European Monitoring Centre
for Drugs and Drug Addiction

Scientific Institute of Public Health
Unit of Epidemiology

2007 NATIONAL REPORT (2006 data) TO THE EMCDDA by the Reitox National Focal Point

BELGIUM

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

REITOX

IPH
Belgian national report on drugs 2007
Epidemiology Unit, Scientific Institute of Public Health, October 2007, Brussels (Belgium)
IPH/EPI REPORTS N° 2007
Deposit number: D/2007/2505/46

BELGIAN NATIONAL REPORT ON DRUGS 2007

Bahija Lamkaddem & Marc Roelands (eds.)

Scientific Institute of Public Health
Unit of Epidemiology/Drugs Programme
rue J. Wytsmanstraat 14
B-1050 BRUSSELS
Email: 41Hbirn@iph.fgov.be
http://www.iph.fgov.be/reitox

Authors and contributors

Belgian National Focal Point
Eva Govarts, Guy Jossels, Bahija Lamkaddem, Marc Roelands, Eline Van der Biest

Sub-Focal Points
CTB/ODB: M. Vanderveken
Eurotox: A. Liesse, M. Pozza, M. Rwubusisi
SPZ: H.Simon, O. Threinen
VAD: M.Geimaert, F.Laudens

In addition, for Chapter 11: B. De Ruyver, S. Van Malderen, F. Vander Laenen
For Chapter 12: P. Jamoulle, F.Laudens, B. Lamkaddem

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

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

A. Arcq (Belgian Defense, Addiction unit)
G. De Boeck (NICC)
P. Deblaere (Federal Police, Road traffic division)
P. Demoulin (French Community Administration)
W. De Pauw (Federal Public Service Justice)
P. De Smet (FARES/VRGT and ULB)
J. Dommicent (Federal Police, Drug programme)
K. Doms (Federal Public Service Public Health)
C. Gillard (Federal Public Service Justice)
A.-C. Huwart (Brussels Hepatitis C network)
C. Matheï (Free Clinic Antwerp)
V. Raes (De Sleutel)
K. Ricour (Federal Police, Road traffic division)
A. Sasse (Institute of Public Health, HIV surveillance)
S. Todts (Federal Public Service Justice)
S. Van Malderen (Gent University)

Call for contribution and comments

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

EMCDDA MANAGEMENT BOARD

Philippe DEMOULIN
Directeur Général adjoint f.f.
Administration de la Communauté française
de Belgique
Bd Léopold II, 44
B – 1080 BRUXELLES
Tel : 32-2/413.24.01 ; Fax : 32-2/413.26.13
e-mail: Philippe.Demoulin@cfwb.be

Claude GILLARD
ConseillerJuridique
Direction Générale de la législation
du Ministère de la Justice
Bd de Waterloo, 115
B – 1000 BRUXELLES
Tel : 32-2/542.67.74 ; Fax : 32-2/542.70.35
e-mail : Claude.Gillard@just.fgov.be

EMCDDA SCIENTIFIC COMMITTEE

Brice DE RUYVER
Hoogleraar
Universiteit Gent
Universiteitsstraat, 4
B – 9000 GENT
Tel: 32-9/264.69.37; Fax : 32-9/264.69.71
e-mail : Brice.Deruyver@UGent .be

MINISTERS involved in health problems related to drugs in 2006

Mr. Rudy DEMOTTE
Minister of Public Health and Social Affairs, Belgium

Mr. Benoît CEREXHE
Ministre de l'Economie, de l'Emploi, de la Santé et de la Recherche scientifique, Région Bruxelles-Capitale

Mrs. Christiane VIENNE
Ministre de la Santé, de l'action sociale et de l'Egalité des chances de la Région Wallonne

Mrs. Catherine FONCK
Ministre de la Santé et de l'Enfance et de l'Aide à la jeunesse de la Communauté française de Belgique

Mrs. Inge VERVOTTE
Minister van Welzijn, Gezondheid en Gezin, Vlaamse Gemeenschap

Mr. Bernd GENTGES
Vize-Ministerpräsident, Minister für Ausbildung und Beschäftigung, Soziales und Tourismus

Mr. Guy VANHENGEL
Member of the Health and Budget College in the Brussels Mixed Community Commission

Table of contents

Belgian National Report on Drugs 2007

SUMMARY

National policies and context

In 2006, new laws and directives on drugs were issued. They focus on the following topics:

- Police and prosecution policy concerning driving under the influence of alcohol and drugs,
- Illegal drugs in prison,
- Drug-related public nuisance,
- Introduction of two substances newly considered as “psychotropic” (mCPP and pCPP).

We also note changes concerning laws and policies implementation. The possibility to create “drug plans” in the security and prevention fields is now considered in a long term view. Moreover, funding is now available for projects aiming to reduce drug-related public nuisance but limited to outreach work. Some changes were also made in the criteria for substitution treatment prescription and finally, the obligatory daily notification of the results of drug analyses to the REITOX Focal Point by each clinical and toxicological laboratory was stated in a decree.
It seems that research and prevention remain poorly funded compared to the security and treatment fields (most of the population regard fight against drug traffic as “very important”).

Drug use in the population and specific sub-groups

All recent studies reported the popularity of cannabis among the general population and youngsters. During the school year 2005-2006, the last year prevalence of cannabis use among Flemish teenagers (11-22 years), is about 8% compared to the last year prevalence of use of all other illicit drugs that is 2%. From the school year 2000-2001 to 2005-2006, prevalence of cannabis use seems to slightly decrease and prevalence of other illicit drug use seems to stabilize among this school-age population.

Prevention

Universal prevention programmes, which are under the responsibilities of the Communities and /or Regions, are mainly held in schools and more precisely in the secondary ones. The general population is still interested in information on drugs, even if a decline is perceived in the number of calls received by the regional phone help lines. This could be explained by a more common use of internet mediums like e-mails and websites.
Few projects targeting very specific groups (ethnic groups, children at risk…) were found.
In recreational settings, selective prevention is well developed in the country. Mainly, youngsters are targeted and projects are harm reduction oriented.

Problem drug use and the Treatment Demand population

Thanks to the implementation of a Belgian version of the Treatment Demand Indicator protocol, comparable data on treatment demands at national level are available for the years 2004-2005 since few.
Data from needles exchange programmes still report heroine and cocaine as the more common injecting substances and polydrug use as a common practice.

Drug-related treatment

Since different treatment methods are used and due to the federate political structure, a large diversity of treatment settings exists in Belgium. These settings can be classified in three main groups: a number of treatment centres entered in a revalidation agreement with the federal social security organism and therefore are the so-called “specialised substance abuse treatment centres with RIZIV/INAMI convention”. The second group of services is composed by the psychiatric hospitals and psychiatric units in general hospitals, and the third one consists of Centres for Mental Health Care (CMHC).
The treatment offer is thus very broad and differentiated (residential settings, low-threshold programmes, e.g.), but varies geographically.

Health correlates and consequences

Recent data on drug-related deaths aren’t available for the whole country but general mortality data could be extracted for the Flemish Region and the Brussels Region for the years 1998-2004: opiates are the substances most frequently mentioned on the death certificates and in almost half of the cases, multiple drugs were involved.
Concerning drug related infectious diseases, HIV and hepatitis figures are available for both Flemish and French Regions: the decrease in the proportion of IDU among HIV cases is confirmed, from around 10% in 1986 to approximately 2% in 2006.
In the French Community, the HBV self-reported prevalence between 2003 (30.8%) and 2005 (33.7%) is high and seems to raise. The self-reported HCV prevalence remains quite high in 2003 (71.6%) and 2004 (62.9%) and then drops down in 2005 (32.9%).
In the Flemish Community, the reported data on biological testing for HBV, indicate a decreasing prevalence from 1997(21%) to 2006(15.8%). Results of biological testing for HCV showed a prevalence ranging from 36.2% in 2006 to 40% in 1997 according to source data.
In the framework of the “Road Safety Action Plan”, blood samples were taken during police road controls when results of standardised physical and urine tests were positive. In 2006, out of 1337 samples, 82% were found positive to illicit substance use. The most important substances detected were cannabinoids in almost 50% of those samples.

Responses to health correlates and consequences

An Early Warning System was developed, aiming at the exchange of information on new and/or dangerous drugs. The National Focal Point, Sub-Focal Points, judicial authorities, police, forensic laboratories, emergency wards, help lines e.g. are part of the Early Warning System network. Information on substances and related risks are broadly disseminated. Other instruments of drug-related prevention are the needles exchange programmes, available throughout the country, except in the German speaking Community.
In 2006, approximately 538000 syringes were distributed and 527000 were handed in one of the needles exchange points of the Flemish Community. For the same reference year, in the French Community, around 246 000 were given and approximately 227304 were brought back. Access to other injection equipment is much lower.

Social correlates and consequences

Except the data gathered by the Police, few information is available on social correlates and consequences.
The number of drug related reports made by the police continued to rise in 2006. Cannabis remains the drug that is the most commonly involved in drug reports, followed by amphetamines. In prison, around a fifth of the prisoners declare having experienced problems (physical threatening, theft…) because of drug use during their current detention.

Responses to social correlates and consequences

Social reintegration projects (housing, training, employment) vary according to geographical areas and local programmes.
In 2005, an inter-ministerial conference was held to discuss housing problems: the homelessness issue and – in that frame - the creation of new kinds of "solidarity housing" for socially casualized people was tackled. It seems that few specific housing facilities for homeless drug users exist.
Some projects aimed at socio-professional reintegration of drug users exist in partnership with e.g. centres of social welfare, institutions specialised in employment.
In prisons, health care is provided by the Ministry of Justice. Substitution treatment is available and managed by GPs or psychiatrists. Efforts to better diagnose hepatitis C in prisons started with a new protocol of detection, however this is not yet implemented on a large scale.

Drug markets

The National Security Plan (2004-2007) specifies four objectives with regard to drug issues. Priority is given to the fight against:

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

Police services report that at national level trafficking is mostly polydrug trafficking.
According to the Police data, from 2005 to 2006, prices of illicit substances slightly decreased, only cannabis became a bit more expensive. In 2006, a gram of cannabis was approximately sold at EUR 5 and cocaine at around EUR 48.
A general decrease of mean purity of seized drugs was observed between 2005 and 2006, except for heroin and methamphetamine purity which seem to increase.

Public expenditures

Public expenditures are understood here as "public expenditures by Belgian public authorities (regional, provincial, municipal and depending public services) on policy actions expressly and directly aimed at the issue of illicit drugs". Four categories of drug sectors are taken into account to evaluate the expenditures: "prevention", "treatment", "law enforcement" and "other" (expenditures difficult to clarify in the previously mentioned sectors). A top-down approach (public authorities' drug budgets are collected and analysed) and a bottom-up one (starts from activities in the work field and traces the money flow back to the authorities funding) were used for the collection of financial data.
In Belgium, over 50% of public expenditures on dealing with the drug problem go to law enforcement. The treatment sector accounts for approximately 40% of public expenditures. The prevention sector is dealt with less than 4%. "Other" expenditures are negligible, amounting to only 0.36%.

Vulnerable groups of young people

Since few quantitative studies or field works are centred on specific groups as defined in the EMCDDA guidelines, the amount of available data on vulnerable groups of young people in Belgium is limited.
Some Flemish quantitative data reveal among others that, in services for special youth assistance, 44.9% of the workers are often or always confronted with youngsters having problematic cannabis use.
Moreover, from an anthropological point of view several factors (eg. employment tightening, socio-spatial segregation, family and cultural conflicts, identity problems…) make young people particularly vulnerable to practices linked with drugs. Identifying the

basic processes which produce vulnerability allows outlining an appropriate preventive approach.

PART A. New developments and trends

CHAPTER 1.
National policies and context

In 2006, among others issued laws and decrees, a long-awaited directive focusing on the inmate's rights to get medical and psychosocial care in prison was published. Moreover, new products were introduced in the Royal decree on psychotropic substances (1998), the Narcotic Drug Act was amended and the substitution treatment topic was also tackled in a decree.

According to a new study on drug-related public expenditures released in 2007, research and prevention remain poorly funded compared to the security and treatment fields.

1.1. Legal framework

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

On 31 March 2006, the Minister of Justice and the Council of Prosecutors-general issued a circular on police and prosecution policy concerning driving under the influence of alcohol and drugs. Among others, it stipulates that when the driver is under the influence of certain psychoactive substances, his/her driver's license is immediately suspended, and prosecution before the police court is recommended. Note that this also applies to the person accompanying the driver as a guide / instructor during driving exercise.

The Minister of Justice has drawn up a directive regarding illegal drugs in prison (18 July 2006). The paper states that inmates have the right to get a treatment offer as good as the one proposed outside prison. They should also be considered as autonomous persons that have a part of responsibility in their treatment. A treatment consists of medical and psychosocial care and possible prescription of medicines.
The directive focuses on a close cooperation between prisons and external specialized services. It emphasizes also the importance of prevention and drug possession control inside penal institutions.

The law of 20 July 2006 includes two amendments to the Narcotic Drug Act. First, it gives the town mayor the power to close private places that are nevertheless open to the public (bars for example) for a limited time if there are indications of repeated illegal drug-related activities. Secondly, the law provides the possibility of an administrative arrest for the duration of maximum six hours of a person under influence who causes disorder, danger or disgrace to either himself or others. If needed, the person receives medical care, and will be informed about existing voluntary treatment options.

On 6 October 2006, a Royal Decree was signed modifying the decree on substitution treatment. For further information, see 1.2.c.

The Royal Decree of 22 October 2006 introduces mCPP (m-chlorophenylpiperazine), oCPP (o- chlorophenylpiperazine) and pCPP (p- chlorophenylpiperazine) in the Royal Decree on psychotropic substances of 22 January 1998. This means that from 17 December 2006 onwards, the import, export, production, possession, sale or purchase of mCPP, oCPP and pCPP is subjected to the same rules as for e.g.

MDMA, GHB, Ketamine, etc. Salvorine A is replaced by the psychotropic substance Salvinorine A (Divinorine A), the active principle of Salvia divinorum.
Besides this, the new Royal Decree places plants and part of plants with psychoactive substances in a separate category, subject to the same rules as the psychotropic substances mentioned in Art.2. This is the case for fungi with hallucinogenic characteristics, in particular the Stropharia, Conocybe and Psylocybe species, Khat, Peyotl and Salvia Divinorum.

Finally, a draft circular has been written by the Council of Prosecutors-general concerning the prosecution policy towards "drug tourists". This circular defines drug tourists and divides cases among three different categories, each with their own recommendations concerning seizure (e.g. the drugs, money, mobile phone, vehicle…), arrest, measures, … Furthermore, this circular describes how police and justice organisations stay in touch internationally.
This circular will not be described here more elaborately until it has been officially approved.

For an overview of the main legislative and policy framework, please refer to the previous National Reports.

1.1.b Laws implementation

The Royal Decree of 17 January 2005 providing the possibility to create “drug plans” (local action plans aiming at the prevention of drug-related nuisance and local coordination of the actions taken concerning drug problems) has been replaced by a new one (*Royal decree concerning security and prevention plans - December 7th 2006).* With this decree the security and prevention plans are fitted within a long-term perspective starting on 1st of January for a period of 4 years. The decree describes the practical and financial modalities of the security and prevention plans.

According to the new *Ministerial decree concerning the implementation of security and prevention plans* (*January 15th 2007*), drug-related public nuisance is one of fifteen phenomena for which funding is available in the framework of the security and prevention plans. Though, with this new decree the objectives for projects aiming to reduce drug-related nuisance have been narrowed. The objectives shouldn’t relate to primary prevention or to medical-therapeutical approach. This means that possible projects are in concrete more or less limited to outreach work with a strong emphasis on prevention of nuisance and crime. This issue has been explicitly clarified by the circular of 23 May 2007, clarifying among others the terms "primary prevention" (all the general prevention measures for the benefit of the whole population) and "medical-therapeutical approach" (supplying medical assistance in the counselling of drug addicts). This means that in 2008, costs due to the counselling itself (the medical aspect) cannot be recovered from the security and prevention plans anymore.
The Royal decree of 9 April 2007 determines the conditions for allocation, use and control of the grants received means of these plans.

1.2. Institutional framework, strategies and policies

1.2.a Coordination arrangements

The cooperation agreement of 2 September 2002 between the State and the different federate levels regarding the realisation of a global and integrated drug policy still has to receive the formal approval of the Brussels Capital Region.

1.2.b National plan and /or strategies

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

➢ **Federal level**

At federal level, the government continues the implementation of the Federal Drug Policy Note that started in 2001. In 2002, three pilot projects[1] were initiated in collaboration with the federate entities. They concern specific units for the treatment of patients with dual diagnosis, crisis intervention and case-management projects, and finally the creation and support of networks for integrated drug treatment programs (health coordinator). These projects have been evaluated, but the results have not been published yet.

In 2006, an Addiction Fund was created.Its aim is to encourage and finance innovative projects in the drug field. For the year 2006-2007, 36 projects were financed for an amount of EUR 4665000.

➢ **Federate levels**

♦ **Drug Policy in the Flemish Community**

In the policy paper of the Flemish government ('Flanders 2004-2009'), a paragraph deals with the prevention of addictive substances (tobacco, alcohol and drugs) and expresses the commitment of the Flemish government to strengthen a sustained and integrated prevention policy with extra financial means.
This commitment is repeated in the annual policy paper of the Flemish minister of health.
In 2006, the minister of health organised a Health Conference on tobacco, alcohol and illegal drugs, in which main health objectives are formulated: the general aim is to realise health benefit at a population level by decreasing the use of tobacco, alcohol and illegal drugs with 25% by the year 2015. For illegal drugs, it means that

- the percentage of young people of 17 years or younger whom ever used illegal drugs is not higher than 14%;
- the percentage of young people of 17 years or younger whom used illegal drugs during the last 12 months is not higher than 7%;
- the percentage of people between 18-35 years old whom used illegal drugs during the last 12 months is not higher than 8%.

In addition to these general objectives, evidence based strategies were selected to reach these objectives. These proposals have to be further developed and the minister has to bring a policy plan to the Flemish Commission, the Flemish

[1] More information on these projects on: http://www.health.fgov.be

government and parliament, before a budget can be allocated and the strategies can be put into practice.

The cooperation agreement between the Flemish government and the co-ordinating agency VAD (Vereniging voor Alcohol- en andere Drugproblemen) is renewed in 2006 for a period of 5 years.
The needle exchange programme is also renewed with a new agreement between the Flemish government and the Medical Social Care Centres in each province.

- **Drug Policy in the French Community**

The five-yearly programme on health promotion (2004-2008) defines the priority health issues. Among these, the Minister of Health has further determined the priorities for developing an *operational community programme* (2005-2006). For more information, please refer to last year's Belgian National Report (2006).
A directive has been drawn up focussing on addiction prevention at school (19 July 2006). Four main topics are addressed:

- The addiction prevention approach at school :
  - School should only be dedicated to prevention, not to repression
  - Health as a priority
  - Comprehensive policy involving all psychoactive products

- Goals of addiction prevention policy :
  - informing and giving the students a sense of responsibility concerning drugs
  - directing the students to appropriate specialized structures

- Method and quality criteria of prevention :
  - Global approach: target on all kinds of drugs and student personal development
  - Positive approach: no threat, no repression, prevention
  - Active methods aiming student's participation
  - Information to parents and family
  - Long term action

- French Community structures and resource-services :
  - PMS (Psychological, Medical and Social centres at school) and PSE (Health Promotion at School)
  - Associative intermediaries
  - Documentation centres

- **Drug Policy in the Walloon Region**

The drug policy in the Walloon Region remained unchanged: no new operational community program strictly dedicated to drug addiction has been implemented.

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

The German-speaking Community issued a decree stating the 2006-2007 health promotion guidelines (7 March 2006). Three main topics are tackled in this decree: food, sports and mental health. The drug matter is mentioned within this last framework. The aim up to 2009 is to "Avoid the beginning of legal and illegal drug consumption / restrict the consumption". That goal should be reached through the following action plan:

- Continuation of the "0 Tolerance under 16 years!" project
- Pilot project "Towards a school without tobacco"

- Prohibition to smoke in public corporations/on the work place
- Nicotinic weaning classes to population (courses given in companies for example, informing people about the different possibilities and methods to quit smoking)
- BOB campaigns stressing the fact that, in a group of people, one person not drinking alcohol during the party should be designated to drive the others back home
- Offer cheaper soft drinks (restaurants, clubs…)

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

The drug policy in the Brussels-Capital Region emphasizing demand reduction remained unchanged.

1.2.c Implementation of policies and strategies

- **Federal level**

On 6 October 2006 a Royal Decree was signed modifying the decree on substitution treatment (19 March 2004). This decree states that any physician prescribing substitution treatment for at least 2 patients, should be registered in a day centre, a network for drug users or in a specialized centre for drug treatment. This implies that the physician agrees to follow scientific recommendations regarding substitution treatments, takes care of a psychosocial dimension and keeps several items in the medical file of the patient. Methadone and Buprenorphine are still mentioned as the two substitution substances.
The maximum number of patients by practitioner by year is reduced from 150 in 2004 to 120.

The Royal Decree of 17 October 2006 amends the 2003 Decree on information transmission to the Focal Point in scope of the Early Warning System. This document describes the obligatory daily notification of the results of drug analyses to the REITOX Focal Point by each clinical and toxicological laboratory, even if the analysis was done in the framework of a judicial case. From 23rd December 2006 on, all results of analyses of drug samples (e.g. powders, capsules, tablets, liquids…) which revealed the presence of illegal drugs, except cannabis, and of new synthetic drugs have to be reported. For human samples (blood, urine…), there is only a reporting duty for the results of analyses revealing the presence of new synthetic drugs. Additional, all forensic laboratories have to communicate results of analyses of human samples of person death due to opiates, cocaine, amphetamines and/or ring substituted amphetamines. As new synthetic drugs are considered all substances that are not included in the articles 2 or 25 of the Royal Decree of 22nd January 1998 regulating some psychotropic substances, nor in article 1 of the Royal Decree of 31 December 1930 on the regulation of narcotics but that contain a comparable severe threat to the public health and have a limited therapeutic value. Only end products are considered and no precursors. The data that have to be communicated are maintained but have been clarified for human samples. These include the location of seizure or intoxication, the moment of seizure or intoxication, characteristics of the sample, composition of the sample.

- **Federate levels**

- **Flemish Community**

On 8 November 2006, the Flemish Government signed a decree containing an updated list of drugs considered as illegal in and out of the sports competition context.

A new agreement between the Flemish Government and VAD was signed for a period of 5 years (2006-2010). This agreement includes a policy plan in which 5 main areas of policy implementation are described:

1. Information
2. development of evidence based models and strategies
3. implementation of a Flemish drug prevention policy
4. evaluation
5. training

The implementation is organised in close co-operation with the prevention workers in the Centres for Mental Health. At provincial level, the provincial networks continue their activities as liaison between regional and local prevention workers.
The local prevention workers, working in prevention and security contracts of the ministry of internal affairs are under pressure since a Ministerial Decree of January 2007 limits drug related crime prevention with the exclusion of primary prevention and therapeutic projects. As a result, there is a huge decrease in manpower in the field of drug prevention in Flanders.

1.2.d Impact of policies and strategies

Through the changes of the drug law, a distinction is made between cannabis and other illicit substances. The possession of a small amount of cannabis, even for personal use, still is a criminal offence. However, following the common directive of January 25 2005, the public prosecutor will give the lowest prosecution priority to the possession of cannabis as long as the possession of an amount for personal use (3 grams) is not accompanied by aggravating circumstances or disturbance of the public order.
It is important to note that the criminal law and, as a consequence, the prosecution policy, does not apply to minors. In Belgium, behaviour by minors that is criminalised by law is not called a criminal offence, but “a fact described as an offence” and minors receive a different “measure” instead of a punishment.

1.3. Budget and public expenditure

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

The latest figures on drug-related public expenditures (2002 versus 2004) show a trend towards an increase in the Belgian funds dedicated to prevention, assistance and security (De Ruyver et al 2007). The budgets for these 3 sectors increased with respectively 21.1%, 54.3% and 61.2%. The budgets for policy management and research decreased respectively with 6.0% and 21.0%. However these changes are partly the result of different methodologies used for the 2002 and 2004 estimations. The 2002 estimates are based on staff expenditures only whereas the 2004 estimates also take capital and functioning expenditures into account.
Prevention and research remain very poorly funded. In 2004, the “security” area received 56.2% of the total budget, 39.6% went to “treatment”; 3.8% to “prevention”, 3.8% to “policy management & research”, which is the least financed area.
In 2004, the global public expenditures amounted to EUR 297137441.00. This corresponds to a contribution of EUR 28.57 per inhabitant. Per capita drug-related public expenditures in Belgium are relatively low compared to other European countries (e.g. Netherlands: 134.4 €/capita in 2003 and Sweden: 101€/capita in 2002). For more details on this topic, please refer to chapter 11 of this report.

1.3.b Funding arrangements

The complexity of the Belgian political organisation has an impact on the design of the budget related to drug issues. There are as many financing modes as there are levels of power. In order to reach the objective of a global integrated policy of drugs, all of these actors should agree with it (De Ruyver et al 2004).
The percentages of the financial contributions to the drug policy by the different authorities are presented in the next figure. By "Federal" it should be understood the Federal Government. "Federate entities" regroup the Communities, Regions, and Provinces. It has to be noticed that for "Security" federate entities only correspond to municipalities and cities (Figure 1).

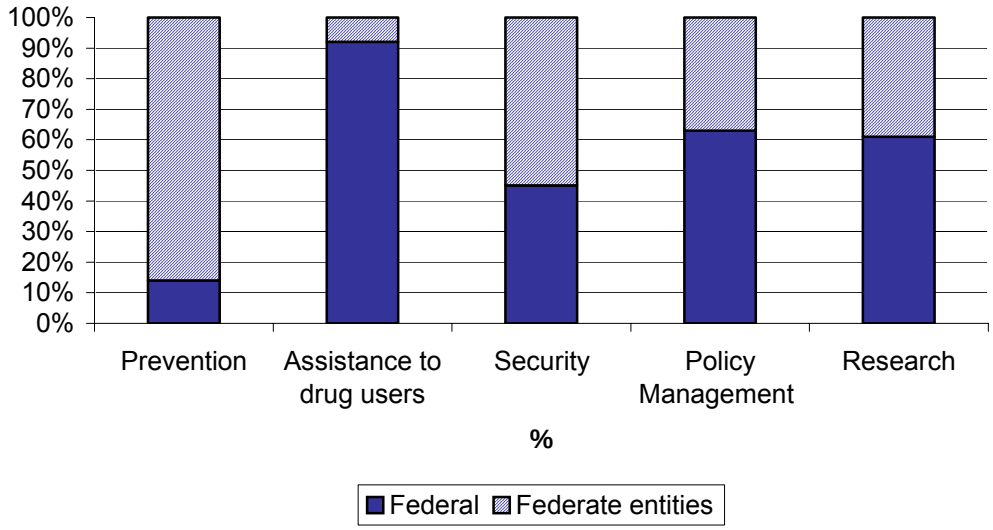

Figure 1: *Percentage of financing for each sector by the Federal Government and the other entities in 2004 (De Ruyver et al 2007)*

From figure 1 it is clear that "prevention" is almost completely under the responsibility of the federate entities. Prevention, financed by the Federal government, may be characterised as prevention of nuisances or prevention of drug related crime. The prevention activities financed by the federate entities are oriented towards well-being and health.
For "assistance" the situation is totally different. "Assistance" is almost completely subsidized by the Federal government. Concerning "security", "policy management" and "research", the financing is more equally distributed between the Federal government and the federate entities.

For more details on this issue, please refer to chapter 11 of this report.

The Minister of Public Health has also established a "Fund to combat addictions". This fund provides a yearly sum of 5000000 EUR to be allocated to projects concerning tobacco (for a total of at least 2000000 EUR), alcohol and other drugs (for a total of maximum 3000000 EUR). To be accepted, these projects should match at least one of the following criteria's: inform about the dangers of drug consumption, reduce the consumption, especially among young people, promote laws comprehension and respect and encourage medical and psychosocial caring.

The choice of projects is not directed "top-down". Instead, organisations can apply spontaneously for funding. A supervising committee makes recommendations to the Minister concerning the choice of projects. The funding procedure has been enacted by the Royal decree of 28 December 2006 and the first list of 36 projects (every one of them by Ministerial decree) has been published on 27 April 2007.

