital	15.3	11.6	14.8
Walloon	54.8	39.0	52.6

Source: NIHDI, 2014

#### 2.4.2. Dual diagnosis patients

Over the past few years clinicians have noted increasing numbers of patients subjected to dual diagnosis (De Hert et al., 2010). Such patients are particularly vulnerable and currently lack any form of provision. Therefore, a pilot project was launched in 2002, setting up two specific units (one in the Flemish region and one in the Walloon region) (Sabbe et al., 2008). These units provide intensive and integrated treatment for both problems (drug use and mental disorders). The aim is to stabilise patients after a period of intensive treatment to then refer them to other services to continue treatment.

#### 2.4.3. Crisis and case management

Emergency departments play an important role in offering first aid to persons with substance use-related disorders. These facilities inform patients on the treatment options and refer them to specialised treatment. They increase motivation for treatment and changing their behaviour. In Belgium, crisis care can be situated within two projects. First, a national pilot project exists for the crisis and case management of patients with substance use-related disorders (8 centres in Belgium offer four crisis beds with a maximum stay of five days). Second, the so-called Crisis Intervention Centres (CICs) (also described in chapter 7) intervene in crisis situations and arrange quick admission or support. On the other hand, they assist in physical detoxification and motivate to continue treatment. An important supportive strategy that may facilitate crisis management for persons with substance use-related disorders is case management. Case management has been implemented in Belgian substance abuse treatment since 1999. It has been institutionalized as part of the federal pilot project 'Crisis and case management for persons with substance use disorders'. However, little is known about the effectiveness of this intervention, nor is there consistency concerning its application (Bruffaerts et al., 2010).

### 2.5. Quality assurance of drug treatment services

Different legal documents or conventions are available, describing the type of treatment or the type of functioning that should be applied in centres dealing with patients with a substance-related use problem:

- All low-threshold agencies (MSCC) have signed a convention with the NIDHI precisely describing the expected medical or social activities and the way their organization is to be arranged. For the other residential or ambulant centres with this type of convention, the document describes specific objectives for each facility. In this way, a diverse panel of therapeutic solutions is made available.



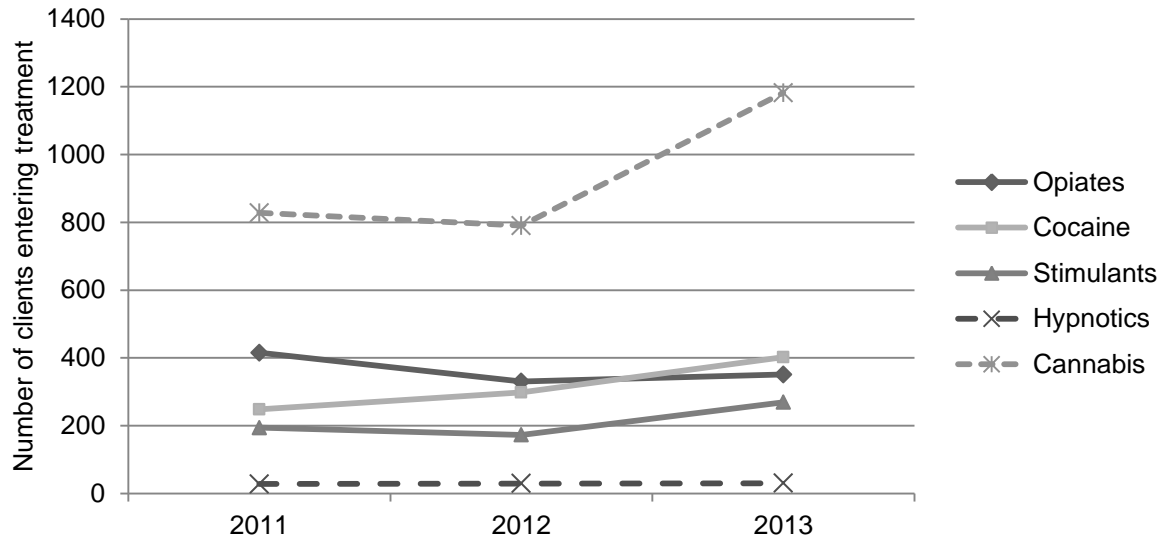
- Centres in the Walloon region that request funding for specialised addiction treatment activities, need to fulfil the missions and the functioning stated in the regional decree of 30 April 2009.
- For the French-speaking centres in Brussels, a decree (B.S./M.B. 08.05.2009) describes directions for all ambulatory services working on social action and amongst them the drug addiction facilities.
- Centres for Mental Health in the Flemish region recognized by the Agency for Care and Health have additional rules to respect on quality of care and organization to get the agreement.

### **3. Trends**

Currently, trends in treatment offer and demand are only studied based on the TDI data registered by the specialised centres that participate in a convention with the NIHDI. These centres are indeed obliged to complete this registration since 2011, while this is not yet the case for the other types of centres. These centres represent around 70% of the TDI registrations for 2013 for treatment demands for illicit drugs (10 out of the 34 day centres, 9 out of the 9 low-threshold centres, 8 out of the 8 crisis centres and 15 out of the 15 long-term residential centres)

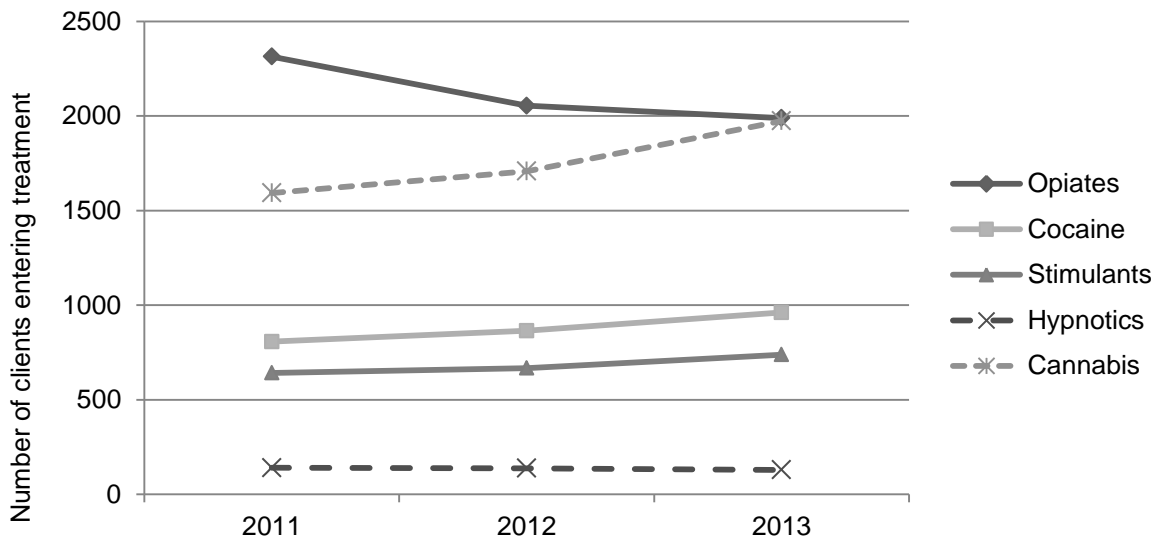
Since 2011, a decrease is observed in the number of clients entering treatment for opiates. At the same time, there has been an increase for clients in treatment for cannabis, cocaine and stimulants. In 2013, cannabis is the main substance for entering treatment. (see Figure 5.2). This trend is due to a shift in the group of new patients (see Figure 5.3). Indeed, when looking at the trends concerning the primary drug used among people entering treatment for the first time a steep increase in cannabis patients and a decrease in opiates patients are noticed. This decrease of the proportion of treatment demand of opiates as primary drug is also notable in all European countries (EMCDDA, 2014). Concerning cannabis, the increased proportion is also partially explained by a high(er) proportion of judicial referral for treatment.

Figure 5.2. Trends in numbers of clients entering treatment for the first time, by primary drug in the centres with a convention with the National Institute for Health and Disability Insurance between 2011 and 2013



Source: BTDIR, 2014

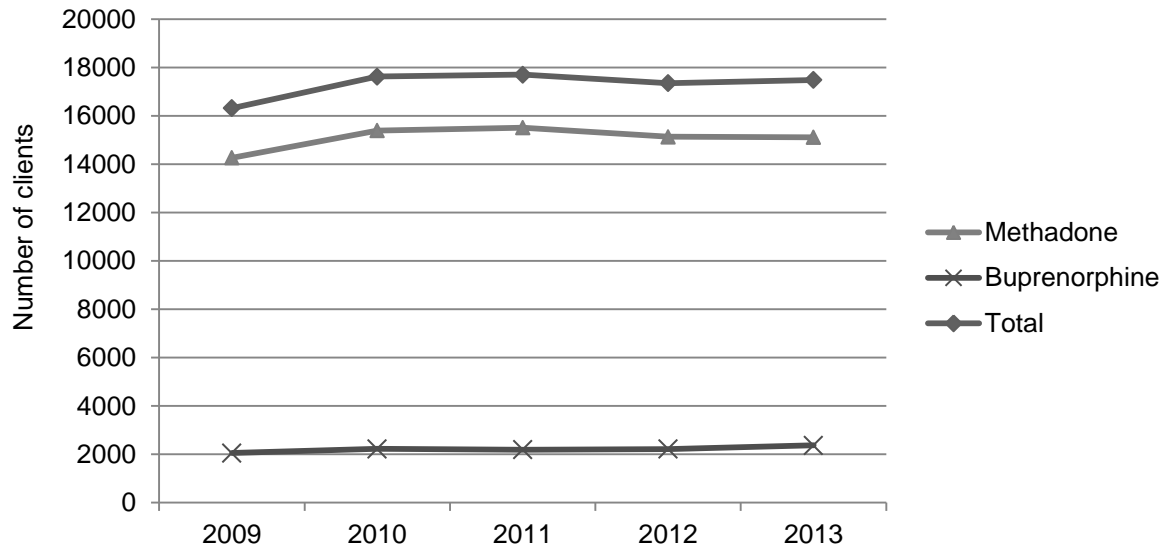
Figure 5.3. Trends in number of all clients entering treatment, by primary drug in the centres with a convention with the National Institute for Health and Disability Insurance between 2011 and 2013



Source : BTDIR, 2014

There is a stability in the number of patients in substitution treatment since 2009 (see Figure 5.4). A slight decrease since 2011 can be nevertheless observed in the number of methadone treatments and a slight increase in buprenorphine treatments.

Figure 5.4. Trends in number of clients receiving methadone or buprenorphine between 2009 and 2013



Source: NIHDI, 2014

#### 4. New developments

##### 4.1. Cannabis use disorder in troubled youth - The INCANT project

The INCANT trial was performed in 5 European cities (Berlin, Brussels, Paris, Geneva, The Hague) and included a comparison of Multidimensional Family therapy (MDFT) with individual therapy among 450 youngsters aged 13 up to 18 showing problematic patterns of cannabis use. The project followed the adolescents and their relatives for 12 months to determine both information about mental and behavioural characteristics (Rigter and Dekker, 2014).

There is a strong belief among a selection of therapists in Western Europe that forced treatment of teenagers will harm the chances of the therapist to establish a therapeutic alliance with the adolescent and consequently influences the outcome of the treatment. Data from the study however contradict this notion: adolescents coerced into treatment accepted therapy and remained in therapy as long as other teens (Rowe et al., 2013).

Yet, Schaub and colleagues demonstrated that both MDFT and individual treatment reduce the rate of externalising and internalising symptoms and in addition did improve family functioning. However, MDFT proved to be more efficient in decreasing externalising symptoms, especially in coerced adolescents (Schaub et al., 2014).

#### 4.2. Heroin-assisted treatment - The TADAM project

The pilot-project on assisted treatment with diacetylmorphine (TADAM) aimed at comparing the efficacy and feasibility of this treatment with regular approach of methadone treatment. To this order, 36 people in the experimental group and 38 in the control group were observed for one year.

The project was finished in 2012 and conclusions were delivered in terms of efficacy of the treatment, socio-economic aspects, criminological aspects and patient satisfaction. The difference in efficacy between the two groups was significant at 3, 6 and 9 months but no longer significant after 12 months. This could be a false negative effect due to experimental conditions (patients of the experimental group knew that the treatment ended after 12 months). The treatment via diacetylmorphine showed less efficacy in socio-economic aspects than the methadone treatment. Due to limited observation time, the study under-evaluate the amount of positive impacts on society. The diacetylmorphine treatment could reduce delinquency of severe addicted persons. The treatment with diacetylmorphine met the expected help better than the methadone treatment. In conclusion, the extension of diacetylmorphine treatment for people who continue to use street heroin despite treatment with methadone was recommended. This treatment should remain a second-line treatment, only available to patients refractory to methadone. For these patients, treatment with diacetylmorphine has proved to be more effective, but only if its length is not arbitrarily restricted. Recommendations were made on the conditions for the installation of such a centre, the inclusion criteria of the patients, the treatment organization, the infrastructure of the building and the staff (Demaret et al., 2013).

#### 4.3. Analysis and optimization of substitution treatment - The SUBANOP project

Although substitution treatment has been applied on a large scale for over 15 years now, research on this topic remains limited. In order to gain more insight and optimize current practices of OST in Belgium, the SUBANOP study was set up. There's a need of a centralized and comprehensive database that allows the mapping of providers of OST as well as the follow-up on evolutions in treatment demand and practice. The combination of treatment-related data (e.g. dosage, type of medication and treatment regimen) with client data (e.g. characteristics, support needs and benefits from treatments) provides valuable information regarding a personalised approach in the allocation of treatment options. Additional research is advised regarding the nature and type of psychosocial support that is required for opiate dependent persons (Vander Laenen et al., 2013).

## 5. Conclusions

In Belgium, different institutional partners are in charge of the treatment for addictions which is coordinated by the General Drugs Policy Cell. A large variety of treatment facilities are available in the country providing ambulatory (including low-threshold) or residential services.

In 2013, more than 9,000 patients entering treatment were registered by over 100 centres, mainly in outpatient services. Opiates and cannabis represent the main type of substance for a large majority of the patients entering treatment. However, these two groups of patients are very different in terms of age (older people in treatment for opiate use), sex (less women in treatment for cannabis) and high-risk drug use profile (less ever-injecting drug use for people in treatment for cannabis).

Moreover, a clear evolution is observed in the number of people entering treatment by primary drug. The number of treatment demand for opiates is declining and the number of treatment demand for cannabis is increasing. The latter, however, is partly due to the increased number of treatments referred by justice.

The number of people receiving methadone or buprenorphine remains relatively stable over time and is more often prescribed in the French Community in comparison with the Flemish Community. Buprenorphine remains less often prescribed.

Several studies were conducted on specific aspects of treatment to work towards potential developments in treatment. A remarkable pilot study on assisted treatment with diacetylmorphine concluded that treatment with diacetylmorphine is only more effective than the methadone treatment for a specific target group: assisted treatment with diacetylmorphine is recommended for people who continue to use street heroin despite the treatment with methadone. Recommendations were made on the main aspects (target group, infrastructure, rules,...) for the development of a similar new project. Nevertheless, there are currently no further plans on implementing these results.

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We would like to thank Mr Hogge (Ph.D.), Mr Verstuyf, Mrs Huard, Prof. dr. Broeckaert, Prof. dr. Dom, Prof. dr. Pelc and Prof. dr. Soyez for their contribution of the data collection and their valuable feedback. Their essential involvement is gratefully acknowledged.

## Chapter 6. Health correlates and consequences

*De Ridder K.*

- Needle exchange programmes have reduced the number of people reporting to share needles and syringes, but still many injecting drug users keep sharing other injecting equipment such as spoons, filters and water.
- In line with other European countries, a reduction of drug-induced deaths was observed in 2010, especially in the Walloon region.

### 1. Introduction

This chapter describes observed health consequences of illicit drug use in Belgium. Regarding drug-related infectious diseases, data from national registers (the HIV/AIDS and tuberculosis register) and from diagnostic testing in drug services (Standard Table 9 to EMCDDA) are summarized (section 2.1 and 2.2). Behavioural data were collected by 'Needle Exchange Flanders' ('Spuitenruil Vlaanderen') and Modus Vivendi (section 2.3). Data from the National Poison Centre were used to provide information on drug-related emergencies (section 3.1). In addition, psychiatric comorbidity is described based on the EuropASI, used as part of the intake interview at treatment centres from 'De Sleutel' (section 3.2). Finally, information on drug-induced deaths was obtained using the General Mortality Register (GMR) (section 4).

### 2. Drug-related infectious diseases

#### 2.1. HIV/AIDS and viral hepatitis

##### 2.1.1. National HIV/AIDS register

The national HIV/AIDS register, hosted by the Scientific Institute of Public Health (WIV-ISP) contains the AIDS- and HIV notifications since 1984-1985 (Sasse and Defraye, 2009). For every confirmed seropositive case, additional information on age, sex, nationality, residence, sexual orientation and probable mode of HIV transmission is collected at the 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 deaths. The HIV/AIDS register is deemed to be exhaustive.

In 2012 and 2013, respectively 14 and 17 persons newly diagnosed with HIV, reported intravenous drug use as the probable mode of HIV transmission, yielding a percentage of

1.1% and 1.5% of the persons newly diagnosed with HIV being probably attributable to injecting drug use (IDU). For the years 2012 and 2013, respectively 1 (1.1%) and 2 (2.5%) AIDS diagnoses related to IDU were reported. It is clear that the percentage of injecting drug users (IDUs) among persons newly diagnosed with HIV are much lower compared to the beginning of the HIV epidemic in the mid-eighties, but has been on a stable level since 2005. 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.

#### 2.1.2. HIV diagnostic testing among ever-IDUs

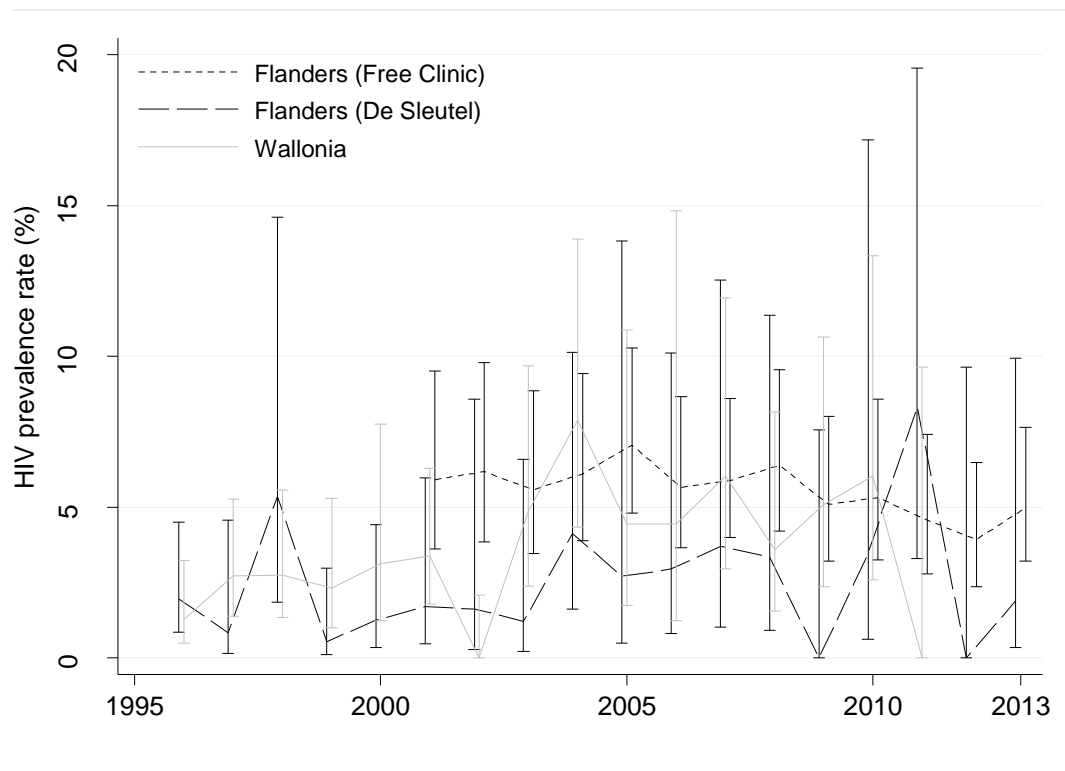
The prevalence rate of HIV-sero-positivity among ever-IDUs at treatment was obtained through serological data. Serological data among ever-IDUs, however, are only available for the Flemish region since 2012. The prevalence estimates are based on test results of blood screening collected through De Sleutel, an institution of several ambulatory and residential treatment centres located throughout the Flemish region, and through Free Clinic, an outpatient clinic located in Antwerp. De Sleutel collects serological information for clients entering treatment. In 2012, there were no new HIV seropositive registrations among ever-IDUs in De Sleutel, but in 2013, one new person (N=53, 1.9%) was registered. In the outpatient treatment centre Free Clinic, 4 to 5% of the tested ever-IDUs were HIV seropositive in 2012 and 2013. An overview of the prevalence rates for the period 2006-2013 is provided in Table 6.1 and illustrated for the period 1995-2013 in Figure 6.1, showing moderately fluctuating prevalence rates without clear time trends.

Table 6.1. Prevalence rate (%) of HIV-seropositivity among ever-IDUs in treatment in the Flemish region between 2006 and 2012

Year	De Sleutel		Free Clinic	
	N	%	N	%
2006	68	2.9	336	5.7
2007	54	3.7	408	5.9
2008	60	3.3	329	6.4
2009	47	0.0	334	5.1
2010	29	3.4	282	5.3
2011	48	8.3	328	4.6
2012	36	0.0	357	3.9
2013	53	1.9	382	5.0

Source: De Sleutel and Free Clinic

Figure 6.1. HIV-prevalence rates among injecting drug users and 95% Wilson's confidence intervals by year and source between 1995 and 2013



Sources: Walloon Region: l'Observatoire socio-épidémiologique alcool-drogues (EUROTOX), Flemish region: De Sleutel – Free Clinic

### 2.1.3. Hepatitis diagnostic testing among ever-IDUs

The prevalence rates of a positive hepatitis test among ever-IDUs at treatment was obtained analogously to the HIV prevalence rate described above and is based on diagnostic serological data from De Sleutel and Free Clinic. Additionally, the four Medical Social Care Centres (MSCC) in the province Flemish-Brabant started in 2014 with providing diagnostic



serological data for hepatitis C among ever-IDUs. An overview of the hepatitis B (HBV) and C (HCV) prevalence rates for 2006-2013 is shown in Table 6.2 and Figure 6.2. In case of a viremic infection (either acute hepatitis or chronic carrier status and thus currently infected), HBsAg will test positive. AntiHBc will appear shortly after infection. In case of vaccination, antiHBc will be negative and only antiHBs will be detected. Regarding Hepatitis B, only a few (0 to 2%) of the clients tested positive for the HBV-indicating antigen HbsAg in 2013, while 6 to 48% were positive for antiHBc and 14 to 50% were positive for antiHBs. Regarding Hepatitis C, 7.5%, 22% and 73.4% of the clients in respectively the MSCC Flemish-Brabant, De Sleutel and Free Clinic tested positive for HCVab in 2013. A positive HCVab test is associated to either a (acute or chronic) viremic infection or a no longer viremic, undergone infection. Comparing these results with previous years does not reveal significant time trends.

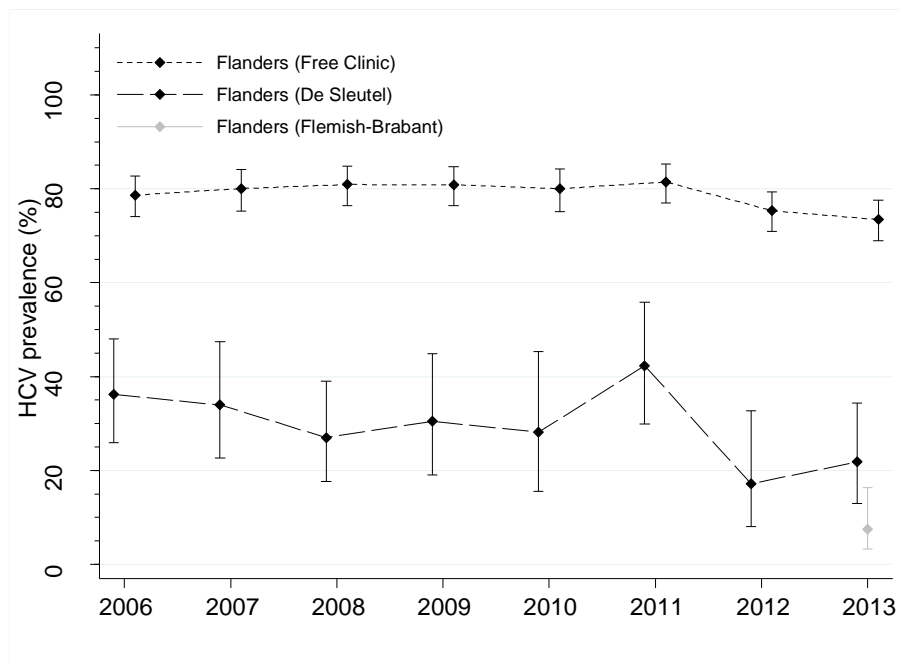
Table 6.2. Prevalence rate of Hepatitis B among ever-IDUs at treatment and other diagnostic settings in the Flemish Community between 2006 and 2013

Hepatitis B		Years							
		2006	2007	2008	2009	2010	2011	2012	2013
<b>De Sleutel</b>									
HBsAg	N	63	45	54	44	29	47	36	50
	%	0.0	0.0	1.9	0.0	0.0	4.3	3.0	0
antiHBc	N	38	28	38	28	22	36	28	32
	%	15.8	25.0	2.6	7.1	0.0	16.7	11.0	6.3
antiHBs	N	57	45	49	40	30	47	33	43
	%	12.3	11.1	18.4	25.0	20.0	25.5	33.0	13.9
<b>Free Clinic</b>									
HBsAg	N	334	307	328	336	281	326	386	379
	%	1.5	2.6	4.0	4.2	2.8	3.7	2.6	1.6
antiHBc	N	329	303	323	330	277	323	374	366
	%	55.0	53.5	57.3	56.1	56.3	55.1	49.5	48.1
antiHBs	N	-	-	327	334	279	327	379	371
	%	-	-	50.2	51.8	55.2	52.3	49.9	50.1

N: total number of IDUs who were tested (valid tests only)

Source: De Sleutel and Free Clinic

Figure 6. 2 Prevalence rate of Hepatitis C among ever-IDUs at treatment and other diagnostic settings in the Flemish Community between 2006 and 2013



N: total number of IDUs who were tested (valid tests only)

Source: De Sleutel, Free Clinic and Medical Social Care Centres in Flemish-Brabant

## 2.2. Syphilis and tuberculosis

### 2.2.1. Syphilis diagnostic testing

The prevalence of a positive screening test for syphilis (TPHA) was obtained from Free Clinic. In 2012 and 2013, about 5% of the tested clients had a positive result (2012: 18/342; 2013: 16/339). It should be noted that a positive TPHA-test is a strong indication for a syphilis infection, but the test does not distinguish a recent from an old infection, nor an already treated infection.

### 2.2.2. National tuberculosis register

The Tuberculosis register is hosted by the Belgian Lung and Tuberculosis Association (BELTA), together with the 'Flemish association for respiratory health and tuberculosis control' ('Vlaamse Vereniging voor Respiratoire Gezondheidszorg en Tuberculosebestrijding, VRGT) and the 'Fund of respiratory diseases' in the French Community ('Fonds des Affections Respiratoires', FARES). The notification of tuberculosis cases is compulsory in Belgium. Notifications of both regions are joined and checked for duplicates in the national register.

Since 2001, the national tuberculosis incidence has declined slightly, from 12.8 cases per 100,000 residents in 2001 to 8.8 cases per 100,000 residents in 2013, which is the lowest incidence since 2001. The highest incidences in 2013 were observed for Brussels (26.2/100,000), Liège (21.9/100,000) and Antwerp (18.5/100,000). Of the 981 cases registered in Belgium in 2012, 85% (N=840) had reported a known risk factor of which 1.2% (n=10) 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

As described in chapter 4 section 3.1, data on risk behaviour among IDUs who frequent one of the needle exchange programmes (NEP) located in the Flemish Community, have been collected since 2001 (Windelinckx, 2014). Yearly, a sample of IDUs contacting one of the needle exchange programmes is asked to fill out a questionnaire which is based on the Injecting Risk Questionnaire (IRQ) (Stimson et al., 1998). This questionnaire contains additional items on health status, drug use and access to health care. An overview of the responses related to the IRQ is shown in Table 6.3.

In 2013, 264 valid questionnaires have been filled out. Of the participants, the mean age was 35 years and 80% were males (n=210). The majority of the participants (63%) reported no sharing of injecting equipment with someone else during the last weeks. 34% of the participants shared injecting equipment with one or more persons during the last four weeks. Exchanging needles and/or syringes with sexual partners is less common; 26% and 22% of the participants reported having respectively given or lent needles and/or syringes from a sexual partner. The sharing of other injecting equipment during the last four weeks is more frequently reported: e.g. spoons (receptive/having used: 42%), water (receptive: 40%) and filters (receptive: 36%). These results are in line with those from 2010-2012.

Table 6.3. Responses to the Injecting Risk Questionnaire (IRQ) within the needle exchange programmes in the Flemish region in 2013

Questions	N	Answers			
		0	1	>2	Don't know
<b>During the last 4 weeks, ...</b>					
How often have you shared injecting equipment?	261	63%	13%	17%	7%
With how many different people have you shared injecting equipment?	263	65%	24%	10%	1%
How often have you given used needle/syringes to a sexual partner?	188	73%	11%	15%	1%
How often have you lent used needle/syringes from a sexual partner?	179	77%	9%	13%	1%
How often have you used a spoon that has already been used by someone else?	263	56%	21%	21%	2%
How often have you used a filter into which someone else had put a used syringe?	262	62%	20%	16%	2%
How often have you used the same water or bleach as someone else for flushing out?	263	56%	21%	19%	4%
How often have you injected with needles/syringes that had already been used by someone else?	261	77%	11%	7%	5%
How often have you filled your syringe from one that already been used by someone else (frontloading/backloading) ?	263	82%	11%	4%	3%
How often have you used old syringes that had been kept in the same container as someone else's old syringes?	263	71%	14%	7%	8%

Source: Spuitenruil Vlaanderen (Windelinckx 2014)

Similar to previous years, the percentage of participants who claimed not to have shared needles/syringes is higher compared to the percentage claiming not to have shared other paraphernalia. Although based on these (limited) results, the harm reduction campaigns with a focus on not sharing needles/syringes of previous years, seem to be successful, but there is still too little available time for raising awareness on the risks of sharing paraphernalia (Windelinckx 2014). Drug users remain not or less aware of the risk associated with sharing paraphernalia, which might explain the very high Hepatitis C prevalence rates among IDUs.

More risky injecting drug behaviour is increasing in comparison with previous years. Injecting at (semi-) public places, which implicates less hygienic and mostly hasty way of use, occurs more and more frequently (45% in 2013 versus 36% in 2011). The most common chosen injecting zones on the body are elbow, legs, arms and hands. Nevertheless, risky body parts as neck, groin, shoulder, penis and armpit are also regularly used. This way of injecting is increasingly mentioned compared to last years and increases the risk of health complications.

Skin and soft tissue infections are a common complication of injecting drug use. The infections are caused by a combination of several factors: the injection of drugs into the fatty layer under the skin or by drugs leaking out of the veins, the increased number of bacteria on the skin, and tissue death due to the toxic materials in the drugs. Of the 240 respondents in the survey of Needle Exchange Flanders, about 65% did not experience an injection abscess during the last year, but 24% reported more than one injection abscess (Windelinckx, 2014).

### 2.3.2. Risk behaviour in injecting drug users recruited at the street in the French Community

Data on risk behaviour among IDUs in the French Community is collected using snowball operations, which have been organised by Modus Vivendi since 1993. The main objective of these snowball operations is peer prevention and targeting hard-to-reach subpopulations (see also chapter 3, section 3.1.3). To this end, volunteering IDUs serve as 'jobistes' and are trained and paid to disseminate information on aids and hepatitis prevention and other harm reduction information among their peers.

The information on risk behaviour collected through surveys administered during these snowball operations, is summarized in Table 6.4 for the years 2006-2013. However, these results are not deemed to be representative for IDUs on the street in the whole French Community. The results are not corrected for their dependence on the social network of the 'jobistes' and 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 behaviour remains common among the recruited sample. Up to 44% reported to have shared injecting equipment and nearly 12% even injected with needles/syringes found on the street during the last six months. The time trends of these percentages are difficult to interpret due to the limits exposed above. Although the data do not allow conclusions on the extent and frequency of the risk behaviours, they clearly indicate that extreme injecting risk behaviour is not ruled out.

Table 6.4. Proportion (%) of injecting risk behaviour among street-recruited injecting drug users in the French Community (Modus Vivendi) between 2006 and 2013

Injecting Risk behaviour	Year							
	2006	2007	2008	2009	2010	2011	2012	2013
<b>Sample size (N)</b>	<b>135</b>	<b>236</b>	<b>228</b>	<b>119</b>	<b>196</b>	<b>63</b>	<b>117</b>	<b>109</b>
During the last 6 months, did you ...								
inject with needles/syringes that had already been used by someone else?	30.4	42.4	31.1	33.6	13.8	19.0	12.8	34.9
inject with needles/syringes found at the street?	6.7	5.9	5.7	0.8	1.5	1.6	2.6	11.9
use injecting equipment already used by someone else?	47.4	53.8	56.6	29.4	26.0	31.7	21.4	39.4
give or lend used needles/syringes to someone else?	32.6	38.6	35.1	20.2	24.0	17.5	32.5	40.4
give or lend used injecting equipment to someone else?	31.1	25.8	26.3	21.0	35.2	34.9	38.5	44.0

Source: Eurotox (Modus Vivendi (Opérations Boule de Neige)), 2007-2014

### 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 receives more than 50,000 telephone enquiries each year related to acute or suspected poisoning by the general public and health professionals. In 2013, 302 of the 53,591 calls were related to substance intoxications among adults (> 14 years old; Dr. Mostin, personal communication). In 58% of the cases (n= 176), only one substance was involved. 204 questions were related to illicit substances. An overview is provided in Table 6.5. The majority (22%) of the intoxications were related to cannabis and their derivatives. 15.7% were related to cocaine. The total number of calls related to illicit substances and the proportion in the major groups is similar to the previous years.

Table 6.5. Proportion of Illicit substances mentioned during telephone enquiries received by the Belgian National Poison Centre in 2013

Substances	N	%
Cannabis	45	22.1
Cocaine	32	15.7
not specified*	29	14.2
Amphetamine/speed	21	10.3
Ecstasy	18	8.8
GHB/GBL	15	7.4
Poppers	11	5.4
Heroin/Methadone	10	4.9
Mushrooms/hallucinogenic plants	7	3.4
Others**	7	3.4
LSD	4	2.0
Mescaline	3	1.5
Mephedrone	1	0.5
Phencyclidine	1	0.5
<b>Total</b>	<b>204</b>	<b>100</b>

\*Unknown products

\*\* Products about which there is no or little information at the moment of the call (e.g. blue boy, dse, shabu, horse anesthetics, FEZP, N'EYE'ZZZ, 5FPB-22)

Source: National Poison Centre (Mostin, personale communication 2014)

### 3.1.2. Non-fatal overdose in injecting drug users in contact with syringe exchange in the Flemish region

Of the 235 valid responses in Needle Exchange Flanders 2013, 16% of the participants reported to have had at least one drug overdose the last year (Windelinckx, 2014). 7.2% even have had multiple overdoses the last year.

## 3.2. Other topics of interest

### 3.2.1. 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 patients as mild (severity scores 0-3), moderate (severity scores 4-5) and severe (severity scores 6-9) on the areas 'alcohol and drug use' and 'psychiatric status'. Patients were 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. Patients were classified as ‘severe dual diagnosis’ when they had severe problems in both the substance misuse and psychiatric domains.

Table 6.6 summarizes the prevalence of the psychiatric comorbidity of patients entering treatment facilities of De Sleutel in the Flemish Community for the years 2006-2013. The prevalence of psychiatric comorbidity is very common among illicit substance users (52.1%) and stable during the period 2006-2013. Also the prevalence of a severe dual diagnosis (12.6%) has been stable in this period.

Table 6.6. Prevalence of psychiatric comorbidity of clients entering treatment in the Flemish Community (De Sleutel) between 2006 and 2013

Psychiatric comorbidity	Year							
	2006	2007	2008	2009	2010	2011	2012	2013
<b>Sample size (N)</b>	631	639	651	814	581	668	670	720
<b>Dual diagnosis (total, %)</b>	51.8	52.9	49.6	50.6	53.8	53.9	48.6	52.1
Severe (%)	13.9	12.1	16.7	13.6	12.7	12.0	11.0	12.6
Moderate (%)	37.9	40.8	32.9	37.0	41.1	41.9	37.6	39.4

Source: De Sleutel (Lombaert, personal communication 2014)

### 3.2.2. Health consequences of synthetic substances

The purity and composition of illicit drugs might result in serious health consequences (see chapter 10). Despite the concerns about the number of newly detected new psychoactive substances (NPS), a significant gap remains in our knowledge on the toxicity of these drugs. Research on the health implications of most NPS is very limited. Moreover, usually only the most serious consequences (drug-related deaths) are documented through the Belgian Early Warning System on Drugs. The MDMA content in ecstasy tablets has been rising to levels with a high risk for toxicity symptoms and even deaths, certainly in combination with dehydration in festivity settings (for more details, see chapter 7, section 2.2.). On the other hand, less ‘pure’ drugs were reported to be contaminated with potentially life-threatening substances (such as 4-MA in amphetamine samples) (Blanckaert et al., 2013).



## 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 is available from the General Mortality Register (GMR). Since 1991, the Federal Public Service Economy (FPS) – Directorate-general Statistics and Economic Information, centralizes the data coming 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) Community 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) is used. The mortality information is registered with residency as a base (*de jure* information) as opposed to the region where the death occurred (*de facto* information). Data on drug-induced deaths among non-residents is available at national and regional level for the years 2003-2010.

Cases of drug-induced deaths were extracted from the 2003-2010 national mortality database using the EMCDDA “Selection B” case definition. According to this definition, cases are selected when the underlying cause of death was drug psychoses, drug dependence, non-dependent 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 in Belgium by year and region are summarized in Table 6.7. In 2010, 87 drug-induced deaths were reported in Belgium of which 49 in the Flemish region, 24 in Brussels and 14 in the Walloon region. The total number of drug-induced deaths in Belgium indicates a remarkable decrease compared to 2007-2009 and abate the level of 2006. This decrease is the largest for the Walloon region. Follow-up data is needed to decide whether it is random variation or a sustainable positive trend. Of the reported drug-induced deaths, 71 persons were between the age of 25-64 years (81%). 6 persons were under the age of 25 years (7%) compared to 17 persons (12%) in 2008 and 14 persons (11%) 2009. On the other hand, we observed in 2010 that 10 persons (12%) were older than 64 years of age compared to 4 persons (3%) in 2009 and 2008.

Table 6.7. Number of drug-induced deaths (15-64yrs) based on the General Mortality Register (Selection B) between 2004 and 2011

Region	Year								
	2003*	2004*	2005*	2006*	2007*	2008*	2009*	2010*	2011
<b>Belgium</b>	<b>97</b>	<b>74</b>	<b>105</b>	<b>86</b>	<b>118</b>	<b>146</b>	<b>132</b>	<b>87</b>	<b>NA</b>
Flemish region	43	36	53	39	68	80	73	49	NA
Brussels	24	14	16	25	29	22	19	24	16**
Walloon region	30	24	36	22	21	44	40	14	NA

Sources:

\* GMR 2004-2009 (FPS Economy – Directorate-general Statistics and Economic Information)

\*\* Brussels: Observatoire de la Santé et du Social de Bruxelles-Capitale

#### 4.2. Drug-related deaths registered by the Belgian Early Warning System on Drugs

The post-mortem toxicology results reported by the Belgian Early Warning System on Drugs (BEWSD) give some more detailed information on the substances associated with drug-related deaths. It should be mentioned that this is a non-exhaustive list, as post-mortem toxicology is not systematically reported to the BEWSD by all laboratories performing post-mortem analyses.

In 2012, the BEWSD received 13 reports related to a drug-related death. Opioids were detected in seven cases, as well as methadone was detected in all these cases. Heroin was reported in only one case. Stimulants (mainly amphetamine) were detected in 8 cases. In one case, MDMA was detected; 3 cases also contained 4-MA, an amphetamine contaminant which was already responsible for the death of at least 6 people in Belgium in 2011-2012 (Blanckaert et al., 2013).

A total of 40 drug-related deaths were reported to BEWSD in 2013. In half of the cases (n=21) opioids were detected, mainly methadone (n=14) and morphine (n=9), but also one case with fentanyl. Five of the cases were associated with heroin. Stimulants were detected in three quarter of the cases (n=31), mainly amphetamine (n=20) and cocaine (n=16). Other detected products were MDMA (1), PMMA (1) and GHB (1). As the numbers suggest, polydrug use is quite common. 14 drug-related deaths were associated with both opioids and stimulants.

## 5. Conclusions

Injecting drug use is and remains an important mechanism for the transmission of blood born infectious diseases, especially the Hepatitis C virus. While harm reduction campaigns with focus on not sharing needles/syringes were successful as observed through a reduction of this injecting risk behaviour, about 40-45% of the injecting drug users still reported the sharing of paraphernalia. A recent cross-sectional study from Scotland showed a high risk for HCV when sharing needles and an increased risk of transmitting HCV when sharing paraphernalia (without sharing needles), especially when sharing filters and containers (Palmateer et al., 2014). A review on interventions to prevent HIV and HCV in people who inject drugs indicated that harm reduction interventions could reduce injecting risk behaviour, with evidence strongest for OST and needle exchange programmes (Macarthur et al., 2014). However, there is comparatively little review-level evidence regarding the effectiveness of these interventions (OST; needle exchange programmes; information, education and counselling) in preventing HCV transmission among injecting drug users. Emerging evidence points out that interventions need to be provided in combination with each other and with a high coverage to prevent the risk of HCV (and HIV) in injecting drug users. Additionally, since HCV transmission happens much easier and at an earlier stage among injecting drug users than HIV, many are already infected with HCV before contacting harm reduction programmes such as OST and needle exchange programmes. This emphasizes the need to develop information, education and counselling programmes that can also reach younger injecting drug users.

An interesting finding is the decrease of drug-induced deaths in 2010, especially for the Walloon region. This trend is also observed in other countries in Europe: an increasing trend between 2003 until 2008/2009, followed by a stabilisation and a decrease thereafter (EMCDDA, 2013). At this moment, an evidence-based explanation for this decrease is not available yet. The most common cause of drug-induced death is a drug overdose with opioids as most commonly involved drug. The majority of high risk opioid users is or has been in contact with health care (EMCDDA, 2014). One reasonable hypothesis might be that it reflects a (late) treatment effect of substitution therapy for opioid users (OST). In Europe, it is observed that the cohort with problematic opioid drug users is aging and about 90% of the reported deaths by overdose are people above 25 years old (EMCDDA, 2014). In Belgium, 93% of the overdose deaths were people above 25 years old and we observe a tendency of an increasing number of drug-induced deaths above the age of 64. A recent study of Degenhardt and colleagues showed that the major cause of death in a cohort with OST still was accidental opioid overdose, especially among younger users (<40 years). As the cohort aged, accidental overdoses are still an important cause of death (but it occurred less

frequent), while other causes such as infectious diseases, liver disease, cardiovascular and respiratory diseases gained importance (Degenhardt et al., 2014). Since its introduction, OST has not resulted in a clear decrease of opioid overdose deaths. On the contrary, it has been observed that there is a raised risk of death in the first month of OST and especially during the first month after ending the treatment, which might negate any protective effect of OST on mortality (Cornish et al., 2010). The authors of this study suggested that prolonged OST might result in this expected protective effect. In Belgium, the organization and use of OST differs between the regions, but at this moment, a detailed OST register is lacking. Such a register could be helpful in studying these statements and in formulating policy recommendations.

In general, the drug related health consequences are substantial, but also mainly sparsely documented. Implementation of interventions with a high coverage, e.g. needle exchange programmes, seems to be effective in reducing certain risky injecting behaviour. However, the effects on health consequences seem to be minimal, as there is no high coverage of a combination of interventions to tackle the different facets of risk behaviours in injecting drug use at the same time.

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## Chapter 7. Responses to health correlates and consequences

*Blanckaert P. and Plettinckx E.*

- *In 2013, 916 patients were admitted to the crisis intervention centres hosted by specialised drug treatment centres.*
- *MDMA concentration in ecstasy tablets have nearly doubled during the last few years.*
- *Despite the positive initiative of syringe exchange programmes, injecting drug users still engage in unsafe disposal of their injecting equipment.*
- *Belgian research encourages HCV treatment among currently injecting drug users, as antiviral therapy is approved to be safe and effective among this target group.*

### 1. Introduction

Drug use is related to several health correlates and consequences, such as drug-related infectious diseases, drug-related emergencies, mental health problems, addiction, overdoses and drug-related deaths (for more information please refer to chapter 6). Accordingly, people who use drugs have multiple additional health needs. This chapter aims to understand some of the current practices in reducing direct and indirect harm associated with illegal drug use. In particular, four key interventions are addressed, namely crisis care services targeting drug users who are confronted with acute health concerns (section 2.1.), responses to drug-related deaths (section 2.2.), needle exchange programmes (section 3.1.) and HCV treatment among injecting drug users (IDUs) (section 3.2.).

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

#### 2.1. Prevention of drug-related emergencies through crisis care services

International studies have pointed out that some people who are using drugs are less able to address health concerns before they become acute (Jackson et al., 2014). For this reason specific crisis care intervention units targeting drug users were implemented in Belgium. The aim of these crisis intervention units is to provide professional, but non-intrusive medical and psychological support immediately after the crisis event occurred (James et al., 2013; Roberts, 2005). These units are generally not restricted to drug-related disorders, but provide overall short-term care for people in a crisis situation (“a state of acute psycho-emotional disequilibrium” (Lewis and Roberts R., 2001)).

More than 20 psychiatric hospitals and psychiatric units (including emergency psychiatric units) in general hospitals are providing crisis interventions to drug users. Besides these services, specialised drug treatment centres are providing crisis interventions since 1980. These interventions offer immediate short-term help to persons in crisis, as well as support in seeking continued treatment. The so-called Crisis Intervention Centres (CICs), are accredited by the National Institute for Health and Disability Insurance (NIHDI). Currently eight CICs, with a total capacity of 81 patients per day, are geographically dispersed over Belgium (Koen Deraedt, NIHDI, Personal communication). In total, 916 patients were admitted to the CIC's in 2013 because of illegal drug use. The majority were male (85%) and the mean age was 31 years. Most patients showed a frequent pattern of drug use: 73% were using daily and 91% were using more than one substance. Almost 21% of the patients currently injected drugs. Table 7.1 shows that opiate use was the main reason to be admitted to one of the eight CIC's in Belgium. When compared to other drug users, people who were admitted because of opiate use were in average a little bit older (mean age is 33), tended to use more frequently and often used more than one substance.

Table 7.1. Demographic characteristics and patterns of use of persons admitted to CIC's in 2013 by substance

<b>Variables</b>	<b>Opiates</b>	<b>Cocaine</b>	<b>Stimulants*</b>	<b>Cannabis</b>	<b>Total</b>
Admissions					
<i>Number of persons admitted</i>	370	195	127	110	916
<i>proportion of persons admitted (%)</i>	40.4	21.3	13.9	12.0	100
Demographic characteristics					
<i>Men (%)</i>	85.4	81.0	85.0	92.7	84.6
<i>Mean age (Years)</i>	33.3	30.8	29.9	26.2	31.4
Patterns of use					
<i>Currently injecting (%)</i>	34.3	10.6	25.2	3.5	20.8
<i>Daily consumption (%)</i>	74.7	54.5	72.0	86.4	72.9
<i>More than one substance (%)</i>	93.0	92.3	89.8	84.5	91.2

\* Stimulants: defined in the TDI protocol as amphetamine, MDMA and derivatives and others

Source: BTDI register, 2014

Since October 2002, a national pilot project is implemented for crisis and case management of patients with joint substance use and mental health crisis (Federal Public Service Health, Food Chain Safety and Environment). In this project, nine units in the proximity of the emergency departments of general hospitals in the cities of Antwerp, Brussels, Ghent, Genk, Leuven, Bruges, Liège, Namur and Mons are participating. These units offer in total 40 crisis beds with a maximum stay of five days.

Within these five days, special attention is given to the continuation of health care and referral to treatment. From 2011 onwards, the centres register the number of admissions and the length of stay for every admission on a monthly basis. In 2013, a total of 4,252 admissions were registered of which approximately 1,750 (41.2%) were related to illegal drugs. The average length of stay was 3.7 days. The average occupation degree was 90.7% for the short interventions (< 4 hours) and 72% for night shelters (Katia Huard, FPS Health, Food Chain Safety and Environment, personal communication). These data confirm a stable trend in the average length of stay (3.4 days in 2011).

### 2.2. Prevention and reduction of non-fatal overdoses and drug-related deaths

#### 2.2.1 Collaboration in the framework of the Belgian Early Warning System on Drugs

The Belgian Early Warning System on Drugs (BEWSD) contributes to the prevention of drug-related deaths (DRD) caused by dangerous mixtures of drugs or new psychoactive substances (NPS) circulating in Belgium. The BEWSD is coordinated by the Belgian Monitoring Centre for Drugs and Drug Addiction (BMCDDA), hosted by the Scientific Institute for Public Health (WIV-ISP) and partner of the European EWS REITOX network authorized by the EMCDDA and Europol.

For the collection of reliable information at the Belgian level, the BEWSD relies on a multi-disciplinary network of organizations that work professionally in the domain of illegal substances. Most of the information collected by the BEWSD results from the analysis of drug samples seized by Belgian law enforcement authorities or from the reporting of clinical or post-mortem samples from hospital settings.

It is difficult to obtain a detailed up-to-date overview of the circulating street drugs in Belgium. However, one small-scale drug-testing project is currently active and coordinated by Modus Vivendi in Brussels. People have the opportunity to anonymously hand in a drug sample at Modus Vivendi. These samples are then analysed at the Scientific Institute of Public Health (WIV-ISP, Medicines department) to obtain information on the constitution of the sample. In some cases, Modus Vivendi is also contacted when drug users have experienced bad effects after consumption of an unknown drug. Through this project, the BEWSD receives additional valuable information on contaminated or highly dosed drugs. Sometimes, NPS are analysed as well.

The BEWSD initiated some research projects in 2013 that aim at screening for the drugs used in a certain setting, e.g. a festival or large-scale dance event. The analysis of drug samples seized at these settings provides a better overview of the drugs that are currently circulating. In contrast, analysis of drugs, seized from dealers by police services, provides an

overview of the drug market on the supply side (for more information about drug seizures please refer to chapter 10). For example, a lot of information regarding NPS detected in Belgium is acquired through the analysis of substances seized by the customs. This can explain the discrepancy between the high number of NPS found each year on Belgium territory, and the lack of corresponding clinical samples (from potential intoxications) or reports of NPS use.

By combining all obtained information (based on consumer experiences, law enforcement intelligence and clinical data), the BEWSD manages a unique and extensive database about the composition and effects of illegal substances and NPS in Belgium. On the basis of the results included in this database, the BEWSD is in close interaction with the partners of the network. Whenever a high-risk substance or a NPS is reported in Belgium, the BEWSD distributes an EWS message (alert) to inform prevention and harm reduction organizations.

Messages distributed by the BEWSD are divided into 4 categories according to severity or perceived threat. A distinction can be made between informative messages (level 0) and alert messages (level 1 to 3). Alerts are related to analytically confirmed information and reported intoxications or deaths, while informative messages are less urgent communications containing information about the appearance of NPS in Belgium, neighbouring countries or Europe.

In 2013, the BEWSD sent out around 20 informative messages to its network of toxicological and clinical forensic laboratories. These were mostly notifications of new substances or updates to the mass spectrometry spectral databases of the participating laboratories in Belgium. Analysis methods for certain specific compounds (e.g., the synthetic cannabinoid XLR-11) were shared as well. The main objective of these informative messages is to ensure that labs are capable of detecting the latest psychoactive substances.

The alerts are relayed further to workers in-the-field by the regional focal points (VAD and Eurotox) in order to prevent (additional) casualties. VAD and Eurotox also maintain internet fora, where drug field workers can post messages regarding developments or dangerous trends observed among drug users. Harm reduction organizations and prevention projects such as Quality Nights, Vitalsounds and Breakline further tailor these messages to their specific target audience (for more information about these projects please refer to chapter 3).

After removing the potentially sensitive or privacy-related medical information, these alerts are made available to the general public through the BEWSD website. Cases with a substantial risk to national public health are shared with the media.



### 2.2.2 Current trends and observations

A worrying trend in 2013 is the continuing presence of highly dosed MDMA tablets on the Belgian drug market (see also chapter 10). The first alert with regard to highly dosed MDMA tablets was sent to the network in February 2013. Two deaths related to the consumption of MDMA were confirmed to the BEWSD.