1.3.c Communities and Regions

As presented in previous annual reports, below are given the budgets for the drug demand reduction activities.
Information on the budgets from the Region of Brussels Capital isn't available.
In 2006, the budget supported by the Walloon Region was EUR 1267017.23
In 2006, the annual budget supported by each Community was the following:
Flemish Community: EUR 2375126.00
French Community: EUR 1659562.00
German Community: EUR 357181.15

1.4. Social and cultural context

1.4.a Public opinions of drug issues

- **Eurobarometer**

In 2004, for the second time, a Eurobarometer study "Young people and drugs" was carried out in all EU Member States (EOS Gallup Europe 2004). The sample comprises 7.659 youngsters between 15 and 24 years old.
In Belgium, 83% of the respondents think it is easy to get drugs at parties; sixty percent of the Belgian respondents said it is easy to get drugs in or near school/college.
When asked whether they know people who use cannabis, 74% answered positively. 53% of the respondents know people who use drugs other than cannabis. Half of the Belgian respondents were already offered cannabis, 27% were offered another drug than cannabis. For more info, please refer to the previous National Reports.

- **VRIND**

Since 1996, a survey on public opinion on social issues is regularly carried out among the Flemish population (VRIND, 2007). In 2006 a representative sample of 1500 persons from the Flemish Community was questioned. The results show that 'drug problems among youngsters' is the first problem mentioned before insecurity about pensions and unemployment. Since 1999 drug problems among youngsters is ranked in first position among social issues (Table 1).

Table 1: Percentage of respondents stating drug use as a top 5 problem (VRIND, 2007)

	1997	1999	2000	2003	2006
Use of drugs by youngsters	37.9	39.47	40.4	40.2	35.7

Respondents were also asked to rank the different social issues in order of importance. Males rank drug use among youngsters higher than females (2nd versus 4th place). Drug use among young people is more important as a social issue for the

35-85 year old respondents than for the 18-34 year old respondents. The higher the educational level of the respondents the lower the importance of drug use among young people as a social issue.

1.4.b Attitudes to drugs and drug users

- **Security Monitor**

The Security Monitor 2006, commissioned by the Minister of Internal Affaires, gathered data on security and victimisation among the population as well as on the performance of the police services. A total of 12,000 questionnaires were analysed. All respondents were at least 15 years old.
10.76% of the respondents indicated they definitely experience nuisance related to drug use as a problem in their neighbourhood, while 20.15% rather doesn't, 13.14% a little and 55.05 % doesn't experience it as a problem at all. In general, nuisance related to drug use is more reported as a problem in the Walloon and Brussels Capital Region than in the Flemish Region.
77.34% of the population regard fight against drug traffic as "very important", 18.75% as "rather important", 3% as "rather not important" and 0.75% don't find it "important at all". Furthermore, most respondents think that police is doing a good job concerning drugs: 77.82% express a positive opinion ("good" or "very good" job) of the police's effort in the fight against drug traffic, while 19.17% find it "bad" or "very bad".

- **Leerlingenbevraging ("Student survey")**

In this survey performed in the Flemish Community, children (N=1589) between 12 and 18 years old were asked why youngsters use drugs (Kinable 2006). The most reported answers were: 'to act tough' (54.2%), 'just for the kick' (50.2%), 'pressure from friends' (37.6%) and 'curiosity' (37.2%). The older the respondents are, the more the expected effects of drugs get important e.g. 'to feel great' or 'to relax'.
To the question 'why youngsters don't use drugs?', the most reported answers are: 'afraid to get addicted' (49.0%), 'because they don't need drugs' (33.2%), 'because illegal drugs are dangerous' (28.9%) and 'afraid for the reaction of their parents' (28.5%).
When asked for the reaction of their best friend when he/she would use cannabis, 81.0% of the youngsters think their friend would reject their use. About 15.0% thinks it doesn't matter and almost 3.9% believes that the friend would approve their behaviour. Almost all students think their parents would reject the use of cannabis.

1.4.c Initiatives in parliament and civil society

- **Controlled delivery of pharmaceutical heroin in Liège**

Since 1998, the city of Liège's council wants to apply, as a pilot-project, the controlled delivery of heroin in shooting-rooms. This project would aim drug-addicted persons with whom all other treatments have failed (withdrawal, substitution treatments). Heroin delivery under medical control was also discussed by the federal government with a few other cities since 2005.
The scientific and medical protocol (elaborated by the University of Liège - ULG) were accepted by the political responsible. It was inspired by a similar experience led in Switzerland in the city of Bienne. Both ministers of justice and public health, beyond the mayor and the council of Liège itself, granted their support and funding to the project. This "heroin project" will start at the fall of 2007 and should be ending in 2010.

The declining state of health and the social exclusion of the targeted consumers, as well as a growing "feeling of insecurity" among the population, weighed decisively on the political decision.
The general objectives of this project are: to restore - on the long run - the necessary conditions to a drug-free life, and to decrease delinquent acts. In practice, it will consist of providing 100 consumers of a "control" group with a standard methadone treatment, while a test group of another 100 consumers will be provided with diacetylmorphine (pharmaceutical heroin). Both groups will receive the same psychological, social and medical follow-up. This should allow isolating the effect of the pharmaceutical heroin, compared to the traditional methadone-based treatment.

- **VAD conference**

Every year VAD organises a conference on new trends and topics in the alcohol and drug field. In 2006, the conference was organised around a number of different topics brought in plenary sessions. The topics were cannabis as a risk factor for schizophrenia, residential treatment of double diagnosis patients, party drugs, prevention using non-verbal techniques and controlled heroin prescription.

- **'Trekt uw plant'**

In July 2006 a Flemish organisation 'Trekt uw plant', started a public collective cannabis plantation. Each member of the organisation owned one cannabis plant. The most recent directive allows possession of one cannabis plant. Though police shut down the plantation and arrested several members of 'Trekt uw plant'.

1.4.d Mass Media campaigns

No mass media campaign about drugs has been carried out in Belgium in 2006.

However, in the framework of the Belgian Early Warning System, all the warnings of the Institute of public Health are still published in the media (often involves TV, radio and Print media).
Furthermore, VAD organised one press-conference in 2006 elaborating on the results of a student survey. VAD also issued 5 press-releases covering different topics (presentation annual reports on high school survey, Flemish telephonic helpline and survey in nightlife scene, alcohol research report and cannabis use in Flanders).

CHAPTER 2 .
Drug Use in the General Population and specific sub-groups

Most of the surveys carried out in 2006 and during the previous years show that cannabis is still by far the first illegal substance used or at least experienced by teenagers. The results of the last HBSC and other regional studies are in line with this observation and also reveal that ecstasy and amphetamines are the two most frequently used substances by youngsters after cannabis.

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

2.1. Drug use in the general population

In 2004, the third edition of the National Health Interview Survey was carried out (HIS 2004, 2001, 1997). The objective of this survey is to give a description of the health status of the population in Belgium. The 2004 module only included questions on cannabis (lifetime, last year, last month prevalence and starting age), frequency of use and type of substance.
In 2004, the lifetime prevalence of cannabis use among the general population was 13% (16% in men vs. 10% in women). The last year prevalence of cannabis use was reported to be 5% in the population: 7% in men and 3.2% in women, respectively. Twelve percent of the respondents aged 15 to 24 declared having used cannabis in the last year, while 11% of the 25 to 34 years and 2.3% of the 35 to 44 years declared the same.

The next National Health Interview Survey should be carried out in 2008 and its results will be available in 2009.

2.2. Drug use in the school and youth population

2.2.a ESPAD

From March 2003 to May 2003, the “European School Survey Project on Alcohol and other Drugs” (ESPAD) (Hibell et al 2004) was carried out nationwide for the first time (Lambrecht et al 2004). 2,320 questionnaires were processed for data analysis, focusing on the 15-16 years old.
Lifetime prevalence of any illicit drug use is reported to be 32.6%, with a higher percentage for boys (37.2%) than girls (28.3%). When marijuana and hashish are not included, lifetime prevalence of any other illicit drug is 7.9% (9.1% for boys and 6.7% for girls, respectively). Prevalence of any drug used by intravenous route is for the three prevalence measures below 1% (0.9% for lifetime prevalence, 0.7% for the last year prevalence and 0.5% for the last month). Except for last month prevalence, prevalence is higher among boys than girls.

The next “European School Survey Project on Alcohol and other Drugs” (ESPAD) should be carried out during the spring of 2007.

2.2.b HBSC

The Health Behaviour in School-aged Children aims to gain new insight into, and increase understanding of young people's health and well-being, health behaviours and their social context. This cross-national research study is conducted in collaboration with the WHO Regional Office for Europe and is repeated every four years. In the last HBSC study (French Community: Piette & al., 2007 (University of Brussels) – Flemish Community: Maes & al., 2007 (University of Ghent)), secondary school students (12-18 years old) were asked about their use of drugs and frequency of use (Table 2). There is a slight increase in LTP of cannabis for the pupils aged 17-18 year. LTP of XTC increases slightly between 2002 and 2006 in the Flemish Community. In the French Community, LTP decreases between 2002 and 2006. LTP of amphetamines remained more or less stable between 2002 and 2006 in the Flemish Community.

Table 2: Lifetime prevalence (LTP) of drug use among the school population aged 15-18 years in Flemish and French Community, 1997-2006

			1997/1998	2001/2002	2005/2006
	N	*Fl. Com.*	7.072	16.560	5.606
		Fr.Com.	5.012	5.885	4.698
Cannabis					
15-16	Males	*Fl.Com.*	25.0%	27.6%	29.4%
		Fr. Com.	31.3%	34%	32%
	Females	*Fl.Com.*	16.3%	21.7%	19.7%
		Fr.Com.	25.1%	24%	27.3%
	Mean	**Fl.Com.**	**20.7%**	**24.7%**	**24.6%**
		Fr.Com.	**27.9%**	**29%**	**29.6%**
17-18	Males	*Fl.Com.*	44.7%	45.6%	51.9%
		Fr. Com.	50.6%	49%	55%
	Females	*Fl.Com.*	33.8%	35.8%	35.1%
		Fr. Com.	39.0%	37%	39.3%
	Mean	**Fl.Com.**	**39.3%**	**40.7%**	**43.5%**
		Fr. Com.	**43.9%**	**43%**	**47%**
XTC					
15-16	Males	*Fl.Com.*	3.2%	4.0%	4.5%
		Fr. Com.	7.3%	5%	4.2%
	Females	*Fl.Com.*	1.9%	2.9%	3.0%
		Fr. Com.	5.4%	4%	2.5%
	Mean	**Fl.Com.**	**2.6%**	**3.5%**	**3.8%**
		Fr. Com.	**6.3%**	**4%**	**3.3%**
17-18	Males	*Fl.Com.*	10.1%	9.4%	12.1%
		Fr. Com.	14.4%	8%	8.2%
	Females	*Fl.Com.*	6.1%	5.6%	6.8%
		Fr. Com.	8.9%	7%	4.7%
	Mean	**Fl.Com.**	**8.1%**	**7.5%**	**9.5%**
		Fr. Com.	**11.2%**	**8%**	**6.4%**
Amphetamines					
15-16	Males	*Fl.Com.*	4.1%	3.0%	3.1%
		Fr. Com.	n.a.	1%	n.a.
	Females	*Fl.Com.*	2.6%	2.8%	2.7%
		Fr. Com.	n.a.	1%	n.a.
	Mean	**Fl.Com.**	**3.4%**	**2.9%**	**2.9%**
		Fr. Com.	**n.a.**	**1%**	**n.a.**
17-18	Males	*Fl.Com.*	10.2%	8.3%	8.7%
		Fr. Com.	n.a.	1%	n.a.
	Females	*Fl.Com.*	6.4%	4.9%	5.1%
		Fr. Com.	n.a.	2%	n.a.
	Mean	**Fl.Com.**	**8.3%**	**6.6%**	**6.9%**
		Fr. Com.	**n.a**.	**2%**	**n.a.**

2.2.c Survey in Flemish secondary schools

Table 3: Last year prevalence and frequency of use of illegal drugs (%), VAD, 2005-2006

	Prevalence	
	Boys	**Girls**
Not used last year	88.0	94.4
<1x/week	8.2	4.2
>=1x/week	3.8	1.4

Since 1999, VAD has been conducting a large study in the secondary schools (11-22 years) in the Flemish Community. The three main goals of this study are to draw attention to the importance of drug policy in schools, to study lifestyles of students and to evaluate drug policies in schools. The study uses its own protocol; students are questioned anonymously, in their own classrooms by non familiar teachers. Schools select themselves because they ask to participate. During the school year 2005-2006, 41852 students were questioned (VAD 2007, Standard table 2, 2007). From these, a sample of 1589 questionnaires, representative for grade (age), sex, type of education and type of institution was analysed.

The results of the study show a lifetime prevalence of illegal substance use of 16.5%. In addition, the last year prevalence of illegal substances use amounts to 8.8%.
The frequency of use varies by sex: boys use illegal substances more frequently than girls (Table 3).

Cannabis appears to be the most popular illicit drug used by the Flemish students: 8.5% of them used cannabis during the last year. Only 2.1% of the students have reported the use of illegal drugs other than cannabis during that period (Table 4).

Table 4: Last year prevalence of cannabis and other illegal drugs (%), VAD, 2005-2006

	Not last year	**Last year**
Use of cannabis	91.5	8.5
Use of other illegal drugs (not cannabis)	97.9	2.1

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

Since the school year 2000-2001 lifetime prevalence, last year prevalence and frequency of the use of cannabis declined significantly. This decline occurs primarily in the age group of 15-16, in boys as well as in girls.
During the last six school years, also the use of amphetamines and of hallucinogens has decreased significantly. The (rather marginal) use of all other illegal drugs remained stable during this period (Table 5).

Table 5: Lifetime (LFT) and last year prevalence (LYP) of illegal drugs (%), by school year, gender and age, VAD, 2007

			2000-2001		2001-2002		2002-2003		2003-2004		2004-2005		2005-2006	
	Age	Gender	LFT	LYP	LFT	LYP	LFT	LYP	LFT	LYP	LFT	LYP	LFT	LYP
Cannabis	15-16	boys	33.2	23.0	37.6	27.7	30.6	16.5	37.0	24.7	32.5	19.9	20.7	12.5
		girls	26.2	14.8	23.3	12.9	19.7	11.8	24.5	15.5	18.3	8.3	14.8	6.6
		total	***29.7***	***18.9***	***30.5***	***20.3***	***25.2***	***14.2***	***30.5***	***19.9***	***25.4***	***14.2***	***17.7***	***9.6***
	17-18	boys	51.6	34.0	53.4	36.8	51.1	35.8	55.4	35.3	50.9	30.9	48.0	31.6
		girls	40.7	30.3	39.2	19.0	38.5	16.8	37.7	19.5	32.9	17.7	21.8	12.0
		total	***46.4***	***32.2***	***45.7***	***27.1***	***45.1***	***26.7***	***47.3***	***28.1***	***42.5***	***24.8***	***34.6***	***21.6***
XTC	15-16	boys	4.1	1.2	7.8	3.3	2.9	1.2	5.4	1.8	4.3	2.1	3.5	1.9
		girls	4.9	2.5	2.1	0.8	3.4	2.1	5.5	2.1	3.0	0.9	0.8	0.4
		total	***4.5***	***1.8***	***4.9***	***2.1***	***3.1***	***1.7***	***5.5***	***2.0***	***3.7***	***1.5***	***2.1***	***1.2***
	17-18	boys	10.8	3.8	18.2	7.6	12.4	8.5	7.1	5.5	9.2	4.3	7.3	5.3
		girls	7.6	4.1	9.5	1.3	8.7	2.5	4.5	2.6	7.2	2.1	5.1	2.5
		total	***9.3***	***4.0***	***13.4***	***4.1***	***10.7***	***5.6***	***5.9***	***4.2***	***8.3***	***3.3***	***6.2***	***3.9***
Amphetamines	15-16	boys	6.9	2.4	7.0	3.7	2.9	0.4	4.1	2.7	4.7	2.1	3.5	1.9
		girls	7.0	2.5	2.5	0.4	2.1	0.4	4.3	1.3	1.3	0.9	1.2	0.0
		total	***7.0***	***2.5***	***4.7***	***2.1***	***2.5***	***0.4***	***4.2***	***2.0***	***3.0***	***1.5***	***2.3***	***1.0***
	17-18	boys	12.6	6.3	14.9	6.7	9.6	5.1	8.7	3.3	6.7	1.8	4.7	2.6
		girls	6.8	3.4	6.4	2.5	5.6	1.9	6.5	2.6	5.8	1.4	5.8	3.2
		total	***9.8***	***4.9***	***10.3***	***4.5***	***7.7***	***3.6***	***7.7***	***3.0***	***6.3***	***1.6***	***5.3***	***2.9***
Solvents	15-16	boys	9.0	4.1	12.7	5.3	6.6	1.2	5.8	1.8	3.9	0.4	3.5	1.2
		girls	8.2	2.9	3.3	2.5	3.3	1.3	4.7	0.4	4.3	0.9	2.7	0.0
		total	***8.6***	***3.5***	***8.0***	***3.9***	***5.0***	***1.2***	***5.2***	***1.1***	***4.1***	***0.6***	***3.1***	***0.6***
	17-18	boys	11.3	3.8	10.6	3.8	10.8	2.8	9.2	0.5	8.0	1.8	5.3	2.6
		girls	14.4	0.7	9.5	2.5	5.6	1.2	3.2	1.3	1.4	0.0	3.2	0.0
		total	***12.8***	***2.3***	***10.0***	***3.1***	***8.3***	***2.1***	***6.5***	***0.9***	***5.0***	***1.0***	***4.2***	***1.3***

2.2.d Survey among university and college students in Antwerp

In 2005, the Association of University and Colleges Antwerp, representing more than 27,000 students, participated in a general survey amongst their students. The research project was conducted by four organisations: the University of Antwerp, Altox, SODA and VAD. The main objective of the survey is to provide a reliable base for further strategies in alcohol and drug prevention and counselling in higher education institutions.

A structured questionnaire of 168 questions, including validated assessment instruments (AUDIT, DAST, GHQ-12…), was spread among the students via intranet. Besides questions about personal characteristics, the questionnaire consisted of the following items: prevalence and frequency of (problematic) use of different substances, motives and consequences of substance use, general health, participation in leisure activities, knowledge of networks in drug prevention, counselling and treatment and drug issues in the study curriculum. 5530 students returned a correctly completed questionnaire. This corresponds to 25.9% of the students who use intranet.

The use of alcohol is quite common in the student population. Using the AUDIT-cut-off-score of 16 to indicate high risk drinking behaviour, 10.3% of the male students

and 1.8% of the female student appear to have a high risk for problematic alcohol use. Binge drinking is a risk inducing behaviour for alcohol use disorders. Strong positive correlates were found between the frequency of binge drinking and the AUDIT-score. Binge drinking is more often practiced by male students: about one third of them engage in binge drinking at least once a week. Among female students, this rate is below 10%.
22.1% of the students used cannabis during the last year. About one third of these cannabis users state that they experience some kind of problems or negative consequences due to this use. There is a clear correlation between the frequency of cannabis use and the degree of negative consequences. Other illicit drugs, such as amphetamines, XTC and cocaine, are rather exceptionally used. Between 2.3% and 3.4% of the student population has used these drugs in the past year. Frequent use of these drugs is a marginal phenomenon.
Multi substance use is a risk increasing behaviour for a part of the student population: positive correlations are found between the frequencies of binge drinking and the frequencies of the use of XTC and cocaine.
During the academic year and in holiday periods, the use of alcohol and illicit drugs is significantly higher than in examination periods. During examination periods, the use of stimulant medicine and sedatives or tranquilizers is much higher than in other periods. Two social variables also have a risk enhancing impact:

1. Members of the board of a student organisation drink more alcohol and have higher risks for alcohol use disorders;
2. Students living in a private home consume larger amounts of beer and wine and use cannabis and other drugs more frequently than students still living at home with their parents.

The results show the importance of a broadened prevention focus towards students, since they have specific use patterns and risk behaviours. This does not only occur during the academic year; the exam period and the holiday period host similar risks. This demands particular prevention strategies in the higher education institutions. A more manifest place of substance use items in the study curriculum could serve as a "kill two birds with one stone"-strategy: on one hand it may sensitise the students on the risks of substance abuse, on the other hand it serves as a strategy to enhance the expertise of students who later become prevention intermediaries.
Several strategies will be used for the further dissemination of the results and recommendations, (research report, conferences, articles …).

2.2.e Regional survey by De Sleutel

In 2005, De Sleutel carried out a research project to prepare a cross-border approach for drug prevention in secondary schools (Lombaert, 2005). A random and stratified sample of classes was taken in three provinces: the Dutch province of Zeeland and the Flemish provinces West- and East Flanders. Pupils from the 2nd grade (3rd and 4th year) and the 3rd grade (5th and 6th year) of fulltime secondary schools completed an individual, anonymous and written questionnaire. The results mentioned are based upon 2353 correctly completed questionnaires from West- and East Flanders and weighted for type of education and year of secondary school.
The use of alcohol is most scattered (last year prevalence (LYP) = 90.7%). It is followed by the use of light painkillers (LYP=72.0%) and the use of cigarettes (LYP=42.9%). LYP for illegal drugs is 23.9%. Within the group of illegal drugs cannabis is used most (LYP= 23.4%) followed by XTC (LYP=3.1%) and ATS (LYP= 2.4%). 10.9% of respondents combined alcohol and cannabis over the last year and 3.4% combined alcohol and medication.

Within the group respondents who used cannabis last year 1 in 3 used cannabis 1-2 times over the last year, 1 in 6 used it between 3 and 5 times, 1 in 3 used it between 6 and 40 times and 1 in 6 used it more than 40 times.
Early starters were defined as those pupils who started using a substance at 13 years old or younger. 62.3% of respondents are early starters for alcohol. More than one third (35.0%) of respondents are early starters for cigarettes, 7.5% for tranquillizers without prescription and 7.9% for cannabis. 2.4% of all pupils was 13 years or younger when they first used alcohol combined with cannabis.
A clear relation has been found between the 4 most used substances: cigarettes, alcohol, tranquillizers and cannabis. Schoolboys/ -girls that ever used one of those substances have more chance to have used one of the other substances too. The same can be said for recent use.
This study also assessed the influence of internal and external factors on drug use. An overview of these factors can be found in the BIRN report 2006.

2.2.f Study among students in Hainaut

Through a study on the prevalence of cardio vascular risk factors held from October 2003 to May 2004 in the Hainaut area (Observatoire de la santé du Hainaut, Robert Jates, personal communication, 2006), exposure to drugs and experimentation with drugs were investigated. The study targeted students enrolled at a general school.
The trends already observed in other studies focusing on young people were confirmed: the older the youngsters are, the more likely it is that they know people among their close relations who use drugs (21% knows a drug user at 10.48% and 13.70% at 16 years old). In the same way, the probability to have already had a proposition to try or to use drugs is clearly raising with age. Globally, boys are more exposed than girls.
For 13 and 16 years old groups, cannabis is the substance most commonly used (88% and 95%). Over 50% have used drugs once or more during the last month in both categories.
According to the study results, health promotion action should be implemented before the age of 13.

2.2.g Young applicants for a post in the army

Each year, selections for new applicants wishing to enter the army (all kind of posts) are organized. These selections consist in different tests (medical, physical, school knowledge…). During this process, the applicants have to fill in forms containing – among others –questions about a potential drug use. These questions are strictly anonymous and aren't taken into account for the selection.

In 2006, 1279 candidates between 17 and 28 years old filled these forms in. The results showed that 39.49% had already been using drugs and 8.75% still did at the time of the selection. (Arcq, personal communication)
Concerning the type of drug used; 77.39% declared using or having used cannabis, 9.57% XTC and 6.09% cocaine (Table 6).
Most of them consumed drugs with other people (55.87% vs. 9.71% alone). The given reasons for using drugs were: "for fun" (19.78%), "to feel good" (3.02%), "to do like the others" (1.87%) and "to help coping with a difficulty" (1.12%).

Table 6: Percentages of drugs used by the army applicants in 2005-2006

	2005 (N = 1320)	2006 (N = 1279)
Cannabis	74.00	77.39
XTC	10.67	9.57
Cocaine	6.67	6.09
Speed	4.22	5.22
Hallucinogenic mushrooms	1.33	0.87
Psylocyble	1.11	1.74
GHB	0.44	0.32

2.3. Drug use among specific groups

2.3.a Drug use among sex workers

In the **French Community**, data on drug use among sex workers are collected since 1998 through vaccination campaigns against hepatitis B. Three large cities and their surroundings were monitored on that occasion by the NGO Espace P: Liège, Namur and Charleroi.
From March 1998 until December 2006, 1492 questionnaires were completed. They were filled in when sex workers were vaccinated and during face-to-face interviews by social workers of the non profit organisation Espace P. Since the sample couldn't be selected randomly (practical imperatives, strategic choices), note that the data aren't representative of the prostitutes in general.
The study tackled drug use since injecting is a route for HBV infection.

Respondents were predominantly females (97%) with a mean age of 31.4 years. Sex workers enrolled were mostly working in public places as bars, clubs, showcases, and saloons. Sex workers in private (with appointments) are much more difficult to reach. This explains why they are less represented in these data.
Among the respondents, 12.4% declared to use drugs and 5.8% were injecting drug users (IDU). Since the percentage of missing answers is about 25%, these results should be interpreted cautiously. This is essentially explained by social workers' difficulties to ask about injecting drug use during the first contact.

Non-injecting drugs are more used by Belgians (14.6%) than by non-Belgians persons (7.1%). However, there is no significant difference between these two groups concerning injecting drug use (6.5% Belgians, 4% non-Belgians).
Besides, a statistically significant association was also observed between age and drug use. Concerning non injecting drug use, 9.8% of the persons under 25 years old use non injecting drugs, 8.4% in the age group from 25 to 34 years old, and 1.7% in the group 35 years old and more. Prevalence of IDU's reaches its peak (7.6%) in the age category of 25-34 years old.

As stressed by the study, non-Belgian sex workers or sex workers on the street or in bars have worse social insurance and worse health care access than others. The results pointed out that there are more non-Belgian sex workers who work in bars or street, which is a double risk.
Data show a significant rise of drug use (IDU and non-IDU) among sex workers (from 5% in 1998 to almost 20% in 2006) (Figure 2).

The persons were screened for HBV, HCV, HIV and syphilis. Regarding HCV, injecting drug use was identified as a risk factor and not the prostitution itself. Indeed,

though a sero-prevalence of 2.5% was observed among sex workers, 16.4% of the sex workers (ex)IDUs were HCV positive, for a little less than 1.6% of the sex workers non-(ex)IDUs.

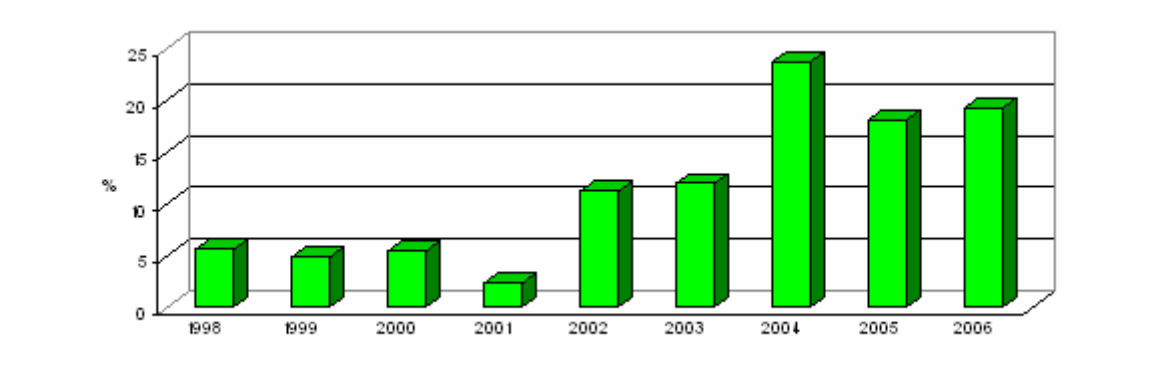

Figure 2 : *Drug use in sex workers, Belgium, 1998 - 2006 (Espace P, 1998-2006)*

2.3.b Drug use in recreational settings

- **VAD « Uitgaansonderzoek »**

Since 2003 VAD conducts research on drug use in different nightlife settings. The main objectives are to study (patterns of) drug use and characteristics of drug users in the nightlife scene.
In 2003 the research started with a survey. In 2004, VAD used a qualitative (face-to-face interviews) methodology to interpret the 2003 survey data, followed again by a survey in 2005. In 2006, the report of the survey was completed and compared with the results from 2003.
Each year respondents were recruited in Flanders in 3 clubs and on 3 events.
In 2003 and 2005, a total of 1.368 respondents completed the questionnaire. Almost half of the respondents used an illegal drug during the last year.
The most used illegal drugs is cannabis. But the last year use of cannabis has decreased between 2003 and 2005. More specifically the proportion of regular users has decreased. Still one out of ten illegal respondents use cannabis on a daily basis.
Second most used illegal drug is XTC: one out of six respondents took a XTC during the last year. One out of eight respondents used cocaine in the last year. International studies and different sources in Flanders show an increase in the use of cocaine. However a comparison between 2003 and 2005 in VAD's research showed no indication of increased cocaine use.
Speed is almost exclusively quoted as 'ever used, but not during the last year' and in comparison with 2003 the use of speed has decreased. The use of GHB, Ketamine and Viagra is limited in the study population.
Almost half of the last year users of illegal drugs regularly combined alcohol with an illegal drug and one out of four combined different illegal drugs. The same pattern of polydrug use is found in the results of 2003.
The last year users of illegal drugs took their drugs mainly while going out and in the company of friends. Cannabis and cocaine are often used before and after going out.
Four out of five users buy their drugs by themselves and mostly before going out.