It seems that, after several years of decline, the MDMA market has recovered. A standard clinical dose of MDMA is about 125mg, expressed as the HCl salt. Keeping this in mind, alarming high dosages of MDMA are frequently encountered in ecstasy tablets. In 2013, tablets that easily contained twice the standard dose were seized; in some cases even up to 360mg MDMA.HCl. The increased availability of precursor material is thought to be the leading cause of this 'revival', although it does not explain the extremely high dosages that are observed in MDMA tablets. This phenomenon is not confined to Belgium, but is reported by our neighbouring country the Netherlands as well.

MDMA was also found in combination with other substances. In July 2013, a death case was reported. Extremely high concentrations of MDMA and lower quantities of PMMA were found in *post mortem* toxicology blood and urine work-up.

Besides MDMA, the BEWSD urged the network to warn for blotters that were sold as LSD. Nevertheless, these blotters contained the NPS 25I-NBOMe which is a potent hallucinogenic 5-HT<sub>2A</sub> agonist. In total, 5 intoxications with 25I-NBOMe were reported in 2013. One of the blotters contained 2,5-dimethoxy-4-chloro-amphetamine (DOC) as well. One patient died even after arrival at the hospital, although it is not clear to what extent the consumption of 25I-NBOMe might have contributed to the exact cause of death of this patient.

Additionally, a PMA warning was released in January 2013 after being informed of a fatal incident. Toxicology work-up of blood and urine revealed the presence of amphetamine, PMA, alcohol and THC.

At the end of the year, an intoxication with methoxetamine and the detection of 6-APB and methylone (two new synthetic stimulants) were also reported.

### 3. Prevention and treatment of drug-related infectious diseases

#### 3.1. Needle exchange programmes

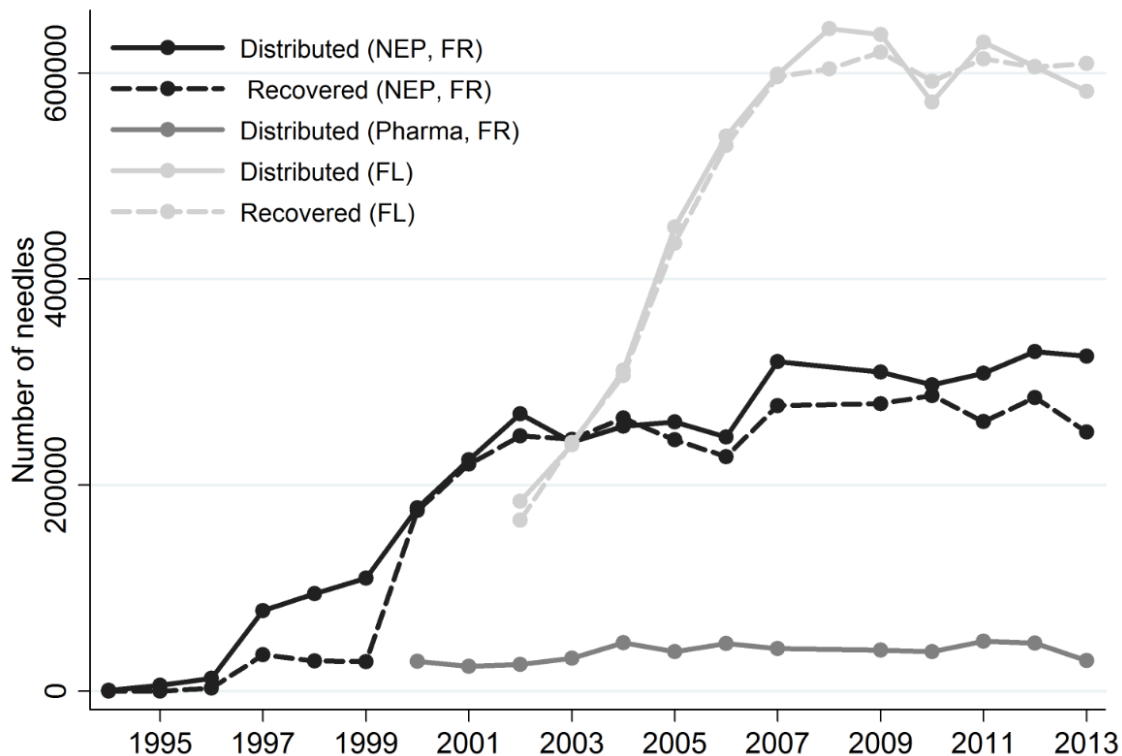
Needle exchange programmes (NEP) distribute sterile injecting material and additional prevention material among IDUs and recuperate used needles. In this way, these programmes aim to prevent the spread of infectious diseases and other health risks, such as overdoses and abscesses. Moreover, NEP can facilitate the referral of IDUs to prevention services or treatment options (Windelinckx, 2014). These NEP are coordinated by Free Clinic for the Flemish Community and by Modus Vivendi for the French Community.

Free Clinic is one of the Medical and Social Care Centres (MSCC) of Belgium and is located in Antwerp. In cooperation with five other coordinators of the MSCC in the Flemish Community (one per province), Free clinic has implemented the NEP in 2001. The provincial coordinator creates a network of health care professionals and pharmacists helping in the distribution of sterile injecting material, including syringes, filters, ascorbic acid, spoons (Exchange©), alcohol swabs, flasks of injectable sterile water, foil, bicarbonate, and containers to recover used syringes. In 2013, sterile injecting material within the Flemish Community was distributed by 49 needle exchange services, dispersed over 28 cities and villages. In addition, 28 pharmacies, dispersed over 8 cities and villages, contributed in the NEP in the Flemish Community. This suggests an increase of 8 new syringe exchange services in 2013, although 3 pharmacies ceased distributing sterile equipment material. In total 582,357 syringes were distributed through NEP and pharmacies, 609,235 were recuperated. This brings the recuperation rate to about 105% (see Figure 7.1 and 7.2).

In the French Community, NEP are coordinated by Modus Vivendi since 1994. In 2008, the organization of the NEP was rearranged, which caused a lack of data for that year. Since 2008, sterile injecting equipment has been offered through 15 official fixed-site and mobile services (with accreditation) located in Brussels, Charleroi, Dinant, Arlon, Namur, Liège, Ciney and Mons. In total, 325,147 sterile syringes were distributed by NEP in 2013 and 251,685 were returned, resulting in a recuperation rate of 77.4%. On top, more than 10 other services distributed sterile injection equipment. However, the number of sterile syringes distributed within these services is not registered. A network of pharmacists participate in the “Stérifix” project. This project involves pharmacists to distribute “Stérifix” kits to IDUs at the cost of 0.5 euro. These kits include two syringes, two alcohol swabs, two dry post-injecting swabs, two spoons, two flasks of injectable sterile water and harm reduction information. In total, 14,905 Stérifix kits were dispatched in the pharmacies participating to the Stérifix project. As each kit contains 2 syringes, 29,810 syringes were dispatched to IDUs. Besides sterile syringes, also 161,934 sterile spoons, 152,256 plastic flasks of water and 271,781

alcohol pads were distributed. Unfortunately, the exact number of sterile injecting equipment effectively sold through the whole network was not registered.

Figure 7.1. Number of syringes distributed and recuperated in the Flemish (FL) and French Community (FR) by needle exchange programmes and by pharmacists between 1994 and 2013



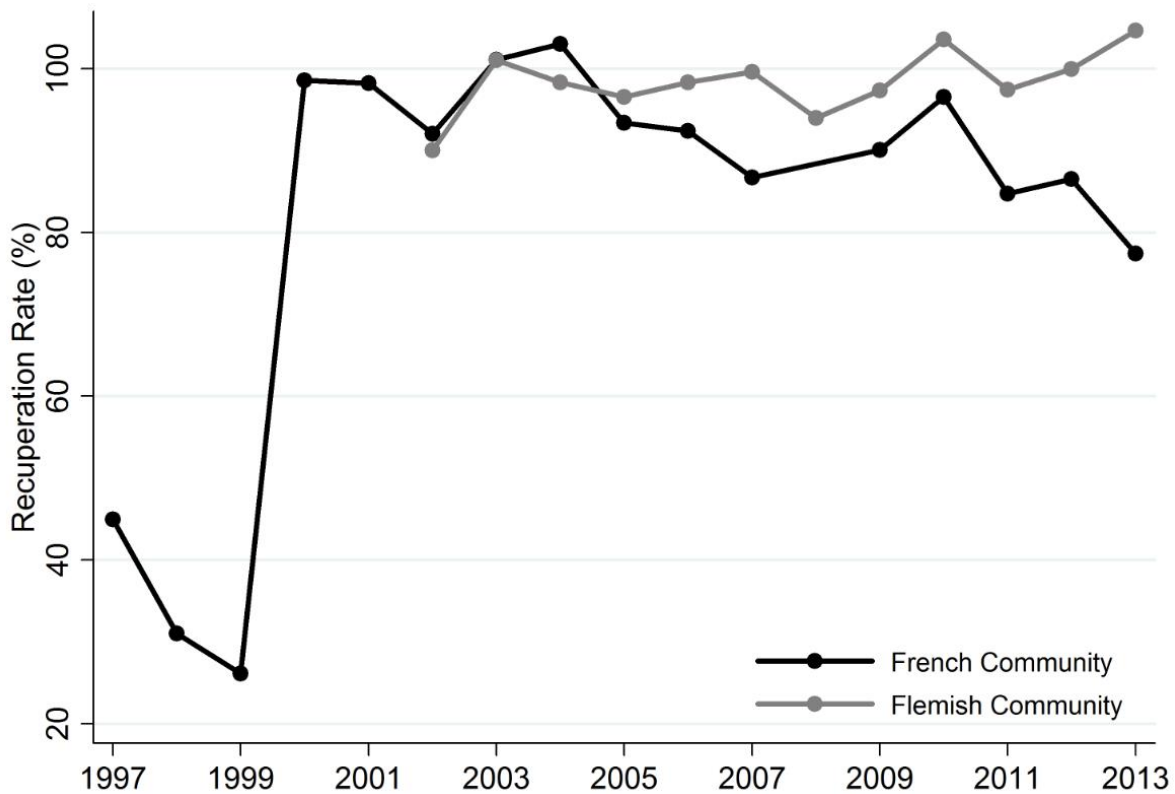
[note: the data 2008 for the French Community are lacking as a result of reorganization; the number of registered needles for the Flemish Community consider both syringe exchange services and pharmacies]

Source: Eurotox (Hogge, personal communication, 2014) and VAD (Windelinckx, 2011; Windelinckx, 2012; Windelinckx, 2013; Windelinckx, 2014)

The fact that the number of needles distributed by pharmacies outside the Stérifix project is not registered in the French Community, may explain the lower number of registered distributed sterile syringes in comparison with the Flemish Community. Moreover, the needle exchange services in the Flemish Community are dispersed among more cities and villages which can influence the number of distributed sterile syringes in a positive way as this increases the accessibility of the needle exchange services.

Compared to the past years, the number of distributed needles remains stable in the French Community whereas the number is declining again since two years in the Flemish Community (Figure 7.1). The recuperation rate (Figure 7.2) however, is increasing in the Flemish Community and decreasing in the French Community. The proven success of the NEP endorses the possibility of syringe recuperation in reducing the risks (e.g. needle-stick injury and consequent infection) for the general population.

Figure 7.2. Recuperation rate of the syringes distributed by Needle Exchange Programmes (NEP) in the Flemish and French Community between 1997 and 2013



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

Source: Eurotox (Hogge, personal communication, 2014) and VAD (Windelinckx, 2011;Windelinckx, 2012;Windelinckx, 2013;Windelinckx, 2014)

Based on an annually anonymous survey of the Flemish NEP, it is possible to weight the usefulness of the programme as well as to form an image on the people who are reached. In 2013, 264 valid questionnaires were filled out (Windelinckx, 2014). For a detailed description of the used methodology, we refer to chapter 4 (section 3.1) of this report.

Most participants of the survey are men (80%). Half of the respondents (52%) rent or own a house and the average age is 35. As most clients of the NEP start to inject at a young age, the mean age shows that people are injecting several years before they get in touch with risk and harm reduction initiatives. Moreover, the results indicate regular injecting drug use and polydrug use among the target group.

It seems that IDUs receive information about syringe exchange programmes mostly through low threshold drug treatment (63%) and through acquaintances (53%). Besides, results pointed out that friends are really important to disperse sterile injecting equipment. Most people obtain sterile injecting equipment through drug treatment or separate syringe exchange services. Nevertheless, pharmacists play an permanent role in the distribution of

injecting materials, as 66% of the IDUs making use of NEP are buying regularly injecting materials in pharmacies.

In 2013, the NEP in the Flemish Community reached 27% new clients, meaning this proportion (almost 1 in 3 of NEP users) only used these programmes for less than one year. Although 12% of the respondents claimed to know minor injecting drug users, the latter group is not reached. Also, despite the large amount of properly returned used needles, 19% of the IDUs indicated to engage in unsafe disposal of their injecting equipment, e.g. throwing uncapped needles into garbage bins or on the street (Windelinckx, 2014). For further discussion of the results about risk behaviour, we refer to chapter 6 (section 2.3.1) of this report.

### 3.2. Hepatitis C Virus treatment among injecting drug users

Chronic hepatitis C is a disease with an impact for public health that should not be underestimated. Injecting drug users are at increased risk of Hepatitis C Virus (HCV) infections mostly because of injecting equipment sharing practices (WHO, 2012). Approximately 65% of IDUs are infected within one year of needle use. HCV typically progresses slowly over a period of many years. The symptoms of HCV are non-specific until the liver disease is already advanced. Consequently, HCV is the most common cause for liver transplantation among adults (Sylvestre, 2002).

Despite that IDUs are the most important risk group for new HCV infections, this group is often excluded from antiviral therapy. Treatment uptake in this group remains low due to concerns about poor compliance, adverse events and reinfection (Backmund et al., 2001; Robaey et al., 2013). Contacts between IDUs and healthcare workers have been characterised with mistrust and discrimination (Crawford and Bath, 2013).

Practitioners claim that current IDUs have a poor compliance with HCV treatment because it is time-consuming and expensive (Backmund et al., 2001; Sylvestre, 2002). A typical treatment regimen comprises 6 to 12 months of Interferon/Ribavirin combination therapy (Robaey et al., 2013). As 45 to 73% of former IDUs know a drug relapse within half a year, HCV treatment was until recently only recommended if former IDUs have lived drug-free for a period of 6 to 12 months. Nevertheless, patients who continue to inject illegal drugs showed a sustained response to the antiviral therapy. This proves that HCV treatment of current IDUs is feasible on the basis of their compliance rate (Backmund et al., 2001).

In addition, based on recently published Belgian research, cessation of injecting drugs is not required to limit the progression of the HCV disease (Robaey et al., 2013). Recent and occasional drug use during treatment seemed to have only a little impact on the treatment

completion. Daily drug use, on the other hand, lowers the level of the treatment completion. Moreover, reported reinfection rates after a successful HCV treatment are also low.

This means that IDUs don't have to be excluded from HCV treatment immediately, as it is not only feasible but also proved to be safe and effective (Robaey et al., 2013). Therefore, the option of treatment has to be assessed individually. Taken this into account, there is a need for a multidisciplinary approach for the evaluation of the educational level, housing situation, social setting and clinical factors (both physical and psychological) of the patient in order to provide HCV treatment successfully. In the context of the treatment, pre-therapeutic education about the course of the disease, the risk factors, the treatment (agreement to maintain regular appointments) and harm reduction strategies are required. Considering the complex health needs of the patient, access to peer support and social support services is also of great importance (Robaey et al., 2013). These services may increase treatment knowledge, treatment uptake and improve service provision (Crawford and Bath, 2013).

### 3.3. Prevention and treatment of drug-related infectious diseases in prison

Prevention projects and treatment initiatives, aiming to reduce drug-related infectious diseases in prison, are discussed in section 6 of chapter 9 of this report.

## 4. Conclusions

Several initiatives in Belgium are implemented to get a better grip on drug-related harms. Among those, various services are available to treat acute drug-related health concerns. The information about the occupation degree of these services indicates a sufficiently large offer. Most of the patients experiencing a crisis are regular polydrug users and 40% are admitted because of opiate use.

In 2013 several research projects were initiated by the BEWSD, with the goal of screening drugs used in recreational settings. Contrary to drugs seized by police services, analysis of drugs found on drug users might provide better information regarding the composition of drugs circulating on the streets. Drugs seized by police services are frequently large-scale seizures and are better suited to provide an overview of the supply side of the drug market. This can explain the discrepancy between the high numbers of NPS seized every year in Belgium and the lack of clinical intoxications with these substances.

The raising MDMA content detected in ecstasy tablets in 2013 remains a big concern. This phenomenon has been closely monitored by the BEWSD for the last years. Compared to 2009, the standard amount of 125mg MDMA processed in ecstasy tablets has nearly doubled, leading to potential dangerous and even lethal situations. Users that are unaware

of a tablet's high MDMA content, can easily overdose. Moreover, several substances other than MDMA were found in ecstasy tablets. These other substances include an additional danger to the user. Raising awareness about the possible dangerous composition of illegal drugs and NPS through drug prevention and harm reduction services, is of great importance. Additionally, attention for targeted overdose fatality prevention training is needed. An American study suggests that individuals who have witnessed overdoses more frequently, are more likely to intervene inappropriately compared to people who have had only a few opportunities to intervene. As such, overdose prevention training is recommended for individuals who are more likely to witness overdoses more often. Homeless people, polydrug users and individuals who have had a prior non-fatal overdose may be potential target groups for these initiatives (Bohnert et al., 2012). Nevertheless, as this study is not representative for other geographical regions, scientific research is needed at national level to assess the situation in Belgium.

Next to the prevention of overdoses, continuing attention to the efficiency of NEP is needed. The general decrease of the number of distributed syringes may be due to a lack of financial means caused by budget cuts in the sector. In 2013, a reduction of three pharmacies participating in the programme was observed in the Flemish Community. Unfortunately, pharmacies are not always willing to participate in NEP and require repeated convincing to be involved in these harm reduction initiatives. The stable or decreasing number of recovered syringes underlines the fact that syringes may be still disposed in an unsafe way. Consequently, highlighting the value of syringe recuperation to reduce the risks (e.g. needle-stick injury and consequent infection) for the general public is recommended.

IDUs that are already in contact with syringe exchange programmes can be encouraged for further oral advertising in their environment. In that way, familiar IDUs may be triggered to reach the provided programmes. It is known that IDUs are already using for a few years before coming into contact with syringe exchange programmes. As the first year of injecting drugs is the most risky year to be infected with communicable diseases, efforts to particularly reach more young IDUs may be forced up as well, e.g. through targeted outreach street corner work or mobile services. These services have the advantage to target (suburban and rural) areas where community-based prevention and harm reduction organizations probably don't exist. Social mapping can improve the knowledge about when, where and how to reach this target group. In addition, social media may be a key channel to disseminate information about drugs and injecting practices among this population (Valdiserri et al., 2014).

The treatment uptake of IDUs concerning infectious diseases remains low as there are still concerns about poor compliance, adverse events and reinfection remain. Recent research,

however, indicated the effectiveness and safety of the treatment in these patients and stresses the importance of also applying antiretroviral therapy of HCV in infected IDUs. In these cases, an integrated and individual approach is required and attention must be given not only to the clinical factors, but also to other life domains such as education and housing. Furthermore, it is important to refer patients to peer support and social support organizations as well (Crawford and Bath, 2013). Consequently, a multidisciplinary strategy lies at the base of further progress in HCV treatment of injecting drug users.

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### **Acknowledgements**

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## Chapter 8. Social correlates and social reintegration

*Antoine J.*

- *Among the drug user population, almost twice as much people are unemployed or low-educated compared to the general population.*
- *Social reintegration by housing is the aim of the Housing First project started in 2013 and offers an unconditional solution for accommodation for homeless people.*

### 1. Introduction

Next to experiencing physical, psychological and social harms as a result of their substance use (see chapter 4), many problem drug users in Europe have unmet social needs concerning housing, education and employment (Sumnall and Brotherhood, 2012). Moreover, drug users can also meet structural barriers such as stigmatisation. Drug dependence is indeed associated with greater stigma than many other health and social conditions, partly because drug dependence is often believed to be the consequence of a lifestyle-related choice which users can control (Livingston et al., 2012).

Although 'social reintegration' is a key aspect of full recovery from drug dependency, it is not a term that is consistently used or defined across all EU Member States. The scope of social reintegration is wider than the traditional treatment focused on pharmacological and psychosocial outcomes. The EMCDDA defines this as 'any social intervention with the aim of integrating former or current problem drug user into the community' (Sumnall and Brotherhood, 2012). In Belgium, the practice of social reintegration with a focus on specific risk groups is stressed in the common declaration as part of the integrated drug policy (Interministeriële Conferentie Drugs, 2010).

With a focus on problems of housing, employment and educational level, this chapter will first look at social exclusion among drug-users registered through the Treatment Demand Indicator (TDI) in comparison with general population registers (section 2.1). Also, the substance use in different vulnerable, excluded groups such as homeless people, sex workers and prisoners will be presented based on specific studies (section 2.2). A second part of the chapter will describe examples of initiatives supporting people from a social point of view (section 3).

## 2. Social exclusion and drug use

Drug use could be considered as either a consequence or a cause of social exclusion. On one hand, drug use may cause a deterioration of living conditions, but on the other hand, the process of social marginalisation can be a reason for starting drug use as well. Nevertheless, the relation between drug use and social exclusion is not necessarily a causal one, as social exclusion does not apply to all drug users. Taking this complexity into account, it is possible both to analyse drug use among socially excluded populations and to study social exclusion among drug addicts (EMCDDA, 2003).

### 2.1. Social exclusion among drug users

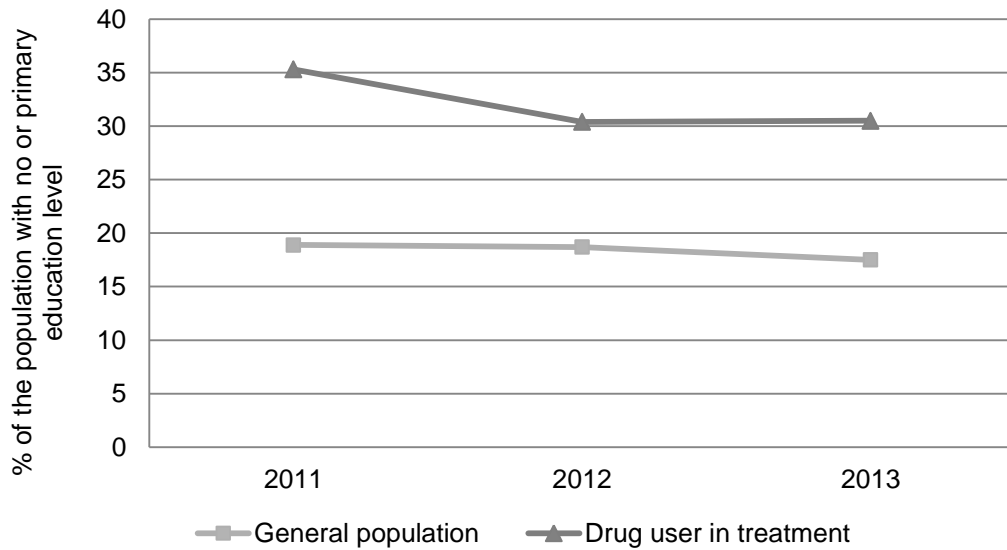
The TDI registration (see also chapter 5) gathers information on every new treatment episode of patients with a problematic use of substances in contact with treatment centres. Social exclusion of these patients can be illustrated through three aspects collected by the indicator: the educational level, the working status and the housing situation.

#### 2.1.1. Educational level

Education is a key factor in the development of social and economic wellbeing (Sumnall and Brotherhood, 2012). Moreover, international research shows a strong evidence linking school attendance and engagement in protecting against drug use (Edmonds et al., 2005).

Figure 8.1 plots the proportion of people with a low educational level in the general population (FPS Economy, 2014) and in the population of drug users in treatment (WIV-ISP, 2014). In 2013, 17.5% of the general Belgian population (15 years or older), has no degree or only a primary degree of education. For the population of people entering treatment for substance use, this percentage is 30.5%. This proportion is decreasing since 2011 in both populations.

Figure 8.1. Evolution of the proportion of people with a lower educational level in the general population and the drug user population (15 years and older) between 2011 and 2013



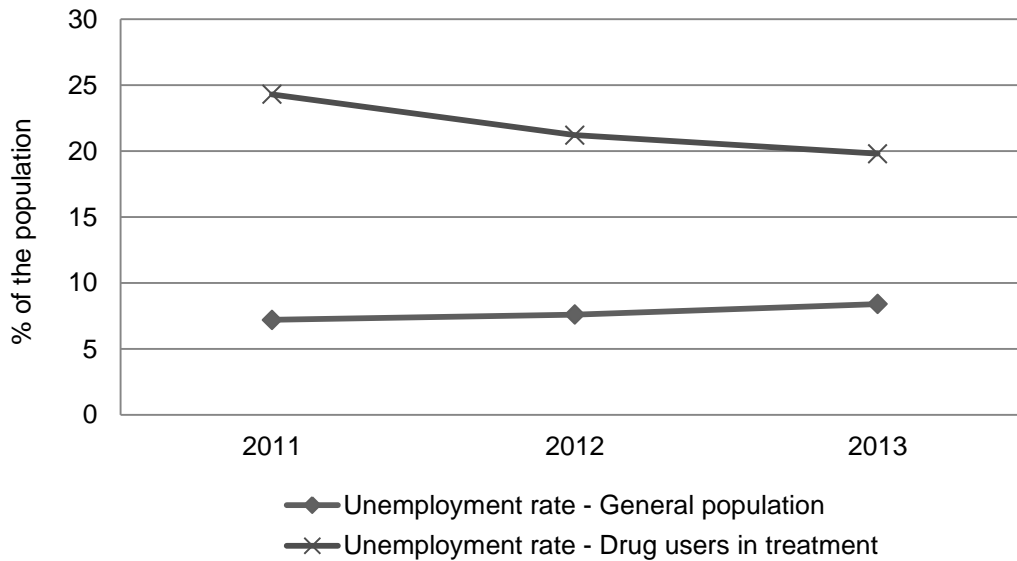
Source: (FPS Economy, 2014;WIV-ISP, 2014)

### 2.1.2. Working status

Although there is a large amount of evidence describing the association between problematic drug use and unemployment, the exact mechanisms and direction of influence are insufficiently examined and thus not fully understood (Henkel, 2011).

In figure 8.2 both the general population and the treated population are compared on unemployment rates. The unemployment rate is representing the proportion of people actively looking for a job. This rate is 8.4% in the general population and 19.8% in the drug user population in treatment. This supports the idea that drug users in treatment are less integrated in employment. Since 2011, however, the proportion of unemployed persons in the general population is slightly increasing whereas this rate is slightly decreasing for persons who are in treatment.