- **Modus Vivendi harm reduction activities**

Through harm reduction activities carried out by the non-profit organisation "Modus Vivendi" and its partners, data are collected in various locations of the French Community. Since 2000, more than 10 different types of events per year are

targeted. Festivals (rock, techno, hip hop, house music), megadancings, city parades, rave parties, traditional events are the main places where questionnaires are filled in. In 2006, 140 events have been covered by 30 associations who meet in total 2313 persons. If possible, questionnaires are filled in and, in 2006, 2313 persons were met during 76 events covered by 12 partners.

Differences in the methodology of the data collection have to be taken into account in the data interpretation.
For example:

- the sample size in one location may be very small,
- the method of recruitment of the respondents varies in function of the event,
- over the years, some changes have been introduced in the questionnaires[2].

It should be noted that the sample of persons who fill in a questionnaire is not representative of the public of the event. Moreover, the sample of events covered by the associations is not representative of all events organised in Belgium (for example, free parties).

The data remain an excellent indicator:

- to evaluate the adequacy of the action with the public of the event
- to adapt the action according to changes/evolution in drug use and behaviours
- to facilitate the contact with the public
- to monitor the characteristics of the population met through harm reduction activities implemented in recreational settings
- to assess the public's knowledge about the risky transmission of HIV and hepatitis (via tattoo, piercing)

Table 7 gives an indication of the prevalence of drug use among the respondents met by "Modus Vivendi". Data of all the events from 2000 to 2006 are pooled.

In 2006, 65% of respondents during all covered events reported an illicit drug use during the last month, and 50% a drug other than cannabis. Among these respondents, 2% use drug by injection.
The most popular illicit drugs are cannabis (44%), amphetamines (17%), ecstasy (15%), cocaine (10%) and hallucinogens (9%).

[2] When created, the goal of this questionnaire was double: the first intention was to collect data and also to establish a contact with persons who were at the event.

Table 7 : Percentages of "current"* drug use in recreational settings, French Community, 2000-2006

	2000 N=1628	**2001** N= 926	**2002** N= 1568	**2003** N= 861	**2004** N=11	**2005** N=1510	**2006** N=2313
Number of events	n.a.	n.a.	10	10	38	48	76
Amphetamines	20	10	9	18	17	15	17
Cannabis	67	62	47	45	51	45	44
Cocaine	21	10	8	11	12	12	10
Crack	6	1	2	3	3	4	3
GHB	n.a.	1	2	2	2	3	2
Heroin	7	2	1	3	3	3	3
Ketamin	n.a.	2	1	3	1	2	2
LSD	14	11	4	5	5	5	5
Hallucinogens	28	30	10	7	11	10	9
XTC	31	23	16	27	21	16	15
Benzodiazepines	7	2	3	6	9	8	6
Injection	1	2	2	2	2	2	2
Any illegal drug	70	67	46	49	58	52	65
Any illegal drug w/out			29	36	31	28	50
Tobacco	n.a.	n.a.	n.a.	49	47	47	46
Alcohol	85	43	81	72	76	75	75

*In 2000, current = last 6 months prevalence, after 2001 current = last month prevalence.

2.3.c Drug use among ethnic minorities

➢ **BELSPO project**

A study project of the Federal Scientific Policy (BELSPO) about the ethnical minorities' addiction care route is currently being carried out. The results should be available in the fall of 2007.

2.3.d Drug use among prisoners

From October to November 2006, a study in all Belgian prisons was undertaken (Todts et al 2007). Its aim was to estimate the drug use prevalence and the related risk behaviours among prisoners. A representative sample of 902 prisoners could be interviewed.

The majority of the respondents were men (94.5%) and more than 40% of the prisoners were more than 35 years old. Around one third (34%) of the respondents declared being detained because of drug dealing, possession and drug use and also for reasons linked or not to drugs.

Sixty per cent of the interviewees state having used one illicit drug at least once in their lifetime and 29.5% declared having used drug(s) in prison. Among those consuming in prison, 92.5% use cannabis (or by-products), 40.6% use heroin and 39.5% use non prescribed sleeping drugs or tranquilizers.

Six per cent of all prisoners declare having been initiated to heroin use in prison.

CHAPTER 3.
Prevention

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

In the Flemish and German Community, VAD and ASL were respectively designated as official structures for the coordination of the respective prevention policies. In the French Community, a similar structure does not exist; prevention is under the responsibility of the Ministry of Health.

Prevention, namely health promotion, among the school population targets mainly secondary schools, but policies encourage prevention activities in the whole range of schools.
Prevention activities seem to become more numerous and varied although they generally still don't aim at some specific groups.

3.1. Universal prevention

3.1.a School

- **Situation**

Prevention activities in schools are identified in the Federal Drug Policy Note as essential. This document also stresses the necessity to continue developing prevention in this area. It also recommends organising coordination of prevention activities as actors are numerous and operating at different levels.
In the Flemish and German speaking Community, VAD and ASL work respectively as official co-ordination structures. Within the French Community, there is no official coordination structure at the level of the community (however, coordination exists at local levels).
Prevention programmes are listed in the standard table 19 (2003).

The decree of the **French Community** related to Health Promotion of December 20, 2001 reorganised the mission of the service for Promotion of Health in Schools (PSE). The use of these services and centres is free. Also now their mission is to ensure the wellbeing of the children in their environment.
PSE has to take into account the health of the children as a whole, ensuring and developing the quality of life and wellbeing at school; setting up projects for aiming at pleasant school environments, making it a place of exchange and communication.
A new decree on the trainings of school professionals during their career was published by the French Community in July 2002 (11 July 2002). It created a new framework, controlled by an "Institute of training courses", and which the services of prevention targeting schools should enter, in order to continue their actions.
The main change is the following: a section on "collective training" replaces the former "pedagogic days", which were followed individually. Concretely, the schools can close six times in a year for half-a-day, to allow teachers to follow the trainings registered in their network. The same is true for the psychological-medical-social centres related to schools. The various sectors offering trainings (including the sector of drug-addiction prevention) must get into position of being included in these new networks if they want to be referred to for these "collective trainings".

Different attitudes are already observed in the sector: some organisations embrace that positioning, while others are more reluctant to work in the framework of that relatively new decree.
In 2004, prevention programmes in schools funded by the Ministry of Health were mostly the initiative of a large number of different NGO's. Following the decree, the projects are based on health promotion, training of adults (teachers, educators, psycho-social workers) and need to be evaluated. These services assist school authorities in solving problems related to drug use, in developing policies regarding the use of drugs and in providing a methodological support to develop tailor made school projects of prevention, involving all actors: students, directors, teachers and parents. Besides these projects, a wide range of local initiatives exist, which are implemented by local authorities.

In the **Flemish Community**, the "school drug policy" is a prevention concept based on three parts: 'regulation', 'education & structural measures', and 'counselling'. The part 'regulation' indicates the limits of what is acceptable, describes the rules concerning drug use and defines the procedures to deal with drug related incidents.
The part 'education & structural measures' focuses on information, attitudes and social skills as well as on the school climate. The approach in kindergarten and primary schools is integrated within the framework of health education and health promotion, in which life skills training and a supporting class- and school-environment are the most important elements. Secondary school education is based on the same framework, but is also characterised by more drug specific activities and teaching packages. To motivate and facilitate healthy behaviour, repetition is necessary.
In the part 'counselling', attention is given to the creation of networks around the school - including school, parents, school health service, prevention workers, social workers - and to the training of teachers in early intervention methods and referral.
A drug policy at school should be set up together with all partners involved in the school setting: students, teachers, other school personnel, parents (associations), school health service, etc and should include tools to evaluate the drug policy.
Training is offered to all these parties to support them in dealing with the different aspects of a drug policy launched at school.
School advisory services give free and multidisciplinary support to students, parents, teachers and schools. These services are active in four fields: preventive healthcare (health promotion of which drug prevention is one aspect), learning and studying, study career, and psychological and social functioning. Advisory services negotiate policy agreements with schools to determine the responsibilities of both schools and advisory services in these four fields.
Specialised health organisations offer a broad range of interventions from training, education and support (for pupils, teachers and parents) to ready-made didactical packages and educational projects. These packages and projects are often grounded in different prevention models.
Evaluation of the prevention projects on a regular basis is also considered as important.

In the **German Community**, priority is still given to prevention projects on alcohol use but more recently also attention is paid to the prevention of tobacco use. A pilot project on tobacco abstinence and prevention of use will be carried out in two schools.
Preventive activities are carried out on a voluntary basis in schools with the collaboration of the local police or ASL.

➢ **Evaluation**

In the **French Community**, all health promotion projects funded by the French Community must have an evaluation built in the project. In addition, one department in the University of Liege -APES[3] - could provide technical support and advise the promoters of health promotion projects.
Most evaluations are "process evaluations" and are led by an internal evaluator. Funding for impact evaluation is most limited.

Despite the numerous recommendations (*inter alia* by the "college of experts" – see chapter 1), prevention activities (MEGA) carried out by police services in French-speaking schools are still common. Indeed, many school directors have difficulties to adopt a prevention policy and are easily seduced by prevention projects carried out by police services, because they are accessible, visible and free of costs. In 2006, many police interventions (drugs search operations) occurred in schools.

Let's remind that the "College of experts" also recommended informing parents' federations (UFAPEC, FAPEO) of the French Community about the place of health promotion in schools and about available specialised services. Moreover, a commission of the "promotion of health at school" services ("PSE", see here above) was created. It involves various actors of the field of health promotion but also spokesmen of the UFAPEC and the FAPEO. Since the PSE services are first line responsible of health wellbeing at school, including *inter alia* drug addictions, the mission of information of pupil's parents is at least partly fulfilled in the framework of that commission.

In the **Flemish Community**, monitoring data from the Ginger programme 2005 showed that about a third of registered prevention activities took place in the educational sector (Rosiers 2006). It is the most reached sector. Two third of the activities in the educational sector are organised in secondary schools. Prevention activities in schools mostly consist of training students and teachers, and organising consultation with teachers and the school board. The monitoring results of 2005 confirm the growing importance of higher educational institutions as a partner for alcohol and drug prevention.
About a fifth of all alcohol and drug prevention activities in Flanders take place in a context of inter-sector-based collaboration (different sectors participate in one activity). Compared to previous years, the health sector becomes a more important partner in alcohol and drug prevention. With regard to prevention activities that are organised in or with the health sector, prevention workers of the regional Centres for Mental Health are the main actors.

In the **German Community**, a new prevention project named "0/000 under 16 years!" was launched in 2005 (see 1.2.b). It consisted of informing young people and their parents about alcohol use but also in establishing contacts with bars owners who agreed not to sell alcohol to young people under 16 years. Also more activities are organised during the carnival.

3.1.b Family

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

[3] Appui en Promotion et Education pour la Santé

➢ **French Community**

In 2005, modules of training on "Addiction and parenthood" continued to be organised, targeting the professionals of the pre and postnatal clinics of the ONE (National office for childhood), i.e. medico-social workers: nurses, welfare officers.
Parents could also be informed through pedagogical school prevention activities.

Moreover, the 24/7 telephone helpline of Infor-Drogues answers numerous "FAQ" on its website, targeting specifically parents, answering questions such as *"How to talk about drugs to my children"* or *"I suspect my son to smoke cannabis, what can I do?"*

♦ **Parentalité-Addiction project**

"Parentalité-Addiction" ("Parenthood-Addiction) is a multidisciplinary team created in the framework of a public clinic (Saint-Pierre, public hospital of the Public Centre of Welfare in Brussels).
The « Parentalité-Addiction » objectives are on one hand, to stabilize the drug consumption of the parents (especially the mother) during the pregnancy and the post-partum and, on the other hand, to prevent the damages suffered by the baby, including withdrawal syndrome after the birth. Other aims are the improvement of the early relationship between the baby and his family circle, the reduction of neglecting or ill-treatment behaviours as well as the social insertion of the family.
In the medical field, a substitution treatment can be considered for the mother, as well as a withdrawal. But it must be a slightly decreasing, or in some cases stable substitution, since a brutal decrease could be damaging for the cerebral and organic development during the first trimester or during the last one (neuronal migration).
In the psychological field, the pre-birth interviews can be individual or in couple. Mostly, the mother comes alone.
In the social field, a social assistant helps the future parents to stabilise their social and administrative situation.
Mothers are occasionally re-directed towards more specialized organizations such as a maternal house or a protected residence.
A particular affective preparation to the birth is also proposed, in the sense that techniques of haptonomy are applied. That discipline develops the affective confidence through the touch. It meets an increasing success among these future parents since the mothers often have a painful relation to their own body, which they uneasily invest as a receptacle of their future baby. Haptonomy can provide them some tools to recognize that body and to establish a contact, by the touch, with the baby they carry. The father, if present, is invited to take part to that (re)discovery.
The team also ensures a medical and psychological accompaniment in case of hospitalization of the baby for withdrawal syndrome. After the hospitalization, the child goes home with a treatment and an ambulatory follow-up is organised at the paediatric department of the hospital.
For older children, specific means of expression are proposed since children mostly express their emotions by somatic manifestations rather than by words. Children can use paper, pencils, modelling clay, toys and books to represent what they feel. If necessary, a follow-up is proposed or in some cases imposed, since dangerous situations can be mentioned to the Specialised Youth Help or Youth Protection.
Beyond that, a psychologist can also follow the child at home when the parents show difficulties to respect a timetable. Finally, a follow-up can be pursued at the office of "Les Alizés" (a department of "Parentalité-Addictions"), where parents can meet other families, which turned out to meet their demand by enlarging their contacts with other "at-risk" families.

➢ **Flemish Community**

In 2006, VAD used 3 publications with 'parents' as target group. Parents are, in consideration of drug use and drug problems of their children, the most concerned.

- Brochure 'Tieners, alcohol en drugs' (Teens, alcohol and drugs. Information for parents of children 10-12 years old'). This brochure wants to inform parents and other educators (also grandparents) how they can prepare their children when they first come into contact with alcohol, smoking and the use of cannabis. Two important aims are linked to this brochure namely: to postpone the onset of drinking and smoking, and to support the non-use as important parenting norm for as well drinking, smoking as the use of cannabis.
- Flyer 'Ouder zoekt info' (Parent search information). Target group: parents. This flyer gives an overview of available folders and brochures for parents and other educators about drugs and drug prevention. The flyer is available for free and is distributed (among other places) in waiting rooms of GPs and in public libraries.
- Flyer 'Alcohol en drugs' (Alcohol and drugs). Giving attention to parents and families) Target group: social workers, GP's, school health services, primary health care workers. This flyer gives an overview of the available support for parents about drugs, drug prevention and care. The flyer is for free.

DrugLijn has put large amounts of information on its website. Besides the common information about the products, the law, the risks, and other random information, parents can also find some specific information on how to address the drugs use of their child. For example: how they can discuss the topic with their children, what they can do to help and a list of interesting books and brochures…. Parents have been for a long time the most important target group which contacts The DrugLijn. Over the years this resulted in a number of brochures on frequently asked questions.

The DrugLijn participates in sensitising campaigns set up by VAD. In 2006, a yearly alcohol campaign focused on partners of people with drink problems. "Als je partner drinkt" invited them to anonymously contact the DrugLijn in order to simply order self-help-booklets or to talk about their problems as a partner. The huge response had its impact on the figures of the helpline for 2006, showing a global increase in the number of calls and e-mail-enquiries on alcohol and from partners.

The registration programme 'Ginger' (created in 1996 to monitor prevention activities in the Flemish community) showed that, in 2006, 50 workshops or information sessions were given to parents of adolescents. The aim of such workshops are to inform parents about drugs and drug use and improve their awareness, skills and ability to positively influence their children.
In general most prevention workers find parents hard to reach of difficult to access.

VAD, in cooperation with counsellors of parent support group, compiled a work map '*Groepswerking ter Ondersteuning van Ouders met Druggebruikende kinderen. Leidraad voor begeleiders* '(Support group for Parents with drug using children. A manual for facilitators). The work map focuses on different subjects (and working materials) such as influence and communication, substance use and the family, motivation to behavioural change, adolescent development and responsibility, self-care and resources. In 2006 the work map was the subject of an evaluation-research. The results of the evaluation will be made public in 2007.

VAD developed a work manual on psycho-education for family members. This manual offers didactical support to care workers who want to inform family members

about the specific perception, consequences and coping possibilities of living together with an alcohol or drug abuser.

➢ **German Community**

For several years the ASL offers education-trainings for interested parents. In this project the parents are used to further distribute the training's content. ASL cares for several groups of single parent families and it arranges activities and holiday-trips with these groups. A self-help group for parents of addicted adults or teenagers was created in 2002.
In addition, the "ligues des familles" (English: associations of families) organizes other educational trainings.

3.1.c Community

➢ **Helplines**

Infor-Drogues and the DrugLijn are respectively the drug helplines for the French and Flemish Communities (Infor-Drogues 2006, DrugLijn 2006). These services not only operate a telephone helpline. Since a few years, both provide an e-mail counselling service through their website

Results indicate that females constitute the larger part of callers and mailers (Table 8). In both communities cannabis is the substance for which questions are most frequently asked.

Table 8: Frequency of substances in related calls (%), Infor-Drogues, Druglijn 2005-2006

	Infor-Drogues		Druglijn*	
	2005	**2006**	**2005**	**2006**
Number of calls	5031	4268	6227	6378
Males	35.9	36,4	41.0	39.1
Females	59.1	63,6	59.0	60.9
Involved substances in calls				
Cannabis	37	34	35.6	34.0
Cocaine	15	17.5	17.2	17.2
XTC	4.3	4.5	8.1	7.4
Heroin	8.6	8.2	7.6	7.3
Alcohol	11	11	18.1	21.9
Psychoactive medicines	6.2	6.4	9.3	8.7
Crack**	3.3	4.2	n.a	n.a
Methadone	5.6	5.3	3.1	3.4
LSD	0.9	1.2	1.0	1.0
Amphetamine	2.3	2.6	10.2	12.1

*Figures for the DrugLijn include telephone calls as well as enquiries by e-mail.
**Since 2004, crack is distinguished from cocaine.

In 2006, the **DrugLijn** saw a continuation of the decrease in the number of calls (-7% compared to 2005). On the other hand, the number of enquiries via e-mail continues to increase strongly (+38% compared to 2005). The most important trend in the enquiries of the DrugLijn in 2006 is the further decrease regarding the number of questions on cannabis (a decrease that was first noticed in 2005). Still it remains the most mentioned substance. The increase in questions on cocaine over the last years seemed to have stopped in 2006 (an increase from 10% in 2000 to 17.2% in 2005 as well as 2006). Questions about alcohol increased strongly, but this is mainly a consequence of the alcohol-campaign "Als je partner drinkt" in which the line participated. Also the number of enquiries on methadone increased in 2006. The

number of questions about XTC continued to decrease, whereas those on amphetamines (speed) rose.
Overall, the decline in number of telephone calls at the DrugLijn, is largely compensated by the increase in e-mail-enquiries. This pushed the total number of questions answered to 6378, an increase of 151 compared to 2005. The DrugLijn noticed that less young people, but more parents use the telephone line, while parents hardly send any e-mails. The e-mail service is mainly popular with young people, amongst which a lot of students. The percentage of drug users, partners and siblings of drug users using e-mail equal those using the telephone.
The fact that 3 out of 10 enquiries the DrugLijn gets are made via e-mails is showing more and more impact on the global figures of the helpline. One example is the fact that for the first time since the line was launched (in 1994) users and ex-users and no longer parents are biggest target group contacting the DrugLijn.

The DrugLijn received 7276 calls in total. Among them, 2419 were outside the opening hours (Mon-Fri 15-21h and Sat 15-21h and since august 2006 Mon-Fri 10-20h) when an IVR (Interactive Voice Response system) is operated; 339 were hoax calls, leaving 4518 effective calls (compared to 4879 in 2005: –7%). On top of that the helpline answered 1,860 inquiries by e-mail.
About one in four callers (26%) are users and ex-users; 32% are parents; 23% family members, partners and friends; 10% intermediates; 8% are simply “interested” persons. Among those using e-mail the “interested” persons (often students) are by far the biggest group (33%). Users and ex-users also represent 28%; only 9% are parents; 24% family members, partners and friends; 6% intermediates
Six calls out of ten concern information on specific substances: mostly about the global effects and risks of specific drugs, about blood- and urine testing, legal information, indications of drug use and withdrawal symptoms.
One call out of two was related to prevention or treatment questions. Most referrals made by the DrugLijn are towards outpatients settings.
In eight calls out of ten some kind of emotional or relational problems were discussed (mostly child-parent-relations, problems with one’s own use and problems in partner-relations).

In 2006, **Infor-Drogues** registered 4268 contacts. Among these, 93% were phone calls and 7% written contacts, e-mail contacts or visits.
In comparison with the previous year, the number of contacts decreased of 15%. This is probably compensated by visits on the website that seems to answer to many questions about products and by the opening of an e-permanence service in May 2005. In 2006, 265 messages were received by the internet permanence, the large majority of them sent by users younger than the ones who usually contact Infor-Drogues by telephone. The public targeted by the E-permanence is indeed young, impulsive, and not necessarily ready to wait on the telephone. Most of the time, they are used to obtain direct answers through the Internet, without bothering to start a therapeutic or help relationship and to give an identity.
Globally, more than 60 % of contacts come from females. Nevertheless, the proportion men-women raise up with age to reach 48% in the 26-35 year old group then diminish to 34% in the 36-50 year old group to drop at 27 % in the over 50 years old group .
In 2006, 46% of all contacts were relatives and friends of drug users (half of them are mothers) and 11 % were professionals. Sometimes people have no evidence of drug use but want to prevent future use.
As mentioned above, cannabis is related in 34% of the calls; cocaine is coming in second place with 18%.
When crack and cocaine are combined, they represent 22% of the calls.

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

Table 9: Frequency by age of callers (%), Infor-Drogues, Druglijn, 2006

	Infor-Drogues	Druglijn*
Under 18	2	11.0
18-25	12.5	24.6
26-35	25	21.1
36-50	42.7	32.5
50 and older	17.8	10.9

*Only 1 in 3 callers is asked about their age; the results are only indicative. E-mailers are free to fill in their age in the question form (78% of them do so).

The higher number of under 25 year olds in the figures of the DrugLijn is at least partly due to the success of the e-mail service among young people.

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

➢ Ethnic groups

♦ French Community

Except the "Projet Matongé" - which has launched a prevention project focussing on a sub-Saharian African community living in a particular neighbourhood of Brussels called Matongé - specific actions for ethnic groups are seldom or not available. The Matongé project makes use of the own resources of that particular community, depending on a common cultural fellowship.

However, another organisation, Espace P[4], although it has no specific project for ethnic groups, takes into account the specific characteristics related to the origin of its public: specialized workers known as "cultural relays" (outreach workers of same origin and language) are hired to ensure appropriate contacts with sex workers coming from the former East Bloc (males and females), from Africa (French-speaking and English-Speaking women) and South-America (women, transsexuals and transvestites ("drag queens"). For example, the south-American males tend to minimise or deny both drug use and prostitution, which requires a specific approach. The 20 French-speaking African sex workers followed in Brussels tended to deny the HIV risk and to avoid the screening, and were unconfident of the Belgian social services. Notice that their "relay" African worker had to stop his activities and still wasn't replaced at the end of 2006, due to a lack of means. In Liège and Seraing, English-speaking African workers ensure the cultural relay towards their fellow countrymen.

[4] Espace P is a centre that gives orientation and assistance for sex workers, their customers and their entourage.

♦ **Flemish Community**
In the city of Antwerp prevention initiatives towards the Moroccan and Turkish community, use existing local networks of associations (Crombé, 2007). The heads and leaders of associations were informed and associations such as mosques were visited. In 2006 several information sessions were held using Turkish/Arabic/Dutch leaflets and movies. Information sessions stressed differences between drugs, risks of drug use and where to get assistance in the neighbourhood. It is important to involve locally-based community centres to maintain a good contact.
In 2007 a visit to a centre for drug abuse was organized in cooperation with locally-based community centres and a number of Moroccan and Turkish grass-roots associations. During this visit, translators were used to facilitate the communication. The same day the personnel of the centre for drug abuse visited one of the mosques.

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

➢ **Other projects**

♦ **French Community**
The principle of the Sesame organization community-based work is to reinforce a statutory networking system by a specific training of adult-relays in charge of youngsters (youth movements, specialized youth help, schools etc.). The trainings are given at their demand and in their institutions. Sesame provides proper tools in order to promote prevention of drug (ab)use by a young public and work on representations and communication. It is based in the city of Namur.

♦ **Flemish Community**
The concept of a global alcohol and drug policy for local communities was developed during the European Drug Prevention Week '98. At that time, the project 'A local alcohol and drug policy: Join in!' was launched. With this project, all local key persons (Youth leaders, supervisors in the workplace, owners of hotels and catering business …) join in a local alcohol and drug policy and get supported in this. Anybody can play a part in stimulating discussions about alcohol and drug problems, in trying to prevent them, in assisting in their treatment.

3.2. Selective prevention

3.2.a Recreational settings

3.2.a.1 Parties, festivals…

➢ **French Community**
Activities are carried out in outdoor events, festivals, clubs… Information brochures on specific substances are distributed, targeting young party drug users. During large events, activities include water distribution, bad trips management and needle exchange.

Within the context of the project "Drogues, risquer moins" (in English: "Drugs, take less risks"), peers give information in recreational settings. Information stands, with brochures on substances, on STDs and condoms are held by trained peers with or

without professionals according to the specificity of the project in different types of recreational settings. Events could be interventions in nightclubs, in raves, in small music festivals, in parties etc. In 2006, 36 actions were led in 16 different places. 4016 brochures on the products were spread by that mean. Moreover, various updates can be listed:

- new edition of booklets :
  - "cannabis" with legal actualizations, precision on the dependence and tolerance, various information resulting from a recent review of international literature
  - "hepatitis" with a feed back about treatment
  - "injection" ("shooter propre")

- reinforcement in various projects as experts in harm reduction activities, trainings, ... with news partners each year.

➢ **Flemish Community**

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

The revellers are predominantly reached through the partywise website, the heart of the concept. In 2006 we restyled the Partywise website and focused specifically on the party people in the club and event scene. The topics EWS and nightlife, party tips, partywise topics, history were restyled. In addition several new topics were added: drug information, combo-drugs module, news, checklist to go out… To promote the new website, the prevention workers and party promoters disseminated 10.000 packs of Partywise chewing gum with prevention information on the backside.

Festival work: every year Partywise informs and sensitises revellers to party 'wise' by giving them tips and make them visit the partywise website by placing banners and party tips on the websites off the biggest events (Rock Werchter, Pukkelpop, Tomorrowland, Ilovetechno, Reverze, Bassleader, 10daysoff, ...). Besides that, we were partner in the Partyguide music awards 2006.

Partywise E-newsletter: In 2006, we also restyled the E-newsletter. The first edition of this restyled newsletter was spread in October 2006 with information on party drugs, relevant research, news items on party drugs, party tips and an interesting E-link. We have two editions: one for the revellers and one for club managers and promoters.

'Streetwise' is an information page to inform the revellers concerning alcohol and drugs and the health risks in nightlife. Since 2006 streetwise has appeared each two months as a component of the trendy nightlife magazine Release (illustrated magazine of ID&T - Belgium). The first edition appeared in September 2006.

Since 2003 Partywise has conducted research concerning alcohol and drug use in the Flemish nightlife. On the basis of the results of this research the different partywise techniques are founded.

In 2006, we maintained the EWS (early warning system) for the nightlife scene. Through this system we inform the revellers and the party promoters when there are dangerous drugs on the market and provide them with prevention information.

3.2.a.2 Sports

➢ **French Community**

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

During the last legislature, the Minister in charge of health was also responsible for controls. However, following the change of government of the French Community, competences of the ministers changed:

- The prevention of doping (diffusion of booklets and other prophylactic measures) and the anti-doping controls are now the prerogative of the Minister of sports.
- The promotion of health in sport is now the prerogative of the Minister of health. The latter has started the compilation of the medical rules applied by the various sport federations. The indications and counter-indications related to a sport practice are also under her responsibility.

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

Under the previous government, in addition to the anti-doping controls (targeting as well amateurs as professionals), booklets on the prevention of doping were spread in the sports federations, in the organizations in charge of training courses for the physiotherapists, the sports general practitioners and the teachers in physical education , and in the secondary sport-schools.
Today, these practices are set aside, despite the statement made by some that repression alone is insufficient to reduce the drug demand (Brussel's FEDITO – „Cannapists day"; quoting the ESPAD survey[5]). The anti-doping controls ratio between amateurs and professionals has switched from 85% amateurs – 15% professionals to the opposite, at least[6]. Indeed, the Minister of sports has considered that he had to concentrate on professionals, since those are far more exposed to doping than amateurs.
Before being abandoned, the distribution of booklets never was evaluated.

The Brussels region does not have a specific legislation in that matter. It has thus made a project of order to delegate the controls to both Flemish and French Communities. The same project aims to create a framework for educative campaigns for a healthy practice of sports. Indeed, competent ministers in Brussels consider the possibility of communicating towards amateurs in order to discourage the use of products improving their performances. Nonetheless, neither the order nor the campaigns were finalized yet.

➢ **Flemish Community**

Since 2006 prevention in sports is a low priority in the Flemish community. That means that there were no new initiatives or trainings to support the work in this

[5] ESPAD (European School Survey on Alcohol and Other Drugs): survey led in schools in 30 European countries. It concludes i.e. that countries applying more « liberal » policies, such as the Netherlands, present lower prevalences of consumption than more repressive countries such as France. Cited in Actes de la journée Cannapistes.FEDITO bruxelloise. Janvier 2005, p.8.

[6] According to the « doping cell » of the ministry of health, that proportion rose to 90% of controls by the professionals, versus 10% by the amateurs, without a complete disappearing of the latter (as opposed to what the press sometimes stated).

setting. Nevertheless some field workers continued their prevention activities in sports.

➢ **German Community**

Since the nineties, projects in close collaboration with the "Mondorf group" (Luxembourg, France, Germany) were set up. They organise adventure camps for young people between 16-18 years. Since 3 years, ASL organises with the cooperation of the DG, Germany and The Netherlands a sport day for persons aged 16 years old. The objective is to offer them a sports experience in order to experience their own limits. This day is called "to climb instead of smoking a joint".

3.2.b At-risk groups

➢ **Flemish Community**

In Flanders, figures concerning the use and the misuse of alcohol and illicit drugs in what is called the 'social economy' do not exist. In 2005, once again, an increasing interest in this type of organisation is noticed for the implementation of an alcohol and drug policy. Different initiatives (seminar, training) have been organised in several communities. Social economy-organisations have to deal with specific 'at risk groups' especially in terms of low education and unemployment. Tailored programs and specialized advice are highly recommended. VAD and its partners in the field support these initiatives.

➢ **French Community**

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

The project was implemented in a municipality of Brussels, Vorst. Nine cannabis users have been recruited by different organisations. After a four-session training on the objective and methodology, the health consequences of cannabis abuse, the legal status of cannabis, and on communication, the "jobists" (trained drug users) were sent in their usual environment to meet their peers and inform them. They used a questionnaire and harm reduction brochures on cannabis. In total these "jobists" met 87 peers. The evaluation allowed the identification of several problems in terms of recruitment, duration of the training, and other weaknesses. As a result the initiators decided to renew the experience in 2005 with a new evaluation.

The analysis of the data collected through the questionnaire showed that the respondents had already experienced several problems related to the use of cannabis.

In 2006, the cannabis snowball operation was repeated in the neighbouring municipality (Saint-Gilles). It was led by the "prevention" service of the Commune (funded for a "prevention and security contract" by the ministry of internal affairs). The aim was to inform cannabis users on the use related risks and on how to reduce them.

In a preliminary session, the workers were provided with medical and juridical information on cannabis. Some of them showed some difficulties to accept the medical information, challenging the authority of the General Practitioner who exposed it. That reluctance had to be passed in the next sessions, which helped the jobists themselves to deal with the same reluctance by their fellow cannabis smokers when they met them on the field as peers in the next stage.

An attempt to define some characteristics of "problematic" use of cannabis was also made (for instance: when the expenses granted to cannabis go beyond what the user's budget allows, or when cannabis starts holding the user from social contacts).
Once led, the operation seemed useful to the workers: they reached some distressed and isolated people (homelessness…); cannabis users eventually received medical information although they did not perceive themselves as "addicted" (interest of the "peer-to-peer approach"); they were able to reach people who had a weak knowledge on cannabis use, although they were "heavy" consumers (15 joints a day); etc.

3.2.c At-risk families

- **Flemish Community**

There are only a few initiatives for children of alcoholics in Belgium. Children of alcoholics are two to four times more likely than other children to become addicted to alcohol themselves, so it is important that health care workers pay attention to this group.
In 2001, "Broeders Alexianen in Tienen", the Catholic University of Leuven and VAD developed a prevention program that helps children of alcoholics to understand and to deal with the addiction of the parent and the consequences in the family.
In 2004, they launched a website www.koap.be for children and partners of alcoholics and participated with the VAD in an active way on the 1st symposium about children in families with alcohol problems. The focus of this European conference was on Coping with Parental Drinking.

Bubbels & Babbels is a prevention project funded by the Flemish government *(Veiligheids- en Preventiecontract)* in Antwerp focusing on the problems of children of (ex) drug dependent parents. Participation of the target group is voluntary. The project offers comprehensive coordinated services to decrease the harmful effects of drug addiction on children, families and the community.
Bubbels & Babbels provides case management to clients, based upon the assumption that the families face multiple services need, which they are unable to address on their own. The family is engaged both in identifying and meeting its own goals, so that the traditional case management approach of simply arranging services is expanded significantly. The case manager assists families in developing their goals, identifying their needs, and obtaining these services.
In 2006, Bubbels & Babbels supported 21 families affected by drug abuse (Bubbels & Babbels, 2007). In addition to the client work, Bubbels & Babbels organised training sessions about drug abuse and pregnancy-parenthood and answered around 50 questions of social workers about this topic. Bubbels & Babbels also publishes newsletters and did create a website with relevant information for professionals about the topic parental drug use and child care. At least, Bubbels & Babbels did coordinate in association with the Antwerp University, a small survey concerning drug use during pregnancy in the maternity clinics in the Antwerp region.

- **French Community**

Several treatment services include the issue "drug addicted parents" as part of their programme. These programmes aim to provide assistance to drug addicted mothers, and improve the mother-child relationship as well as the living conditions of the children.
For instance, the Kangourou project is an initiative of the organisation Trempoline. It meets an increasing success (7 mothers and 8 children in 2006). Since 2003, it accommodates more and more women and noticed an increase in the fathers' involvement in the education of the children. The intervention of Trempoline in the

Kangourou project consists in “pedagogic groups”, individual interviews and “organisation groups”. The pedagogic groups treat various topics such as the limits and territory, how to face children’s violence, how to let the child grow, playing, child food between 0 and 6, etc. The interviews are based on a questionnaire on “well-treating” the child. Finally, the organisation groups offer mothers the possibility to structure the evenings, the week-ends and the extra-time to be shared with their child(ren).

3.3. Indicated prevention

3.3.a Children at risk with individually attributable risk factors

In Belgium, such a specific approach in the prevention of drug problems doesn’t exist. Even if some cases of this population might be treated for addiction problems, it is hardly possible to report about them since no strategies or services specifically consider that problematic.

CHAPTER 4 .
Problem Drug Use and the Treatment Demand population

Thanks to the further implementation of a Belgian version of the European Treatment Demand Indicator (TDI) protocol, comparable data on treatment demands at national level are available for the years 2004-2005 since few.
Data from needles exchange programmes still report heroine and cocaine as the more common injecting substances and polydrug use as a common practice.

4.1. Prevalence and incidence estimates of PDU

4.1.a National Definition

There is no national definition of Problem Drug Use (PDU) in Belgium. A recent research (Decorte et al, 2005) concluded that the concept of PDU is unusable in a legal context. Furthermore, Decorte et al. (op cit.) also mention another notion, the "personal use", which could replace it. In the case of cannabis, the "personal use" could be strictly defined by the detained (and discovered) amounts. As an indication: marihuana (30g), hashish (5g), hashish oil (250 ml) and hashish pastry (200 g). These amounts have an indicative value: they are the ones that were consensually[7] quoted in the work groups led during the study.
On October 21 2004, the Belgian Court of Arbitration dismissed article 16 of the new drug law[8]. One of the reasons for the dismissal was the notion PDU which is too vague from a legal point of view.
The Flemish umbrella organisation VAD advocates the use of the term PDU in a broad sense (VAD, 2001). The P in PDU refers to all medical, psychological and social problems that result from drug use. Examples of medical problems are infectious diseases and physical dependency. Psychological problems can be psychological dependency or mental illness. Social problems range from relational problems to criminal and judicial problems. Important here is that PDU is a process not a state, which does not necessarily, leads to dependency (VAD, 2002). This description of PDU represents the opinion of VAD on how PDU should be best described. It is not a generally accepted definition, neither a consensus among drug health professionals in Flanders.
This definition is broader than the EMCDDA definition. In the EMCDDA-definition the defining characteristic of PDU is a way of administration (injecting) or a high user frequency of certain substances. The VAD-definition looks only at possible problems of drug use. So PDU can result from different ways of administration of all kinds of substances as long as this is associated with medical, psychological or social problems.
Concerning the French Community, the sub-focal point Eurotox stresses that there are almost as many different definitions of "problematic use" as there are texts or actors. As it is mentioned above, Problem Drug Use was defined in the 2203 Belgian act on cannabis (art.16). An additional definition is proposed by the Permanent Secretariat on the Policy of Prevention (Internal Affairs), and yet another one by the Brussels Fedito, *inter alia* (the notion was also defined in the "Federal Policy Note on Drugs" of 2001).

[7] By the various actors coming from the judicial, police and psychological-medical-social sectors.

[8] However, the definition still exists on in a Royal Decree related to the reduction of risks and therapeutic advice – May 16 2003.

That multiplicity points to the fact that *a* definition of problematic use probably helps the actors to *individually* include or exclude users in – or from – their intervention. But that definition remains a patchwork in constant movement and has no legal and permanent value. It is an individual tool, with multiple definitions.

4.1.b Prevalence and incidence estimate of PDU

The Sub-Focal Point of the French Community 'Eurotox' and the treatment centres grouped by the organisations 'Vlaamse Vereniging voor Behandelingscentra Verslaafdenzorg' and 'De Sleutel' delivered data that allowed the National Focal Point to estimate problem drug use based on treatment demand data (Roelands et al, 2007). The estimate concerned the Walloon Region and the Flemish Community during the year 2004. Data on the Brussels Region were only available at the aggregated level and were therefore not included. Persons in low threshold centres, inpatient and outpatient drug treatment centres were included. Data on treatment demands in psychiatric wards of general hospitals, in psychiatric hospitals and related environments could not be included. Information on treatment contacts in centres for outpatient mental health care in the Flemish Community was provided, however not on persons in treatment; therefore, this type of centres was not included in this analysis. Due to these limitations regarding geographic area and the treatment centres included, the figures are underestimations of problematic drug use in Belgium in 2004. In the following, data on low threshold agencies are included in the data on outpatient treatment services.

Most treatment demands in both inpatient and outpatient settings were related to opiates (45% of all inpatient demands (426 persons); 51% of all outpatient demands (1614 persons)). In second order came cocaine (17% of inpatient demands (158 persons); 10% of outpatient demands (311 persons)).

Opiate and cocaine users were mainly between 20 and 39 years old (85% and 85% of the opiate and cocaine users, respectively). In the age group 40 to 49, the large majority of persons demanding treatment were opiate users, demanding treatment in outpatient centres. Opiate or cocaine users demanding treatment were almost never 50 years or older.

Most opiate users with a treatment demand were daily users (82% of the inpatient users and 74% of the outpatient users). Regarding cocaine, persons demanding treatment in inpatient centres were also mostly daily users (63%). Frequency of cocaine use in persons in outpatient centres was more evenly distributed (18% did not use it in the past month, 25% less or equal to once a week, 31% used cocaine 2 to 6 times a week and 27% used it daily (valid percentages)).

In 2004, 1063 men and 234 women demanding treatment had a history of injecting drug use (lifetime prevalence). About half of the persons demanding treatment in an inpatient centre had a history of injecting drug use (50% in women and 47% in men), whereas this was the case in one in three persons demanding treatment in an outpatient centre (34% in men and 31% in women).

4.2. Treatment Demand Indicator

In Belgium, no national reporting system on drug-related treatment exists yet. However, Treatment Demand Data are registered by a number of different registration systems, which often already have a long history.

In recent years, a Belgian version of the European TDI protocol has been developed. This protocol was finalised and approved by the Health Policy Drug Unit. A result of this approval was the foundation of the TDI working group of the Health Policy Drug

Unit. The aim of this working group consists of investigating which adjustments of the existing registration systems are necessary to comply with the Belgian TDI protocol, and to estimate the financial implications of these adjustments. Another aim was to write a report for the Inter-Ministerial Commission of Health.
In December 2005, a protocol agreement regarding TDI was signed by the members of the Inter-Ministerial Commission of Health. This agreement was published in the Belgian Monitor on May 3rd 2006. The agreement stipulates that the TDI-registration will start in the different types of treatment centres on January 1st 2007 in order to deliver the first standard tables in 2008.
In recent years, centres involved in treatment of drug users (including inpatient and outpatient drug treatment centres, low threshold agencies and centres for mental health care) as well as the organisations taking care of the data management have further increased their efforts to come to a harmonised registration of their clients/patients. The registered data meet increasingly the requirements of the EMCDDA and further harmonisation and development is going on. These organisations and the National Focal Point agreed in early 2007 to provide aggregated data that were available about the years 2004 and 2005. Data were merged and analysed by the National Focal Point in collaboration with the data registration systems to provide estimates of the demand for drug-related treatment.

4.2.a Treatment centres

The Treatment Demand Indicator is collected in volunteer inpatient and outpatient centre in the **French Community**. This includes 3 main groups: treatment centres specialized in illegal substance abuse treatment that have a convention with the national institute for invalidity and health insurance, centres for mental health care with a drug addiction agreement in Walloon region and ambulatory treatment centres in Walloon region with a drug facultative subvention from the Walloon government. In 2005, they were 43 treatment centres to participate to the Treatment Demand Indicator collection via 4 systems of data collection (CTB/ODB system for Brussels, Sentinelles system for Charleroi, Citadelle network for Tournai and Eurotox system for the rest of the Walloon region). Besides, Eurotox asbl merges all databases coming from Walloon region and French community of Brussels together in order to make treatment and analysis for the whole French community.
Data coverage varies by type of centres. In 2005, there were 13/17 treatment centres specialised in illegal substance abuse treatment and having a convention with the national institute for invalidity and health insurance who participated (among non participating centre, one was an alcohol centre, two had not joined data collection yet and the last one had some technical problems); 6/7 mental health care with a drug addiction agreement and 19/21 ambulatory treatment centres in Walloon region with a drug facultative subvention from the Walloon government. Besides, 2 psychiatric hospitals participated also on volunteer basis to TDI. As soon as TDI protocol will be operational in the psychiatric hospitals and the psychiatric units in general hospitals, their data will be merged with the hospital ones. Moreover, 2 health integrated associations participated also to TDI via a local network. However, the other treatment facilities which do not participate to TDI data collection (general practitioners, self-employed psychologists or psychiatrists) shouldn't be underestimated.
Data coverage in these 3 groups of data centres did not reach 100% but rate participation was high considering that technical problems occurred every year in some centres which consequently made data unavailable. However, the province of Luxembourg was not covered by any data system. Actually, in this province only one outpatient treatment centre and one regional hospital exist.

Registration systems in the **Flemish Community** collect data for some years. In 2004, TDI data were collected by 4 of the 5 low threshold agencies (Medisch Sociale Opvang Centra) and all fifteen treatment centres specialized in illegal substance abuse treatment that have a convention with the national institute for invalidity and health insurance. All 9 ambulatory treatment centres participated in TDI registration. Local divisions ("satelites") were not counted separately. Each of these 28 centres is supported by the VVBV ("Vlaamse Vereniging Behandelingscentra Verslaafdenzorg") or the daughter organisation De Sleutel. All 97 centres for mental health care (outpatients) of the Flemish Community collected TDI data. In 2005, the 3 organisations that were responsible for data collection in the centres were VVBV (mainly with the computer programme DARTS), De Sleutel with the programme DUX and the centres for mental health care using the programme ARCADE. Because registration in hospitals (including a.o. psychiatric hospitals and psychiatric services in general hospitals) is a federal competence, these data will be included in the data on the Flemish Community when made available by the federal government.

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

4.2.b Profile of clients in treatment

- **TDI**

In 2005, the profile of clients starting a treatment in the **French community** is essentially male (81%), Belgian (62%) and means of their age is 31 years old.
Opiates are designed in 63% of treatment demands as principal product by clients, then Cocaine for 15% of clients and cannabis for 10%.

- **Study of De Sleutel**

Based on more than 3500 EuropASI data of clients, a study was made on different client profiles related to main substance use (Raes & Tomás-Rosselló 2005). Comparison is based on objective measures and composite scores (CS) in the life areas. High scores refer to more problems in a given area.

In the total sample all *personal health* differences in the main substance groups seemed to be significant. The inpatient cocaine group showed highest medical CS, followed by combined drugs and amphetamine groups (CS>=0.30). Psychiatric CS are highest for alcohol plus double addiction (CS=0.39) as well as for combined drugs and amphetamine main substance groups. Psychiatric CS are smaller in outpatient than in inpatient settings (CS<=0.36).

Concerning *social functioning* three types of indicators are distinguished. The *employment* CS ranged between 0.49 and 0.97. Substance related differences were significant. Combined drugs, alcohol plus double addiction and opiate groups showed the highest employment CS. Satisfaction CS are lower than employment CS. Cannabis, amphetamine and cocaine groups have significant lower satisfaction CS - which means in this case more satisfaction- than the other ones. Also substance related differences in *family and social CS* were found significant. Cocaine groups show significant higher family and social CS than cannabis. Only for outpatients the family CS is highest for alcohol plus double addiction. Although inpatients have highest legal CS in cocaine, opiates and combined drugs main substance groups, *legal* CS were only substance related in outpatient settings. The higher outpatient legal CS appear in combined drugs, sedatives/hypnotics and amphetamines.
The study hasn't been renewed since then.

4.2.c TDI data

In 2005, 2108 treatment demands in **French community** are numbered through TDI gathering. This number includes only treatment demands with one illegal product registered in the system (when there was no principal product designed, they were taken out of this analysis). Among new Treatment demand in 2005, 30 % are first treatment demands.

The geographical area (**Belgium without Brussels Region**) and types of centres included in this analysis were described extensively above (see PDU estimates based on TDI). Due to the fact that not all regions and health care organisations in Belgium were included, the demand for drug related treatment is underestimated.

In this area in 2004, 4289 drug-related treatment demands were registered: 971 persons in inpatient centres (15% women) and 3318 persons in outpatient centres (including low-threshold centres) (20% women). Treatment demands in both inpatient and outpatient settings were mainly related to opiates (45% of the inpatient demands; 51% of the outpatient demands; 50% of all demands). Cocaine was the second most important primary substance for treatment demand in inpatients (17%), but was only third in outpatients (10%)(11% of all demands). Other stimulants apart from cocaine (e.g. amphetamines) were the primary drug related to a demand for treatment in 12% of inpatients and 8% of outpatients. Cannabis was relative less important as primary drug in persons demanding inpatient treatment (7%). However, cannabis was the primary drug in 20% of persons demanding outpatient treatment, making it the second most important substance as related to all treatment demands (17%). Treatment demands related to the use of hypnotics, sedatives, hallucinogens and inhalants were rare.

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

Most users with a treatment demand were daily users, regardless whether the primary substance was opiates, cocaine, stimulants or cannabis (Fig 3; value of outpatients opiates “not known” is 890). Exceptions were cocaine and stimulant users demanding treatment in outpatient services. In these centres treatment was asked even more by persons using cocaine or other stimulants 2 to 6 times a week as by daily users.

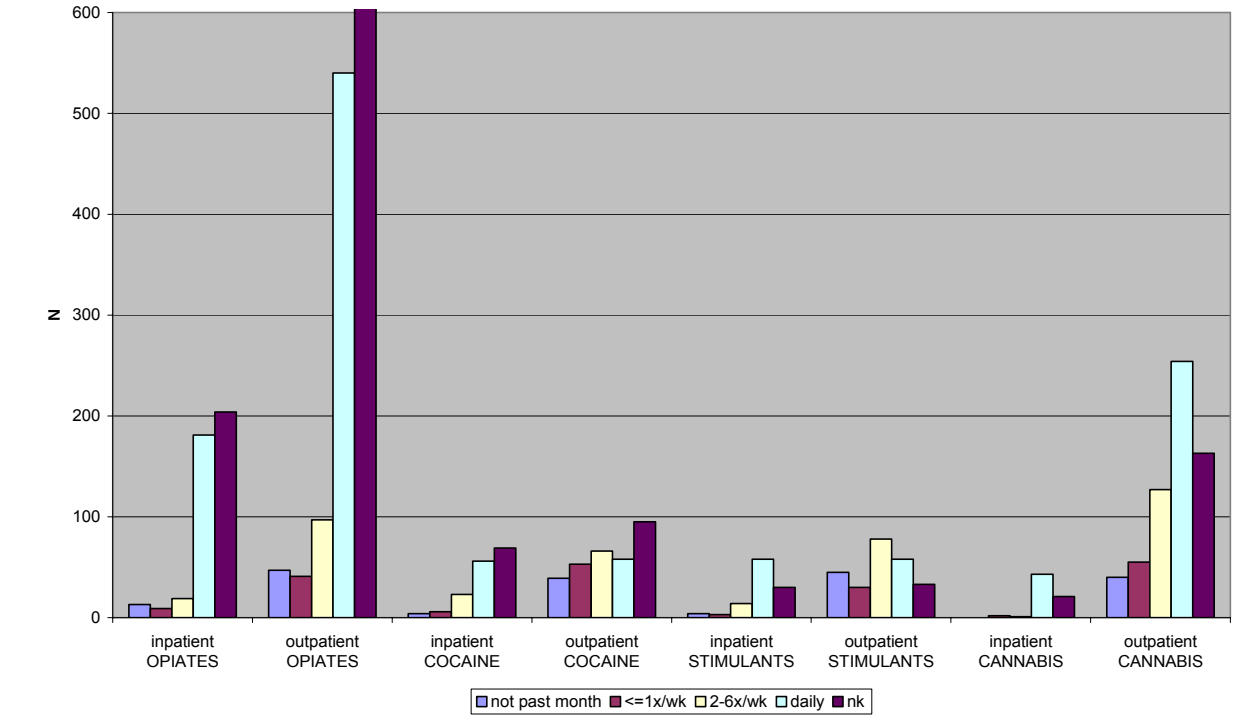

***Figure 3**: Number of treatment demands (all treatments) in Belgium (Brussels Region not included) by frequency of substance use, substance and type of treatment centre, 2004*

4.3. PDUs from non-treatment sources

4.3.a PDUs not in TDI population

Since a common definition of PDU doesn't exist and that the national treatment reporting system isn't fully operational yet, the proportion by primary drug of PDU clients not seen in the TDI population is hardly possible to asses.

4.3.b Other data sources

➢ **<u>Needle exchange programs</u> (Flemish Community)**

In the Flemish Community, 219 IDUs frequenting the needle exchange facilities were interviewed in 2006 (Windelinckx 2007). The most important results are presented below.

1. Socio-demographically:
    - 76.9% are male, 23.10 % are female;
    - average age is 33,7 year with a rage from 19 till 59 years old
    - 86.3% are over 25; amongst those 41.2% are older then 35 and 2.8% is over 50 years old;
    - 3.31% are under 21;
    - 54.2% live alone, 39.6% live with partner or partner and children, 8.9% are homeless, 6% live in squads, 7% live together with friends.

2. Drug use
    - Polydrug use is common; on the average they use 5 illegal substances;
    - Heroin is still the most commonly injected drug in 75.6% of the cases, followed by cocaine (64.4%) and amphetamines (37.5%);
    - The combined use of heroin and cocaine is clearly prevalent in the Flemish cities, 33.2% are injecting these speedballs (snowballs);
    - The exchange programme currently reaches every year more speed and/or cocaine users than previous years.
    - Age first time injecting drug use: 43.40% was under 18, 77.7% was under 25 when first injected (12.6% was under 15 year when they first injected) (see below)

3. Risk behaviour
    - The majority (55.3%) of the IDUs interviewed did not share injection materials in the last month;
    - Sharing occurs more frequently with sex partners than with strangers or friends;
    - Back loading and front loading (using one syringe to squirt drug into the back of other syringes) are not common;
    - 42.2% of the IDUs share the spoon;
    - 56.8% never share their filter;
    - 79.3% did not share water;
    - 52.5% still use their syringes more than once.

4. Evaluation syringe exchanges
    - Syringe exchanges, pharmacists and drug services are most commonly used to get syringes;
    - 36.5% also get syringes for friends, 29.4% for their sex partners;
    - Syringes that are not brought back to the exchange programme or drug services are mostly discarded by using a plastic bottle, breaking the needle or flushing it down the toilet or sewer. 1 person sometimes throws them on the street;
    - Most of the interviewed IDUs got their information about the exchange from drug services (52.6%), 49.7% got the information from other IDU's, 5% from media.
    - 84.6% had no problem to buy syringes from pharmacists;
    - 58% prefer day time opening hours.

5. Health
    - 58.9% had been tested for HIV in the previous year;
    - 58% had been tested for HBV in the previous year;
    - 56.8% had been tested for HCV in the previous year;
    - 56.8% had been tested for TBC in the previous year;
    - most of the interviewed IDUs already had drug treatment in the past, mostly in residential institution;
    - 45% are still in a drug treatment while contacting the syringe exchange, 68% of them followed a methadone programme.

6. Free-base cocaine
    - 104 (50%) are using freebase-cocaine and are attending the needle exchange;

- most of the users clean their cocaine with ammonia (61.7%),16% with bicarbonate, 8.9% buys it prepared at the dealer
- Most of the interviewed IDUs are both injecting cocaine and using freebase cocaine.
- 8.6% of 104 IDUs smoke freebase cocaine on a daily base, 18.8% smoke weekly, 8.6% a few times a week and 41.7% smoke on a monthly base.
- 15.5% of 104 IDUs inject cocaine on daily base, 21.6% a few times a week, 26.8% once a week and 36.1% inject cocaine monthly.

➢ **Snowball survey (French Community)**

Through a HIV/Hepatitis peers prevention project, snowball surveys are carried out yearly since 1993 to investigate drug use, its pattern, knowledge and attitudes (Hariga, personal communication). The users are interviewed in different regions (Brussels, Charleroi, Liège, Namur, Mons, Verviers and Wavre) but these regions may vary each year.

The 2006 results should be interpreted with caution because the number of current drug users that were interviewed reduced to 1/3 in 2006 compared with 2005 due to external factors.
However and despite the selection bias related to the objective of this project, the results allow drawing some indicative tendencies.
The general tendency to a fall of injecting users among all drug users is confirmed in 2006 (Table 10). One notices a worrying climb of risky behaviours by the current IDUs who, in 2006, borrow significantly more often an already used needle, and share more and more the related injecting materials.