Figure 8.2. Evolution of the unemployment rate in the general population and in the drug-user population (15-64 years) between 2011 and 2013



Source: (FPS Economy, 2014;WIV-ISP, 2014)

### 2.1.3. Housing situation

There is a complex interaction between substance use, homelessness and other housing needs. These are seen as mutually reinforcing and often result from the same disadvantages and inequalities as experiencing family disruption in childhood, school exclusion, health problems or contacts with criminal justice system. It is also recognised that housing stability enhances the achieving of employment (Pleace, 2008;Sumnall and Brotherhood, 2012).

Based on the TDI database, the percentage of patients living in an unstable accommodation (including also homeless people) is 11.5%. Moreover, 5.5% of the patients are incarcerated or reside in an institution (hospital, etc.). There are no similar indicators in the general population to compare these numbers with.

## 2.2. Drug use in socially excluded groups

The most recent available numbers about drug use in different socially excluded groups in Belgium are presented below. Because such information is relatively scarce, the studies taken into account can be large scale studies at national level as well as more small scale studies at the level of a specialised centre working with these specific groups of people.

### 2.2.1. Homeless people

The results of a study in 2010 on homeless people in Belgium, showed that 81.7% of clients of the Flemish and 58.9% of the Walloon and Brussels public centres for social welfare were often confronted with a drug or alcohol addiction (De Boyser et al., 2010).

More recently, for the winter period of 2013-2014, 'Samu social' (an organization working with homeless people), listed in Brussels the observed causes of rupture that brought these people to a social emergency situation. Addiction (including both alcohol and illicit drugs) was given as the fifth most commonly mentioned causal reason (16.7%), right after finance problems, health or mental health problems and administrative problems (Samusocial asbl, 2014).

### 2.2.2. Sex workers

A study about drug use among sex workers took place in Belgium in 2011 (Decorte et al., 2011). The results showed that one in four (25.9%) of the 528 respondents had been using cannabis during the last month, compared to 16.7% for cocaine (also 3.4% crack), 7.2% for heroin and 3.8% for amphetamine.

More recent results among 148 sex workers supported by the association 'Espace P' in Charleroi, show slightly higher results. 35.4% of the sex workers were using drugs or alcohol. The percentage of sex workers using cocaine was 18.3% and heroine 9.7% which is similar to the results of the study of Decorte et al. (Espace P, 2014).

### 2.2.3. Prison

Drug use is also an important issue among prisoners. From the biyearly survey in Belgian prisons on drug use (stopped in 2010), life-time prevalence use was around 60% while the prevalence of drug use in prison amounted to 30% (Van Malderen, 2011).

## 3. Social reintegration

Several initiatives targeting different risk groups are set up to improve social reintegration for drug users. To illustrate the concern and actions on this topic, different approaches are presented targeting the main social exclusion problems such as housing, education and training, employment and social life. The objective is to show the most recent, interesting or original initiatives in the different regions of the country. It is the intention of this report to illustrate the variety of developments on social reintegration specifically dedicated to drug users, rather than to provide an exhaustive list of projects. The presented overview is a

collection of information generally obtained from the websites of the different organizations hosting these projects.

### 3.1. Housing

#### 3.1.1. Temporary housing and emergency accommodation

Many initiatives on housing aim at providing a temporary solution for those with the most pressing housing demands (see Table 8.1). Within these projects, the staff also supports clients in further orientation to more appropriate housing.

Table 8.1. Examples of temporary housing and emergency accommodation initiatives

<b>Institution in charge; Name of the initiative; City</b>	<b>Description</b>
Public centres for social welfare Antwerp; De Biekorf; Antwerp	54 beds available as a temporary housing solution for adult homeless people with an addiction or psychiatric problems (incl. shower, breakfast, soup) - €2,5/night.
Non-profit association Transit; Crisis centre; Brussels	21 beds available for drug users, providing a short term housing option until the person finds a long-term solution. Administrative support and orientation are also available; free of charge.
Non-profit association Comme chez nous and city of Charleroi; Ulysse night shelter; Charleroi	12 beds available for adults having an urgent housing difficulty, which is integrated in the network of support for homeless or addicted people, free of charge.

Source: (Ville de Charleroi, 2014;Goessens, 2014;OCMW Antwerpen, 2014)

Besides these three initiatives, in August 2013, a new national project was launched to be endured for 2 years in the five biggest cities of Belgium (Brussels, Antwerp, Gent, Liège, Charleroi) and based on the principles of Housing First (Housing First Belgium, 2014).

The Housing First model, launched in the USA in the nineties, is guided by the principle to provide housing as a primary action, to then subsequently combine this with supportive treatment services in the areas of mental and physical health, substance abuse, education, and employment. Housing is provided in apartments scattered throughout a community. A project of supportive housing such as Housing First removes the requirements for sobriety, treatment attendance and other barriers to housing entrance (Larimer et al., 2009).

In Belgium, Housing First is still a pilot project. In order to evaluate the impact of this initiative, a research project was launched. A total of 300 people were recruited in 3 groups: 1) an experimental group participating in the Housing First project, 2) a control group living on the streets and 3) a control group living in a fixed accommodation. Among those people,

50% had an addiction problem; mainly with alcohol (40.0%) but also with heroine (18.8%), cannabis (12.5%) and medicines (12.5%) (Housing First Belgium, 2014).

The results which will describe the obstacles and mark guidelines for good practice of Housing First in Belgium, are foreseen for June 2015.

### 3.1.2. Supported housing, halfway houses and supported living

Housing services provided to target clients who are not yet able to live completely independently, including transitional housing as well as supported living are described in Table 8.2.

Table 8.2. Examples of supported housing, halfway houses and supported living initiatives

<b>Institution in charge; Name of the initiative; City</b>	<b>Description</b>
De Kiem; Halfway house; Ghent	Drug users that have completed the therapeutic community programme can benefit from a 6-8 months residential aftercare. Accent is put on working situation, education, development of a social network and financial support.
Non-profit association Transit; Supervised flats; Brussels	8 individuals flats are available for renting for 3 months (period can be extendable). Clients are required to be independent and able to pay the rent. While benefitting from a social accompaniment, they should actively look for new housing.
Non-profit association Thaïs; Welcome house; Liège	9 individual places are preferably allocated to families. A psychosocial support is provided to generally improve the social, housing, health and family situation of the drug user or sex-worker.

Source: (De Kiem, 2014;Goessens, 2014;Thaïs asbl, 2014)

## 3.1.3. Support in finding long-term accommodation

Support for drug users that require assistance in finding long-term accommodation is provided through several services (Table 8.3).

Table 8.3. Examples of initiatives in finding long-term accommodation

<b>Institution in charge; Name of the initiative; City</b>	<b>Description</b>
Public centres for social welfare Brussels; Psychosocial support service; Brussels	Service aiming at helping drug-users in their administrative, social, medical and day-to-day initiatives. One of the main objectives is to help in finding a housing solution.
Projet Lama; 'Hestia'; Brussels	Besides from the studios available for short term housing, Hestia is also working at helping the patient with administrative tasks, creating a personal project together and reintegrate them in society.
Non-profit association Thaïs; Association for the promotion of housing; Liège	A new initiative in Wallonia which promotes social reintegration through decent housing, administrative, technical and judicial support. As from 2014, the first houses will be available for a 9 years lease.

Source: (CPAS de la ville de Bruxelles, 2014;Le Projet Lama asbl, 2014;Thaïs asbl, 2014)

## 3.2. Education &amp; training

Table 8.4 focuses on vocational training and education interventions for unemployed problem drug users. Education refers to formalized education whereby the client are faced with examinations and other forms of assessments to gain nationally recognised qualifications. Vocational training incorporates a wide variety of programmes that support employment strategies, increase self-efficacy, improve commitment to work, etc.

Table 8.4. Examples of education and training initiatives

<b>Institution in charge; Name of the initiative; City</b>	<b>Description</b>
Public centres for social welfare Ghent; 'Perspectief'; Ghent	Persons with a current or previous addiction problem can benefit from an evaluation of their actual situation, a proposition of possibilities for their work situation and guidance and follow-up of new perspectives
Trempline; Programme for psychological; Social and professional reintegration; Charleroi	This programme offers an opportunity for drug users from the therapeutic residential programme to follow training in informatics, language and mathematics or horticulture. They are also prepared for work by a mapping of their competences or possible difficulties, etc.
Non-profit association Free-clinic; 'Buro Actief'; Antwerp	Buro Actief provides the possibility for drug users to engage anyway on a low-threshold level in small work assignments. This initiative is part of an integrated care programme.

Source: (Free Clinic, 2014;OCMW Gent, 2014;Trempline asbl, 2014)



### 3.3. Employment

In theory, problem drug users could access the employment market through traditional means. However, in practice there are significant barriers. Table 8.5 focuses on special interventions that provide a supportive work environment for drug users.

Table 8.5. Examples of employment initiatives

<b>Institution in charge; Name of the initiative; City</b>	<b>Description</b>
WeerWerk; Ghent and Antwerp	'Weerwerk' gives the opportunity to current or former drug users to reintegrate slowly in a social enterprise business. Participants receive additional support to address drug use, financial and other social problems
Modus Vivendi; Peer support ; Brussels	The expertise and cooperation of drug users is useful for harm-reduction projects, prevention programmes or expertise meetings towards their peers. Drug users are recruited for a short period and are obliged to follow a training to be allowed to provide peer support at different places.
Trempline; Programme for psychosocial, social and professional reintegration; Charleroi	This programme offers job opportunities (administrative, gardening or construction tasks) for a maximum of 1 year. The target group are drug users in treatment in Trempline.

Source: (Modus Vivendi, 2013; Trempline asbl, 2014; Weerwerk, 2014)

### 3.4. Leisure activities

Research has shown that physical and social recreation play an important role in improving the quality of life (Fountain et al., 2000). This can benefit at different levels and may result in improved physical health, improved self-esteem, improved mood, increased energy and activity levels, reduced side effects of medication (e.g., weight gain), reduced depression and anxiety and distraction from stressful situations. Table 8.6 describes some of the projects set up in Belgium in order to improve involvement of drug users in social life activities.

Table 8.6. Examples of leisure activities initiatives

Institution in charge; Name of the initiative; City	Description
Free Clinic; Activation project; Antwerp	This project provides opportunities of social activities (music, sport, meetings) allowing drug users to participate to free projects in order to activate them and to force them to be involved in small events
La trace; Brussels	This centre organizes hiking tours of several days at different locations for a reasonable cost to drug users. The objective is to create a common challenge, to stimulate mutual assistance and to provide psycho-social follow-up around these activities.
Medical social care centre Start-MASS; Liège	The treatment centre organizes sports, cooking sessions or artistic activities with their patients in order to motivate them to other activities than their substance use.

Source: (Free Clinic, 2014;La Trace asbl, 2014;Start-MASS, 2014)

#### 4. Conclusions

Social exclusion can be defined as problems of housing, education, employment and social isolation encountered by drug users. Although this information is often only available for the subgroup of users entering treatment, it provides an overview on socio-economic characteristics of drug users.

The drug using population in treatment has a much higher risk on social exclusion. When looking at the education level and working status situation, the drug using find themselves twice as much in a socially problematic situation in comparison to the general population. Furthermore, a non-negligible proportion of the drug users in treatment are living in an unstable accommodation or on the streets.

as the condition of drug consumption in (a few) socially excluded groups in Belgium are only recently been studied and therefore, the available the information is fragmented. Nevertheless, drug consumption is frequently mentioned among homeless people, sex workers or prisoners.

Among all set up initiatives concerning social reinsertion , housing initiatives are the most common ones. Their objective varies from finding temporary housing solutions in an emergency situation to more long-term accommodation solutions. The newly started "Housing first" project of 2013 aims at finding unconditional accommodation solution for homeless people.

Next, employment initiatives allow people who use drugs to regain access to work through small paid jobs or trainings on specific topics. In addition, there is also a strong interaction

between different types of needs. For example, education may improve access to work and regular employment may also help in finding a stable accommodation.

Finally, specific leisure initiatives targeting drug using people have also been set up to provide opportunities and challenges for (ex-)users to reintegrate a social life.

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### **Acknowledgements**

The author would like to thank Mr Dheendene, Mr Fanelli, Mr Joosen, Mr Nicolas, Mr Ruyters, Mr Van Bouchaute, Mr Vinken and Ms Theizen for the information provided. Their essential involvement is gratefully acknowledged.

## Chapter 9. Drug-related crime, prevention of drug-related crime and prison

*Plettinckx E.*

- *The number of trade-related drug law offences is increasing.*
- *Law enforcement data confirm the popularity of cannabis: in 2013, marijuana remains the most wanted drug.*
- *In 4 years, the proportion of mandates for electronic surveillance declined with over 10% compared to the total number of drug-related mandate assignments at the houses of justice.*
- *The prevalence of drug- or doping-related cases entering the youth prosecution system is twice as high as the cases at the level of the prosecutor of first line court.*

### 1. Introduction

A new national safety plan was implemented in 2012 by the federal Minister of Home Affairs and Justice. This national safety plan prioritises different aspects of the competences of the local and federal police in Belgium. As the Belgian police is one of the most important actors regarding drug-related crime, these priorities are of high importance. For the period 2012-2015, drug dealing, import and export of cocaine, the production and trafficking of synthetic drugs and cannabis and driving under the influence of alcohol and drugs are put forward as leading topics (Turtelboom and Milquet, 2012).

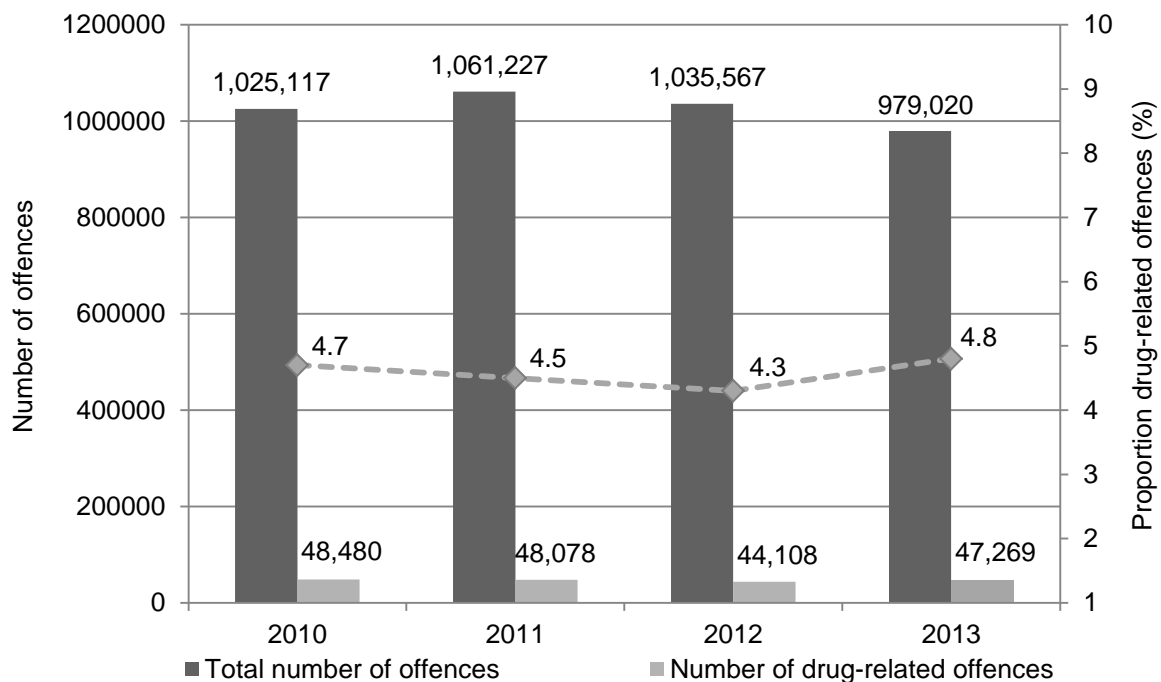
According to these priorities, this chapter provides an overview of the drug-law offences (section 2.1), offences related to driving under the influence of illegal drugs (section 2.2), the prevention of drug-related crime and reoffending (section 3), alternatives to prison (section 4.1) and drug-related cases at (youth) prosecution and court level (section 4.2). The last two sections examine the drug situation in prisons: section 5 covers information on the responses to drug-related health issues in prisons, while section 6 describes the services to improve reintegration of drug users after release from prison.

## 2. Drug-related crime

### 2.1. Drug law offences

The Belgian federal police regularly publishes statistics to support policy makers in identifying priorities. These figures are based on reports of both the local and federal police and describe various crimes (Federale Politie - CGOP / Beleidsgegevens, 2013). Figure 9.1 illustrates the total number of offences in relation to the total number of drug law offences committed during the period 2010 to 2013. Drug use and possession are reported together as one offence since 2010, as individual drug use implies the possession of drugs. Before 2010, use and possession were often separately taken into account, which resulted in an overestimation of the total number of drug law offences. For this reason, numbers are only reported from 2010 on. In 2013, a total of 979,020 criminal offences were registered, of which 47,269 concerned drug law offences (possession (and use), trade, trafficking, or production of drugs). The proportion of drug-related offences raised to 4.8%. This was the first increase of prevalence in four years.

Figure 9.1. Drug law offences in relation to the total number of law offences between 2010 and 2013.

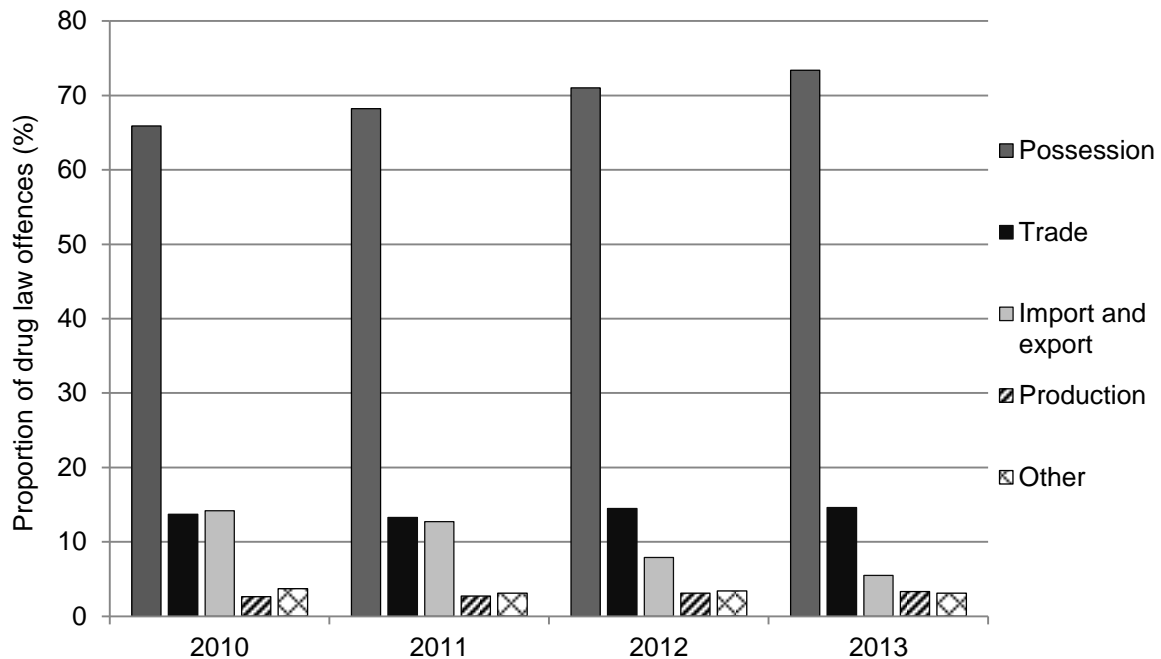


Dotted line indicates the proportion (%) of drug-related offences

Source: CGOP/B (Federale Politie - CGOP / Beleidsgegevens, 2013)

Every year, the Belgian federal police reports about drug law offences by specifying different categories such as use and possession, import and export, trade, production and trafficking of illicit drugs (Federale Politie - CGOP / Beleidsgegevens, 2013). Figure 9.2 describes the evolution between 2010 and 2013 of the drug law offences by category.

Figure 9.2. Proportion of drug law offences by category between 2010 and 2013



Source: CGOP/B (Federal Police - CGOP / policy data, 2014)

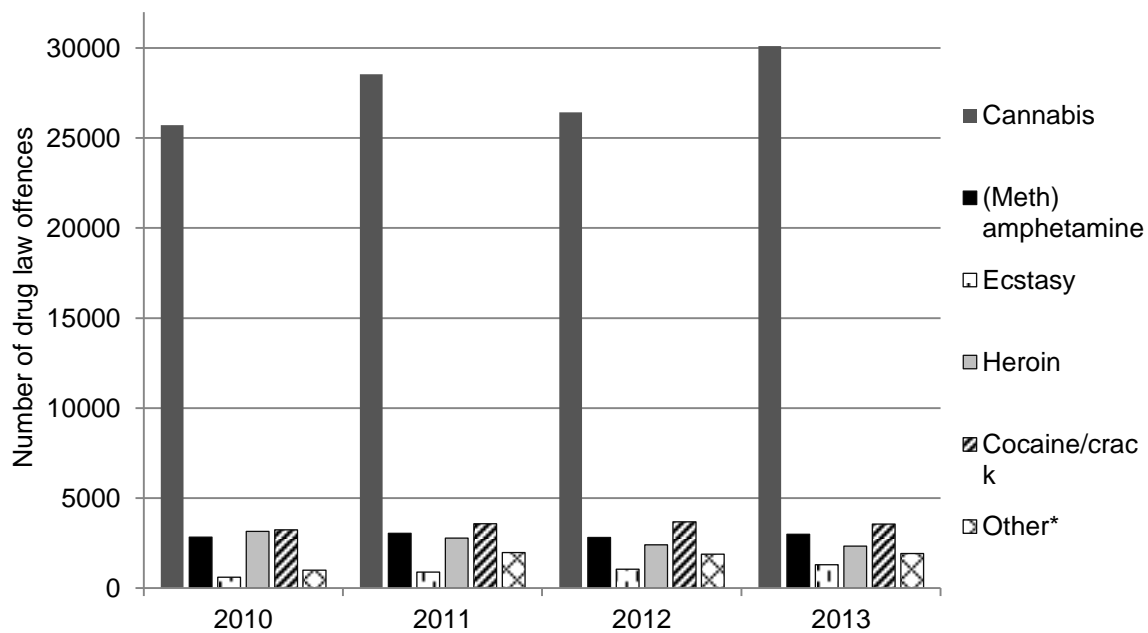
The observed increase of drug-related offences registered in 2013 ( $n=47,269$ ) in comparison with 2012 ( $n=44,108$ ) is mainly determined by the evolution in drug law offences related to the use and possession of drugs. In 2013, the prevalence reached a record of 73.4%. Also the prevalence of production of drugs is increasing and reached 3.3% in 2013. The proportion of drug law offences registered by police forces related to import and export is declining. The registered drug law offences related to trade are stable.

A case study about retail trade (the sale of user amounts) of cannabis, cocaine, amphetamines and ecstasy in Antwerp indicated that dealers are often carrying only very small amounts of drugs with them. They use this precaution as it is known that upon interference, when no evidence for dealing can be demonstrated, the police can only charge for possession of illegal drugs. However, the analysis of police charges and public prosecutor files revealed that dealers carry around more money in one's pockets than the average citizen. The presence of the money presumably refers to the illegal sale activities (Decorte and D'Huyvetter, 2014).

The strategic analysts of the federal police study drug law offences by type of drugs as well (Figure 9.3) and extract data from the national database every two months. Nevertheless, the local and federal police do not always know what kind of illicit drug is involved. As such, some seizures request additional analyses by a laboratory. Although in about 90% of the cases the federal police receives feedback on these results, this sometimes takes several months. For this reason, the total number of drug law offences mentioned in Figure 9.3 is lower than the total number of drug law offences in Figure 9.1 and 9.2.

The federal police reported 71% of these drug law offences to be related to cannabis, 7% to (meth)amphetamine, 3% to ecstasy, 6% to heroin, 8% to cocaine or crack and 5% to other drugs. These data show a slight increase of cannabis-related offences over the years. In 2013, a record number of 30,113 cannabis-related offences was reported. (Meth)amphetamine-related law offences remained stable in the past years. Regarding the same time, the registered ecstasy-related law offences show a slight increase. A similar trend is found for law offences regarding cocaine. Heroin-related law offences are decreasing over the past years. The category 'other drugs' shows a stable trend since three years.

Figure 9. 3. Drug law offences as main offence between 2010 and 2013, by type of drug



\* LSD, benzodiazepine, phenethylamine, codeine, GHB, ketamine, khat, methadone, morphine, opium and mushrooms

Source: Federal police

## 2.2. Other drug-related crime

### 2.2.1. Driving under the influence of drugs

Driving under the influence of drugs increases the risk of severe injury accidents (Hels et al., 2013). The prevalence of psychoactive substances in the traffic in Belgium exceeds the European average of 7.4% (Houwing et al., 2012). Moreover, Belgium is considered as one of the countries with the highest prevalence of injured drivers that test positive for at least one psychoactive substance (Legrand et al., 2013). In this framework, the local police and Federal Highway Police set up control posts to screen drivers for drug use. The first step in this procedure is a visual checklist. In case of positive indications of illicit drug use, an oral fluid screening test is conducted. If this oral fluid test is positive as well, a blood sample is collected for further confirmation through analysis in a laboratory (Ricour, Personal communication, 2011). Most of these blood samples are analysed by the National institute for Criminalistics and Criminology (NICC). Table 9.1 gives a detailed overview of the results of the analyses conducted by the NICC. These results are considered as representative for the analyses performed by other laboratories, as these represent about 87% of the total analyses involved.

Table 9.1 shows that 9% of these samples were related to false positive oral fluid screening tests. Most analyses (74%) indicated only the use of one substance. According to these results, 48% of the drivers was under the influence of cannabis only, 14% used only amphetamine, 10% used only cocaine and 2% used only opiates. Nonetheless, some drivers also combined different substances. In total, cannabis was involved in 61% of the cases, amphetamine in 28%, cocaine in 21% and opiates in 4%. These figures indicate an increasing number of positive tests of driving under the influence of illegal drugs in the past three years. Only the combined use of opiates and cocaine is less observed. Proportionally, there's an increase of the group of persons of drivers under the influence of a combination of amphetamine and cocaine, amphetamine and opiates, and amphetamine, cocaine and cannabis.