Table 10: Percentage of lifetime and current IDUs and of syringes sharing among current IDUs, Snowball surveys, French Community, 1993-2006

	1993-94	1994-95	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
N of current drug users	457	1123	1294	1395	1243	898	550	981	798	616	1033	984	274
Mean age			27	28	28	28	29	30	30	31	32	31	31
% males			66	69	67	70	70	65	67	66	64	65	74
Lifetime IDUs/drug users (%)			68	74	65	68	60	65	65	64	62	59	60
Current* IDUs/drug users (%)	69	57	53	56	43	52	40	46	46	46	43	41	44
Borrowing used needle / current IDUs					39	38	30	33	32	33	30	32	42
Use of needles found in the street / current IDUs (%)								6	7	6	3	9	12
Sharing needles / current IDUs (%)	48	60	60	59	53	52	43	44	44	47	43	41	42
Sharing injecting materials / current IDUs (%)	-	-	-	-	-	61	57	48	52	54	49	55	61

Among the respondents, almost half of all cocaine and heroin consumers use it by injection. The tendency between these two products is reversed in 2006, compared to the last 2 years: heroin “regains” the place of most consumed drug by injection. So, even if the global proportion of heroin users seems to fall, among these, injecting behaviours are increasing.

The injection of methadone and morphine seemingly increases, compared to the last few years, while amphetamines and buprenorphine are less injected (Table 11).

Table 11: Percentage of injection by drug among current users, Snowball surveys, French Community, 1999-2006

	1999	2000	2001	2002	2003	2004	2005	2006
Heroin users								
N	755	397	416	535	443	764	758	231
%	54	50	56	53	53	48	44	53
Cocaine								
N	644	367	362	448	376	674	637	226
%	58	46	55	54	52	50	50	42
Amphetamines								
N	211	171	62	181	85	187	203	61
%	19	19	21	21	27	18	16	13
Methadone								
N	208	208	65	212	146	362	383	88
%	12	16	25	20	27	22	21	28
Buprenorphine								
N	140	60	101	86	57	122	121	23
%	12	18	9	20	12	12	22	13
Morphine								
N	n.a.	60	179	164	62	150	140	30
%	n.a.	33	26	33	24	18	28	37

➢ Injecting and polydrug use at Festivals

♦ French Community

The percentage of IDUs observed since 1999 is decreasing (Table 12). This decrease could be explained by the following reasons: first, the population has changed as the musical programme changed from a mainly rock oriented festival to a more “house” and techno festival. Secondly, since 1999 the size of the festival has grown: from about 10000 people in 1996 to 120000 in 2005.

Table 12: Percentage of current drug users and IDUs, Rock festival, French Community, 1996-2006

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Number of interviews	123	167	157	686	479	454	172	160	222	276	94
Current drug use (%)	87	96	88	88	83	87	78.5	55	73	67	68
IDUs / users (%)	25	13	13	4	4	5	3	3	1	2	3

Concerning polydrug use, almost one out of 3 respondents consumed only one drug in his life, while 39% consumed 3 or more products in their life (Table 13). Notice however that polydrug use went to it’s peak in 2005 (56%) and decreased back to his general historical tendency with the quoted 39% in 2006.

Information on these behaviours should be considered as an indication of the prevalence of these behaviours among some selected groups of drug users. Indeed, there is a selection bias as except for the years 1999 to 2001, these figures are representative of the population met through harm reduction activities.

Table 13: Lifetime of polydrug use, Rock festival, French Community, 1996-2006

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Number interviews	123	167	157	686	435	454	172	160	222	276	94
Only 1 drug (%)	47	40	25	33	30	22	23	26	29	30	31
3 drugs or more	32	45	36	36	40	36	51	52	40	56	39
Total (at least 1)	87	93	88	88	83	93	92	89	88	86	86

Figure 4 shows the evolution of use of different illegal substances in this festival.

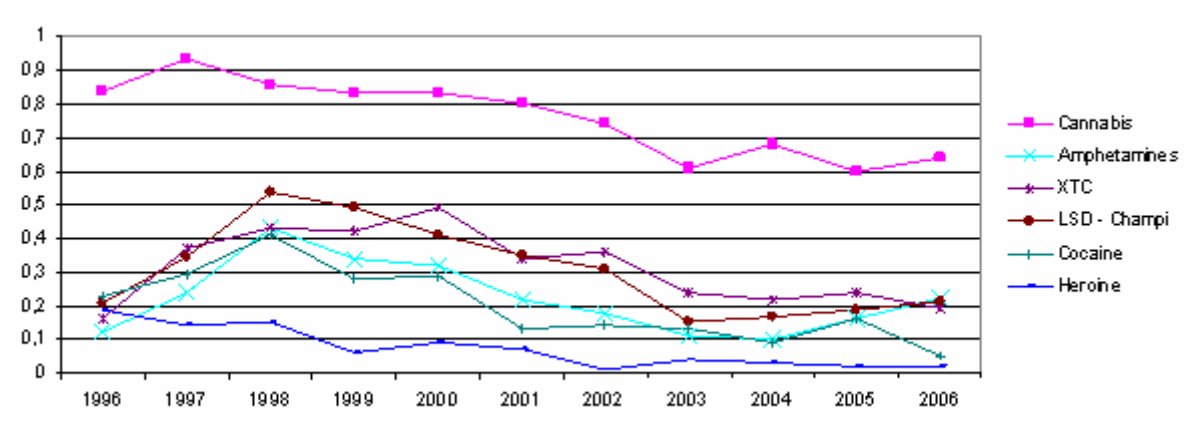

***Figure 4**: Evolution of the current drug use by substances, same event Festivals, French Community, 1996-2006*

The historical analysis of the consumed products at that event shows, globally, a regular decrease of all consumptions since 1998, with an even more sizable fall for LSD and mushrooms. Cannabis remains the most consumed product.

♦ **Flemish Community**

VAD conducts since 2003 a research on drug use in different night life settings. In 2003, 645 respondents completed the questionnaires. 144 respondents (22.3%) used cocaine, speed or heroin during the last year. 32 respondents (5.0%) used during the last year 2 of these 3 drugs and 5 respondents (0.8%) used all 3 drugs during the last year. In 2005 a total number of 670 respondents completed the questionnaires. 134 respondents (20.0%) used during the last year cocaine, speed or heroin. 38 respondents (5.7%) used during the last year 2 of these 3 drugs and 3 respondents (0.5%) used all 3 drugs during the last year.

➢ **Polydrug use during an event (French Community)**

The following data have been collected through harm reduction activities implemented in 76 different events in 2006. These data underestimate the real consumption during the event as they are collected at the time the person is met and not at the end of the event.

The use of several drugs during the same event is quite common. In 2006, including alcohol, 14% of the respondents reported, when they were met, the use of 3 or more different drugs (Table 14). The maximum number of different products reported was 13 in 2006.

Table 14: Polydrug use (including alcohol) during the event; French Community, 2002 - 2006

	2002	2003	2004	2005	2006
Number of events	10	10	38	48	49
N	1118	861	1198	1510	2313
no drug	43%	33%	30%	30%	31%
1 drug	28%	30%	33%	33%	36%
2 drugs	18%	19%	22%	23%	20%
3 drugs or more	11%	18%	15%	14%	14%

4.4. Intensive or frequent patterns of use

4.4.a Other problematic use

➢ **Flemish Community**

In September 2003 all patients attending the emergency department of the Ghent University Hospital were registered by the attending emergency department personnel (Calle et al., 2006). 1933 patients were included: 198 (10%) with substance abuse leading to the emergency department admission (=INTOX group) and 1.735 (90%) in the NON-INTOX group. Males and the 21-50 years age group were overrepresented in the INTOX group. Patients with substance abuse were also overrepresented during the night, but not during the weekend.
In most patients, only alcohol was abused (144/198; 73%), most frequently chronically (102/144; 71%). In 13% (26/198), there was only illicit drug use, and in 14% (28/198) alcohol abuse was combined with illicit drug use. Among the 54 patients with illicit drug use (with or without alcohol abuse) the most frequently reported drugs were cannabis (54%), cocaine (41%), amphetamines (39%) and opiates (39%).
To conclude the abuse of alcohol - and to a much lesser degree illicit drug use – is a frequent cause of emergency department admissions.

➢ **French Community**

Since 2001, the mobile team of Modus Fiesta (MF) developed in Brussels a series of projects of reduction of the specifics risks in festive events for the drug users. One of the project suggested is the “relax zone” (RZ). The main mission is to ensure a reception in a specific place installed on the site of the event for all drug users presenting minor psychic and/or physical problems involved in the use of psychotropic products. These people are accompanied by the team of MF but also by professionals (doctors, nurses, etc.). If needed, they will be directed towards the Red Cross service. However, symptomatology related to drug use is not the only admission criteria: the reception due to tiredness is common. The team of MF also moves in the camp-sites or in the concerts-site to accompany a person in bad trip.
For each contact established in the RZ, a questionnaire is filled out. The main mission being the contact with the person, the data collecting is not a real objective for the team. Thus, we observe an important rate of non-responses (we have the results without the non-responses).
Moreover, from one year to another, the sample strongly varies. Indeed, the recourse to the RZ is extremely tributary to the localisation of the tent. In 2006, 324 people were met at the time of 3 events.

♦ **Population**

The average age (minimum – maximum) of the people for which information is available (49.7% of non-response) is 22 years (14 – 43 years).

The large majority (74.4%) were men and about half of them were not older then 18 years (48.5%; versus 44.9% of the women).
Two persons out of three (63.5%) were students.
More than half (53.1%) of the people came by own initiative and 23.9% of them came via the Red Cross.

The main symptoms were tiredness (58.6%) and cold (17.3%). Women more often came for tiredness (36.5%), cold (14.8%) and nauseas - vomiting (10.4%) while men came primarily for tiredness (45.8%) and cold (11.7%). For 22.8% of the people, no symptom was announced.

- **Drug use**

The most consumed products by people met at the Relax Zone were alcohol (56.2%), cannabis (23.1%) and ecstasy (20.7%).
28.7% of the respondents stated not to have consumed anything, 25.6% consumed only alcohol (average age: 23 years, min. – max: 17 – 43 years) and 11.4% consumed only alcohol associated with cannabis.
The average age (min. – max.) of XTC users met at the RZ tent was 21 years (15 – 35 years); versus 21 years old for amphetamine users (17 – 26 years); and 19 years old for mushrooms users (15 – 23 years).

Among the respondents, 47.7% consumed drugs every day or once a week; 9.7% consumed for the first time and 22.6% consumed less than once a year. The last two types of people (1st time and 1 X/year, N=20) consumed mostly XTC (55.0%), alcohol (45.0%; often in association with another drug), cannabis (40%, also in association), amphetamine (25.0%), mushrooms (15.0%), others (10.0%), LSD (5.0%) and cocaine (5.0%).

The proportion of polydrug users (not counting the common association alcohol/cannabis) was more important among women (31.9%) than among men (19.9%). The average age of the polydrug users was 21.3 years (15-41 years).

The respondents who did not take drugs come to the tent due, primarily, to tiredness (63.4%) and cold (11.8%); just as those who “only” drunk alcohol (respectively 67.5% and 14.5%) with also the presence of nauseas – vomiting (13.3%). Anguishes are more frequent (26.7%) in persons having taken ecstasy,.

4.4.b Relationship with PDU estimates

Since a common definition of PDU doesn’t exist and that the national treatment reporting system isn’t fully efficient yet, we can’t properly discuss here the relationship with PDU estimates, TDI data and General Population Surveys.

CHAPTER 5.
Drug-Related Treatment

The treatment offer is very broad and differentiated (residential settings, low-threshold programmes, e.g.), but varies geographically. Substitution treatments were provided for years although the first law recognizing this practice was published in 2002, followed by a Royal Decree in 2004. In 2006, a new decree recognizes the use of methadone and buprenorphine as legal substitution treatments.

5.1. Treatment systems

In Belgium a large diversity of treatment settings exists, also with regard to the specific methods of treatment used. Furthermore, due to the political structure different types of statutory regulations and financial rules co-exist. Often several authorities are involved at the same time and this leads sometimes to a lack of clarity in terms of the division of competencies.

In first instance a number of treatment centres specialised in (illegal) substance abuse treatment have gradually entered into a so-called 'revalidation agreement' with the National Institute for Invalidity and Health Insurance and consequently fall under the authority of the federal policy level. These centres are often referred to as the *'specialised substance abuse treatment centres with RIZIV/INAMI[9] convention'*. Most of these centres are exclusively oriented towards people with illegal drug problems. Some of them are allowed to treat people with primary alcohol problems.
A second group of services is composed by the *psychiatric hospitals* and the *psychiatric units in general hospitals*. Overall, these treatment centres are not exclusively oriented towards people with illegal drug problems; on the contrary, a variety of psychiatric problems are treated. However, some psychiatric hospitals or psychiatric units in general hospitals have created a specialized substance abuse unit. All of these treatment centres follow the same general regulations as other hospitals and are therefore mostly subject to federal legislation. Communities have however certain competencies on the matter (e.g. quality assurance).
A third group consists of *Centres for Mental Health Care (CMHC)*. As well as the psychiatric hospitals and in the psychiatric units of general hospitals, a large number of psychological or psychiatric problems are treated in these centres. Some of those CMHC have however developed a certain specialisation in the treatment of drug problems. The Communities of Belgium are responsible for the CMHC but due to historical and pragmatic reasons, in the French-speaking part of Belgium the responsibility has been transferred from the French Community to the Walloon Region (COCOF for the Brussels Region).

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

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

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

5.2. Drug Free Treatment

5.2.a Inpatient treatments

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

- **Quality assurance**

In Belgium, standard and formal systems of quality assurance aren't used by common consensus in the field of treatment. Since different practices exist, it is impossible to list them here.
However, the Europ-ASI is a common tool for different treatment centres. The Europ Addiction Severity Index (Europ-ASI) is a semi-structured interview which was created in 1980 in the United states by Mc Lellan, and adapted to European situation in 1993 (Kokkevi, Hartgers, Blanken, Fahrmer, Pozzi, Tempesta, Uchtenhagen, 1993). This tool aims at reconstituting, for each interviewee, the context that led to problematic substance use and at measuring quantitatively the severity rate of their addiction. The severity index translates the need for a treatment. It is based on a multifactor analysis which explores two periods: lifetime and last month. The final score is calculated according to objective (interviewer's) and subjective (interviewee's) assessments. It is used to assess the addiction of a new client, to monitor the evolution of his therapy, or as a post-treatment assessment.
In Belgium, the Europ ASI questionnaire is used since 1998 as a standard in the total network of De Sleutel in Flanders (2 therapeutic communities, 1 crisis centre, 5 ambulatory centres and their "antennas", and in the social workplace). It is also used in the therapeutic community of De Kiem, of Kompas, in Trempoline and in Hautes-fagnes; in two specialized wards of psychiatric clinics (Boechout and Tienen); at the university hospital of Antwerpen; in three Public Centres for Social Action ("Centre Public d'Action Sociale" or CPAS) (Gent, TIelt, Waregem) and in two "Maison d'Accueil Socio-Sanitaire" (MASS) (Antwerpen, Oostende).
This instrument allows comparisons with other units/centres in Belgium as well as in the EU (used in Greece, England, Spain, Holland, notably).
In 2006, Trempoline and De Sleutel worked together to make a training to IBSR (Belgian Institute for road safety) who asked to develop skills to use the ASI questionnaire. It was also the opportunity for both structures to standardize the French and Dutch ASI version. Modifications were on the presentation, definitions and interpretations of items. A particular attention was paid on being on concordance with Treatment Demand Indicator since items were much closed since De Sleutel use ASI questionnaire to collect the Treatment Demand Indicator. Trempoline is using this common version since January 2007 for every person coming into their inpatient programme.

5.2.b Outpatient treatments

Part of outpatient treatment consists of drug free treatment centres. The medical-social care centres on the other hand, which have an agreement with RIZIV/INAMI, mostly do not provide drug free but rather substitution treatment. Finally, the

specialised substance abuse day care centres with a RIZIV/INAMI convention offer both.
However, the type of treatment that is provided will always be tailored to the individual needs of the patient and treatment centres often provide drug free as well as substitution treatment.

5.3. Assisted treatment

5.3.a Withdrawal treatment

The goal of withdrawal therapy (detoxification) is to stop taking the addicting drug as quickly and safely as possible. Detoxification may involve gradually reducing the dose of the drug or temporarily substituting other substances that have less severe side effects. For some people it may be safe to undergo withdrawal therapy on an outpatient basis. Other people may require placement in a residential treatment centre, specialised crisis centre or an addiction unit in a psychiatric hospital or general hospital. Withdrawal from different categories of drugs produces different side effects and requires different approaches.

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

5.3.b Substitution treatment

Substitution treatment aims to prescribe, administer and dispense to a drug addict patient drugs delivered as medicines, with the objective, within the frame of the treatment, to improve health, quality of life and if possible to attain abstinence (Law of August 22 2002).
It is stated that psychosocial counselling and assistance to patients are factors improving the results of substitution treatment. Substitution treatment should be part of a medical-psychological-social approach; this is stated to be an essential component to make substitution treatment work.

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

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

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

SSMG-Alto is a network of General Practitioners giving care to drug users in the French part of Belgium. They also offer “intervisions” and trainings to the caring for addicted patients in several towns of Wallonia.
In 2005, a study was performed in the Walloon region by SSMG-Alto. The purpose of the study was to assess the number of prescribing GPs of the network, the number of patients receiving substitution treatment and the main types of drug use. Since only General Practitioners identified as members of SSMG-Alto network were enrolled, the results of this study cannot be generalized to all GPs.
Analysis showed that 2640 patients were receiving a substitution treatment (methadone) from 164 General Practitioners. The mean number of patients receiving substitution treatment per GP stood at 26. After taking out of the group the 8 “biggest prescribers” (GPs prescribing to 90 up to 300 patients), the mean was 8.20 patients per GP.

5.3.c Other pharmacologically assisted treatment

A project on controlled heroin provision in the city of Liège will start at the fall of 2007. For more details, please refer to 1.4.c.

CHAPTER 6.
Health Correlates and Consequences

The National Institute of Statistics provides mortality data from which the drug-related deaths can be extracted; no other databases on drug-related deaths at national level exist. Although the last national data on drug related death date back to 1997, Flemish and Brussels figures could be extracted for the 1998-2004 period.

The decrease in the IDUs proportion among HIV cases observed during the past years, thanks to the AIDS and HIV Belgian database, seems to be confirmed by the 2006 data. Moreover, regional data concerning hepatitis show HCV is the most frequent type of hepatitis among drug users.

In the frame of the “Road safety action plan” launched by the Federal Police (2002), controls focusing on drivers under the influence of alcohol and drugs are performed. In 2006, a large majority of the analysed samples were positive. The most important substances detected were cannabinoids.

6.1. Drug-related deaths and mortality of drug users

6.1.a Direct overdoses and indirect drug related deaths

No eligible registers are available to estimate direct overdoses and indirect drug-related deaths.

6.1.b Mortality and causes of deaths among drug users

Using the EMCDDA's "Selection B", general mortality register data on drug-related deaths could be extracted for the Flemish Region and the Brussels Capital Region. The data analysis for the years 1998 through 2004 results in the following graphs:

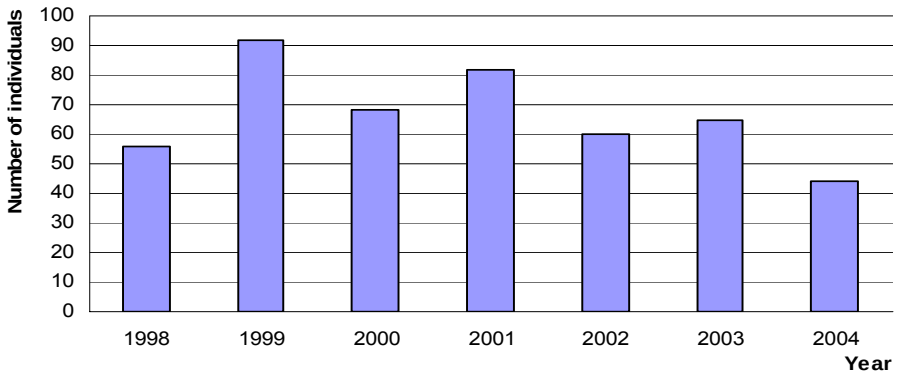

Figure 5: Number of drug-related death by year, Flemish region and Brussels Capital Region, 1998-2004 (N=467)

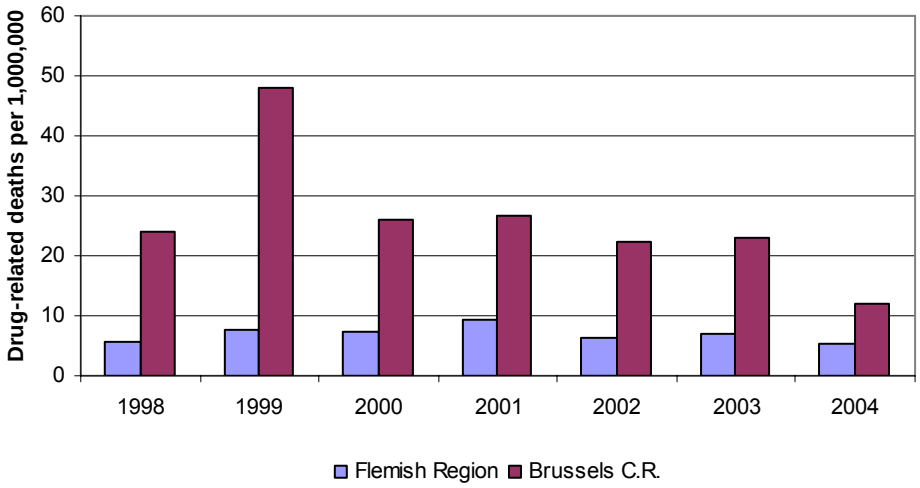

***Figure 6**: Number of drug-related deaths by region per 1,000,000 inhabitants, 1988-2004*

The mean number of drug-related deaths amounts to 66 per year. Over 80% of the individuals were men. Opiates are the substances most frequently mentioned on the death certificates (31.9%). However, in almost half of the cases, the only information available is the fact that "multiple drugs" were involved, making it difficult to assess the impact of specific drugs. More than 60% of the individuals had "drug dependence" mentioned on the death certificate as cause of death.
For more information, please refer to the study report (Jossels, Govarts & Roelands, 2006).

6.1.c Total mortality

There is no data available to estimate the total mortality among drug users.

6.2. Drug related infectious diseases

6.2.a HIV/AIDS

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

In Belgium, diagnosed HIV seropositive people and AIDS cases are registered in two integrated databases at the Scientific Institute of Public Health in Brussels[10].
From the beginning of the epidemic to December 2006, 18.959 HIV infected patients were registered.
The proportion of all IDUs among HIV cases (cases of HIV with intravenous drug use as risk factor) decreased from around 10% in 1986 to approximately 2% in 2006 (Figure 7).

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

Infection via intravenous drug use was higher among young people, but in recent years it has become comparable to the observations among older people. Among infected people aged between 15 and 24 years, one new case was registered in 2006.

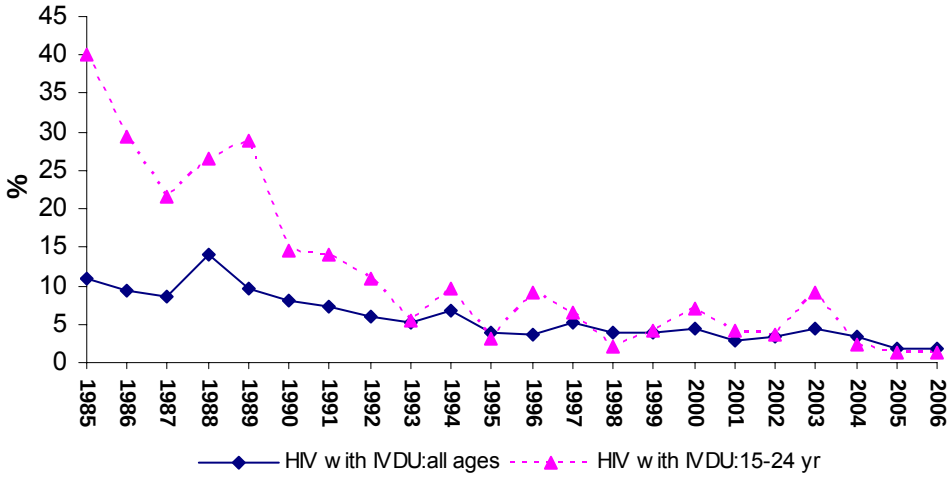

***Figure 7**: Percentage of IDUs among new HIV-cases from 1985 to 2006 in Belgium (Sasse, personal communication 2007)*

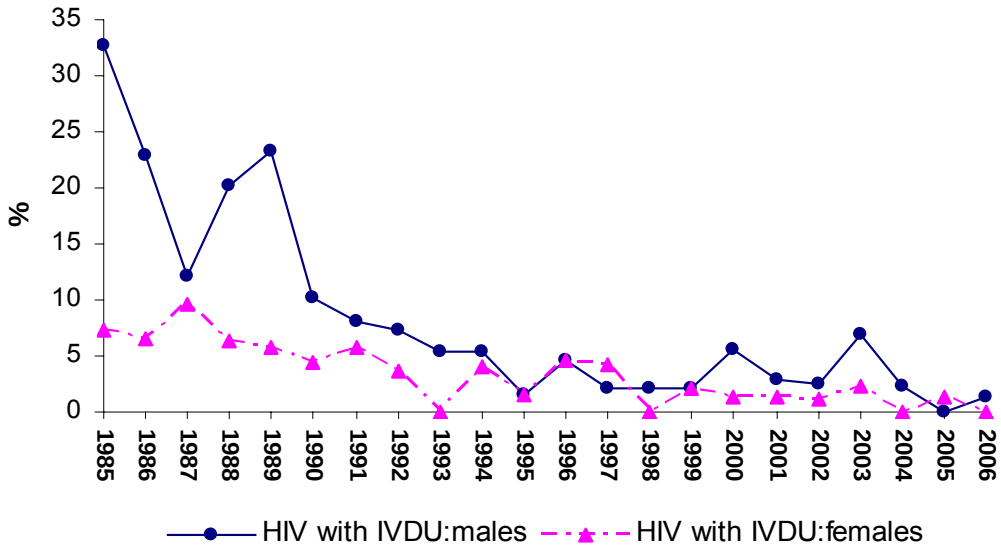

***Figure 8**: Percentage of IDUs among new cases aged between 15-24 years from 1985 to 2006 in Belgium, according to sex (Sasse, personal communication 2007)*

Trends of IDUs among HIV new cases according to gender are quite similar since 1995 (Figure 8). In 2006, only one male case was registered.

6.2.a.2 HIV seropositivity among drug users

Among the people met through the Snowball Survey (French Community, already described in 4.3.b) in 2006 (N=428), 58.9% have had an HIV test during their lifetime and 22.4% during the last year. Among the tested HIV, 6.4% have a positive result.
Mostly, they were tested by their GP (26.6%) or at hospital (24.3%). A minority made test in prison (12.9%) or in a follow-up centre (9.3%).
Moreover, the HIV positive prevalence was higher among IDUs (4.5%) than among the other respondents (0.9%) ($p < 0.02$).

6.2.a.3 HIV seropositivity among treated patients

The next table gives information gathered by two different sources. For the French Community, the data on HIV are self-reported and collected through the CCAD/EUROTOX monitoring system.
Biological data on HIV are made available through “De Sleutel”, a Flemish institution composed by several ambulatory and residential treatment centres. This biological testing is only performed for the clients seen by a doctor. A doctor follows all clients in substitution and / or other medication treatment. Criteria for seeing a doctor are not influenced by the type of drugs or by their modes of consumption. HIV seropositivity among IDUs seems to fluctuate (Table 15).

Table 15: Percentage of HIV-seropositivity among IDUs asking for treatment in De Sleutel (1997-2006) and in centres of the French Community (1994-2002)

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
De Sleutel (Flemish institution)													
Number of treatment demands from IDUs	n.a.	n.a.	n.a.	236	75	352	303	241	306	269	295	164	228
Number of IDUs tested	n.a.	n.a.	n.a.	120	56	186	161	118	62	82	97	37	68
% HIV+ (tested)	n.a.	n.a.	n.a.	0.8	5.4	0.5	1.2	1.7	1.6	1.2	4.1	2.7	2.9
French Community													
Number of treatment demands from IDUs	607	550	666	620	505	697	412	579	761				
Number of IDUs self-reported	270	255	314	294	255	217	128	267	180				
% HIV + (self-reported)	7.4	3.1	1.3	2.7	2.7	2.3	3.1	3.4	n.a.				

The next table provides the same kind of information than Table 15 for the French Community for the years 2003-2005: since a data collection tool change process was initiated in 2000 by Eurotox in order to better match the TDI requirements, the 1994-2002 data shouldn’t be compared with the more recent ones. Moreover, the infectious disease data are collected on a voluntary basis: all the French Community centres don’t deliver data on infectious diseases. Only centres registering with EUROTOX system (15 centres) in the Walloon region include the infectious disease indicator in their questionnaires.

Table 15 a.: Percentage of self-reported HIV-seropositivity among IDUs asking for treatment in 15 centres of the Walloon region, 2003-2005

Year	2003	2004	2005
Walloon region			
Number of treatment demands from IDUs	288	263	190
Number of IDUs self-reported	144	127	90
% HIV + (self-reported)	5,2	8,1	4,7

In the outpatient centre “Free Clinic” (medico-social centre in Antwerp) all attending patients are offered a blood screening on a regularly basis.
In 2006, 19 patients were tested positive for HIV (Table 16).

Table 16: Percentage of sero-prevalence of HIV in an outpatient centre, Antwerp, Free Clinic 2006

IDU	2003	2004	2005	2006
Number of IDUs	408	416	512	478
Number of IDUs tested	287	295	24	19
% HIV+ (tested)	5.6	6.1	7.1	5.7

6.2.a.4 HIV seropositivity among prisoners

The study undertaken in Belgian prisons in October - November 2006 (Todts et al. 2007, see 2.3.d) also investigated the infectious diseases topic.
About 30% of the prisoners (N=902) have been voluntarily tested for HIV during their detention. 34.8% of the drug user prisoners (N = 541) and 51.4% of the injecting drug user prisoners (N=163) did the test. Only 1.5% of the tested prisoners declared being infected and 82.1% stated not being infected (16.4% didn’t know or didn’t give an answer).

6.2.b Hepatitis B and C

The prevalence of HCV is higher among the IDUs and the non-IDUs than among the general population (Matheï et al. 2005a). In Belgium, current hepatitis C prevalence in the general population is estimated to be around 1% (Beutels et al. 1997).
Sharing contaminated needles and syringes and other injecting materials are risk factors of infection. The transmission of HCV among non-IDUs could be due to sharing of snorting materials, high risk sexual behaviour or via household contact with IDUs (Matheï et al. 2005). It seems that the significance of sexual transmission among IDUs is very limited since HCV is far more effectively transmitted by parenteral route. However, among the non-IDUs the sexual transmission might contribute to the higher prevalence rates of HCV than in the general population (non-IDUs having most often IDUs as sexual partners, which are often infected with HCV). Moreover, a low level of education, unemployment, marginalisation and loss of social network were found associated with HCV infection (Matheï et al. 2005).

Monitoring of infection is important in order to provide a feedback on the effectiveness of interventions. However, it is difficult to monitor trends in HCV

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

6.2.b.1 HBV- and HCV seropositivity among treated patients

The sources of information used for HBV-HCV are the same as for HIV which are presented in the related section.

Data on prevalence of HBV in the Flemish Community are available from "De Sleutel": they seem to show a general decreasing trend from 21% (15/73) in 1997 to 15.8% in 2006(6/38) (Table 17). One should be cautious in interpreting these data because biological testing is performed only for the clients seeing a doctor and there are no guidelines with criteria specifying which patients are to be tested.

The prevalence of self-reported HBV infection in surveyed lifetime IDUs registered in the monitoring system of the French community (1997-2002) seems to increase with age. The same trend is also observed in the results of the tested patients in "De Sleutel".

Table 17: Percentage of hepatitis B infected among IDUs asking for treatment, in De Sleutel (1997-2006) and in centres of the French Community (1997-2002)

HBV	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**
De Sleutel (Flemish institution)										
Number of treatment demands from IDUs	236	75	352	303	241	306	269	295	164	228
Number of IDUs tested	73	54	155	123	89	47	58	66	37	38
Number of hepatitis B +(anti-HBc+)	15	13	37	27	14	10	10	11	3	6
Prevalence rate (%)										
All IDUs	**21**	**24**	**24**	**22**	**16**	**21**	**17**	**17**	**8.1**	**15.8**
Males	23	23	28	22	14	22	21	16	9.4	17.6
Females	8	33	7	20	25	14	0	18	0.0	0.0
<25 years	11	7	12	8	0	10	7	0	0.0	0.0
25-34 years	27	21	26	26	21	50	100	21	6.7	11.1
>34 years	57	50	44	42	32	44	33	36	14.3	50
IDUs using opiates	24	29	34	n.a.	18	21	18	15	6.3	21
IDUs not using opiates	13	8.3	n.a.	n.a.	0	27	13	22	20	6.7
French Community										
Number of treatment demands from IDUs	620	505	697	412	579	761				
Number of IDUs (self-reported)	115	240	195	127	275	184				
Number of hepatitis B + (self-reported)	27	57	39	20	38	17				

Prevalence rate (%)						
All IDUs	**23**	**24**	**20**	**16**	**14**	**9**
Males	21	22	27	16	15	10
Females	28	29	19	15	7	7
<25 years	14	18	10	7	5	n.a.
25-34 years	25	22	21	16	14	12
>34 years	33	35	26	22	18	7
IDUs using opiates	23	24	21	16	11	11
IDUs not using opiates	25	18	17	15	21	6

For the same reasons than the ones exposed in the HIV section, a new Table was created (Table 17a.) for the 2003-2005 data of the French Community. Moreover, these data couldn't be presented according to the different categories (age, sex…) because of the small subgroups sizes (N<100).
Between 2003 and 2005, the percentage of hepatitis B among IDUs is high and seems to raise.

Table 17a.: Percentage of hepatitis B infected among IDUs asking for treatment, in 15 centres of the Walloon region, 2003-2005

HBV	2003	2004	2005
Walloon region			
Number of treatment demands from IDUs	288	263	186
Number of IDUs (self-reported)	131	110	87
% of hepatitis B + (self-reported)	30.8	31	33.7

Among lifetime IDUs, i.e. IDUs having injected at least once, hepatitis C is more prevalent than hepatitis B. Between 1997 and 2002, the number of lifetime IDUs registered through the monitoring system of the French Community, reporting to be positive for hepatitis C, increased from 47% to 67%.
In 2006, 36.2% of tested lifetime IDU patients of "De Sleutel" have antibodies against hepatitis C (Table 18).

The prevalence of HCV infection among tested IDUs (having injected at least once) registered in the French Community (1997-2002) as well as in De Sleutel's data increases also with age (Table 18).

Table 18: Percentage of hepatitis C infected among IDUs asking for treatment, in De Sleutel (1997-2006) and in centres of the French Community (1997-2002)

HCV	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
De Sleutel (Flemish institution)										
Number of treatment demands from IDUs	236	75	352	303	241	306	269	295	164	228
Number of IDUs tested	114	56	195	164	120	65	80	96	38	69
Number of hepatitis C + (biological testing)	45	26	74	59	43	28	28	36	19	25
Prevalence rate (%)										
All IDUs	**40**	**46**	**38**	**36**	**36**	**43**	**35**	**37**	**50**	**36.2**
Males	40	40	39	34	33	42	35	37	45.5	35.6
Females	39	100	30	47	53	50	33	38	80	40

<25 years	25	21	14	16	16	19	28	9	37.5	19.2
25-34 years	53	52	51	45	42	50	0	43	29.4	38.7
>34 years	77	62	63	60	56	85	50	78	84.6	66.7
IDUs using opiates	47	50	50	n.a.	34	48	41	32	48.5	38.3
IDUs not using opiates	21	33	n.a.	n.a.	50	33	24	50	50	26.7
French Community										
Number of treatment demands from IDUs	620	505	697	412	579	761				
Number of IDUs (self-reported)	115	240	195	127	275	184				
Number of hepatitis C + (self-reported)	54	124	100	66	182	124				
Prevalence rate (%)										
All IDUs	**47**	**52**	**51**	**52**	**66**	**67**				
Males	46	49	49	52	66	68				
Females	48	60	57	52	67	64				
<25 years	41	47	32	27	55	29				
25-34 years	46	49	57	54	65	68				
>34 years	67	58	54	57	74	73				
IDUs using opiates	44	53	56	48	66	59				
IDUs not using opiates	62	39	59	63	67	82				

The next table (Table 18a.) was created for the 2003-2005 hepatitis C data of the French Community (see Table 15a. comment).
The percentage of hepatitis C among IDUs remains quite high in 2003 and 2004 and then drops down in 2005.

Table 18a.: Percentage of hepatitis C infected among IDUs asking for treatment, in 15 centres of the Walloon region, 2003-2005

HCV	**2003**	**2004**	**2005**
Walloon region			
Number of treatment demands from IDUs	288	263	186
Number of IDUs (self-reported)	141	120	93
% of hepatitis C + (self-reported)	71,6	62,9	32,9

The data below are the results of the blood testing diagnosis in Free Clinic (the context is already described in 6.2.a.3). In 2006, 78,7% of the patients tested at Free Clinic were tested positive for hepatitis C and almost 55% of the tested patients were positive for HBV(anti-HBc+) (Table 19).

Table 19: Percentage of hepatitis B and C infected among IDUs asking for treatment, in Free Clinic, 2003-2006

Free Clinic Antwerp	2003	2004	2005	2006
HBV				
Number of treatment demands from IDUs	408	416	512	478
Number of IDUs tested	281	252	323	329
Number of hepatitis B + (biological testing) (anti-HBc+)	174	147	190	181
Prevalence rate (%)				
All IDUs	**61.9**	**58.3**	**58.8**	**55.0**
Males	64.6	59.7	60.1	58.3
Females	56.5	55.3	56.0	47.5
<25 years	33.3	57.1	25.0	33.3
25-34 years	54.9	51.4	22.1	40.0
>34 years	67.4	61.4	64.6	60.4
HCV				
Number of treatment demands from IDUs	408	416	512	478
Number of IDUs tested	287	258	337	342
Number of hepatitis C + (biological testing)	227	196	272	269
Prevalence rate (%)				
All IDUs	**79.1**	**76.0**	**80.7**	**78.7**
Males	81.5	78.0	82.6	81.3
Females	73.9	71.1	76.2	72.5
<25 years	50	64.3	40.0	60.0
25-34 years	76.9	82.7	72.0	67.5
>34 years	82.4	74.0	85.9	82.9

6.3% of the tested patients were positive HBV surface antigen (HBs-Ag) in 2001 and this percentage decreased to 1.5% in 2006 (standard table 9, 2007).

A study compared the prevalence of HCV and related risk factors in drug users in two regions[11] of the Flemish part of Belgium. Prevalence rates of hepatitis B and C were higher in the city (respectively 62% and 71%) than in the mixed area (21% and 46%). It appears that the difference in HCV prevalence is entirely explained by differences in behaviour and characteristics. The findings also suggest that variations in sexual risk behaviour and socio-economic status in addition to drug-related risk factors have to be taken into account when trying to understand geographic differences of HCV prevalence in drug users (Matheï et al. 2005a).

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

The Snowball Survey**,** for which details are given in section 4.3.b, provides additional information on hepatitis for the French Community.

Among all the respondents (N = 428) in 2006, half of them (51.9%) state having made the hepatitis test and 14.7% the vaccine. IDUs report more often having made the test (67.6%) than the others respondents (36.7%)

[11] City of Antwerp and mixed rural and urban area of Limburg.

Among various hepatitis, hepatitis C seems to be the most frequent: 15.4% for hepatitis C, 4.4% for hepatitis A, 6.8% for hepatitis B, and 0.7% for hepatitis D.

The seropositivity rate is significantly higher for IDUs than for the other drug users (Table 20).

Table 20: Percentages of self-reported positive results among tested IDUs and non-IDUs for hepatitis, Snowball surveys, French Community, 2005-2006

	2005	2006
IDUs		
HIV +	8.2%	5.8%
(N tested)	(428)	(138)
HBV+	30.8%	19.0%
(N tested)	(415)	(142)
HCV+	56.1%	40.8%
(N tested)	(415)	(142)
HDV+	1.4%	2.1%
(N tested)	(415)	(142)
Non-IDUs		
HIV+	4.5%	1.8%
(N tested)	(291)	(113)
HBV+	15.5%	5.0%
(N tested)	(239)	(80)
HCV+	21.8%	10.0%
(N tested)	(239)	(80)
HDV+	0.0%	0.0%
(N tested)	(239)	(80)

In 2006, 2.9% of the lifetime IDUs reported a co-infection HIV and HCV.

6.2.b.3 Hepatitis among prisoners

The study performed in Belgian prisons in 2006 (Todts et al. 2007, see 2.3.d) also investigated the hepatitis topic by obtaining and analyzing an oral fluid sample for testing on hepatitis B and C.
For methodological reasons, all the samples couldn't be analyzed (around 50% were). Only 2% of all tested samples were positive for hepatitis B and 7.5% were positive for hepatitis C.
Moreover, some of the prisoners were also tested for hepatitis another time during their detention and were able to state if they were infected or not. 4.5% of that sample (N=276) declared being infected by HBV, 14.1% by HCV, 3.0% by both and 1.1% knew they were infected but didn't know by which type of hepatitis. 69% stated not being infected and 10.8% didn't know or didn't answer.
A large majority of the infected prisoners have a history of drug injection (81.8%). More than a third of them (37%) performed injection daily on themselves during the month preceding the current detention. Among them, one out of three (29.6%) shared his/her materiel during the last injection.
The prisoners having an injection history are fifteen times more likely than the others to be infected by hepatitis. One drug user out of four (25.9%) states having already performed injection during detention.

6.2.c Tuberculosis

In 2005, 1,144 tuberculosis cases have been registered (incidence rate: 11/100,000 inhabitants) (FARES/VRGT, 2007). Among them, 14 cases (1.2%) stated intravenous drug use.

6.3. Psychiatric co-morbidity

- **Minimum Psychiatric Summary (RPM)**

In Belgium, no national specific estimation of the number of double diagnosed patients has been implemented yet.
Nonetheless, thanks to the Minimum Psychiatric Summary (RPM), we can approximately evaluate the percentage of dually diagnosed patients.
The RPM is a data registration system applied in psychiatric hospitals, psychiatric services of general hospitals, protected homes and psychiatric care homes. The data collected are, among others, patient's socio-demographic data, diagnosis and treatment data.

In 2004, 3.5% of the patients admitted for a psychiatric trouble presented also a drug problem (defined as "abuse and addictions to opiates, cocaine, cannabis, amphetamines, hallucinogenic products, inhaled products and poly-substances"). 0.5% of these psychiatric troubles were induced by drug use.
Furthermore, 54% of the patients admitted for a drug problem didn't present any psychiatric trouble. (Gorissen, personal communication)

- **De Sleutel estimation**

De Sleutel made an estimation based on patients documented with EuropASI between 1998 and April 2007[12]. Percentages were calculated for those patients having a severity index of 4-5 and/or 6-9 for drug problems as well as for psycho-emotional problems (i.e. depression, anxiety, tension …). During the period 1998-2007, 46.5% of the patients (N=4929) could be assigned to moderate (35.4%) or severe (11.1%) double diagnosis (Table 21). For the period 2004-2007 De Sleutel found 50.8% (N=1849) patients with double diagnosis. In 2006, 51.8% (N= 631) of patients were labelled with double diagnosis. Throughout the years, it seems that an increase of the double diagnosis has been observed.

Table 21: Psychiatric co-morbidity in the Flemish Community (De Sleutel, 2007, personal communication)

	1998-2007	2004-2007	2006
	N=4929	N=1849	N=631
Moderate DD	35.4 %	39.0 %	37.9 %
Severe DD	11.1 %	11.8 %	13.9 %
Total DD	46.5 %	50.8 %	51.8 %

[12] De Sleutel-Dept. Of Research, Dubbel diagnose: analyse van de omvang en de hulpvraag (*Double Diagnosis: analysis of number and treatment demand*), Personnal communications.

6.4. OTHER DRUG-RELATED HEALTH CORRELATES AND CONSEQUENCES

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

- **Minimum Clinical Summary (RCM)**

From January to December 2005, in 146 general hospitals of Belgium, a drug-related problem (primary or secondary diagnosis) was mentioned in 0.47% of all hospitalizations (stays spent entirely in psychiatric services not included)
Data come from the RCM (Minimum Clinical Summary) database, selection on the basis of ICD9 codes (drug addictions and drug abuses in non-addicted patients). Because the use of ICD9 is not mandatory for ambulatory patients, this percentage is probably an underestimation. (Legrand, personal communication).

- **Anti-poison centre**

In 2006, 359 calls were received by the anti-poison centre regarding drug intoxications. For 251 calls only one substance was involved, 108 calls concerned the use of multiple substances. In order of importance, of the 251 cases, 40 were related to cannabis and derivates, 30 to XTC, 29 to inhaling substances, 18 cases to cocaine and 15 to heroine. 24 calls concerned non-identified substances. (Mostin, personal communication)

6.4.b Driving and other accidents

6.4.b.1 Data from police services

In October 2002, the Federal Police launched a "Road safety action plan". This plan is aimed to reduce by half, the number of deaths and injured people on the roads by 2010. Driving under influence of alcohol and drugs is one of the key points of this new action plan. In practice, the frequency and number of controls by police services are increased. Places and moments of those controls are published (Federal Police Press releases).

Table 22 shows the results of the controls done by the federal police on the motorways. It concerns only the actions led by the Federal police for 2005-2006.

Table 22: Results of the controls in the framework of the "Road safety action plan", Deblaere, personal communication, 2007

		2005	2006
Controls		486	599
Urine tests	**Positive**	168	171
	Negative	68	79
	Total	*236*	*250*
Blood tests		168	171
Refusals		4	2
PV's		172	173
Driving license revocation		36	11

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

The methods of control are divided into two phases: detection and observation.
The detection follows standardised tests on physical and attention signs. If after the completion of all the tests, several of them were positive, a urine test is done. If this result is positive, then a blood test is requested. Policemen should have followed a theory training of 2 days and 8 hours of practical tests before carrying out such tests.
Figure 9 presents the results of the blood analysis performed in 2005 and 2006 (Gert Deboeck, NICC personal communication). Blood samples were taken during police road controls (both local and federal police services). In 2006, out of 1337 tests, 1096 were positive and 241 were false positive.
Almost half of the samples contained only cannabinoids, followed by amphetamines and then cannabinoids associated with amphetamines.

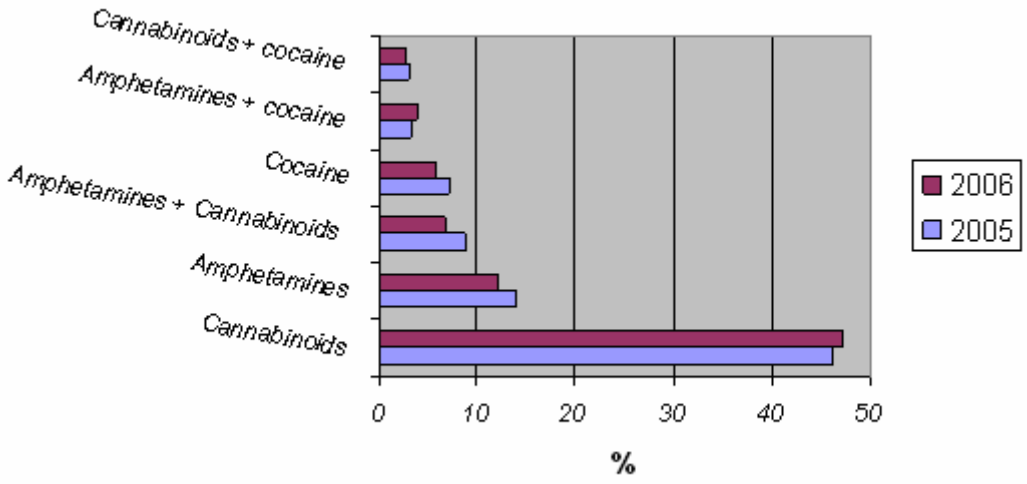

***Figure 9**: Results of positive blood tests in the framework of road controls done by local and federal police services, N= 1111, N= 1337, NICC 2005-2006*

6.4.b.2 Road traffic accidents

A study on the issue of "Driving under influence of psychoactive substances[13]" (ROPS) was carried out in 2004-2006.
In the literature review, the results of different studies are outlined: 3.6% of the population declare having driven under the influence of illegal substances and 85% among the drug users make the same statement.
Five main conclusions were made by the experts:

- there is a data lack concerning the number of accidents related to drug use;
- the Police has to face several practical problems when reporting driving under influence (e.g. long and complicated testing procedure);

[13] An extended summary of the research is given on the web site : http://www.belspo.be

- depending on the different Public ministry services, divergent points of view and given orders are noted;
- law lack of substance (e.g. some drugs aren't mentioned in the driving license withdrawal law);
- Problems concerning the blood sample analysis methods

Political recommendations on the basis of the literature study and experts conclusions were made.

6.4.c Pregnancies

Until now there is no systematic data collection on pregnant female drug users or substance-abusing mothers (even in treatment) with (young) children in Belgium.

CHAPTER 7.
Responses to Health Correlates and Consequences

In 1998, a law allowed the organisation of needle exchange (royal decree of 5 June 2000). Needle exchange programmes are implemented since 1994 in the French Community and since 2001 in Flanders. Both of these regions generally get a satisfactory syringes exchange rate (around 90%).

Generally speaking, it could be underlined that special emphasis is given to counselling and testing for hepatitis C and HIV. It seems that less prevention projects are dedicated to other drug use consequences (e.g. HBV, psychiatric co-morbidity…) or specific vulnerable groups (e.g. prisoners, pregnant women…).

7.1. Prevention of drug-related deaths

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

In 2004, several warnings were distributed concerning highly-dosed MDMA tablets. This trend decreased again in 2005, with only three occurrences in 2005 and 2 in 2006. On the other hand, MDMA in liquid form e.g. in small bottles, named 'original 69', appeared on the illegal market at the beginning of 2006. These bottles contained a high dose of MDMA and were as a consequence at risk for overdose. There were only few analyses of such bottles reported in Belgium.
Furthermore, tablets containing mCPP (metachloro-phenyl-piperazine), kept on circulating since their first detection in Belgium in July 2005. In first instance, mCPP was put in tablets with specific characteristics, known under the name of "Arc-en-ciel" or "Regenboogjes" ("rainbow"). Afterwards, these tablets disappeared from the market and mCPP was sold as XTC in XTC-like tablets, alone or mixed up with MDMA. mCPP has poor recreational effects but the following unwanted effects are frequent: headache, nausea, trembles, dizziness, sickness…Since December 2006, mCPP is controlled as a psychotropic substance in Belgium. At European level, a joint report on mCPP was sent to the European Commission because of the widespread presence of mCPP in Europe. However, since mCPP was in some countries used in the production of medicines, a risk assessment could not been carried out.
In addition, some warnings were sent in 2006 about some isolated but probably dangerous cases. So there was a warning message on some, at first view, 'unusual' methadone deaths, a case on atropine intoxication after the intake of drug tablets and one on the sale of buprenorphine as speed. Since September 2006, many cannabis users claimed the bad quality of cannabis but it was difficult to verify these statements in the laboratory results. France and the UK communicated the presence of micro-beads of glass and quartz crystals in cannabis and similar samples were finally found in Belgium in 2007.

Brochures on overdose or other harm prevention are disseminated in the **French Community** through street workers, needle exchange programmes, peers (snowball project) and in recreational settings.
In 2006, the NGO Modus-Vivendi re-edited the 5-versions brochure on syringe-exchange programmes (one version for each of the 5 concerned cities: Charleroi, Liège, Arlon, Dinant, Bruxelles). The brochure (in fact a small flyer-trailer) gives general information on the concept of needle exchange (above all the gratuity and anonymity of it, but also the concrete actions, e.g. reception of sterile material, bringing back of used needles, reception of information on AIDS and hepatitis). Beyond that, each version provides the addresses and contact details of the various programmes/desks available in the concerned town.
This re-edition also appeals to the logo "Sterifix" (safe-injection kit, see below, 7.2.a.), in a better-identification purpose.

In the **Flemish Community**, a local training in overdose prevention for drug workers was set up through the provincial co-ordinators of the needle exchange programmes (it was also formerly addressed to drug users, but not anymore).
An information brochure on overdose prevention is also available and distributed through drug services, street corner workers and needle exchange programmes (Windelinckx, 2007).

7.2. Prevention and treatment of drug-related infectious diseases

7.2.a Prevention

➢ **Needle exchange programmes**

Different types of needle exchange programmes are available in the country except in the German-speaking Community: stationary exchange places, street programme and programmes in pharmacists (structured questionnaire 23, 2004). Safe injection rooms do not exist in Belgium.

♦ **Flemish Community**

In every province of the Flemish Community a coordinator for syringe exchange was appointed and several exchange places exist (low threshold organizations, pharmacies, outreach workers …). Via the projects, syringe exchange injection kits are spread among users, including: syringe, sterilized water and alcohol swabs (to clean the spoon). Collaborators of the project also distribute baking soda (for cooking base-cocaine) and inform users about base-cocaine. A handbook for syringe exchange programmes was developed about e.g.: the legal framework, good practice, infectious diseases, health problems related to injecting and alternative ways of using (Windelinckx, 2005). A CD-Rom was also developed for making crack cocaine with baking soda (this is available in low threshold services). The needle exchange program has started to give aluminium foil to drug users (promoting a switch to an alternative way of using drugs).
For the whole Flemish community, 538783 syringes were distributed and 527789 were given back in 2006 (Table 23) (Windelinckx 2007).

Table 23: Number of given and returned syringes (Flemish Community, 2001-2006)

	2001	2002	2003	2004	2005	2006
given	38297	192409	237023	309666	448502	538783
returned	n.a.	174776	239452	306594	431377	527789

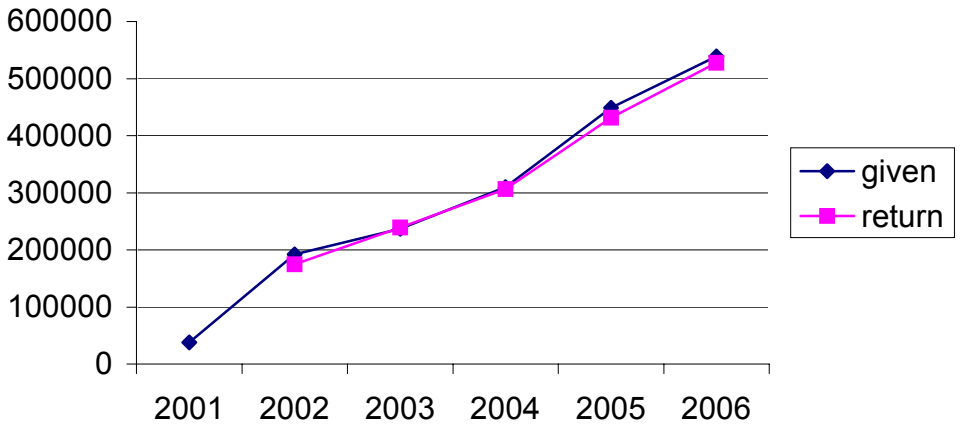

***Figure 10**: Volume of the exchanged syringes, Flemish Community, 2001-2006*

A noticeable increase in the number of syringes given and returned is observed between 2001 and 2006 (Figure 10).

♦ **French Community**

In the French Community, needle exchange programmes are available in 5 cities (Brussels, Charleroi, Liège, Dinant and Arlon).
The various programmes complete each other. Beyond the syringes, water and disinfecting swabs as well as ascorbic acid and sometimes spoons and filters (Stéricup©) are delivered. This is because; beyond by the needle in itself, the viruses can be transmitted by the *entire* material of injection.

All the programmes also promote other ways of consumption than injection and aim to prevent the spreading of sexually transmittable diseases. They thus propose sniff kits, condoms, lubricant, etc. And they also give advice on the reduction of risks related to drugs consumption.

Since 2002, the amount of distributed syringes through needle exchange programmes within the French Community fluctuates around 250.000, with a peak of almost 270.000 in 2002 (Modus Vivendi, Progress Report 2006) (Table 24).

Table 24: Amount of distributed syringes, French Community, 1996-2006

Year	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Amount of distributed syringes	12431	78231	94810	109474	177869	224343	269209	241746	257289	261182	246519

An increasing trend in the amount of syringes distributed in the French Community between 1996 and 2006 is observed (Figure 11).