Table 9.1. Substances detected in blood samples after a positive oral fluid screening test between 2011 and 2013

Substances detected in blood	Year					
	2011		2012		2013	
	N	%	N	%	N	%
Amphetamine	202	14.6	261	15.2	274	13.8
Amphetamine + cannabis	73	5.3	76	4.4	106	5.3
Amphetamine + cocaine	19	1.4	28	1.6	56	2.8
Amphetamine + opiates	1	0.1	4	0.2	5	0.3
Amphetamine + cannabis + cocaine	7	0.5	11	0.6	14	0.7
Amphetamine + cannabis + opiates	0	0.0	0	0.0	0	0.0
Amphetamine + cocaine + opiates	0	0.0	0	0.0	1	0.1
Amphetamine + cannabis + cocaine + opiates	0	0.0	0	0.0	0	0.0
Cannabis	726	52.5	777	45.2	956	48.2
Cannabis + cocaine	70	5.1	78	4.5	118	6.0
Cannabis + opiates	3	0.2	9	0.5	8	0.4
Cannabis + cocaine + opiates	2	0.1	5	0.3	2	0.1
Cocaine	124	9.0	181	10.5	203	10.2
Opiates	31	2.3	38	2.2	35	1.8
Cocaine + opiates	11	0.8	27	1.6	5	1.3
<b>Total positive tests</b>	<b>1,269</b>	<b>91.7</b>	<b>1,495</b>	<b>87.0</b>	<b>1,803</b>	<b>91.0</b>
Below legal cut-off value	115	8.3	223	13.0	179	9.0
Total blood tests	1,384	100	1,718	100	1,982	100

Source: NICC, Personal communication, 2014

### 3. Prevention of drug-related crime

In order to prevent drug-related crime described earlier in this chapter, it is of crucial importance to obtain further insight into the national and international dynamics of the drug markets. The information of the supply side is currently fragmented among various members of the law enforcement community. Moreover, the displacement of illegal activities is a side effect of successful law enforcement activities. Consequently, law enforcement experiences difficulties to respond to the ever changing drug market. As such, these actors often have insufficient knowledge about the drug markets in order to act proactively. Although information concerning arrests and seizures is available, much more detailed knowledge is needed on 1) the different actors involved, 2) the modus operandi and 3) the locations where these illegal activities take place (Smet et al., 2013).

In this light, the institute of international research on criminal policy (IRCP) of the Ghent University started the SUPMAP project in 2011 to indicate supply indicators (SUPMAP). These supply indicators ought to combine the fragmented information of the law enforcement community. In this way, these indicators would enable proactive acting and prevention of drug law offences (Smet et al., 2013).

Within this research project, attention was given to the classic drug markets, namely heroin, cocaine, amphetamines, ecstasy and cannabis. Next to a profound literature review on drug markets and drug-related crime, additional information was collected through interviews with different members of the law enforcement community and some actors active in the drug trade as well (Smet et al., 2013).

Law enforcement experts confirmed the importance of the police and the customs as a source of information. By combining this data with information from the public prosecutor, toxicological laboratories, hospitals and drug treatment, a better monitoring is enabled of the drug supply in Belgium. Nevertheless, customs and the airport police are currently the only two groups who are using indicators in daily practice (Smet et al., 2013).

The study pointed out that quantitative data (such as number of seizures and arrests, currently collected for policy purposes) are less useful in order to reduce drug-related crime. As a result, both quantitative as well as qualitative (the so-called soft information) data should be involved in order to make the use of drug supply indicators of better interest (Smet et al., 2013).

Obtaining both qualitative and quantitative data in order to act proactively, requires general as well as echelon specific indicators. In Belgium, indicators are available on retail and production level, though sufficient indicators at middle and international drug trade level are lacking. Systematic and efficient prevention of drug-related crime imposes to determine 1) the role of Belgium as a transition country and the connection with The Netherlands, 2) organised crime networks and 3) the role of facilitators (independently and within criminal networks) at different levels. Profound monitoring of this type of information showed to be feasible by slightly adapting an existing registration tool used by police forces. This tool gives the possibility to specify the context of committed crimes and consequently a better insight in the different types of crimes and the functioning of the (European) drug market. The SUPMAP study provided the initial impetus to strengthen the current efforts in preventing drug-related crime. For this, a first priority would be to improve the dataflow between different law enforcement services and laboratories. Subsequently, additional and more detailed information about the organization of drug markets can be collected (Smet et al., 2013).

#### **4. Interventions in the criminal justice system**

##### **4.1. Alternatives to prison**

Alternative sanctions are stimulated among others by the Inter-ministerial Conference Drugs (De Wree et al., 2009; Interministeriële Conferentie Drugs, 2010). Research has indicated that imprisonment does not have a deterrent effect on the commitment of crimes (Freiburger and Iannacchione, 2011; McGrath and Weatherburn, 2012; Nagin et al., 2009). Detention may not only risk the increase of drug use and crime, but can also give cause to negative effects on social, physical and psychic aspects of life (Hardy and Snowden, 2010; Liebling and Arnold, 2012; Nieuwbeerta et al., 2009; Schnittker and John, 2007). The positive effects of alternative sanctions on crime reduction and several life domains has been demonstrated (Cid, 2009; De Wree et al., 2008; De Wree et al., 2009; Spohn, 2007). As a result, alternative sanctions present a more adequate answer to offences than imprisonment (Cid, 2009; De Wree et al., 2008), including the advantage to fine-tune measures to the individual situation and needs of each offender (De Wree et al., 2008; De Wree et al., 2009). Research promotes alternatives to prison especially for drug users if drug treatment is part of the alternative sanction (Lurigio, 2000; Vormea et al., 2013).

Judicial alternatives are applicable in various stages of the criminal justice system and include conditions which have to be met by the offenders. These conditions may, among others, be related to drug treatment (Defillet, 2012). As a large number of homeless, low educated and unemployed people are involved in drug-related crime, the criminal justice system may also broaden their scope and insist on conditions related to work, housing or education (whether or not in combination with drug treatment) (De Ruyver et al., 2008).

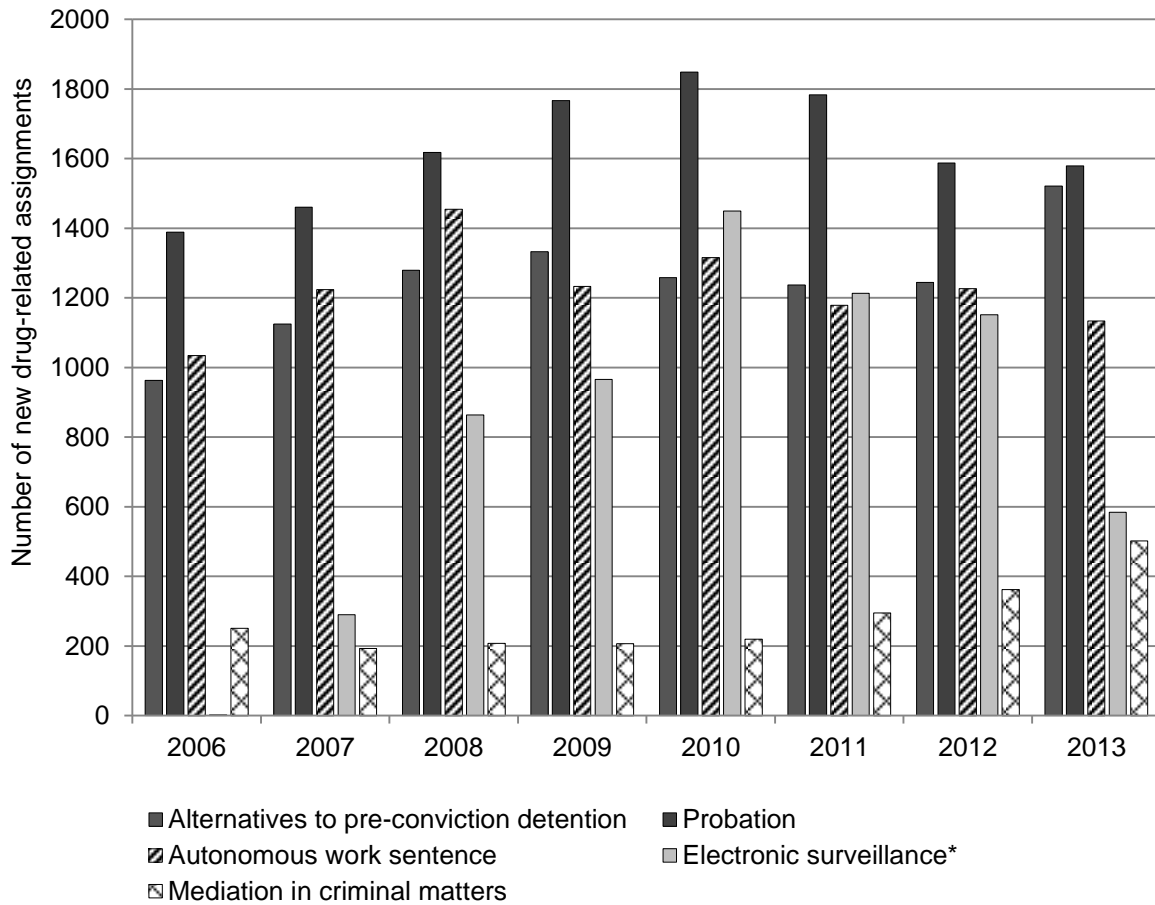
The prosecutor or judge has the possibility to propose (at prosecution level) or impose (at court level) an alternative measure in certain circumstances (e.g. adult offender, maximum sentence of 5 years, ...). In this case, since 1999, the offender will be referred to a justice assistant who is responsible for the supervision and guidance of these alternative measures and works in one of the 28 houses of justice in Belgium.

All guided mandates of the alternative measures are recorded in a general database 'SIPAR' (Système Informatique PARajudiciaire) within the Directorate-General for Houses of Justice (Bursens, 2012). This registration is mandatory since 2005. In 2012, the data analysis and quality service of the Directorate-General for Houses of Justice extracted for the first time all mandates related to drug offences from the SIPAR database.

The analysis of new drug-related mandates between 2006 and 2013 show that most of the clients of justice houses who receives an alternative sanction have the Belgian nationality (77%). The majority of all clients is male and between 18 and 34 years old.

Figure 9.4 illustrates the number of new assignments related to drug offences at the houses of justice between 2006 and 2013. A decrease of the total alternative measures is noticed since 2010, based on the number of new assignments concerning alternatives to pre-conviction detention, probation, autonomous work sentence, electronic surveillance and mediation in criminal matters. Alternatives to pre-conviction detention and mediation in criminal matters are the only alternative measures which deviate from this pattern: a slight increase of the number of new assignments related to drug offences for these two alternatives can be observed. Mediation in criminal matters, however, includes the smallest number of new mandates over the last years. The purpose of mediation in criminal matters is to facilitate the communication between the victim and the offender in order to repair the material or emotional harm of the offence. As such, both parties have to agree on this alternative measure before mediation in criminal matters can start. Moreover, active collaboration of both parties is required (FPS Justitie, 2014). Probation, although declining, remains the alternative measure with the highest number of new mandates each year. Probation has a long history in the Belgian criminal justice system and can be imposed since 1964 (B.S./M.B. 17.07.1964).

Figure 9.4. Number of new assignments at the houses of justice for drug-related crimes between 2006 and 2013



\* Although a national centre for electronic surveillance was implemented in 2000, electronic surveillance got only a legal basis in 2006 and is only legally entrusted to the houses of justice since 2007 (Bursens, 2012; Devos, A., 2009; Vanhaelemeesch, 2012). This explains why the registered mandates do not exist or are very scarce for 2006

Source: DG MJH service - Data Analysis and quality 12 June 2014

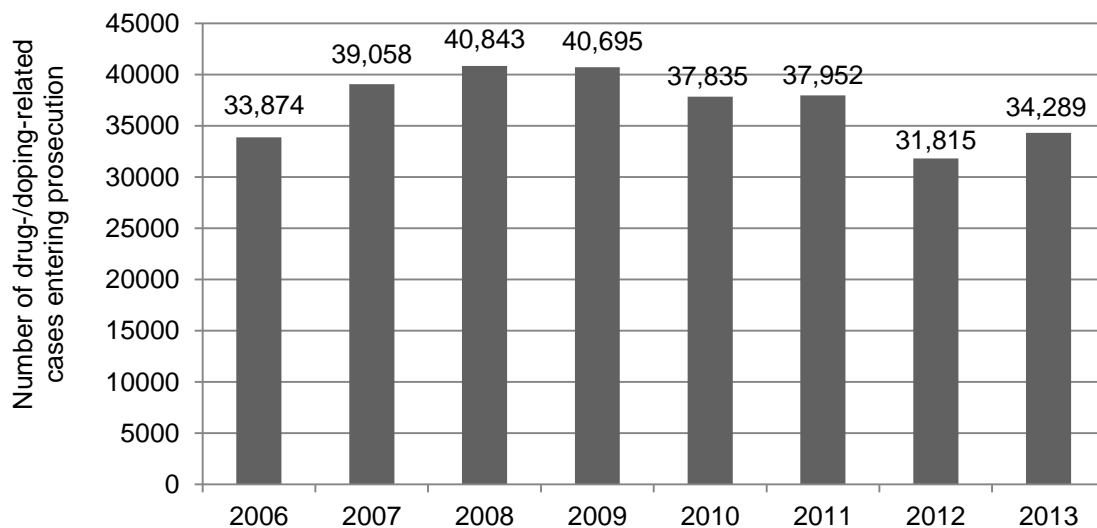
An Important pilot project on this topic is the Drug Treatment Court (DTC) Ghent (also described in chapter 1 of this report). It is an additional alternative to prison which was implemented in the judicial district Ghent in 2008. The DTC Ghent is specifically targeted at persons who committed crimes because of their drug use in order to redirect them to treatment. Drug using offenders are supported and supervised intensively by a judge, prosecutor and liaison. The past years, this pilot project was subject of different evaluation studies which proved the added value of a DTC as implemented in Ghent (Colman et al., 2011; De Keulenaer, S. and Thomaes, S., 2013; Vander Laenen et al., 2013). As described in chapter 1, DTC meets the deficits of probation and enables to focus more on the ‘person with a drug issue’ rather than to focus only on the ‘offender’. By focusing on different life domains, this individual approach creates the possibility to work towards reintegration. Moreover, an evaluation was performed by the service criminal policy of Federal Public

Service Justice and indicated that persons who followed the DTC trajectory conducted less recidivism during the first 18 months after the trajectory in comparison to persons who answered to the classic judgement or probation. Nevertheless, recidivistic persons that followed the DTC trajectory, committed more frequently recidivism in comparison with probation clients. However in general, compared to probation, less drug-related offences are committed by persons who followed the DTC trajectory. Also, as the sample size was relatively small in this evaluation study, it is preliminary conclusion that persons who followed the DTC trajectory shows the largest progress. The analyses pointed out that persons who followed the DTC trajectory, covers the largest group of respondents that do not longer commit any crime after the judicial intervention (De Keulenaer, S. and Thomaes, S., 2013).

#### 4.2. Other interventions in the criminal justice system

Approximately 34,000 drug- or doping-related cases entered the prosecution system of first line courts in Belgium during 2013. This represents almost 5% of all cases entering prosecution. Figure 9.5 illustrates the numbers about drug- or doping-related cases entering the prosecution level of the last 8 years and indicates a fluctuating trend in the drug- or doping-related cases. An increase of the prevalence was found until 2008, after which a declining trend is observed, with exception of a slight increase in 2013.

Figure 9.5. Drug/doping related cases entering the prosecution system of first line court between 2006-2013

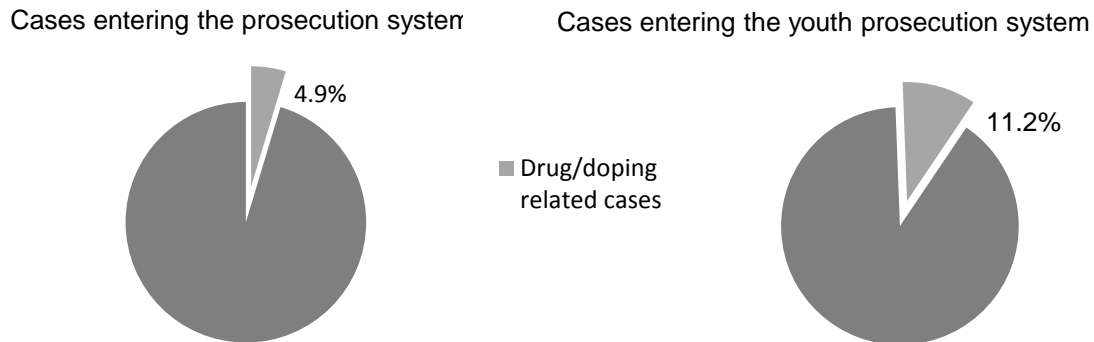


\* both new and reopened cases

Source: Chamber of the Prosecutor General (College van procureurs-generaal, 2013)

The prevalence of drug- or doping-related cases entering the youth prosecution system is twice as higher than at the level of the prosecutor of first line court in 2013 (see Figure 9.6). 11% of all cases entering the youth prosecution were related to drugs or doping. This is the highest prevalence reported in the last eight years.

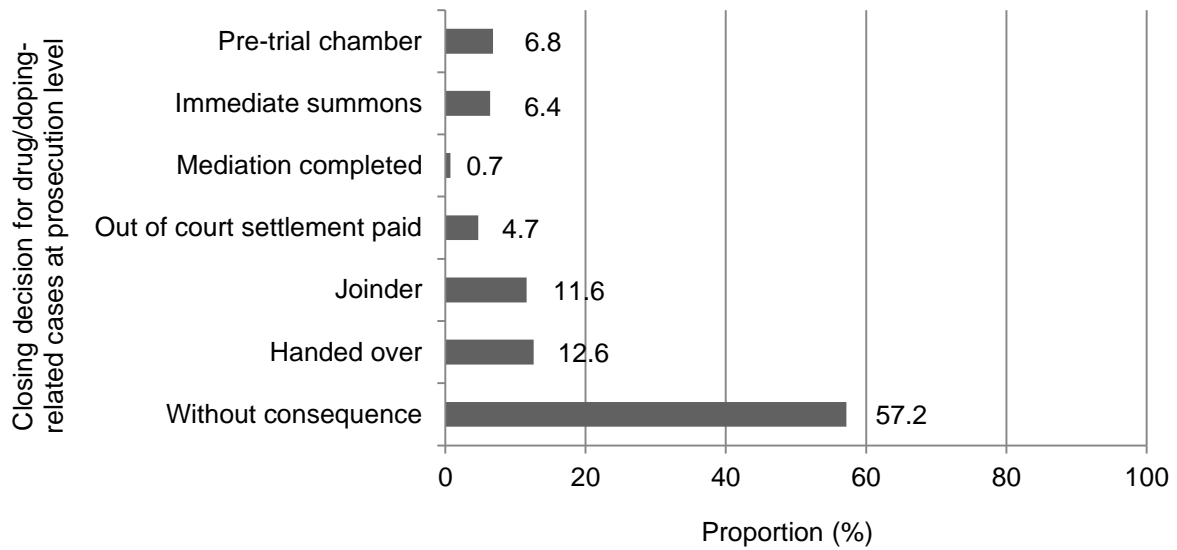
Figure 9.6. Drug/doping related cases entering the youth prosecution system in 2013



Source: chamber of the prosecutor general (College van procureurs-generaal, 2013)

Figure 9.7. illustrates the closing decisions for drug- and doping-related cases at prosecution level (youth prosecution is not included). The greater part of the cases at the prosecution system of first line court (57%) were still closed without consequences in 2013, while 13% of the cases were handed over. Joined drug- or doping-related cases are less common. The prosecutor redirected 7% of the drug- or doping-related cases to a pre-trial chamber. 6% of the cases were summoned immediately. An out of court settlement was paid in 5% of the cases and a mediation was only completed in 1% of the cases. These two last closing decisions turn out to be more often completed successfully in the recent years. The immediate summons seem to slightly increase over the years.

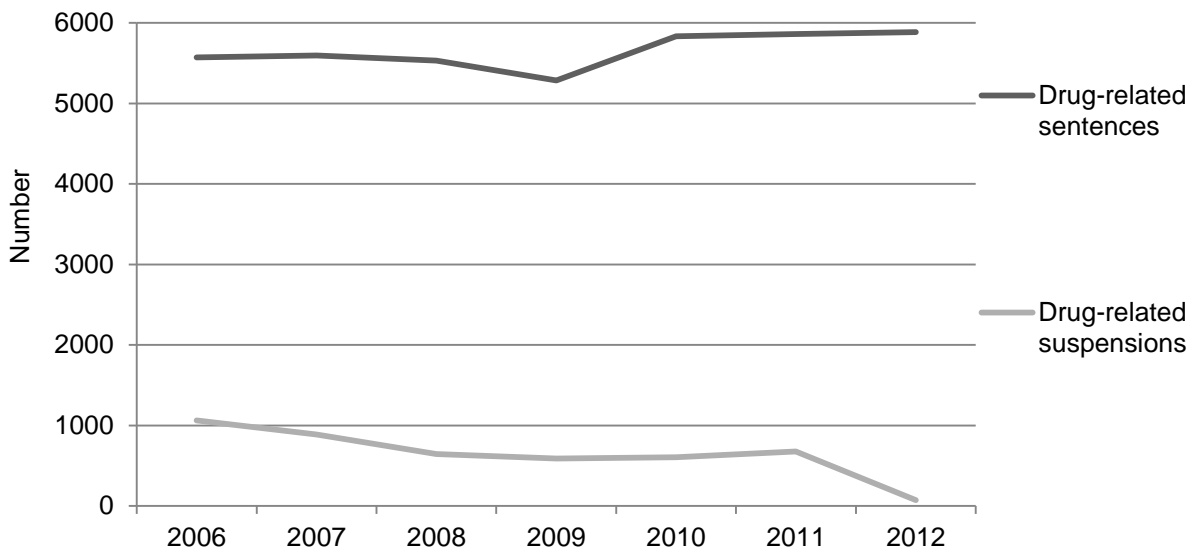
Figure 9.7. Number of closing decisions for drug/doping-related cases at prosecution level of first line court in 2013



Source: Chamber of the Prosecutor General (College van procureurs-generaal, 2013)

The Service for Criminal Policy collects the information about the final judgements in all Belgian courts. The established database was updated in 2014 and was published online (Dienst voor strafrechtelijk beleid, 2013). Due to a delay of the registry of the 'judgement extractions' from the courts to the central criminal registry, the most recent data available are those from 2012. Figure 9.8 describes the evolution of sentences and suspensions for narcotic drugs, sleeping pills and psychotropic substances judged in Belgium in the years 2006 until 2012.

Figure 9.8. Sentences and suspensions for narcotic drugs, sleeping pills and psychotropic substances between 2006 and 2012



Source: Service for Criminal Policy: sentences and suspensions (Dienst voor strafrechtelijk beleid, 2013)



Based on the central criminal registry, drug-related sentences have increased slightly from 2006 to 2012. Nevertheless, a dip of 5,284 drug-related sentences is noticeable in 2009. Drug-related suspensions, on the contrary, have decreased over the last seven years. This trend is confirmed when looking at the drug-related suspensions and drug-related sentences in relation to the total suspensions and sentences.

## **5. Responses to drug-related health issues in prisons**

In Belgium, prison health care is a competence of the Minister of Justice. In Belgian prisons, there is a clear division between providing health care to prisoners (health perspective), which is the responsibility of the central service for health care, and providing medical and psychosocial advice as part of security measures and probation (security perspective), which in its turn is the responsibility of the psychosocial service.

In each Belgian prison a single service for health care is installed for executing the health policy as formulated by the central service for health care in prisons. Providers of care are bound by professional secrecy. A minority of the staff members in prisons are medically or paramedically trained. Therefore, the provision of treatment by this physician in the prison setting is only possible on reasonable grounds and upon agreement by the head of the prison health care service.

Within the Belgian prison system only basic medical services exist. However, transferring a prisoner to a specialised prison (e.g. with a section functioning as outpatients' clinic performing hospital assignments to a limited extent), hospital or health care institution is possible. Special care for detainees using illicit drugs is consequently limited. Nevertheless, the objective is to adjust the drug policy in prison as much as possible to the drug policy outside prison, as services and treatment for drug users may prevent re-offending. This implies that attention ought to be given to the four pillars of the drug policy (prevention, reduction of harm, treatment and enforcement) in prisons as well. To this end, two regional coordinators were assigned.

Services for drug users are delivered both by experts that are part of the prison health teams and by external providers. Cooperation with external drug service providers exists with intention to work towards community drug treatment upon release. Prison health teams are also supported by experts who are specialised in a specific drug-related field, such as physicians that function as a reference for the opiate substitution treatment. Unfortunately, due to the economic crisis and the associated savings, the capacity of the (drug-related) treatment services in prisons has been decreasing over the past years.

## 5.1. Drug treatment

Drug treatment is gradually put into practice in Belgian prisons. Different drug-related health services, such as cognitive-behavioural interventions, opiate substitution therapy (OST), therapeutic communities (TC) and drug-free programmes are available.

### 5.1.1. Cognitive behavioural interventions

In 2012, a first 'short duration drug programme' of six weeks was installed in the prison of Bruges. This programme was developed on the occasion of the experience of the British prison system with cognitive behavioural therapy for drug using offenders. This drug programme of short duration is based on the trans theoretical model of change of Prochaska and DiClemente (Prochaska and DiClemente, 1984). An existing manual is used as reference in order to develop a prison-oriented, standardised manual, based on practical experience.

### 5.1.2. Opiate substitution therapy

Methadone and buprenorphine are used for opiate substitution therapy in Belgian prisons. In august 2012, almost 4% of the total Belgian prison population received OST. Methadone is used for 74% of those treated with OST and buprenorphine is prescribed in the other 26% of the cases (FPS Justitie, 2014). Detoxification as well as maintenance programmes are available in prison in order to enhance the social and personal functioning of the clients. A technical protocol as a strict procedure on OST is used as a quality assurance of service. In prisons for remand prisoners, addiction specialists are assigned as a reference.

The pressure from the prisoner's environment is experienced as an obstacle for detoxification, as well as the lack of health care staff and former prosecution of prison physicians in cases of overdose where methadone was involved.

### 5.1.3. Therapeutic communities

Within the pre-therapeutic drugs programme ('B.Leave') of the prison of Ruiselede, efforts are made towards a TC-oriented approach. The prison of Ruiselede has an open regime excluded from many security provisions, providing an intense programme oriented towards reintegration and education. Detainees are compelled to work and to live as a community.

#### 5.1.4. Drug-free Programmes

Only two Belgian prisons, namely the prison of Ruiselede and Bruges, are offering a drug-free programme to their detainees.

In the open prison of Ruiselede, the use of medication to treat mental illness, alcohol and illegal drugs are not allowed.

In this perspective, a high intensity, cognitive behavioural programme of eight months (from the beginning of October to the end of May) is offered to 16 prisoners for whom drug addiction has led to their offending. Due to financial reasons, the capacity of this programme was forced to decrease from more or less 50 prisoners to 16 in 2012. This pre-therapeutic drugs programme, called 'B.Leave' (also mentioned in section 5.1.3.), was implemented in 1995 with objective to cram drug using prisoners for a drug-free life through education, therapy and sport. Prisoners have to take a drug test before they can participate to the programme. By means of therapy, they learn to develop personal, social and life skills through a strict day structure of work and leisure activities. Once the programme is finished, the continuation of care is provided by offering a follow-up of relapse prevention and social skill training. Finally, also the release of these prisoners is assisted in Ruiselede.

In 2009 a new drug-free wing was set up in the Bruges prison which in time proved to be successful. One drug-free section was initially available for a maximum of 20 prisoners. Despite the economic crisis, the capacity of this drug-free wing increased to 44 prisoners. Standardised procedures for screening, intake of prisoners and voluntary drug testing (a condition for admission) were developed as well as clearly defined in- and exclusion criteria. Prisoners within this programme are living together, but are separated from the other prisoners. Next to relapse therapy, the service aims at the development of prisoner's social, personal and other life skills in order to increase personal functioning. Similar as the programme in Ruiselede, the daily structure with obliged working and leisure activities is of great importance.

#### 5.2. Prevention and reduction of drug-related harm

To prevent and reduce drug-related harm in prisons several initiatives were implemented the past years. This paragraph describes the medical consultation and information available for prisoners who are using drugs.

### 5.2.1. Medical consultation, screening and assessment of drug use upon entry into custody

The law of principals of 2005 (B.S./M.B. 01.02.2005) and the Royal Decree of 8 April 2011 (B.S./M.B. 21.04.2011) foresees a medical consultation within 24 hours upon entry into custody. As standard procedure, a medical intake is executed with attention for drug use and psychopathological disorders.

Prison staff is informed on risk behaviour, drug use, drug policy, effects of different drugs and drug users' behaviour by offering training.

### 5.2.2. Drug prevention and harm reduction information

Flyers, brochures, and posters to inform prisoners on the effect of different drugs, are available in every prison.

A booklet on drug-related health problems and risk behaviour in prison is made by and for prisoners, in collaboration with Modus Vivendi and is financed by the Federal Public Service (FPS) Justice. This booklet is available in the French prisons since 2009, and since 2011 in the Flemish prisons. In 2011, a new information campaign oriented on hepatitis C has been launched in Belgian prisons.

Peer support projects are installed in French speaking prisons. Snowball operations (see chapter 3 for more details) and prisoners' health contact ('Détenus contact santé') are two projects with aim to train prisoners on health-related topics. Prisoners can contact these people to receive more detailed information if wanted. This will help prisoners on being informed about drug-related health risks, such as sharing needles and communicable diseases.

## 5.3. Prevention, treatment and care of infectious diseases

In order to prevent the spread of infectious diseases among prisoners treatment is provided in the Belgian prisons.

### 5.3.1. Diagnosis and treatment of drug-related infectious diseases

In Belgian prisons, treatment is possible upon the diagnosis of HIV, hepatitis B and C,. Antiretroviral treatment is offered for HIV and interferon therapy for hepatitis B and C. Moreover, a cooperation exists with Aids resource centres.

#### 5.4. Prevention of overdose-risk

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

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

#### 6.1. Social services for drug users in prison

The Belgian regional governments encourage organizations and services that support prisoners in the development of skills in different life domains. The appointed staff is not employed by the prison authorities, but is represented by the social services of the community. The Flemish Government has implemented a strategic plan for providing services including vocational training, education and cultural activities in every prison. The government of the French Community supports several prison projects according to local needs.

In general, these services are not oriented specifically towards drug users. Nevertheless, as these services focus on general life domains such as education, employment, housing and social-cultural skills, they also have an impact on drug use. As a matter of fact, a balanced lifestyle might help people to avoid drug use or relapse. Specific programmes for drug users to strengthen the different life are rare. Although in some prisons, such kind of services exist, but the type of service and service provider show a great variety. An example of such a service is the option of therapeutic group sessions for drug using detainees in the prison of Hoogstraten. Also in the prison of Verviers, prisoners can receive not only training, but also the opportunity to attend sociocultural and sport activities.

#### 6.2. Central intake units

A Central Intake Unit (CIU), intended for drug using prisoners within the prospect of their release, was installed in 2011 in every prison to facilitate a referral to treatment in the community.

These units are run by external social drug workers. Prisons are pragmatically divided into several (geographical) clusters in order to link each drug worker to one prison cluster. Based on an assessment of the prisoner's need, the social drug worker defines a proper treatment programme. The social drug worker arranges the contact with external drug treatment

organizations, and a referral to health care and treatment services outside the prison is realised after release.

Since prison health care and drug policy is a competence of the FPS Justice, the CIU is financed by this authority. Nonetheless, the drug workers of the CIU are working from a health care perspective and do not formulate advice concerning risk taxation or recidivism.

The advantage of such a team lies within the preparation of an efficient referral to specialised treatment and services by one specialised person. Moreover, in this way, a fixed team of external drug workers are in contact with different drug treatment providers in the region.

## **7. Conclusion**

Based on the analysis of law enforcement, the vast majority of drug law offences is related to the demand side. Drug law offences related to possession reached a record in 2013. The prevalence of production and trade is increasing over the years as well. This may be a result of law enforcement forces setting priorities. Since 2012, drug dealing, smuggling of cocaine, driving under the influence of drugs as well as the production and traffic of synthetic drugs and cannabis are prioritised in the national safety plan of 2012-2015. The observed firm action of police forces and customs are a possible reason why drug dealers often only carry a very small amount of drugs. Without exact evidence of the act of dealing, the police can only charge for possession of illegal drugs. This might explain the record charges for possession of drugs. Caution is needed as well when interpreting the increasing number of positive tests of driving under the influence of illegal drugs. As this is a set priority for the law enforcement authorities, it is possible that more resources were reserved to tackle this phenomenon. Therefore, it cannot be concluded that more people are driving under the influence of illegal drugs in comparison with the past years. Nevertheless, the increased prevalence of amphetamine use in combination with cocaine, cannabis or opiates suggests a real increase in the involvement of these substances while driving.

This chapter shows amongst others that the situation of the middle and international drug trade level has been quite unparalleled. A better understanding of the national and international dynamics of the Belgian drug market is needed to allow the prevention of drug-related crime by law enforcement. In this light, the research project SUPMAP identified several supply indicators, to combine existing qualitative and quantitative information from different sources. The triangulation of contextual information - not only about the supply side, but also about the demand side - is shown to be one of the key elements to act proactively and to assess fast changes in the drug market. Improved detailed qualitative data and amending the dataflow between services should stimulate actors in using this kind of

indicators. This profound monitoring of the Belgian drug market is bound to increase the strength of drug supply reduction.

The observed firm actions of police forces and customs towards drug-related offences are also noticed in the criminal justice system. More drug-related sentences are reported at court level. Moreover, the drug-related suspensions are slightly decreasing. Although alternative sanctions are a more adequate answer to offences than imprisonment, the number of probations, alternative work sentences and electronic surveillance at the houses of justice are declining as well. Despite the fact that prisons are confronted with overpopulation, more and more drug-related detentions are registered in recent years. Research revealed that the type of judicial settlement has a significant effect on whether or not to reoffend. Detention may risk the increase of drug use and crime. Additionally, detention may cause negative effects on social, physical and psychic aspects of life. Nevertheless, health care (specialised drug treatment in particular) is limited in prison. Moreover, the capacity of (drug-related) treatment services in prisons decreased over the past years due to the economic crisis and the associated savings. Although this is a general objective, prisoners are not provided with the same health care service as they would have in society. As a reaction to this evolution, professionals advocate the transfer of the competence of healthcare in prisons to the Minister of Public Health. In conclusion, further progress of these challenges in the prevention or reduction of drug-related crime will rely on heavy investment in evidence-based policy.

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## Chapter 10. Drug markets

*Blanckaert P.*

- *Record amounts of seized labs and precursors in 2013 confirmed the role of Belgium as a producing country for synthetic drugs such as MDMA and amphetamine.*
- *MDMA content in ecstasy tablets reached an all-time high level in 2013, pointing towards a fully recovered MDMA market.*
- *For the first time ever, considerable amounts of methamphetamine have been seized.*
- *Pre-precursors continue to play a growing role in the synthesis of amphetamines.*

### 1. Introduction

This chapter provides an overview of the drug market in Belgium. Information about the origin of illegal drugs (section 2.1), drug trafficking (section 2.2) and drug seizures made by federal police services (section 3), as well as drug price data (section 4.1) and data regarding drug purity (section 4.2) in Belgium is discussed. The used contaminants and cutting agents are also briefly covered in section 4.3.

### 2. Supply to and within the country

Information regarding drugs origin and trafficking is provided by the Drug Programme of the General Directorate of the Judicial Police, Direction of Crime against Persons (DGJ-DJP).

#### 2.1. Drugs origin: national production versus imported

For cannabis, most seizures in Belgium originated from The Netherlands or Belgium itself. Cannabis resin is an exception, for which Morocco remained the most frequent country of origin (Ovaere, personal communication). Additionally, three tonnes of cannabis resin coming from Pakistan were seized in 2013. Nevertheless, several tonnes of herbal cannabis were imported from Ghana, Honduras and Senegal (see also 3.1).

Heroin and cocaine are not produced in Belgium and hence always imported (Ovaere, personal communication, 2014). In 2013, heroin was largely imported from Turkey. In addition, heroin seizures were also imported from Africa and Pakistan. The predominant countries of origin for cocaine remain Colombia, Peru and Bolivia. Cocaine is also imported from other Latin American countries such as Chili, Panama, Costa Rica, Mexico and Venezuela. A new tendency is the import of cocaine from Brazil. In 2013, a very small amount of cocaine was also imported from Africa (Ovaere, personal communication).



Belgium and The Netherlands are well-known for their production capacity of amphetamine and ecstasy. In 2013, the largest synthetic drug lab ever was discovered and seized in Belgium (see also 3.3). The predominant country of origin for most seized NPS remains China.

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

The drug market is a complex phenomenon (Decorte and D'Huyvetter, 2013; Smet et al., 2013). Besides being a country of destination, Belgium is also a transit country for most illicit substances.

As a result of increased pressure on cannabis cultivation in The Netherlands, the majority of the Belgian cannabis production is destined for export to the Dutch drug market, where it is sold in “coffee shops”. The motivation to grow cannabis can be either for personal consumption or profit. The materials used for the cultivation are often purchased in Dutch grow shops, although also more Belgian grow shops have started to appear (Decorte and Paoli, 2014). During the growth process, several strategies are used to maximise profit. For example, avoiding electricity costs by illicit manipulation of the electricity meter is a common practice (Decorte and Paoli, 2014; Vanhove et al., 2014). Also, in order to minimise conviction, false identity cards are used to rent locations suited for cultivation. These and other factors contributing to the damage caused by domestic cannabis plantations have been investigated in the CANMARKT study. In addition, this research reported other additional harms related to the cultivation of cannabis, including theft of plants, harvest or equipment and the destruction of plants. Threats and the actual use of violence have also been documented. The results also show that growers were mainly motivated by the pleasure of the growth process itself and growing cannabis for personal consumption rather than profit-oriented. The majority of growers worked alone (66.3% of respondents) or collaborated with one partner (21.4%). However, since this research was survey-based, it is assumed that criminal growers did not participate in this investigation (Decorte and Paoli, 2014).

Also, in this context, cannabis social clubs are operating in Belgium. Currently, five clubs are known with a total membership of 450 persons. These clubs grow cannabis for the personal consumption of their members, without any intention of selling cannabis products to non-members. Members are carefully selected as the clubs have strict criteria for enrolment. These include, among others, a minimum age (18 or 21 years), residence in a certain area, absence of a criminal record and absence of drug abuse problems. In addition, members also have to take part in an intake interview. These clubs operate on the premise of collectively growing one plant per member. As the possession of one female cannabis plant

currently has the lowest priority for prosecution, cannabis social clubs try to evade legal issues. A statement of ownership signed by a member, with a copy of his/her identity card, is attached to each individual plant. Crops are usually harvested every 2 to 3 months. The cannabis is distributed among the club's members after every harvest by paying a fixed amount per gram. As such, there is no constant availability of cannabis. Also, there are imposed limits to the amounts each member can buy (Decorte, 2014).

Belgium also remains a transit country for cocaine traffic from South- or Central-America to Europe. The main routes of entry in Belgium are the port of Antwerp and the Brussels airport (Zaventem, for mostly only smaller quantities). Cocaine is also still imported through passengers of international flights originating from the Dominican Republic, Jamaica, Suriname or the Dutch Antilles. The cocaine is mostly destined for export to The Netherlands. The share that is destined for Belgian consumption is first exported to the Netherlands. Only after Dutch organizations have cut and split the drugs, the cocaine is imported again for the Belgian drug market.

Heroin is imported by road (Turkish origin), air (East and South African origin) and maritime traffic (mainly from Mozambique and Pakistan) (Ovaere, personal communication).

Similar to the cannabis and cocaine market, Dutch citizens probably play a prominent role in the Belgian production and distribution of synthetic drugs. Synthetic drug laboratories in the Belgian-Dutch border region involve international organised criminal networks (Smet et al., 2013). In addition, most NPS imported in Belgium are destined for further transport to countries including Germany, France, Spain and the UK.

Over the last few years, the Belgian retail drug market has changed as well. According to the results of a case study in Antwerp on retail trade of cannabis, cocaine, amphetamine and ecstasy, the drug market became less visible the past years. Analyses of police charges and public prosecutor files conducted by researchers of the Institute of Social Drug research (ISD) show that different channels are used for drug dealing. Besides dealing on the street, dealers prefer to sell their drugs in private houses, bars, (rented) cars and through the internet. Consequently, these transactions attract less public attention (Decorte and D'Huyvetter, 2014). Reducing the number of visible transactions can be considered as risk management (Smet et al., 2013). Face-to-face interviews with drug users, drug dealers and experts professionally working in the drug domain reveal that the retail market of cannabis is largely separated from the retail market of cocaine and heroin on the one hand and the market of ecstasy and amphetamine on the other hand (Decorte and D'Huyvetter, 2014). Nevertheless, some retail dealers are also involved in polydrug trade (Decorte and D'Huyvetter, 2014). This is especially the case for dealers of synthetic drugs. The retail

market of synthetic drugs is very open and informal. The wholesale market of these drugs, on the contrary, is less accessible. Consequently, more knowledge concerning these wholesale and middle market echelons is needed in order to optimize the monitoring of drug supply in Belgium (Smet et al., 2013).

### **3. Seizures**

Information regarding drug seizures and seized illicit drug laboratories is provided by the Drug Programme of the General Directorate of the Judicial Police, Direction of Crime against Persons (DGJ-DJP). These data are extracted from the General National Database (GND), which gathers all police reports in Belgium, both at the local and at the federal level. In Belgium, federal police services collect data on drug prices for both the Flemish and the French Community.

#### **3.1. Quantities and numbers of seizures of illicit drugs**

An increase of around 10% was seen in the total number of drug seizures in Belgium in 2013 (38,069 total seizures in 2012 versus 41,824 seizures in 2013) (Table 10.1).

Large increases were observed in the number of both cannabis resin and herbal cannabis seizures. In 2012 a total of 27,004 seizures were made, in comparison to 30,641 in 2013. As a consequence, an increase of 13% cannabis-related seizures was observed. In total, 73.2% of all seizures made in 2013 were related to cannabis, with cocaine being the second primary seized drug (8.7% of all seizures). The proportion of amphetamine and heroin seizures was 7.1% and 5.8% respectively. The numbers of seizures of synthetic drugs in general also increased compared to 2012. The increase in the number of ecstasy-related seizures over the years (21% in comparison with 2012) demonstrates the recovery of the ecstasy market.

Table 10.1. Number of drug seizures by substance between 2007 and 2013

	Year													
	2007		2008		2009		2010		2011		2012		2013	
Drug type	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Cannabis														
Total	25,532	69.6	22,418	69.7	29,212	71.8	27,512	71.2	29,847	72.0	27,004	70.9	30,641	73.2
Resin	5,870	16.0	4,921	15.3	6,206	15.3	5,048	13.1	5,622	13.6	4,818	12.6	5,529	13.2
Herbal	19,196	52.4	16,831	52.3	22,274	54.8	21,485	55.6	23,155	55.9	21,075	55.3	23,900	57.14
Plants	4,660	1.3	666	2.1	732	1.8	979	2.5	1,070	2.6	1,111	2.9	1,212	2.89
Heroin	2,850	7.8	2,307	7.2	3,054	7.5	3,433	8.9	2,930	7.1	2,507	6.6	2,431	5.8
Cocaine	3,656	10.0	3,345	10.4	4,021	9.9	3,448	8.9	3,777	9.1	3,859	10.1	3,653	8.7
Amphetamine	2,767	7.6	2,646	8.2	2,944	7.2	2,912	7.65	3,079	7.4	2,830	7.4	2,978	7.1
Methamphetamine	.	.	.	.	.	.	64	0.2	99	0.24	102	0.26	107	0.25
Ecstasy-type	1,798	4.9	1,412	4.4	921	2.3	650	1.7	919	2.2	1,098	2.9	1,338	3.2
LSD	1	0.0	.	.	.	.	59	0.2	85	0.2	49	0.12	76	0.2
GHB*	.	.	.	.	473	1.2	503	1.3	605	1.4	550	1.4	546	1.3
Khat*	.	.	.	.	49	0.1	51	0.1	87	0.2	70	0.18	54	0.13
<b>Total</b>	<b>36,604</b>	<b>100</b>	<b>32,128</b>	<b>100</b>	<b>40,674</b>	<b>100</b>	<b>38,632</b>	<b>100</b>	<b>41,428</b>	<b>100</b>	<b>38,069</b>	<b>100</b>	<b>41,824</b>	<b>100</b>

\*GHB and Khat are only monitored by BMCDDA since 2009

Source: Federal police

In parallel with the number of seizures, the quantity of seized cannabis has drastically increased (Table 10.2). In 2012, 1,338 kg of cannabis resin were seized; this number changed to 4,274 in 2013 and presents an increase of over 300%. This phenomenon can be explained by one exceptionally large seizure from Pakistani origin (3,020 kg), made in February 2013 by the customs services in the port of Antwerp (Ovaere, personal communication). Likewise, for herbal cannabis, 14,882 kg was seized in 2013, compared to only 5,635 kg in 2012 (or a 250% increase). Especially three large shipments contributed to the total amount of seized herbal cannabis. In November 2013, 7,600 kg of herbal cannabis was seized in the port of Antwerp in a shipment of coconuts originating from Senegal. A few days later, another 4,178 kg of cannabis were seized, this time coming from Ghana. Another container coming from Honduras was seized earlier in the year, containing a smaller amount of 1,781 kg of herbal cannabis (Ovaere, personal communication).

For cocaine, the seized amount in 2013 was drastically lower compared to 2012. This has to be put in perspective, since one very large seizure was responsible for the large quantity of seized cocaine in 2012. As such, the total quantity of seized cocaine is comparable to the years previous of 2012. In 2013, the largest cocaine seizure was 353 kg, coming from Chili (Ovaere, personal communication).

A drastic increase in the quantity of seized heroin was observed in 2013: 1,182 kg of heroin were seized; an increase with over 1,000% compared to the previous year. This rise is due to one very large seizure of 865 kg coming from Mozambique and destined for The Netherlands (Ovaere, personal communication).

A worrying observation is the tenfold increase in seized quantities of methamphetamine. For years, methamphetamine has been practically absent from the Belgian drug market. However, these last numbers indicate a gain in availability. It is currently unclear whether this synthesized methamphetamine was destined for consumption on the Belgian market or for export. The amount of seized amphetamine has more than tripled (54kg in 2012 versus 178kg in 2013). Also, a 38% increase was observed in the number of seized ecstasy tablets. These developments are a logical consequence of the drastic increase in the number of seized synthetic drug production laboratories (Table 10.4). Comparable to other European countries, the presence of LSD in Belgium remains anecdotal, at least judging by the quantities seized in 2013. Moreover, the total quantity of seized LSD blotters keeps decreasing over the years. A decrease was also observed in the amount of seized GHB. The amount of seized khat plants roughly remained the same.

Table 10.2. Total quantities of seized drugs by substance between 2007 and 2013

Drug type	Unit	Year						
		2007	2008	2009	2010	2011	2012	2013
Cannabis resin	kg	58,544	1,529	18,659	3,153	5,020	1,338	4,274
Herbal cannabis	kg	12,732	4,891	4,486	5,208	6,095	5,635	14,882
Cannabis plants	units*	148,251	177,190	272,714	312,528	337,955	330,675	396,758
Heroin	kg	548	63	275	386	140	112	1,182
Cocaine	kg	2,470	3,851	4,605	6,844	7,999	19,178	6,486
Amphetamine	kg	483	411	49	362	112	54	178
Methamphetamine	kg	.	.	.	39	2	3	38
Ecstasy-type substances	tablets	541,245	162,821	31,025	32,954	64,384	26,874	37,152
LSD	units	1	.	.	3,924	838	225	121
GHB	litre	.	.	104	24	82	76	45
Khat	kg	.	.	1,685	1,018	1,128	1,298	1,149

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

\*\* GHB and Khat are only monitored by BMCDDA since 2009.

Source: Federal police

Besides the quantities seized of the more classic illegal substances, also a seizure of 4 tonnes of mCPP was reported. This shipment was destined for a company that did not have the required documents for importing mCPP (mCPP can also be used for the production of trazodone, a registered anti-depressant). In the previous years, 13 shipments (ranging from 3 to 7 tonnes) had already been received by this company (Ovaere, personal communication).

With regard to NPS, each year, very large quantities of these substances are seized in Belgium, mostly in transit from China to another EU country. For example, almost 12 kg of JWH-018, a synthetic cannabinoid, was seized in 2013. Other synthetic cannabinoids, such as 5F-AKB48 (1 kg), 5F-UR144 (20 kg) and AM-2201 (1 kg) were seized as well. Also 4.5 kg of ketamine and 2.3 kg of Ayahuasca plant material were seized in 2013.

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

The Federal Agency for Medicines and Health Products (FAMHP) together with the Federal Police Services provided information with regard to drug precursors in Belgium.

The majority of seized drug precursors in 2013, as well as the largest seized quantities originated from China and were generally destined for The Netherlands. Other quantities have been seized in synthetic drug production laboratories and/or labs for the conversion of

pre-precursors (see also section 3.3). An overview of drug precursors seized in the time period 2011-2013 is provided in Table 10.3.

A decrease is observed in the amount of seized 1-phenyl-2-propanon (benzylmethylketon, BMK), the direct precursor for amphetamine synthesis: only 40 litres were seized in 2013. This may indicate that this precursor is being used less and less for the production of amphetamines. In light of the decreasing amounts of seized BMK, the drastic increasing amount of APAAN that was seized in Belgium in 2013 is of special attention.

In April, a seizure of 4 tonnes of APAAN was performed by the custom services in the port of Antwerp. The container's origin was China and was destined for The Netherlands. In July, again 1,120 kg were seized. Other seizures of APAAN were made in conversion labs or in amphetamine or ecstasy production laboratories (Ovaere, personal communication). This confirms that most illicit amphetamine laboratories in Belgium used APAAN as a pre-precursor in 2013. However, it is worth noting that European regulation listed APAAN as a controlled precursor since the end of 2013 (EU regulations 1258/2013 and 1259/2013). Hence, it is expected that, once the current stock of the suppliers APAAN is sold out, illicit drug producers will turn to other non-controlled (pre-)precursors to evade drug and precursor laws.

An important quantity of (iso)safrole has been discovered in 2013 in the largest synthetic drug laboratory ever seized in Belgium (see also section 3.3). The 720 litres of this product are meant to be pre-precursors for PMK, which in turn is the direct precursor for MDMA, the principal component of ecstasy tablets. Additionally, 2 containers coming from China with a total content of 45,838 kg of methylamine, a reagent for the synthesis of MDMA, were seized in the port of Antwerp (Ovaere, personal communication).

Table 10.3. Amounts of precursors seized between 2011 and 2013

Substance	Unit	Year		
		2011	2012	2013
1-phenyl-2-propanon (BMK)	litre	.	503	40
Phenyl-2-nitropropene	kg	1	.	.
N-methyl-L-alanine	kg	.	1.150	.
Formamide	litre	15	.	.
Formic Acid	litre	265	.	.
Sodium hydroxide	kg	896.5	5,875	.
(iso)Safrole	litre	9,000	.	720
Gamma-butyro-lactone (GBL)	litre	30	91	7.5
Alphaphenylacetoacetonitrile (APAAN)	kg	10	8,763	5,392
Methylamine	kg	.	.	45,838
Piperonylmethylketon (PMK)	litre	.	.	2,781

Source: FAMHP, data 2011-2013, personal communication; Ovaere, personal communication, 2014

### 3.3. Number of drug production sites dismantled, description of methods of production and precise type of illicit drugs manufactured there

As mentioned above and similar to our neighbouring country The Netherlands, Belgium is a well-known production country for synthetic drugs as well as cannabis. Since the years 2000, organised criminal networks are active in the Belgian-Dutch border region to set up synthetic laboratories, sometimes combined with cannabis cultivation (Smet et al., 2013). The different steps of the production are often spread over the two neighbouring countries (Ovaere, personal communication). The capacity of criminal organizations to separate the different stages of drug production makes the law enforcement effort particularly difficult. Nevertheless, every year, a number of illicit ecstasy or amphetamine laboratories are seized. Also other types of illicit drug laboratories are found. Table 10.4 gives an overview of dismantled synthetic drug labs in the period 2007-2013.

Table 10.4. Number and type of synthetic drug labs dismantled by Belgian police services between 2007 and 2013

Lab type	Year						
	2007	2008	2009	2010	2011	2012	2013
<i>Labs for synthetic drugs</i>							
Amphetamines	3	3	1	4	1	.	2
Methamphetamine	.	.	.	.	1	.	.
APAAN conversion lab	.	.	.	.	.	2	1
MDMA	.	1	.	.	1	1	2
MDMA + amphetamine + APAAN conversion	.	.	.	.	.	.	2
Amphetamine + APAAN conversion	.	.	.	.	.	.	4
LSD	1	.	1	.	.	.	.
GHB	.	1	.	2	.	2	2
DMT	.	.	.	.	.	.	1
Unknown/unspecified combinations	4	.	.	.	.	.	2
<i>Other</i>							
Creation of tablets	.	1	.	.	.	1	.
Production of NPS	.	.	.	.	.	1	.
<b>Total</b>	<b>8</b>	<b>6</b>	<b>2</b>	<b>6</b>	<b>3</b>	<b>7</b>	<b>16</b>

Source: Ovaere, personal communication, 2014

Whereas in the last few years the number of seized drug labs tended to be relatively stable, a drastic increase in the number of seized synthetic drug production laboratories (pre-precursor conversion labs included) was noticed in 2013. 16 production sites (3 partially dismantled) and 2 sites for the stocking of products or materials were found, compared to only 7 laboratories in 2012 (Ovaere, personal communication).