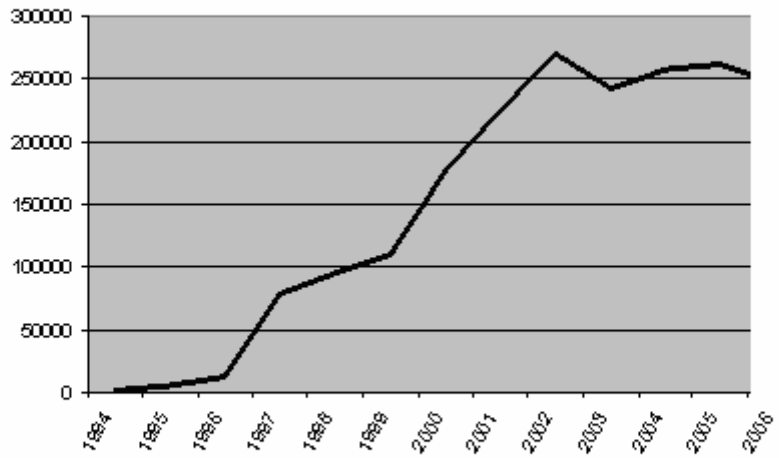

***Figure 11**: Evolution of the amount of distributed syringes via the syringe exchange programmes of the French Community, 1996-2006*

Notice that the rate of exchange is very satisfying since 2000, and even higher than 100% on two occurrences (Table 25). This is due to the fact that more syringes were brought back than taken away.

Table 25: Rate of exchanged syringes, French Community, 1996-2006

Year	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Exchange rate	24.3%	45.0%	31.0%	26.1%	98.6%	98.2%	92.1%	101.1%	103.0%	93.4%	92.4%

The tendency is thus encouraging since 2000, even if an effort could be made to develop the use of some tools (Stericup) and to spread syringe exchange in some regions (Namur, for instance) ore some environments (prison, for instance). A lack of financial means must unfortunately be pointed out: the Stericups are for instance insufficiently distributed via the exchange desks and in the streets (outreach work), and not at all in the Sterifix bags.

Injection kits: Stérifix

The Sterifix bag is a kit containing 2 alcohol-soaked swabs, 2 flasks of injectable sterile water, sanitary advices and useful local addresses. It is prepared by volunteers and provided to pharmacists by Modus Vivendi, free of charges. The pharmacists are advised to add 2 syringes to it and to sell it for euros 0.5. Sterifix bags can be found in the 5 following cities: Bruxelles, Namur, Charleroi, Chimay and Couvin. They can find the supplies directly by the local partners/relays. Indeed: either the bags are prepared by Modus Vivendi and sent to local relays, or they are made locally by partners of Modus Vivendi who spread them after. They also can receive from the latter material, financial or methodological support.

A global amount of 23050 bags was made in 2006. An average number of 2 syringes was added to the bags by pharmacists, which brings the figure to 46100 distributed syringes by that channel (Table 26).

Table 26: Evolution of the amount of syringes sold in pharmacies via Stérifix, in the French Community, 2000-2006

Year	2000	2001	2002	2003	2004	2005	2006
Amount of sold syringes	28986	24166	26000	31850	46850	38500	46100

Prevention of HIV/hepatitis in prison

- *Access to safe injection equipment*

During the study undertaken in Belgian prisons in October - November 2006 (see 2.3.d), a saliva sample for testing on hepatitis B and hepatitis C was obtained (see 6.2.b.3).

A small majority of the respondents (58.3 %) claim having disinfected their equipment on the last occasion. These persons have used alcohol (38.1%), boiling water (33.3%), bleach (19.0%) or other methods (4.8%).
It is appropriate at this point to highlight the fact that there is no access to safe injection equipment, nor to disinfectant in prison.

- *Access to condoms and lubricants*

As regards prevention, we can also notice the lack of accessibility to condoms. This access is limited and there is no access to lubricants.
Only one tenth of the persons (11.4 %) who report sexual contacts in prison (outside of the allowed conjugal visits) reported to use a condom every time, while 70.4% of the respondents declared never to use condoms. A smaller group (18.2%) use sometimes condoms.

- *Access to hepatitis B vaccination*

There is no structured vaccination program in the Belgian prisons. However, physicians are advised to vaccinate all HIV-positive and/or HCV-positive prisoners against hepatitis A and/or hepatitis B.
About one out of four prisoners claim to be vaccinated against HBV, but a large part of the sample (more than 1/4) do not even know whether they were vaccinated or not (Table 27).

Table 27: Vaccination for HBV in Belgian prisons on June 1st, 2006 (N = 902)

	%
No	47.3
Yes	24.6
I don't know	26.2
No answer	1.9

A booklet ("Vogue la Galère") was created by Modus Vivendi to give information on health in prison issues and is distributed in each prison. But it seems that the booklet is not often read.

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

Prevention of hepatitis C transmission through "sniffing" drugs
Sniffing kits are available in limited number in some harm reduction projects in recreational settings. These kits contain an information flyer and a straw.

Hepatitis B immunisation
Hepatitis B immunisation is poorly available, as intravenous drugs users are not identified as a priority group for hepatitis B immunisation policy. Therefore, the high costs of the vaccines make its access low. Programmes of vaccination against hepatitis B are developed but only target children.
The results of the snowball peers project indicate that the immunisation rate against hepatitis B among IDUs is very low and varies from 1.4% (2005) and 1.1% (2006) for recent IDUs (less than 2 years) up to 16.5% (2005) and 7.9% (2006) among all IDUs (Pozza 2007, personal communication), as shown in table 28.

Table 28: Results of the snowball peers project, 2005-2006

	2005		2006	
	N	%	N	%
Total amount of IDUs*	564	100.0%	190	100.0%
Vaccinated IDUs	93	16.5%	15	7.9%
Vaccinated IDUs <= 2 years	8	1.4%	2	1.1%
Vaccinated IDUs (current)**	64	11.3%	5	2.6%

*IDUs <= 2 years: persons declaring having started consuming injecting drugs since 2 years or less.
**Current IDUs: persons declaring having used injecting drugs within the last month.

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

- about Aids;
- time table flyer with the addresses of the different needles exchange programmes;
- brochure "Shooter propre", targets intravenous drug users and provides information on how to inject safely;
- brochure "A,B,C des hépatites": information brochures for drug users on hepatitis prevention.

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

Other HIV and hepatitis C prevention activities

A small brochure ("Vous êtes en contact avec des seringues usagées") targeting staff of public parks, police or any professional who might be in contact with used syringes in public areas was published. The objective is to inform them objectively on the risks of contamination, on how to prevent accidental punctures and how to react in case of accidents. Since 2004 and for 3 years already, the brochure is completed by a training targeting the same professionals. These professionals are "non-dedicated" or "generalist" actors. Hence the need to sensitize them to the reality of injecting drug use and to give them the most appropriate tool (brochure + training) in order to choose freely the most appropriate attitude. The operational aim is to lower the fear / incomprehension of these generalist actors regarding the drug users and the injecting practice so that they can eventually, if they want, pick up used syringes and bring them to a special recuperation container without being hurt by the needle, preventing also other persons from that same risk. The second operational aim is to broaden these actors' mind on the imago of the drug users, so that they can start a dialogue with them if they want to.

For that purpose, the training also introduces the policy of harm reduction.

In 2006, 223 persons followed these trainings. They were park guards, social housing workers or road maintenance employees.

Peer prevention project

The '*Operation Boule de neige*' ("Snowball Operation"), is a peer prevention project, concerns HIV, hepatitis and other drug-related risks and aims at reaching, through a snowball methodology, specific groups that are not easily accessible. (Ex-)drug users in short-term contracts ('jobist') are trained on HIV, hepatitis or overdoses prevention. After their training, the "jobists" go back to the "drug scene" to contact drug users, diffuse their prevention messages and material and recruit new candidate jobists. The jobists are assisted in their work by a questionnaire, used also to collect data on patterns of use and attitudes. Evaluation of each intervention is made with the "jobists" and is both collective and individual. About 1,500 drug users, mainly IDUs are reached every year in the French Community.

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

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

Fortunately, it was recently re-activated: during the period from 2006/03/01 to 2007/02/28, 2 snowball operations were led again in the prisons of Jamioulx and Namur, thanks to a financial partnership with the Federal Public Department of Justice.

Nonetheless, with regard on the future planned operations in several prisons (St. Gilles, Forest, Jamioulx, Andenne, Lantin and Tournai) in 2007, Modus Vivendi stresses some lacks. The communication and dialogue between the various actors should for instance be improved. Indeed, too often are the movements inside the prison slowed down, due to a suspicion atmosphere. It challenges the quality of the operation. The "drugs steering committees" related to the new circular and act (July the 18th 2006, see point 1.1.a.) should point in that direction.

7.2.b Counselling and testing

In 2003, a new network "Hepatitis C-drug addiction" was set up in **Brussels**. This network proposes a support to patients (two socials workers make a personal follow-up of the seropositive persons) and make easier the links between hepatologists, GP's, psychologists and several services active in the field of drug addiction.

The necessity to screen more patients for HCV in Brussels was the first reason for which the network was set up (Mulkay, personal communication).
The objectives of the network are to improve the prevention of hepatitis C among drug users and ameliorate the access to screening and to hepatitis C treatment. The network organises seminars on hepatitis C treatment but also monthly meetings to discuss the treatment of patients who are in drug treatment services or GP patients and treated or followed by hepatologists for their hepatitis C infection. In 2004, a seminar was organised and 150 patients were included in a clinical protocol for hepatitis C treatment (CARE).
Furthermore, new prevention activities were applied since then: a snowball operation and a screening operation (the third) targeting drug users and socially weakened persons.
Beyond the specialised institutions taking care for drug users, the HCV network turned indeed towards other accommodation structures, targeting socially disabled persons (home Baudouin, Cols Satinte Thérèse, etc) or sex-workers (Espace P). Since June 2007, the network established a partnership with Elisa Center. They organise information sessions about HIV – hepatitis B and C for jeopardized persons and/or drug users. The persons wanting it can make the HIV – hepatitis B and C tests.

Two hospitals (Saint-Pierre, Brugmann), took part to the screening operation, and two syringe exchange desks (Clip and LAIRR). 24 persons showed up and 18 of them were screened. Four revealed HCV+, and they were all injecting drug users. Four out of eighteen means more than one out of 5. It was the third screening operation led by the Hepatitis C network; the global amount of patients for all three operations being 101.
Eight of these 101 persons have revealed HCV+.
The national average of HCV+ being 1%, these screening operations comfort the network in the idea that prevention should be further promoted among drug users, the most exposed social group to HCV. 50 to 80% of the injecting drug users are generally estimated HCV+.
One of the improvements brought to the network after 3 years of activity is to offer those socially disabled/injecting drug users a free-of-charges and anonymous screening, along with a clear and accurate information on hepatitis C, its treatment and how to prevent it.

Since 2003, the needle exchange programme (“Le comptoir”), in partnership with the NGO “Sida IST” (HIV reference centre) in Charleroi, offers IDUs the opportunity to be tested freely and anonymously for HIV and hepatitis during the opening hours of the needle exchange programme. In 2006, 84 tests on these TSI were realised. The handing-over of the results turned out to be problematic (33% of non-handed results), this because these users did not come and take their results. The methodology was improved in 2006 (handing-over of the results by mail, telephone contacts with the doctor, follow-up of the teachers), which led to a rise of the handed results (+ 45%). An average 60% of the users were HCV positive, even if that proportion fell to 45% in 2006. No HIV positive was detected. An average 10% of the users were HBV positive, but that proportion decreased from 25% in 2003 to 0% in 2006.
Adapted prevention messages are delivered, but they do not always prevent risky behaviours, so that some users come back yearly for a new test.
“Le Comptoir” and “Sida IST” wish to impel a project of free vaccination against hepatitis B targeting drug users of the area.

The Belgian Association for the Study of the Liver (BASL[14]) published guidelines for the management of chronic HCV among drug users (Robayes et al. 2005). The implementation of these guidelines should avoid the evolution of chronic HCV to end-stage liver disease, prevent liver transplantation in those patients and reduce the spread of viral infection.

In **Flanders**, drug users have many places to be tested for infectious diseases. The screenings (HIV, HCV, and HBV) are mostly offered in outpatient and inpatient treatment centres. For TBC-screening, there is cooperation between the MSOC's and the VRGT (Flemish association for respiratory health and prevention of tuberculosis) (Windelinckx, 2007).

Treatment of hepatitis C infection costs the patient who has no medical insurance about 1800 Euro per month. If the patient has a social insurance it costs him EUR 30. The criteria for reimbursement of the hepatitis C treatment by the social security were revised in 2004. In addition to a PCR positive and to an elevation of the ALT (twice in a 1 month minimum interval), according to the type of genotype to get reimbursement the diagnosis must be confirmed by a biopsy for genotypes 1, 4, 5 and 6. There is no need for a biopsy for genotype 2 and 3.

7.3. Interventions related to psychiatric co-morbidity

The project "Effectiveness of inpatient treatment programs for dually diagnosed patients"[15] funded by the federal authorities is still going on. Its aim is to answer two questions:

a) are dually diagnosed patients effectively treated when they follow a residential integrated treatment programme?
b) do the residential integrated treatment programme and the residential non-integrated treatment programme differ in efficiency?

The residential integrated treatment program is defined as a combination of special assessment, outreach, motivational interviewing, individual and group counselling, a pharmacological treatment, psycho-education, a long-term perspective, different treatment phases and social network factors.
Forty dually diagnosed patients who followed an integrated treatment program were compared with 40 dually diagnosed patients who followed a non-integrated treatment program.
As a part of this project, two hospitals (in Sleidinge and Liège) started in 2002 a pilot project 'intensive care for patients with a double diagnosis'. The main objective of this programme is to try out and rephrase a care policy for the specific target group (De Cuyper 2003). Secondly, an integrated care plan was developed that guarantees collaboration and continuity of acute treatment, prevention and aftercare. The federal authorities fund the project.

The final results of this project should be available in the fall of 2007.

[14] http://www.basl.be

[15] Results of the first phase of this research are available at http://www.belspo.be/belspo/fedra/proj.asp?1=en1&COD=DR/21
Sabbe, B., De Wilde, B. (2004). Effectiveness of inpatient treatment programs for dually diagnosed patients.

7.4. Interventions related to other health correlates and consequences

7.4.a Somatic co-morbidity

In the MSOC in Gent every new client is screened for HIV and hepatitis B & C (Dr. Swinnen, personal communication). Another standard test used is the Mantoux test (TBC). With hepatitis B seronegative persons the MSOC starts an active immunisation (3 vaccines). Since the start of this immunisation they managed to decrease the active hepatitis B prevalence and incidence in their population.
Hepatitis C seropositive persons are referred to Ghent university hospital if eligible for therapy. HIV-positives are also referred to Ghent university hospital.

7.4.b Non fatal emergencies and general health-related treatment

In general hospitals, problematic substance users can both be treated in the general services, in the emergency department as well as in the psychiatric ward for serious somatic or psychiatric problems. Because of a non-selective and easily accessible policy, a number of people with problematic substance use can, for instance via the emergency admission, end up in general hospitals. There are no recent data on the specific topic. In 2002, a new pilot project started as an implementation of the federal drug note. In each of the five provinces of Flanders a new crisis unit was set up. The units are part of five general hospitals. Per hospital 4 beds will be reserved for alcohol and drug addicts in crisis for maximum stay of five days. Every crisis unit is linked to a case manager who guides the patients and does outreach work.

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

The use of illegal or legal drugs while driving a vehicle wasn't enough to establish an offence. It is necessary that the use of these products causes impairment similar to drunkenness before driving. A new specific offence has been introduced that penalises the simple use of certain illegal drugs, cannabis among other, while driving. A similar specific rule does not exist for benzodiazepines. A control procedure exists for drivers while cannabis is supposedly been used (THC).
Prevention activities have been developed. The Belgian Institute for Road Safety organised campaigns regarding driving under influence of drugs and developed leaflets. Police officers of the federal highway police specialised in prevention and teaching, organise lessons in secondary schools about road safety, including the dangerous combination of using drugs and driving. The Federal Police launched a "Road safety action plan" that aims to reduce the number of deaths and injured people on the roads by 2010. Driving under influence of alcohol and drugs is one of the key points of this new action plan. In practice, the frequency and number of controls by police services are increased.

For more information, please refer to chapter 12 of previous national report.

7.4.d Other health consequences reduction activities

The syringe exchange project in **Flanders** sensitises drug users to test for TBC and offers them the opportunity to be tested for TBC in cooperation with the MSOC's and the VRGT (Windelinckx 2007).

In June 2002, a first "charter of well-being in recreational settings" was signed in **Brussels** by owners of discotheques (Minister Gosuin 2002). The signatories of the «Charte du bien-être dans les lieux festifs» agreed for example to offer free water in a chill-out place. Dissemination of prevention messages was also to be organised in these discos. But it had to be recently re-activated by the "mobile harm-reduction team" of Modus Vivendi. Indeed, the training work realised then with clubs owners was a little too short and superficial to produce long-term effects: the consequences of it amounted to these fountains of free water, and they were sometimes confined to the VIP chill-out places.

That mobile harm reduction team is active in the **French Community:** during major events (major in size or because of an expected high prevalence of drug use during the event), a team with both professionals and trained peers is present and offers various services such as: information on drugs and STDs distribution of brochures, needle exchange, sterile injection material distribution, water distribution, safe sniff kits, and "bad trips" management *in situ.* Moreover, pills testing activities, which were stopped for several years under the impulsion of the ministry of justice, take place again in the festivals and in dancings. Two types of tests are applied. The "Marquis test" is a short-term analysis which allows to detect a tendency of concentration in some active principles such as MDMA (XTC) or amphetamines, but not to detail the exhaustive composition of the products. The result is handed to the consumer directly, at the event itself. On the other hand, the laboratory analysis is a more exhaustive test but is realised, of course, in a laboratory and handed 24h later to the consumer. This leads 40% of the demanding users met in the festivals to choose exclusively the "Marquis" test (30% choose the laboratory analysis, and 20% choose them both).
And so, last but not least, because of the variety of the publics in the particular environment of the Brussels nightlife places (underground, upper-middle or lower-upper class, etc.) and the resulting difficulty to ensure a continuous offer of the mobile team's services, the managers of these places were invited to join a think tank focused on the concept of "Quality nights". It has started a reflection on a selective training that would be given to these managers, and on the making of a (second) "charter of wellbeing in recreational settings" that would ensure a minimal common approach and common concepts concerning harm reduction.

The Modus Fiesta, Information, harm reduction, and orientation for "party drugs" users service opened in Brussels end of 2002 with the objectives of offering a "friendly" place where party drug users can come to get information, harm reduction equipment, express their problems and possible medical, social and psychological needs. The premises are convivial, and decorated in line with party drugs users' culture.
Cultural events are regularly organised, because "party drugs" users are quite young, very difficult to reach and not receptive to "primary prevention" messages since they do not regard themselves as "drug-addicts". Expositions were already organised, and were completed in 2006 by a movie-club. A movie is played to illustrate a theme affecting users. It is followed by a discussion. The chosen subjects in 2006 were: hallucinogenic plants through their recreational or therapeutic use; social control and finally freedom of press.
Service opens on Monday, Wednesday afternoon and on Friday evening. During opening hours, drug users can come and meet trained peers and harm reduction professionals. Since 2004, in order to answer the "problems" met by the public in link with their drug use, psychologists from linked specialised treatment services (Enaden, Infor Drogues and Projet Lama) are also on duty in order to answer some of the problems and to create a first contact with drug users who would like to start a treatment. This "co-permanency" made the emergence of more specific demands

(housing, public welfare, withdrawal…) possible. The latter, in the past, were not clearly expressed to the workers of Modus Fiesta, but now party drug users present a relatively high level of demand for assistance. The referral to the other institutions was difficult to achieve before the co-permanency (only 6% in 2004). But, now they ensure an *internal referral* (they offer at Modus Fiesta the same follow-up as in their own institutions). It is much easier to accept for the drug users.
In 2003, the service achieved 200 contacts. In 2004, 496 contacts were made, 80% with "party drug" users, 5% with professionals, and 15% with students or artists.
The total amount of contacts rose in 2005 (N=521), among whom 81% drug users (sometimes jobists at Modus Fiesta), 9% professionals, and 10% « students » or « curious ».
And finally, 668 contacts were made in 2006 (+ 28%), among which 5% with professionals, 81% with "target" people and 14% with "others" (students, adolescents of the neighbourhood, party organisers…).

7.4.e Pregnancies and children born to drug users

In the **Flemish Community**, De Kiem (therapeutic community) started a project called "Tipi" in 1996. This project provides housing and care for 4 woman and their children in 4 separate new build studios. Recently also man with children are allowed. The mean duration of a stay in the Tipi is approximately one year.

The specific counselling at the Tipi consists of a weekly group session. During this gathering, participants extensively speak about topics concerning the evolution of the children, the planning and organisation of the household and the feelings of parenthood. Besides, separate trainings concerning specific topics are organised on a regular basis. The Tipi-mentors are regularly present (participating or not) to observe, support and provide individual coaching. Each mother makes up a plan regarding the education of her child(ren), this plan is regularly evaluated and adjusted. Individual educational support and video-interaction-counselling are provided.

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

The number of specific admissions to the Tipi during the past few years is on average 8.53% of the total amount of registrations. Table 29 shows a survey of the amount of specific registrations in function of the Tipi since it was created.

Table 29: Number and percentages of admissions in therapeutic community and in Tipi, 1996-2005

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
General	182	207	208	195	208	200	241	216	174	228	226
Tipi	11	20	15	22	17	19	26	19	16	13	17
%	6.0	9.7	7.2	11.3	8.2	9.5	10.8	8.8	9.2	5.7	7,5

A lot of women drop out before or after the start of the introduction conversations. This confirms that a lot of women struggle with the idea to let themselves be admitted together with their child. They are afraid of what is going to come, and they hope, often against better knowing, that they can manage without intake to get their

addiction under control. This is also seen in data concerning referrals (Derluyn, et al. 2002).

In the **French Community** (Liège), the NGO's ALFA (Centre for Mental Health) and Trempoline ("Kangaroo" programme), among quite few, propose a project on parenthood. They offer a psycho-medico-social follow up for pregnant women or women with a newborn baby, in order to prevent future drugs problems for the children. Kangaroo also proposes a residential accommodation for these women.
About one third of the patients following the ALFA programme come voluntarily, while the rest come under mandate of an institution such as the specialised youth help (SAJ) or the Service of Judicial Protection (of youngsters) (SPJ). Even day nurseries occasionally send drug-using parents to ALFA, in order not to have to warn the SAJ or SPJ. Nonetheless, whatever the motive (mandatory or voluntary), the last decision to follow the parental program of ALFA is left to the parent herself.
As to the Kangaroo programme: during the day, the women participate in the treatment programme alongside other residents. However the evenings, weekends and holidays are dedicated to the kangaroo service which allows mother and child to stay together, focusing on the child and (developing) the mother-child relationship in a special separate residential setting."[16]

Both programmes pursue *inter alia* the aim of avoiding a (legal constraint) separation of mother and child (and even of father and child in the case of ALFA).

[16] See: http://eddra.emcdda.europa.eu/

CHAPTER 8.
Social Correlates and Consequences

Few quantitative studies focusing specifically on drug-related social consequences exist. Qualitative, ethnographic research is more common. However, partial data are available from treatment centre and from the Police.

In 2006, first in the top three of substances mentioned in police reports is cannabis, second are amphetamines and third is cocaine.
In prison, around 21% of the prisoners declare having experienced problems (physical threatening, theft…) because of drug use during their current detention.

8.1. Social exclusion

In 2005, a study was made on disadvantaged environments, families and especially men/fathers in the pauperised central region of Belgium (French Community)[17]. Qualitative interviews were realised in the particular environment of "project" buildings ("cités"). The *physical* exclusion of the "projects" inhabitants (these buildings are built in the suburbs, far from the cities themselves and their various opportunities) engenders shame, related to a fall of imago and self-esteem. And so does the "wasters" reputation of the youngsters living there. To regain that lost self-esteem and sweep that shame, pride is sought, sometimes by adopting risky behaviours such as drug consumption or dealing. All the central region of Belgium is concerned since the disappearing of the old industries (coal mines, steel…) relegated a large proportion of that population from the active professional and social world. It is especially true for the parents and grand parents of today's adolescents or young adults; a part of them being immigrates.

8.1.a Homelessness

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

In the **Flemish Community**, the registration system 'Tellus', operated by the CAW (centres for general welfare care) provided a profile of the homeless. In 2006, 3860 clients out of 109447 (3.52%) were registered at their admission identifying any addiction problem (Mendonck, 2007). Most of these homeless drug users, the majority of which is unemployed, are accommodated in residential centres.
According to the CAW these data are an underestimation of the real figures because of difficulties in the registration system. In the future this problem will be solved (Mendonck and Van Menxel 2006).

The study in the province of Antwerp (see 4.2.a) indicated that among all clients demanding treatment in one of the treatment centres, almost 10% was homeless or lived in unstable living conditions (Colpaert et al. 2005). Compared to non-homeless clients, they appear to be more often polydrug users, use to a larger extent opiates,

[17] JAMOULLE P., Des hommes sur le fil, La constitution de l'identité masculine en milieu précaire, La Découverte, Paris, 2005, 292p.

cocaine, alcohol and hypno-sedatives, and have a longer treatment history. They are not significantly older or younger. Among homeless drug users, the percentage of women is lower (16.4%) than among drug users living in a more stable environment. Homeless drug users hang around in the city centre of Antwerp and less in the surrounding cities and towns.

In the **French Community** – central region (Jamoulle 2005), some of the disadvantaged fathers living in the "projects", lacking a real convincing role as head of family (causes: unemployment, cultural gap between "traditional" and Belgian environments…), face a fall of authority and credibility, sometimes related to inappropriate reactions (violence…). That process occasionally leads the families to set these men aside, and to repel them out of the domestic sphere. Some of them experience homelessness. In this very hard context (street), risky behaviours such as drug consumptions are quickly de-regulated. Many of these men think that they must embody that image of weakness to its extreme limit before being able to re-climb the slope. Help-and-care institutions sometimes help them after that downward path to rebuild themselves and to re-invest their paternity, but not always.

8.1.b Unemployment

Pascale Jamoulle (2005, op. cit.) insists on the long-term genesis (two or three generations) that led to the current situations of de-regulated consumptions. In the evoked popular spheres, there is a tradition of investment of the person's (the father's) *body* in a dangerous (professional) activity: formerly, it happened in the coalmine; but due to today's unemployment, and lacking a transformation of that ancient noble risky behaviour, that proud engagement occasionally turns into an involvement of the body in dangerous underground activities – drug dealing and consumptions.
Beyond that, the fact that nowadays young men, once relieved of the scholar obligation, could not find an immediate professional occupation (as their fathers and sometimes grand-fathers did), *also* motivated occasionally their recourse to that underground business, from a strict economic point of view.

8.1.c School drop out

In the 2003 HBSC study (Piette et al., 2003), the particular issue of the school drop-outs was covered thanks to a single survey. Patterns of tobacco, alcohol and cannabis use were considered. Students were asked if they were current users of cannabis and if yes to define the frequency of use (daily, at least once a week but not daily, less than weekly, never).
Daily use of cannabis was declared by 5% of the regular students in comparison to 26% among the less regular ones; 7% of the regular students versus 17% of the less regular reported a weekly use but not daily; and 14% versus 17% reported an occasional use. Finally, 74% of the regular students declared to never use cannabis compared to 40% among the less regular ones.

8.1.d Financial problems

No recent survey was carried out on this issue.

8.1.e Social networks

In the French Community's central region, Pascale Jamoulle (2005, op.cit.), shows how original social networks are sometimes created by socially weakened people, and how they can help them re-defining familial challenged relations involving underground trafficking and consumptions. The successive waves of immigration in the regions of former industries composed a multi-cultural society. In some of the immigrate cultures (ex: Alévis), there is a tradition of submission to the "grand", the eldest. Fathers get angry against the misbehaviour of their sons (in case of underground trafficking and consumptions), though that misbehaviour is partly a reaction to the social violence the fathers themselves underwent. They might then want to use the tradition of submission to the eldest authority to calm down the sons and re-direct them into "the right path". But there is a dimension of escaping the traditional domestic authority of the eldest, in that misbehaviour: at least in the "underground" business, the son exists for himself, and flees the submission obligation. That process partly deprives the father of his traditional identity and control.
Nonetheless, a worker-based spare tradition called "cagnotte" (kitty), adapted to today's realities, creates by side-effect a network of re-defined, less traditional relations that sometimes helps the fathers to adopt new social behaviours. That might, on the long run, help them to create new types of links inside their own families, and not to loose contact and control of their children involved in risky behaviours and underground business. Indeed, sparing money once a week at the same place, meeting the same persons and following the same rules engage the fathers in a network of multi-cultural relationships were traditions have been adapted through various influences, among which the Belgian environment. Women's roles are re-defined, and so are youngster's and father's roles. Though not easily transposed to the domestic sphere, these newly invented links can be a source of inspiration for a better comprehension between "weakened" fathers and "risky behaving" children.