The most mediatized cases concerned 2 production sites of exceptional capacity (Ovaere, personal communication): 1 active site and 1 non-active site. After chemical analysis, several



substances such as isosafrole (precursor for PMK), PMK (precursor for MDMA), MDMA, APAAN (precursor for BMK), BMK (precursor for amphetamines), amphetamines and even traces of methamphetamine (produced from BMK) were found.

Also worth mentioning is the seizure of an MDMA laboratory with a large scale production capacity, estimated at 179 kg of MDMA per batch. This equals to more than one million ecstasy tablets per production run (Ovaere, personal communication).

In 2012, the emergence of APAAN/BMK conversion laboratories was noticed. This phenomenon increased in 2013. The labs for production of amphetamines and the conversion of APAAN into BMK represent the largest number of dismantled labs. It is worth mentioning that the set-up of these labs was strikingly professional and with enormous production capacity.

MDMA production has reached an industrial level in Belgium. The past shortage of precursors, *in casu* PMK, clearly has been resolved by the use of alternative precursors. Currently, PMK is synthesized starting from pre-precursors such as safrole and PMK-glycidate (comparable to the APAAN-BMK conversion for amphetamine synthesis). This renewed availability of MDMA precursors is yet another indication of the recovering market and might contribute to the higher average concentrations of MDMA in ecstasy tablets found on the Belgian market. Consequently, an increased number of early warnings with regard to highly dosed MDMA tablets were sent in 2013 (see also chapter 7, section 2.2).

The reported number of GHB production labs is probably an underestimation as a lot of GHB is produced in so-called “kitchen labs”. These “pop-up labs” convert  $\gamma$ -butyrolactone to GHB through alkaline hydrolysis. No sophisticated materials are required for the synthesis (Ovaere, personal communication).

Similar to synthetic drugs, the Netherlands are inextricably linked to a majority of cases with a commercial character concerning the production of cannabis. The materials used for the cultivation are often purchased in Dutch grow shops (Decorte and Paoli, 2014; Vanhove et al., 2014). The discovered plantations are also often linked with persons having connections with The Netherlands or even Dutch criminal entrepreneurs (Vanhove et al., 2014). Moreover, the connections with The Netherlands increase with increasing plantation size (Ovaere, personal communication). Cannabis crops produced in Belgium, especially large scale/industrial, are most often destined for export to the Dutch market (Decorte and Paoli, 2014). Paradoxically, a lot of Belgians travel to the Netherlands to buy cannabis and re-import it to Belgium.

In general, an (indoor) cannabis plantation can generate on average 575 g cannabis/m<sup>2</sup> (Smet et al., 2013). Most of the plantations (57.4%) can be categorised as micro or mini

plantations and contain less than 50 plants. Although not all of these growers cultivate cannabis for commercial reasons, research has shown that even micro scale plantations can generate high profits (Decorte and Paoli, 2014; Vanhove et al., 2014).

The data from Table 10.5 show that the Belgian cannabis production capacity keeps increasing in 2013. Compared to 2012, the number of seized plantations increased with about 10% (from 1,111 plantations in 2012 to 1,212 plantations in 2013). Compared to 2012, an increase in the number of micro-, mini-, middle-sized and industrial plantations was observed.

Table 10.5. Number of seized cannabis plantations between 2008 and 2013, by plantation size

Plantation size*	Year											
	2008		2009		2010		2011		2012		2013	
	N	%**	N	%**	N	%**	N	%**	N	%**	N	%**
Micro	136	21.1	138	18.7	211	21.8	190	17.9	172	15.6	228	18.9
Mini	219	33.9	227	30.8	312	32.2	376	35.4	453	41.0	465	38.5
Small	125	19.3	161	21.8	165	17.0	187	17.6	166	15.0	156	12.9
Middle sized	58	9.0	73	9.9	94	9.7	101	9.5	89	8.0	119	9.9
Large	63	9.8	67	9.1	104	10.7	119	11.2	142	12.9	141	11.7
Industrial	45	7.0	71	9.6	82	8.5	88	8.3	83	7.5	98	8.1
<b>Total (with info)</b>	<b>646</b>	<b>100</b>	<b>737</b>	<b>100</b>	<b>968</b>	<b>100</b>	<b>1,061</b>	<b>100</b>	<b>1,105</b>	<b>100</b>	<b>1,207</b>	<b>100</b>
No info***	20		1		11		9		6		5	
<b>Total</b>	<b>666</b>		<b>738</b>		<b>979</b>		<b>1,070</b>		<b>1,111</b>		<b>1,212</b>	

\* Micro: 2-5 plants; Mini: 6-49 plants; Small: 50-249 plants; Middle sized: 250-499 plants; large: 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: Ovaere, personal communication, 2014

## 4. Price/purity

### 4.1. Price of illicit drugs at retail level and wholesale level

In Belgium, information on drug street prices from both the Flemish and the French Community is collected by the federal police services. These data are obtained during interrogation of (suspected) drug dealers and users. An overview of the reported mean, minimum and maximum prices by drug type and region is provided in Tables 10.6 to 10.10

for the time period 2008 to 2013. Information regarding the street prices of drugs in the French Community is also collected by Eurotox through the use of surveys. Since no significant difference is observed with the federal police data, these data are not shown here.

The average retail prices for cannabis products for the time period 2008-2013 are presented in Table 10.6. Depending on the region, the average price for 1 gram of herbal cannabis varied between €8 and €9.5 in 2013. These values are practically identical to the previous year. The same goes for cannabis resin: the average price was €9 to €10 per gram.

Table 10.6. Cannabis price at street level (euro) between 2008 and 2013

	Year																	
	2008			2009			2010			2011			2012			2013		
	mean	min	max	mean	min	max	mean	min	max	mean	min	max	mean	min	max	mean	min	max
<b>Cannabis resin per gram</b>																		
Federal Police, French Community	7.9	3.0	15.0	7.5	4.0	12.0	7.0	3.0	15.0	6.7	2.0	25.0	9.3	2.5	18.4	10.0	3.0	20.0
Federal Police, Flemish Community	6.8	3.0	12.0	6.5	5.0	10.0	7.5	5.0	10.0	7.4	2.0	25.0	8.6	2.5	18.4	9.0	3.0	20.0
<b>Herbal cannabis per gram</b>																		
Federal Police, French Community	8.1	3.0	25.0	6.9	3.3	12.0	8.2	5.0	12.5	8.0	2.5	16.7	8.9	1.8	25.0	9.5	2.75	20.0
Federal Police, Flemish Community	5.9	2.6	10.0	7.4	3.0	12.5	6.4	2.8	10.0	6.9	2.5	16.7	8.9	1.8	25.0	8.0	2.75	20.0

Source: Federal police: Ovaere, personal communication

Heroin prices at street level between 2008 and 2013 can be found in Table 10.7. In 2013, the mean prices for heroin varied for the different parts of the country. There is no significant difference compared to the previous years. The prices varied between €25.5 and €31.3 per gram.

Table 10.7. Heroin price at street level (euro) between 2008 and 2013

Drug type	Year																	
	2008			2009			2010			2011			2012			2013		
	mean	min	max	mean	min	max	mean	min	max	mean	min	max	mean	min	max	mean	Min	max
<b>Heroin unspecified per gram</b>																		
Federal Police, French Community	23.9	5.0	50.0	24.4	10.0	50.0	24.2	8.0	50.0	29.7	7.0	100.0	27.3	6.0	100.0	25.5	7.4	125.0
Federal Police, Flemish Community	25.2	12.0	40.0	22.7	10.0	40.0	23.8	9.0	62.5	30.0	7.0	100.0	28.3	6.0	100.0	31.3	7.4	125.0

Source: Federal police: Ovaere, personal communication

Retail prices for cocaine are shown in Table 10.8. Average prices varied between €49 per gram in the Flemish Community, versus €67 per gram in the French Community. For crack cocaine, no price data are available as it is almost never found, except in a few very large cities such as Antwerp and Brussels. Compared to the previous year, a 10% price increase has been observed for cocaine in the French Community. Prices in the Flemish Community remained unchanged. One explanation why cocaine prices are lower in the Flemish Community could be the presence of the port of Antwerp in Flanders, which is the major source for cocaine entering Belgium. This could potentially result in an increased supply of cocaine in that region, hence the lower prices.

Table 10.8. Cocaine price at street level (euro) between 2008 and 2013

Drug type	Year																	
	2008			2009			2010			2011			2012			2013		
	mean	min	max	mean	min	max	mean	min	max	mean	min	max	mean	min	max	mean	min	max
<b>Cocaine per gram</b>																		
Federal Police, French Community	47.8	5.0	87.0	52.8	10.0	100.0	52.2	30.0	100.0	51.8	20.0	100.0	60.9	20.0	125.0	67.0	14.3	133.3
Federal Police, Flemish Community	50.8	30.0	70.0	48.9	15.0	70.0	49.1	30.0	100.0	56.0	20.0	100.0	51.6	20.0	125.0	49.0	14.3	133.3

Source: Federal police: Ovaere, personal communication

Table 10.9 reflects retail prices for amphetamine, or “speed” as it is called in Belgium. A slight increase in price was observed in the French Community (from €9.8 per gram in 2012 to €10.5 per gram in 2013), whereas a very slight but negligible decrease was seen in the Flemish Community (from €8.4 per gram in 2012 to €8.2 per gram in 2013). However, the observed maximum prices decreased with 20%. A price difference between the Flemish and French Community was observed. The fact that most amphetamine laboratories are found in the Flemish Community could suggest a shorter supply route in the Flemish Community, possibly responsible for the lower price.

Table 10.9. Amphetamine price at street level (euro) between 2008 and 2013

	Year																	
	2008			2009			2010			2011			2012			2013		
Drug type	mean	min	max	mean	min	max	mean	min	max	mean	min	max	mean	min	max	mean	min	Max
<b>Amphetamine per gram</b>																		
Federal Police, French Community	6.6	1.5	10.0	10.9	2.8	25.0	9.1	2.5	10.0	8.4	3.0	16.7	9.8	3.0	25.0	10.5	3	20
Federal Police, Flemish Community	8.7	3.5	20.0	8.1	5.0	12.0	8.4	2.5	15.0	7.5	3.0	16.7	8.4	3.0	25.0	8.2	3	20

Source: Federal police: Ovaere, personal communication

The evolution of retail prices for ‘ecstasy’-tablets and LSD blotters between 2008 and 2013 is presented in Table 10.10. Prices are given per unit (per tablet or paper trip). The price of LSD has remained unchanged compared to previous years. It is however remarkable that the average price for a single ecstasy tablet has decreased from €5.8 to €4.6 per tablet in the French Community. Prices in the Flemish Community remained unchanged and also minimum and maximum prices have not changed whatsoever. Taking this into account, together with data on seizures and purity (see 4.2), this is once more a confirmation of the recovery - or even more, the blooming - of the ecstasy market in the last couple of years in Belgium.

Table 10.10. Ecstasy and LSD price at street level (euro) between 2008 and 2013

	Year																	
	2008			2009			2010			2011			2012			2013		
Drug type	mean	min	max	mean	min	max	mean	min	max	mean	min	max	mean	min	max	mean	min	max
<b>Ecstasy per tablet</b>																		
Federal Police, French Community	4.1	1.1	10.0	4.1	1.2	10.0	5.2	2.0	10.0	4.6	2.0	10.0	5.8	1.0	10.0	4.6	1.5	10
Federal Police, Flemish Community	3.2	1.8	5.0	3.5	1.0	8.0	3.4	1.0	10.0	4.5	2.0	10.0	4.5	1.0	10.0	4.4	1.5	10
<b>LSD per dose</b>																		
Federal Police, French Community	8.3	6.5	10.0	.	.	.	.	.	.	.	.	.	10.0	3.0	10.0	10	10	12
Federal Police, Flemish Community	.	.	.	10.0	10.0	10.0	12.0	12.0	12.0	11.8	7.0	15.0	10	3.0	10.0	10	10	12

Source: Federal police: Ovaere, personal communication

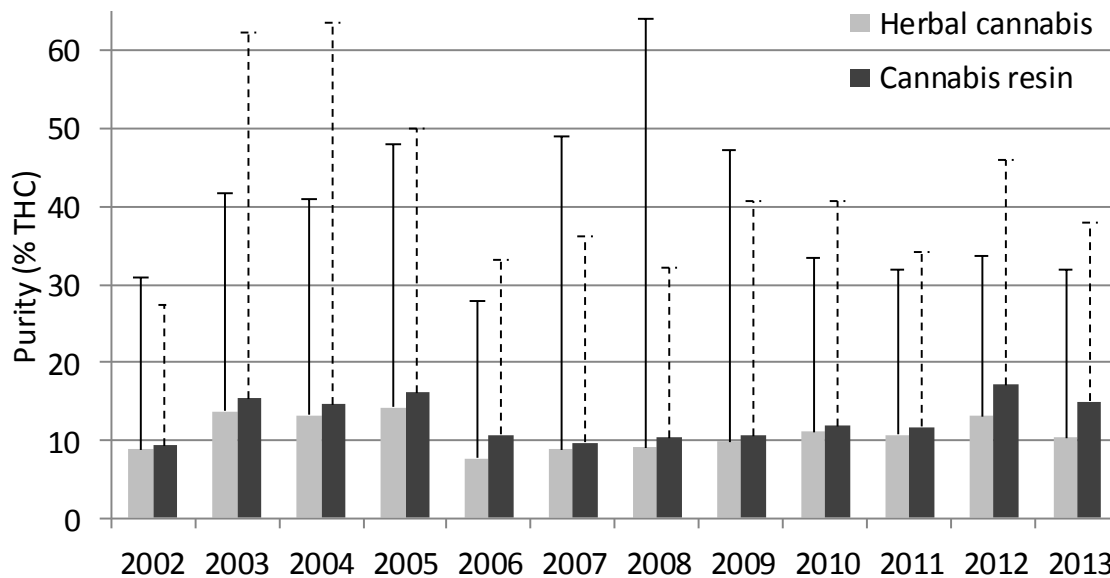
#### 4.2. Purity/potency of illicit drugs

Mean concentrations of the most common illicit drugs (cannabis, amphetamine, MDMA, cocaine and heroin) found on the Belgian drug market between 2002 and 2013 are presented in Figures 10.1, 10.2 and 10.3. Data regarding the composition and purity of the classic illicit drugs circulating on the Belgian market are provided by the Belgian Early Warning System on Drugs (BEWSD) which keeps a database of all reported analysed drug samples in Belgium. Drug samples are mostly collected after seizure by police or federal customs, and are analysed by the National Institute on Criminalistics and Criminology (NICC). In a minority of cases, drug samples are submitted through a small-scale local drug testing project in the Brussels region (Modus Vivendi). Some research projects also aim to analyse the contents of drugs circulating at street level (e.g. analysis of the contents of amnesty bins at dance festivals). For police seizures, the results of both large and small-scale seizures are reported. Caution is needed when interpreting these results, since police seizures often encompass larger, more pure drug seizures. This can result in a potential overestimation of the purity of drugs in Belgium, especially drugs that can be cut or contaminated (powders such as cocaine or heroin).

As clearly illustrated in Figure 10.1, there have been no large changes in the concentration of tetrahydrocannabinol (THC, the active component in cannabis) for herbal cannabis or cannabis resin in the last 4 years. For herbal cannabis, the mean THC concentration in 2013 was 10.4%, which is not significantly different with the mean concentration in 2012 (13.1%). No significant differences in maximum or minimum concentration compared to the previous year were found either. For cannabis resin, a peak 17.2% THC was observed in 2012. In 2013, the mean THC level in cannabis resin decreased, approaching previous levels (15%). The observed maximum THC concentrations in cannabis resin were lower in 2013, compared to 2012.



Figure 10.1. Mean THC concentration (%) in samples of cannabis (herbal and resin), 2002-2013

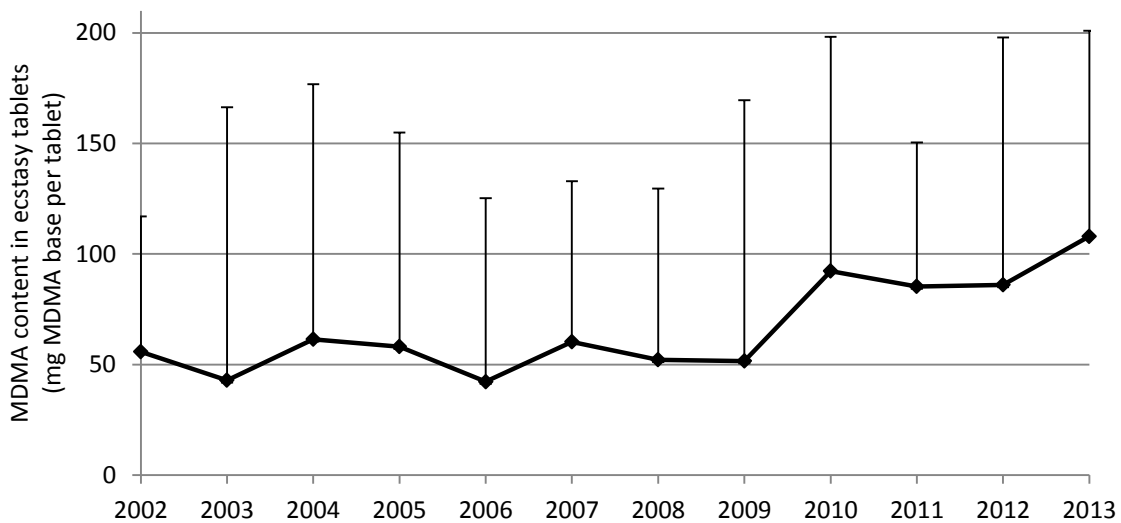


Source: BEWSD database. Error bars indicate maximum observed concentration values

As already mentioned several times, multiple factors point towards a revival of the ecstasy market after a decline in the period 2005 to 2008. Since 2009, the mean MDMA content in ecstasy tablets has kept on rising, reaching a new record in 2013 (128.6mg MDMA base per tablet). Also, the maximum amount observed in one ecstasy tablet was the highest ever seen in Belgium (221mg MDMA base per tablet in 2013). This trend is alarming, especially since it has also been observed in our neighbouring countries France and especially The Netherlands. It seems that the ecstasy market in Belgium and The Netherlands is largely similar. During 2013, several alerts were issued concerning highly dosed MDMA tablets (see chapter 7, section 2.2). Tablets containing even more than 250mg MDMA base have been found in the Netherlands. For young users or first-time users, such dosages can easily result in toxicity symptoms, especially when combined with e.g. dehydration in festive settings. The BEWSD has warned its partners extensively regarding this phenomenon. Harm reduction services in Belgium are currently well aware of this changing ecstasy market. Unfortunately, despite the swift actions to alert both field workers and users, several people in Belgium (and The Netherlands) died in 2013 due to consumption of highly dosed ecstasy tablets, or tablets contaminated with other substances, e.g. PM(M)A.

A relatively new phenomenon is the appearance of MDMA on the drug market in crystal or powder form (slang term: “molly” or “sand”). Reported average purity for MDMA powder in 2013 was fully comparable to the purity in 2012 (61.4%); however, the sample size was only 13 samples.

Figure 10.2. Mean MDMA content (mg) in ecstasy tablets between 2002 and 2013



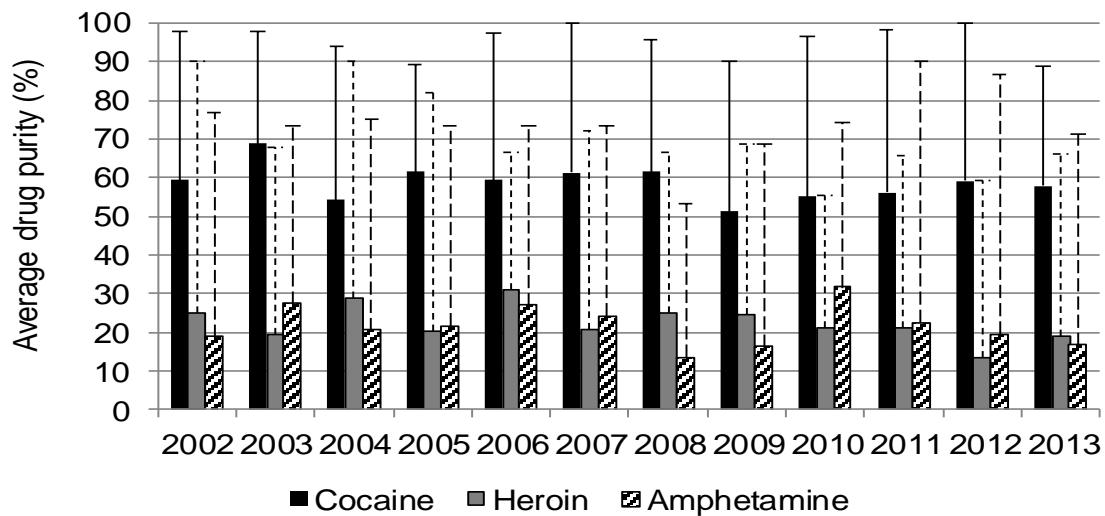
Source: BEWSD database. Error bars indicate maximum observed concentration values

The trend of the last three years regarding the purity of amphetamine powders in Belgium was again confirmed in 2013: the purity of seized amphetamine samples keeps on decreasing sharply. Whereas mean purity values of 19.4% were observed in 2012, the mean purity was only 16.6% in 2013. Also, the maximum purity value dropped from 86.8% in 2012 to 71.2% in 2013. 4-Methylamphetamine (4-MA) remains an important contaminant on the Belgian amphetamine market (see 4.3.2.).

Concerning the purity of cocaine samples, no significant difference was found between the mean cocaine concentration in 2012 and 2013 (59.1% and 57.8% respectively; the number of collected analysed samples was similar: ~350). Compared to other EU countries, the purity of cocaine in Belgium remains very high. Also, the maximum reported concentrations are high (88.6%), but significantly lower than those in 2011 and 2012 (98.19% and 100% respectively). It has to be noted that in 2011 and 2012, large seizures of (more pure) cocaine were made, which could have skewed the results.

Contrary to the cocaine market, the purity of drugs on the heroin market remained poor. The mean heroin purity was higher in 2013 compared to 2012 (18.7% purity in 2013 versus 13.3% in 2012), but is still lower than the purity values obtained in 2011 (21.1%). The maximum obtained value was comparable to previous years (66.2%).

Figure 10.3. Mean purity (%) of cocaine, heroin and amphetamine between 2002 and 2013



Source: BEWSD database. Error bars indicate maximum observed concentration values.

#### 4.3. Composition of illicit drugs and drug tablets

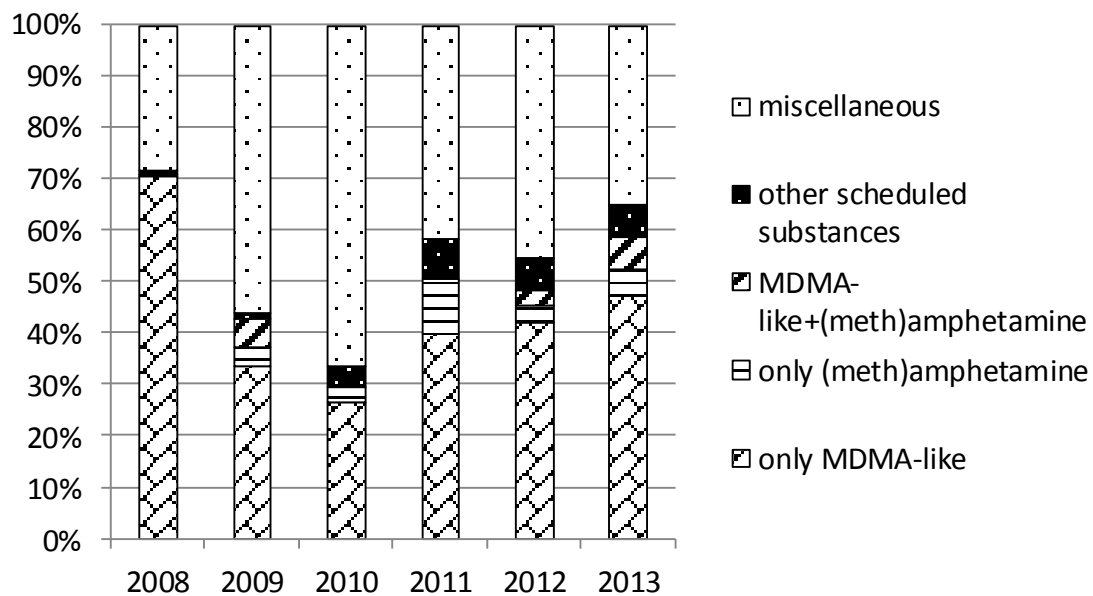
Similar to the information obtained for drug purity in paragraph 4.2, information on the specific composition of seized drug samples (tablets, powders and liquids) is available through the BEWSD database.

##### 4.3.1. Tablets

Compared to 2012, the amount of seized tablets containing only MDMA-like substances increased. Most tablets that were sold as MDMA effectively contained only MDMA as the active component. Only 3 tablets were analysed in 2013 containing amphetamine.

Figure 10.4 represents a summary of the contents of tablets seized as illicit drug tablets for the time period 2008-2013.

Figure 10.4. Composition of illicit drug tablets between 2008 and 2013



<sup>1</sup> Scheduled drugs refer to substances controlled under the 1971 UN Convention on Psychotropic Substances Schedules I and II and under European legislation (Council Decisions).

<sup>2</sup> The category 'MDMA-like substances (as the only scheduled substances)' refers to tablets containing MDMA and/or other MDMA-like substances (MDEA, MDA) as the only scheduled substances, together with or without non-scheduled substances (e.g. mCPP, caffeine).

<sup>3</sup> The category '(meth)amphetamine (as the only scheduled substances)' refers to tablets containing only amphetamine and/or methamphetamine, together with or without non-scheduled substances (e.g. mCPP, caffeine).

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

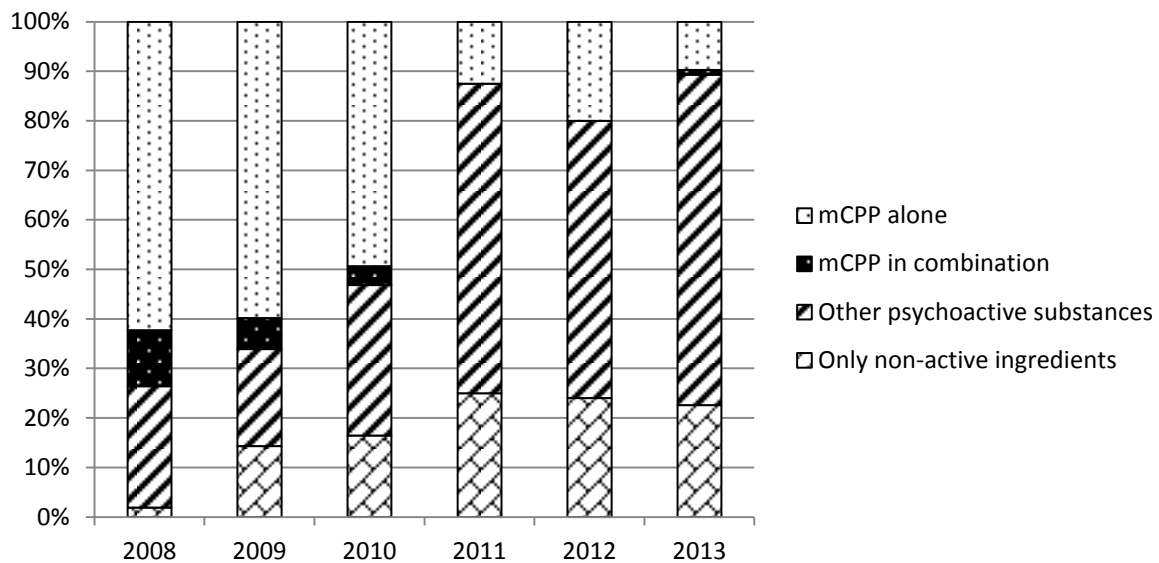
<sup>5</sup> The category 'Others (scheduled substances)' refers to tablets containing other scheduled substances (than MDMA-like substances or (meth)amphetamine), alone or in association with MDMA-like substances and/or (meth)amphetamine, together with or without non-scheduled substances (e.g. mCPP, caffeine, DOB).

<sup>6</sup> The category 'Miscellaneous' refers to tablets seized/submitted as illicit drug tablets but containing none of the scheduled substances under the 1971 UN Convention on Psychotropic Substances Schedules I and II or under European legislation (Council Decisions).

Source: BEWSD database

Seized tablets that did not contain any psychotropic substances (e.g. tablets containing only lactose or inert fillers) were not included in these calculations. They were also not included in the "miscellaneous" category. A detailed description of the composition of the tablets in the "miscellaneous" category is provided in Figure 10.5.

Figure 10.5. Description of tablet category 'miscellaneous' between 2008 and 2013



The category "Other psychoactive substances" included mostly benzodiazepines, antidepressants, hormones, tramadol and sulpiride

Source: BEWSD database, 2014

The miscellaneous category mostly comprises tablets that do not contain illegal drugs, but other psychoactive substances such as pharmaceuticals. A lot of (counterfeit) benzodiazepines and prescription stimulants, such as methylphenidate, were found in the "other psychoactive substances" category. Compared to previous years, no real differences in the composition of the 'miscellaneous' category were observed, except a small decrease in the number of tablets containing mCPP. Also, a substantial amount of tablets were analysed and found to contain pharmaceutically active, but non-psychoactive substances. These predominantly included hormonal agents such as clenbuterol, methandrostenolon and oxymetholone. Also, (counterfeit) tablets containing erectile dysfunction therapy agents were observed, such as sildenafil citrate and derivatives.

#### 4.3.2. Other product types

An overview of the adulterants/cutting agents and their mean concentration in seized and analysed amphetamine, cocaine and heroin powder samples is presented in Table 10.11.

Similar to previous years, amphetamine remains the least pure drug in Belgium. Again in 2013, 4-MA was frequently found as a contaminant for amphetamine (12% of tested samples). Its presence in amphetamine samples is probably the result of a contamination of BMK with 4-methyl-BMK. In 2012 and 2013, several people have died due to this contamination (Blanckaert et al., 2013). However, the frequency of contamination with 4-MA was lower compared to last year (18% in 2012 versus 12% in 2013). The mean concentration was also lower compared to previous years (1.9% versus 7.6%).

Other frequently encountered cutting agents in amphetamine samples include caffeine (62% of tested samples, mean concentration 53%). Although 4-Fluoro-amphetamine (4-FA) is already a scheduled substance in Belgium, it was detected multiple times as a contaminant in amphetamine samples (5 samples, 3%, mean concentration 3.3%). As already observed in The Netherlands, this might indicate a growing popularity of 4-FA.

Considering the high purity of cocaine in Belgium (see 4.2, Figure 10.2), the low concentration of adulterants and cutting agents in cocaine samples analysed in Belgium does not come as a surprise. In 2013, levamisole was the most frequently encountered adulterant in cocaine samples (present in 48% of samples, mean concentration ~10%). Levamisole is found worldwide in cocaine samples, and is added in the country of production (mostly Latin-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 with the acid/base reaction required to produce smokable cocaine or crack. Due to the risk of serious side effects (such as agranulocytosis), the addition of levamisole is problematic. Levamisole can also be metabolized to form aminorex, a relatively toxic compound with stimulating properties. Caffeine, hydroxyzine, lidocaine and phenacetine were also frequently encountered.

The most used cutting agent in heroin samples in Belgium was caffeine (present in 21% of samples in a mean concentration of 20%), together with acetaminophen (paracetamol, present in 18% of samples in a mean concentration of 40%). Monoacetylmorphine (MAM), noscapine and papaverine are natural impurities or impurities originating from the heroin manufacturing process. They were present in 16 to 20% of tested samples, in relatively low concentrations (1 to 10%).

Table 10.11. Adulterants/cutting agents found in seized drug powders in 2013

Drug type	Adulterants	Samples (N)	% of samples	Mean adulterant concentration (%)
<b>Amphetamine</b>	4-MA	19	12.0	1.9
	Caffeine	101	62.3	53.0
	4-Fluoro-amphetamine	5	3.1	3.3
	mCPP	3	1.9	10.7
<b>Cocaine</b>	Levamisole	255	48.0	9.0
	Caffeine	74	14.0	6.7
	Phenacetine	96	18.0	27.0
	Hydroxyzine	52	10.0	4.0
	Lidocaine	36	7.0	4.5
	Diltiazem	5	1.0	2.0
<b>Heroin</b>	Caffeine	178	21.0	20.0
	Acetaminophen	151	18.0	40.0
	MAM	178	21.0	8.8
	Noscapine	175	21.0	9.0
	Papaverine	172	20.0	0.8

Source: BEWSD database, 2014

## 5. Conclusion

Drug supply to and within Belgium is rather complicated: despite being a small country, Belgium has historically been an important production country for cannabis and synthetic drugs (mostly amphetamine and MDMA). Also, the central geographical location within Europe in combination with the easy existing access points such as the large port of Antwerp and the national airports, ensures a major role in the trafficking of other narcotics. For example, the last two years, Belgium has taken up an important role in the distribution of NPS or precursor products from Asia to the rest of Europe.

As a consequence of the production capacity and the large import scale, drug prices in Belgium tend to be generally low compared to other EU member states (EMCDDA, 2014). No significant changes in price were observed in 2013 compared to previous years. Cocaine still remains the most expensive drug in Belgium.

Moreover, another result is the overall high quality of drugs observed in Belgium. With regard to drug purity in Belgium in 2013, no major differences compared to previous years were observed. No change was observed in the purity of cocaine. However, an increase was seen in the purity of analysed heroin samples. Although some slight fluctuation in the THC concentration of herbal cannabis and cannabis resin was observed in the past five years, no large changes were observed in 2013 concerning the potency of cannabis.

Amphetamine remains the least “pure” drug in Belgium. Although the contaminant 4-MA has still been reported, its presence starting to disappear from the market. An important

evolution on the amphetamine market is the introduction of pre-precursors. Since international regulations with regard to drug precursors are enforced more strictly, drug producers have been forced to find new precursors. In 2013, very large amounts of APAAN, a pre-precursor for (meth)amphetamine, were seized. Also, the number of synthetic drug production laboratories reached an all-time high in 2013.

An alarming observation on the stimulant-market is the introduction of methamphetamine; for the first time, considerable amounts of methamphetamine were seized in Belgium. Historically, methamphetamine use has been confined to eastern European countries such as the Czech Republic and Slovakia. So far, methamphetamine (also known as “crystal meth”) and the social and national health problems associated with its use, remained absent in Belgium.

In terms of drug potency and correlated health problems, the main issue in Belgium is an obvious revival of the ecstasy market. After a few years of low MDMA content and many reported contaminants in ecstasy tablets, a drastic increase was observed in the concentration of MDMA in ecstasy tablets. Nevertheless, apart from the increased MDMA amounts in ecstasy tablets, the composition of illegal drug tablets hasn't changed significantly compared to previous years. Less seized tablets were contaminated: most tablets that were sold as MDMA, actually contained only MDMA as active component.

In general, with regard to the information on drug purity, it is important to emphasize that the majority of the results of drug analyses are obtained from large seizures of drugs. It is well known that drugs get cut and contaminated when shifting from wholesale to retail. As such, these figures may not reliably indicate the purity of drugs circulating on the streets in smaller amounts. The latter are sometimes reported through the early warning system, however there is no consistent system for these kind of analyses. Hence, a solid data collection and data reporting system encompassing all and regular performed drug analyses are still lacking in Belgium. Although, it is of paramount importance for the accurate monitoring of the current and changing landscape of the Belgian drug market.

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## **Alphabetic list of relevant internet addresses and databases**

This alphabetic list contains only specific drug-related websites in Belgium, which contains background information about illegal drugs. (accessed on 31/10/2014).

### **Belgian Early Warning System on Drugs - Information about the Early Warning system [EN]**

[ewsd.wiv-isp.be](http://ewsd.wiv-isp.be)

### **Belgian Health Interview Survey - Information about the general population survey [FR-NL-EN]**

[his.wiv-isp.be](http://his.wiv-isp.be)

### **Breakline - Prevention group for partygoers [NL]**

[www.breakline.be](http://www.breakline.be)

### **Cannabis Hulp - Online treatment and prevention for cannabis users [NL]**

[www.cannabishulp.be](http://www.cannabishulp.be)

### **De Druglijn - Information about drugs in general [NL]**

[www.druglijn.be](http://www.druglijn.be)

### **Drug Hulp - Online treatment and prevention for drug users [NL]**

[www.drughulp.be](http://www.drughulp.be)

### **Drugs in beweging - Prevention initiative for youth [NL]**

[www.drugsinbeweging.be](http://www.drugsinbeweging.be)

### **Federal public service Health - Cell Drugs [FR-NL]**

[www.health.belgium.be](http://www.health.belgium.be)

### **Federal public service Justice - Theme drugs [FR-NL]**

[www.justitie.belgium.be](http://www.justitie.belgium.be)

### **Flemish Agency for Care and Health - Mental health theme [NL]**

<http://www.zorg-en-gezondheid.be>

### **VLASPAD (VUB) - Flemish school research project about alcohol and other drugs [NL]**

[www.vlaspad.be](http://www.vlaspad.be)

### **Infor Drogues - Information about drugs in general [FR]**

[www.infor-drogues.be](http://www.infor-drogues.be)

### **Mental Health Consultation platform in Brussels-Capital Region [FR-NL]**

[www.pfcsm-opgg.be](http://www.pfcsm-opgg.be)

### **Modus Vivendi - Prevention and harm-reduction information [FR]**



[www.modusvivendi-be.org](http://www.modusvivendi-be.org)

**VAD - non-profit association for alcohol and other drug problems [FR-NL-EN]**

[www.vad.be](http://www.vad.be)

**SPZ - Social and psychological center in the German Community [DE-FR-NL]**

[www.spz.be](http://www.spz.be)

**EUROTOX - Socio-epidemiological observatory for alcohol and drugs in the French community [FR]**

[www.eurotox.org](http://www.eurotox.org)

**Treatment demand indicator Belgium - Information about the indicator collection [FR-NL]**

[tdi.wiv-isp.be](http://tdi.wiv-isp.be)

**BELSPO - Federal scientific policy office financing research projects on drugs [FR-NL-EN]**

[www.belspo.be](http://www.belspo.be)

**VAD Ginger – Information about prevention activities related to drugs or alcohol [NL]**

[www.vadginger.be](http://www.vadginger.be)

**PortailDrogues – Collection of treatment centers, trainings or documentation related to drugs and alcohol [FR]**

[www.ida-fr.be](http://www.ida-fr.be)

**IDA - Information about drugs and alcohol [NL]**

[www.ida-nl.be](http://www.ida-nl.be)

**BiblioDrogues - Collection of publications over drugs and alcohol [FR]**

[www.biblio-drogues.be](http://www.biblio-drogues.be)

**OutilsDrogues - Directory of tools related to drugs or alcohol prevention and harm reduction [FR]**

[www.outils-drogues.be](http://www.outils-drogues.be)

**FEDITO BXL - Brussels federation of centers for drug addiction [FR]**

[www.feditobxl.be](http://www.feditobxl.be)

**FEDITO Wallonne - Walloon federation of centers for drug addiction [FR]**

[www.feditowallonne.be](http://www.feditowallonne.be)

**Plate-forme de réduction des risques - Initiative to reduce drug-related harm [FR]**

[reductiondesrisques.be](http://reductiondesrisques.be)

## Annex 1: List of abbreviations

Abbreviation	Explanation
4-FA	4-fluoro-amphetamine
4-MA	4-Methylamphetamine
5F-AKB48	N-((3s,5s,7s)-adamantan-1-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide
5F-UR144	XLR-11
6-APB	6-(2-aminopropyl)benzofuran
A&D	Alcohol and Drugs
ADHD	Attention Deficit Hyperactivity Disorder
AIDS	Acquired Immune Deficiency Syndrome
ALFA	Aide Liégeoise aux Alcooliques et à leur Famille ( <i>Help Liege to Alcoholics and their families</i> )
AM-2201	1-(5-fluoropentyl)-1H-indol-3-yl]-1-naphthalenyl-methanone
APAAN	Alphaphenylacetoacetonitrile
APB	Algemene Pharmaceutische Bond - Association Pharmaceutic Belge ( <i>General Pharmaceutical Association Belgium</i> )
ARLs	AIDS Reference Laboratories
ASBL	Association sans but lucratif ( <i>Non-profit association</i> )
ASL	Arbeitsgemeinschaft für Suchtvorbeugung und Lebensbewältigung ( <i>Association for addiction prevention and life management</i> )
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
B.S/M.B	Belgisch Staatsblad/Moniteur Belge ( <i>Belgian official Journal</i> )
BELSPO	Belgian Federal Science Policy Office
BELTA	Belgian Lung and Tuberculosis Association
BEWSD	Belgian Early Warning System on Drugs
BHIS	Belgian Health interview Survey
BMCDDA	Belgian Monitoring Centre for drugs and drug addiction
BMK	benzylmethylketon (1-phenyl-2-propanon)
BTDIR	Belgian Treatment Demand Indicator Register
CAD	Centre for Alcohol and other Drugs
CAO	Collectieve arbeidsovereenkomst ( <i>Collective Agreement</i> )
CAPI	Computer-Assisted Personal Interviewing
CBPS	Centre Bruxellois de Promotion de la santé ( <i>Centre for the Promotion of health Brussels</i> )
CD4	Cluster of Differentiation 4

CEBAM	Belgian Centre for Evidence-Based Medicine
CGOP	Centraal Georganiseerd Overleg Politie ( <i>Centrally Organised Consultation Police</i> )
CI	Confidence Interval
CICs	Crisis Intervention Centres
CIU	Central Intake Unit
CLDB	Coordination Locale Drogues Bruxelles ( <i>Local Coordination of Drugs in Brussels</i> )
COCOF	Commission communautaire française ( <i>Commission of the French Community</i> )
COCOM	Commission Communautaire Commune ( <i>Common Community Commission</i> )
CPAS	Centre Public d'Aide Sociale ( <i>Public Centre of social assistance</i> )
CRA	Community Reinforcement Approach
DAST	Drug Abuse Screening Test
DGJ-DJP	Directorate General of the Judicial Police - Directorate of crime against persons
DG MJH	Directoraat Generaal Justitiehuzen - Direction générale des Maisons de justice (Directorate General – Houses of Justice)
DMT	N,N-Dimethyltryptamine
DOB	Dimethoxybromoamphetamine
DOC	2,5-dimethoxy-4-chloro-amphetamine
DRD	Drug-Related Deaths
DSM	Diagnostic and statistical Manual on Mental health
DTC	Drug Treatment Court
ED	Emergency Department
EHIS	European Health Interview Survey
EMCDDA	European Monitoring Centre for drugs and drug addiction
ESPAD	European School survey Project on Alcohol and other Drugs
EU	European Union
EuropASI	European Addiction Severity Index
EWS	Early Warning System
FAMHP	Federal Agency for Medicines and Health Products
FARES	Fonds des Affections Respiratoires ( <i>fund of respiratory diseases</i> )
FEIAT	Federation of the Employers of the Ambulatory Institutions for Drug addiction
FPS	Federal Public Service
GBL	Gamma-butyro-lactone
GHB	Gamma-Hydroxybutyric acid
GHQ	General Health Questionnaire

GMR	General Mortality Register
GND	General National Database
GP	General Practitioner
GPS	General Population Survey
HBsAg	Hepatitis B Surface antigen
HBSC	Health Behaviour in School-aged Children
HBV (ab)	Hepatitis B Virus (antibody)
HCV (ab)	Hepatitis C Virus (antibody)
HIV	Human Immunodeficiency Virus infection
ICD	International Classification of diseases, injuries and causes of deaths
ICT	Information and communications technology
IDA	Information on Drugs and Alcohol
IDU	Injecting Drug Use
IDUs	Injecting Drug Users
IPSA	<i>Instituut voor Permanente Studie voor Apothekers</i> ( <i>Institute for Permanent Study for pharmacists</i> )
IRCP	Institute for International Research on Criminal Policy
IRQ	Injecting Risk Questionnaire
ISD	Institute of Social Drug research
LSD	Lysergic Acid Diethylamide
MAM	Monoacetylmorphine
mCPP	meta-Chlorophenylpiperazine
MDA	3,4-Methylenedioxyamphetamine
MDEA	Methylenedioxyethylamphetamine
MDFT	Multi-Dimensional Family Therapy
MDMA-HCl	3,4-Methylenedioxy-N-Methamphetamine hydrochloride salt
MSCC	Medical and Social Care Centres
NAP	National Alcohol Plan
NEP	Needle Exchange Programme
NGO	Non-Governmental Organization
NICC	National Institute for Criminalistics and Criminology
NIHDI	National Institute for health and disability Insurance
NPS	New Psychoactive Substances
OCMW	Openbare Centrum voor Maatschappelijk Welzijn ( <i>Public centre for social welfare</i> )

OST	Opioid Substitution Treatment
PMA	para-Methoxyamphetamine
PMK	Piperonylmethylketon
PMMA	para-Methoxymethamphetamine
RAR	Rapid Assessment and Response
SBIRT	Screening, Brief Intervention and Referral to Treatment
SEM-J	Screeningsinstrument Ervaringen met Middelengebruik – Jongeren ( <i>Screening instrument experience with substance use – youth</i> )
SIPAR	Système Informatique PARajudiciaire
SLCD	Survey, Lifestyle and Chronic Diseases
SSPF	Société Scientifique des Pharmaciens Francophones ( <i>Scientifique association of French Speaking Pharmacists</i> )
ST	Standard Table
TAD	Tobacco, Alcohol and Drugs
TDI	Treatment Demand Indicator
THC	Tetrahydrocannabinol
TPHA	Treponema pallidum haemagglutination
UCL	Université catholique de Louvain ( <i>Catholic University of Louvain</i> )
UK	United Kingdom
ULB	Université Libre de Bruxelles ( <i>Free University of Brussels</i> )
UN	United Nations
UNODC	United Nations Office on Drugs and Crime
USA	United States of America
VAD	Vereniging voor alcohol en andere drugproblemen ( <i>Association for alcohol and other drug problems</i> )
VIGEZ	Vlaams Instituut voor de Gezondheid ( <i>Flemish institute for health</i> )
VLASPAD	VLAams SchoolonderzoeksProject naar Alcohol en andere Drugs ( <i>Flemish School survey Project on Alcohol and other Drugs</i> )
VRGT	Vlaamse vereniging voor Respiratoire Gezondheidszorg en Tuberculose bestrijding ( <i>Flemish Association for Respiratory health and Tuberculosis control</i> )
WHO	World Health Organization
WIV-ISP	Wetenschappelijk Instituut voor Volksgezondheid – Institut Scientifique de Santé Publique ( <i>Scientific Institute of Public Health</i> )

(*Italics*): English translation

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## Annex 4: List of full references of laws in original language

### *Dutch*

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31 december 1930 - Koninklijk besluit houdende regeling van de slaapmiddelen en de verdovende middelen en betreffende risicobeperking en therapeutisch advies (B.S. 10.01.1931).

29 juni 1964 - Wet betreffende de opschorting, het uitstel en de probatie (B.S. 17.07.1964)

22 januari 1998 - Koninklijk besluit tot reglementering van sommige psychotrope stoffen en betreffende risicobeperking en therapeutisch advies (B.S. 14.01.1999).

4 juli 2001 - Koninklijk besluit tot bepaling van de voorwaarden voor het afleveren van geneesmiddelen die één of meer tetrahydrocannabinolen bevatten (B.S. 19.07.2001)

29 juni 2003 - Koninklijk besluit betreffende het informeren van het Belgisch Focal Point van het Europees informatienetwerk over drugs en drugsverslaving (B.S. 14.07.2003)

19 maart 2004 - Koninklijk besluit tot reglementering van de behandeling met vervangingsmiddelen (B.S. 30.04.2004)

12 januari 2005 - Basiswet betreffende het gevangeniswezen en de rechtspositie van de gedetineerden (B.S. 01.02.2005)

Interministeriële Conferentie Volksgezondheid Drugs 13.2. - Registratie van de behandelingsaanvragen via de Treatment Demand Indicator Registratie van de behandelingsaanvragen via de operationalisatie van de Europese Treatment Demand Indicator (B.S. 03.05.2006)

7 december 2006 - Koninklijk besluit betreffende de strategische veiligheids- en preventieplannen (B.S. 22.12.2006)

5 maart 2009 - Decreet betreffende het aanbod van ambulante diensten in de domeinen van de sociale actie, het gezin en de gezondheid (B.S. 08.05.2009)

30 april 2009 - Decreet betreffende de erkenning met het oog op de toekenning van subsidies en de toekenning van subsidies aan de zorg- en hulpverleningsnetwerken en -diensten gespecialiseerd in verslavingen, alsook de erkenning met het oog op de toekenning van subsidies en de toekenning van subsidies aan hun federaties (B.S. 25.06.2009)

25 januari 2010 - Een global en geïntegreerd drugsbeleid voor België. Gemeenschappelijke verklaring van de Interministeriële Conferentie Drugs (B.S. 15.04.2010)

8 april 2011 - Koninklijk besluit tot bepaling van de datum van inwerkingtreding en uitvoering van verscheidene bepalingen van de titels III en V en VII van de basiswet van 12 januari 2005 betreffende het gevangeniswezen en de rechtspositie van de gedetineerden (B.S. 21.04.2011)

Protocolakkoord 'HIV-plan 2014-2019' Gelet op de specifieke bevoegdheden waarover de Federale overheid en de Overheden bedoeld in artikel 128,130 en 135 van de Grondwet (B.S. 21.11.2013)

24 december 2013 - Ministerieel besluit tot bepaling van de indienings-, opvolgings- en evaluatievoorwaarden en tot bepaling van de toekennings-, toepassings- en controlevoorwaarden van de financiële toelage van de strategische veiligheids- en preventieplannen 2014-2017 (B.S. 31.12.2013)

7 februari 2014 - Wet tot wijziging van de wet van 24 februari 1921 betreffende het verhandelen van gifstoffen, slaapmiddelen en verdovende middelen, psychotrope stoffen, ontsmettingsstoffen en antiseptica en van de stoffen die kunnen gebruikt worden voor de illegale vervaardiging van verdovende middelen en psychotrope stoffen (B.S. 10.03.2014)

#### *French*

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31 décembre 1930 - Arrêté royal réglementant les substances soporifiques et stupéifiantes, et relatif à la réduction des risques et à l'avis thérapeutique (M.B. 10.01.1931)

29 juin 1964 - Loi concernant la suspension, le sursis et la probation (M.B. 17.07.1964)

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29 juin 2003 - Arrêté royal relatif à la transmission d'informations au Point Focal belge du réseau européen d'information sur les drogues et les toxicomanies (M.B. 14.07.2003)

19 mars 2004 - Arrêté royal réglementant le traitement de substitution (M.B. 30.04.2004)

12 janvier 2005 - Loi de principes concernant l'administration pénitentiaire ainsi que le statut juridique des détenus (M.B. 01.02.2005)

Conférence interministérielle Santé publique Drogues 13.2 - Enregistrement des demandes de traitement via le Treatment Demand Indicator Enregistrement des demandes de traitement via l'opérationnalisation du Treatment Demand Indicator Européen (M.B. 03.05.2006)

7 décembre 2006 - Arrêté royal relatif aux plans stratégiques de sécurité et de prévention (M.B. 22.12.2006)

5 mars 2009 - Décret relatif à l'offre de services ambulatoires dans les domaines de l'action sociale, de la famille et de la santé (M.B. 08.05.2009)

30 avril 2009. - Décret relatif à l'agrément en vue de l'octroi de subventions et à l'octroi de subventions aux réseaux et aux services d'aide et de soins spécialisés en assuétudes ainsi qu'à la reconnaissance en vue de l'octroi de subventions et à l'octroi de subventions à leurs fédérations (M.B. 25.06.2009)

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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)

8 avril 2011 - Arrêté royal déterminant la date d'entrée en vigueur et d'exécution de diverses dispositions des titres III et V de la loi de principes du 12 janvier 2005 concernant l'administration pénitentiaire ainsi que le statut juridique des détenus (M.B. 21.04.2011)

Protocole d'accord 'Plan VIH 2014-2019' Vu les compétences respectives dont l'Autorité fédérale et les Autorités visées aux articles 128, 130 et 135 de la Constitution (M.B. 21.11.2013)

24 décembre 2013 - Arrêté ministériel déterminant les modalités d'introduction, de suivi, d'évaluation et déterminant les modalités d'octroi, d'utilisation et de contrôle de l'allocation financière relatives aux plans stratégiques de sécurité et de prévention 2014-2017 (M.B. 31.12.2013)

7 février 2014 - Loi modifiant la loi du 24 février 1921 concernant le trafic des substances vénéneuses, soporifiques, stupéfiantes, psychotropes, désinfectantes ou antiseptiques et des substances pouvant servir à la fabrication illicite de substances stupéfiantes et psychotropes (M.B. 10.03.2014)