8.2. Drug related crime

8.2.a Drug offences

In 2006, 34718 drug related reports (use, possession, traffic…) were registered by police services (Dommicent, personal communication).

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

Cannabis remains the most commonly involved drug of all drug related reports throughout the years (Figure 12). When it comes to compare the different substances, the trends remain almost the same, cannabis and amphetamines being the two most reported substances (standard table 11, 2007; Dommicent, personal communication).

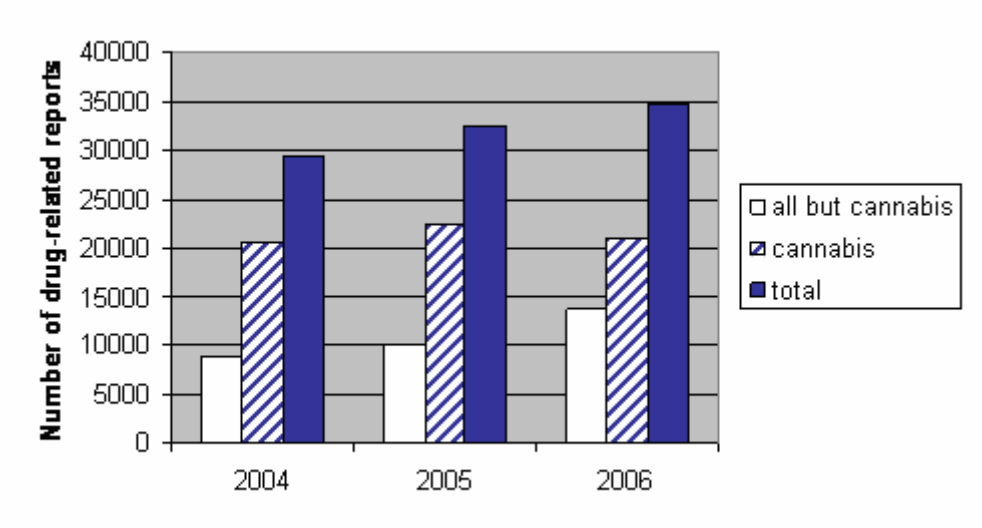

***Figure 12**: Number of drug-related reports, Belgium, 2004-2006, standard table 11, 2007 (Dommicent, personal communication)*

A specific analysis of the drug-related reports between 2002 and 2004 in Brussels reveals an increase of 29.6% (Buy, 2005). Of 8,889 reports, 75% concerned possession/use, 15% drug dealing and 10% trafficking/drug tourism. As regards possession/use of drugs, the rise in the number of reports is about 25%, reports about drug dealing increased by 50% and finally reports for drug trafficking by 35%.

Table 30 gives the figures of the drug related offences. Compared to 2000, in 2005 there is a decrease of 14.2% in the number of drug-related offences. A decrease of 0.50% is also observed in 2005 compared to 2004.

Table 30: Number of offences related to illegal drugs, Belgium, 2000-2005 (NIS[18])

Year	Total	Possession	Use	Trafficking
2000	51398	20604	17022	12255
2001	43336	17480	13337	11171
2002	46128	19207	14491	11473
2003	42188	18191	12399	10866
2004	44284	19888	11962	11722
2005	44062	19935	11094	12408

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

In 2006, the Federal Police has trained 33 specialised police teams who are assisted by dogs. Of these teams, 5 had an active or passive sniffer dog (an active sniffer dog barks when drugs are detected, a passive one sits down in front of the person the dogs smells a suspicious odour from).

[18] http://www.statbel.fgov.be

During 2006 there were 2041 interventions of the sniffer dogs. 1740 were house searches and 902 had a positive result: drugs were found. Among other drugs 22000 XTC pills, 25 kilos of heroin and 69 kilos of marihuana were seized.

The Ministry of Justice publishes on an annual basis a report which summarizes the main criminal data. This document, "Justice in numbers 2007" contains among other things information about the number of convictions for drug-related offences. Throughout the years, the number of convictions for drug-related offences seems to vary, although from 1998 on, the numbers stay remarkably lower than before (3934 in 2003, 5343 in 1997).The last data available dating back to 2003, further information can be found in previous national reports.

8.2.b Other drug related crime

In 2004, chapter 13 of the national report was dedicated to "public nuisance" and chapter 1.4 provided results of the study "drugs and nuisances [19]"(Ponsaers & al. 2005). This information will not be repeated in this year's report.

8.3. Drug use in Prison

The study performed in Belgian prisons in 2006 (Todts et al. 2007, see 2.3.d) includes various sets of items investigating the effects of drug use on prison life.
All the respondents (using drugs or not) were asked if they've ever experienced problems with drug users during their current detention. 21.5% of the sample said they had indeed experienced such problems.

It seems that women are significantly more numerous to meet problems linked with drug use in prison (see Table 31).

Table 31: Drug scene related problems versus demographic and forensic variables, in Belgian prisons, 2006 (N = 902)

		YES	NO
		%	%
Gender	***Male***	21.3	78.7
	Female	34.0	66.0
Detention type	***Remanded***	16.1	83.9
	Convicted	23.5	76.5
	Mentally disordered	28.	71.6
	Other	9.1	90.9
Nr of detentions	***First detention***	18.1	81.9
	More than one	24.6	75.4
Lifetime drug use	***Yes***	14.5	85.6
	No	26.9	73.1
Prison drug use	***Yes***	17.3	82.7
	No	36.6	63.4

[19] An extended summary of the research is given on the web site: http://www.belspo.be

The prisoners who are in prison for the first time and the ones remanded in custody seem to face fewer problems than the other prisoners.
Concerning drug use; prisoners who have ever used illegal substances and these who have ever used drugs in prison, experience significantly less problems than prisoners who have no experience with drug use.

Table 32 makes an inventory of the kind of problems prisoners experience. Since more than one answer was possible, the total exceeds 100 %.

*Table 32**: Kinds of drug-related experienced problems in Belgian prisons, 2006 (N=194)***

	%
I was physically threatened	***24.2***
I was robbed	***22.2***
I was pressured to give up money or goods	***16.0***
I was pressured to use drugs (but refused)	***13.4***
I was pressured to use drugs (and gave in)	***8.3***
I was forced to give up my medication	***10.8***
Other problems	***35.6***
Nothing	***11.3***

8.4. Social Costs

No study on social costs is available in Belgium.

CHAPTER 9.
Responses to Social correlates and Consequences

Social reintegration projects (housing, training, employment) vary according to geographical areas and local programmes.
In 2005, an inter-ministerial conference was held to discuss housing problems: the homelessness issue and – in that frame - the creation of new kinds of "solidarity housing" for socially casualized people was tackled. It seems that few specific housing facilities for homeless drug users exist.
Some projects aimed at socio-professional reintegration of drug users exist in partnership with e.g. centres of social welfare, institutions specialised in employment.
In prisons, health care is provided by the Ministry of Justice. Substitution treatment is available and managed by GPs or psychiatrists. Efforts to better diagnose hepatitis C in prisons started with a new protocol of detection, however this is not yet implemented on a large scale.

9.1. Social Reintegration

The Walloon Region makes the distinction between social rehabilitation and professional reintegration. This distinction is recent (see Decree of the Walloon Region of 17 July 2003 relating to the social Integration): the idea is to permit the most excluded people to find employment or a vocational training, but only after completing a social integration procedure.

9.1.a Housing

Housing is a regional matter but at the federal level, it is under the competence of the Minister of social integration.
In 2005, an inter-ministerial conference was held to discuss housing problems. Work groups were created: one of these tackled the homelessness issue and the creation of new kinds of « solidarity housing ». In order to examine this particular topic, a study about solidarity housing was carried out (Mignolet & al 2007)[20]: in addition to the existing registered type of solidarity housing, other kinds of unofficial housing have been developing (e.g. gathered housing for socially casualized people). These types of housing might be useful and therefore shouldn't be penalized by the authorities.

In the framework of social reintegration, the NGO "Alliage" (**French Community**), though multi-disciplinary, could be mentioned under the designation of "housing".
Indeed, it offers a specialized care and accommodation in rural or farmer families, from whom the ex-drug user will share the professional, home-based activities. The purpose is to let the former drug addicts regain self-esteem (along with standards, references, habits, rhythm of life) by accomplishing well-defined tasks and to take part in a (familial) professional achievement. It also aims to place the person in an intermediary context on his way back from drug-addiction (with possible stay in a treatment centre) to "normal life". Indeed, a return to his usual living environment could result in a relapse. On the other hand, an immediate dive in a normal professional environment could be too abrupt, as the patient might need to be accompanied by well-trained persons, aware of his life course and problems (which won't be the case in a normal professional environment).

[20] An extended summary of the research is given on the web site: http://www.politiquedesgrandesvilles.be

The rural framework is chosen as appeasing and balancing in comparison to the usual neighbourhood of the former drug addict.
In the field of housing, the « Walloon Code of Housing » specifies various possibilities:
Temporary housing for households in a precarious state or deprived of housing (timeframe: max. 6 months, once renewable); reintegration housing for households in a precarious state (timeframe: min. 3 years); social housing for households in a precarious state or having a modest income.
Emergency accommodation/shelter is not governed by the Walloon Code. It falls within competences of the Minister of Social Action and includes the reception houses and night shelters for homeless.
There are two types of assisted housing facilities integrating every-day life:

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

In the **Flemish Community,** several Therapeutic communities and inpatient units for drug users offer a sort of aftercare in the sense of housing. A few centres (CAW - centres for general welfare care) are specialised in the reception of homeless drug users.
There are several possibilities for drug users to find shelter in centres not specifically dedicated for drug users.

a) Reception centres. These homes are open for different target groups like women, refugees, addicts. The length of stay and the intensity of coaching is related to the population.
b) Night-shelters. Night-shelters accept clients for a short period. They mostly offer a bed, a meal, a shower and some basic needs like rest, safety and anonymity. During the short stay in these houses the client is reoriented to find a solution for his problems.
c) Accompanied living. This form of housing is created for people who want to move on to an independent living but still need a minimum of guidance and support. Outpatient guidance is provided in these houses (www.caw.be).

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

9.1.b Education, training

In 2006, VAD organised 5 trainings in collaboration with the VDAB on how to work with drug users. The training contains a short introduction on the problems, information on substances, relation between the labour market and employment, the organisation of assistance and the role of the VDAB. Also in 2006, 3 follow-up modules were organized recognising addiction and opening discussion on this issue.

This type of service is well developed in the **French Community** and often takes place in reception facilities such as specialised centres that have an agreement with the RIZIV/INAMI like day care centres or therapeutic communities. However other types of facilities can offer education or trainings to drug users also.
The suggested trainings are numerous and varied, such as cooking, data processing, horticulture, painting, building works, joinery.
Workshops focusing more on the education of drug users also exist. Certain institutions organise workshops in the field of culture and leisure, elimination of illiteracy or social information.

There are two types of structures that deal with the professional reintegration: the Organizations of socio-professional reintegration ("Organismes d'Insertion Socio-Professionnelle »/ OISP) and the Enterprises of training by work ("Entreprises de Formation par le Travail"/ EFT). The OISP concern people without higher secondary degree at school, the EFT concern people without lower secondary degree at school. Several specialised institutions in the drug field work with or hold the title of EFT or OISP.
The Expert Group Report underlines the same conclusions as for housing: accessibility and availability problems. The Group recommends more particularly creating a specific supply of EFT for the drug users (Collège d'experts en assuétudes 2005).

9.1.c Employment

In the **Flemish Community**, the social workplace from 'De Sleutel' offers a job to (ex) users. The target group is not an easy employable group. The changeover from unemployment to work seems to be hard for them. Working in the social workplace gives (ex) users the opportunity to reintegrate slowly in the normal structures of life. Meanwhile the clients are guided in their personal problems like dependence, financial problems and relational problems.

The 'Smid-project' (cooperation social reintegration drug addicts) in the province of Limburg is a cooperation between CAD Limburg and Katarsis. Employment is a very important form of daily activity, which gives people status, identity and development of personal abilities. By bringing the employment sector and treatment centres closer to each other a more fluent stream of patients moving between treatment and employment is realised. Since 2005, clients have the possibility to work in a farm/agrarian company.

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

This type of service is also well developed in the **French Community** and tends to be central in some institutions working at the reintegration of drug users. The search for a job is done according to active methods with assistance of specialised facilities and in collaboration with general structures specialised in employment (ONEM/FOREM, CPAS).
The association « Autrement » aims at social and socio-professional accompaniment of persons with a drug-addiction problem (Autrement 2005). These persons are sent to « Autrement » by CPAS (public centres for welfare), prisons or other actors of social help. They offer individual psychotherapeutic follow-up as well as group therapy. Psychosocial follow-up includes social and administrative help but also support to the families. Internal training is organised (renovation of buildings and initiation to software programs).

A pilot project of socio-professional insertion is led since June 2002 by the NGO Phenix (Namur), in partnership with the CPAS of Namur and under the aegis of the Ministry of Social Integration. Drug-addicted persons, who receive the minimum welfare allowance from the CPAS, are addressed to the NGO Phenix, which manages different projects in the field of drug addictions (Phenix 2005).
The drug users are considered for the occasion as "trainees". It means they are remunerated (EUR 1/hour) to achieve a weekly program, in the framework of various workshops (cooking; renewing of the association's buildings – as in the NGO "Autrement"; joinery; communication, computer initiation ; etc.)

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

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

9.1.d Basic social assistance

Not exclusively addressing drug users but all individuals in precarious situations, the **Walloon Region** (Ministry of Social Action, Health and Equality) created "Urban Social Relays". They aim at coordinating, networking public and private actors involved in helping excluded persons (Decree of the Walloon Government 29/01/2004[21]). Five social relays exist in the Walloon Region (Charleroi, Namur, Mons, Liège, Verviers). Two of those Relays (Liège and Charleroi) have clearly integrated drug users as their target group.
If the general objectives are the improvement of living conditions, the final aim of the social Relays is social integration. In the field of health, social relays organise harm reduction activities (condom distribution and needle exchange). More information on harm reduction activities is available in chapter 7.

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

Since 1982, the Interdepartmental Direction of Social Integration ("Direction Interdépartementale d'Intégration Sociale"/ DIIS) is a coordinating body aiming to follow, assess and initiate projects against exclusions. The DIIS facilitates social integration through other local initiatives such as street sport, youth training, travellers' reception, etc.
In 2003, in the Decree concerning the Proximity Prevention Plans ("Plans de Prévention de Proximité"/PPP), the Walloon Government clearly established links between the fight against poverty and social exclusion on the one hand and addiction on the other hand. The Proximity Prevention Plans wants to develop the following actions:

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

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

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

For Fly Tox (a specialised institution), social reintegration is considered an essential tool in the progression of drug users and a goal of treatment. Fly Tox developed a partnership

[21] 29/01/2004 Arrêté du Gouvernement wallon relatif à la reconnaissance et aux subventions des relais sociaux.

with the CPAS of Liege for juridical services. A jurist is on duty to help drug users with debt counselling, problems with owner about rent, e.g.

Some organisations ensure a basic, sometimes emergency social assistance, *inter alia* for homeless drug users or users in a very precarious situation. Examples are Transit NGO and DUNE (Brussels).

Transit is a crisis and emergency centre of reception for problematic drug users, working on the principle of "low threshold" access. It offers, within the same buildings, two modes of intake: the first one as a day centre, the second one as a short term residential centre with a capacity of 20 beds. In that matter it can be considered a pilot project. The centre offers an unconditional, 24h/7 days a week first line reception to the most marginalized drug users. The framework is ensured by a multi-disciplinary team realising the functions of social assistant, psychologist, nurse and educator. Besides the work focusing on the recovery of the user's social rights, the psycho-social team, at the user's request, accompanies him in the accomplishment of a project. For some, the idea is to gain access to health care by an admission to a specialized centre or a hospital, which can bring a therapeutic answer to the addiction problem. For others, the idea is to aim a reintegration to the family environment, to have access to a specialized reception house or to have an individual lodging (supervised or not).
On average half of the people are redirected, via Transit, towards a specialized service which can provide them with a concrete answer to their problems. For those who are not redirected, either the problems in question found a solution at the centre itself, or the person did not wish to be redirected.

DUNE ensures a first help to drug users in the streets in the framework of a « street-network ». Besides providing clear information regarding the reduction of risks related to drug use, and participating with several other institutions in a syringe-exchange desk ("CLIP"), it also re-directs drug users towards various facilities, in order to help them re-sequencing their life, just as TRANSIT NGO does.
Related to that last activity, DUNE edited a small brochure/map of Brussels, describing and locating several facilities where marginalised street drug users can go seek assistance for various matters (social assistance, medical care, housing and emergency housing, hygiene, safe-injecting material, judicial information, safe-sex material). The brochure is named "La bon plan".
124 different organisations are listed. Only 12 of them are exclusively oriented towards drug users, among which 3 offer housing facilities (including TRANSIT).
Nonetheless, an extra 25 of the listed organisations, even if not targeting only drug users, offer housing facilities for people in precarious conditions.

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

9.2. Prevention of drug related crime

9.2.a Assistance to drug users in prison

Prison authorities are aware that drug use and trafficking are a reality in the Belgian prisons, and that their existence has serious consequences for the prisoner and his environment. The prisons cooperate with external caregivers. Some specialised

organisations offer informative and educational sessions for prisoners, others offer psychosocial help and treatment, either individually or in group. Introduction sessions inform prisoners of the treatment possibilities upon release.
Assistance to drug users is provided by the prison health services and the prison psychosocial services. In addition, a number of external specialized therapeutic services are invited to assist the prisoners. Finally, prisoners can ask to see their own medical doctor or therapist. In that case, they have to pay for this service themselves. If the prisoner is examined by an external doctor, this physician can propose a specific treatment (e.g. methadone therapy) to the prison doctor, who stays in charge of the patient.
In the Flemish community, a structured cooperation ("strategisch plan") between the prison service and the complete range of services offered by the Flemish government (culture, education, psychosocial treatment, job training and assistance in procuring a job) has been initiated in a pilot region. There is also an ongoing project in some Flemish prisons with a central intake unit ("centraal aanmeldingspunt") that aims to improve the through-care for prisoners. In this project, prison staff and specialised drug workers cooperate to link prisoners with treatment upon release. The project will be expanded to include more prisons.
Specialised drug treatment organisations also provide treatment to ex-prisoners on parole or on probation.
A drug policy coordinator is active in the prison service administration and, since 2005, a second (French speaking) coordinator started to work.

- **Drug free sections**

A drug free, therapeutic community-like program (Believe-project) exists in the prison of Ruiselede since 1995. A training program for guards, prison personnel and prisoners has been realised. It focuses on drug use, HIV, hepatitis…
In order to celebrate the 10th year anniversary of this program, a study day was organized in 2006. Among the studies presented during this day, one of them stressed the significant effect the Believe-project has on re-offending (Todts, S., 'The Believe treatment program: effects on reoffending', Studiedag PSD, gevangenis Brugge, 8 September 2006).
This project is now working in four big Flemish prisons and in Oudenaarde. More than half of the Flemish prisoners were reached through this project. A further expansion is planned for 2008.

- **Substitution treatment**

The Ministry of Justice provides health care in prisons. GPs or psychiatrists may choose or reject available therapies (Stöver et al. 2004).
Substitution treatment is available in prisons. Although the possibilities were rather limited, there is more and more acceptance of substitution treatment (including maintenance treatment) in the field (see directive described in section 1.1.a.).
Maintenance is now recommended for all prisoners who enter the prison while already in treatment, and who won't stay longer than one year. In case of longer penalties, trying tapering is recommended. Initiation of substitution treatment is also possible.

The 2006 study in Belgian prisons (already described in 2.3.d) deals also with the treatment issue. 9.6% of all respondents (N=902) had a history of drug use and were in substitution treatment (methadone or buprenorphine) when they started their current detention. Furthermore, this sample was asked what kind of follow-up treatment they received from prison medical staff. Answers are shown in table 33.

Table 33: Follow-up of substitution treatment by prison medical staff (N=87)

	%
Maintenance	35.6
Tapering	19.5
Stopped by prison medical staff*	17.2
Stopped upon request of patient	24.1
No answer	3.4

* These treatment programs had to be stopped because the staff hadn't all the necessary information about the substitution treatment to carry it on in prison

One third of the considered group (35.6%) could maintain the treatment.

- **Harm reduction measures**

Educational information material developed for outside prison can be distributed in prisons. In most of them, when entering, the detainees receive a package including several information materials on HIV, hepatitis, tuberculosis and harm reduction linked to drug use. However, there is no strategy on informing prisoners of STDs and drug consumption. Activities of this type exist in certain institutions, sometimes under the supervision of an external NGO. The availability of information material depends on each individual prison and its medical service and/or on the possible presence of an NGO (e.g. "Conseil Education de Huy" which places material at the disposal of the prisoners and gives various information and advices).
Moreover, specific information material on AIDS and hepatitis prevention for drug users in prison has been developed by NGOs in coordination with health services of the penitentiary administration of the Ministry of Justice and has been widely distributed in prisons[22]. A second edition has been developed, in 2000 including a specific chapter for women. This version has been translated in Dutch.

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

Bleach is available in some prisons only for cleaning the cells. In 2002, all medical services were advised to make disinfectants available whenever prisoners ask for it.
There is no needle exchange programme in prison.
A new protocol for the detection of viral infections and for the treatment of hepatitis C started in 2004.

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

[22] "Vogue la Galère" Modus Vivendi Question santé 1998.
« Wat als je binnen zit? » Free Clinic 2000.

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

- **Community Links**

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

Different handbooks, leaflets with useful information and addresses about specialised NGO are specifically addressed to detainees. The **Flemish Community** regularly publishes a prison specific journal, distributed in all the prisons of the pilot region.
Moreover, in 2006, a new project aiming at a better drug policy implementation in prisons started with the VAD collaboration. A first part of this project, the composition of a course in order to increase the knowledge concerning drugs of the local experts' commission leaders, was completed in 2006. In 2007, trainings for other experts' commission will be implemented. The second part of the project, the development of a synopsis for the local experts' commissions in order to get to a concrete worked out policy, will start in 2007.
In the **French Community,** on the initiative of some establishments, an internal journal was released, with an editorial board made up of prisoners and professionals. It aims at an "internal" use and targets the direct partners.

In the **French Community**, the NGO Sesame (Namur) reports a strictly indicative proportion of 35% of clients in a probation situation, for 5% with an electronic bracelet and 60% of detainees (followed in the prison itself).
The follow-up of persons in a probation situation is crucial for that organisation, in the spirit of a middle/long run intervention. Indeed, 57% of the patients coming at the centre itself as "parole" prisoners or with a bracelet were already followed in prison by the same therapist.

The organisation CAP-ITI, active in two Brussels prisons, makes an additional statement. It proposes namely a reception for detainees and ex-detainees, information on cure and post-cure centres, social and psychological follow-ups during and after the detention.
At CAP-ITI itself, 50.7% of the clients are sent by the justice department, forced to follow a therapeutic treatment (vs 24.3% in the prisons). CAP-ITI noticed that the psychological follow-ups are less successful at their office than in the prisons themselves, probably because of that therapeutic constraint. Inside prison, the proportion of people choosing by themselves to follow a psychological treatment is higher – hence the higher success.

A third organisation, "Aide et reclassement" (Huy), confirms these figures/tendencies. Its department specialized in drug addictions (called "SIT") carries out interventions inside and outside prisons. In the prison environment, 45 persons were met by the SIT in 2006. Outside the prison environment (at his office), the SIT managed 25 files in 2006, containing a total amount of 355 distinct demands. The majority of the files concerned ex-detainees[23], most of them being "parole" prisoners followed (and controlled) by a social assistant for several years.

All three organisations focus more on the well-being (or "better"-being) of the (ex)-detainees, and on the sense and function of the drug consumptions than on the products by themselves.

[23] Some of the files are open at (ex)-detainees' families' request

In the prison environment, another organization, Modus Vivendi, takes care of spreading information and promotes practices to reduce the risks related to drugs consumption.
A relatively recent act and a new minister circular (see 1.1.a) lay down an ancient principle called “principle of equivalence” which, according to Modus Vivendi, was rather the exception than the rule up to last year. According to that principle, the punishment of the detainees sums up to a deprivation of liberty. The other rights of ordinary citizens should not be withdrawn from detainees, according to the law. Among them, the right to a proper care or prevention approach in all health matters, including drugs consumption.

This has motivated Modus Vivendi to re-edit for the third time a leaflet called “Et vogue la galère”, which aims at answering the numerous questions that might concern the detainees in matters of drugs consumption, transmission of hepatitis’s and HIV, and health as a whole in prison. It was supported by the Federal Public Department of Justice, and written in collaboration with the Local Centre of Promotion of Health (CLPS) of Brussels and the NGO “Question Santé”.

9.2.b Alternatives to prison for drug users

Different laws are used to organise alternatives to prison. With a few exceptions, none of these are specifically targeted to drug users. The Belgian drug law was thoroughly reworked in 2003 (4/04/2003). As a consequence, the field of application for (conditional) probation is enlarged, allowing for probation, regardless of the criminal record of the concerned person and even in the case of retail sale to support personal use, be it for (young) people aged 16 and older (Vander Laenen and Dhont 2005).
Emphasis is now on a primordial orientation toward rehabilitation, with prison remaining as an “ultimum remedium”. A specific law sees to it that drug users can leave prison as early as possible in order to join a treatment program.
Depending on the stage of the case, there are different possible alternatives to a prison sentence: an amicable settlement, conditional probation, mediation, conditional release from remand, suspended sentence, conditional release (or “parole”) and electronic surveillance. More often than not, some sort of therapy will be part of the condition(s).
Justice assistants exercise control over suspects and convicts in different alternative regimes.
The revision of the drug law of 2003 created the function of Justice Case Manager. This case manager would assist the Public Prosecutor in drug cases, among others orientating drug users to therapeutic advise. For different reasons, these case managers are still not active. In the meantime, public prosecutors have successfully tried alternative ways to cooperate with drug treatment organizations (Project Proefzorg, Ghent 2005).

9.2.c Other interventions for prevention of drug related crime

In 2004, a study aimed at examining the local measures and initiatives in order to prevent or to reduce social drug-related nuisances was carried out (Ponsaers & al. 2005). The authors report that if policy documents insist on the prevention and or decrease of social drug-related nuisances, in practice it remains a general objective in most local projects (Ponsaers et al. 2005). Drug-related nuisances obtain a secondary place within the projects but all the actors agree that projects directed towards the health, financial and social situation of the drug user have an indirect positive effect on the reduction of drug-related nuisances. Few impact or evaluation studies concerning drug-related nuisances are available. Collaborations at local level are based on goodwill. The authors suggest that an integrated policy at a local level, allowing reacting in time to the fast changing social reality is needed. A harmonization of competences between the federal, community, provincial and local policy level must be achieved. Tasks of the local

coordinator should be clarified, and collaboration should be valorised in order to overcome problems related to the voluntary collaboration. Monitoring of the drug local situation should be promoted, evaluation of projects should be stimulated and drug users should be involved in policy development.

CHAPTER 10.
Drug Markets

In March 2004, a National Security Plan 2004-2007 was approved by the council of Ministers (Federal Police 2004). This document mentions an overall policy for police services focusing on the fight against:

- Illegal laboratories producing synthetic drugs;
- Cocaine importation, re-exportation of heroin and exportation of synthetic drugs;
- Criminal organisations specifically active in synthetic drugs and heroin on the territory;
- Drugs tourism and related nuisances.

The quantities of seized illegal drugs may vary largely from one year to another but overall it seems that seizures have increased over the nineties. No general trend can be defined for the recent last years.
Except for some substances, the purity and price of seized drugs seem to decrease between 2005 and 2006.

10.1. Availability and supply

10.1.a Availability of drugs

➢ **General population**

In 2003-2004, a study was initiated by a provincial organisation on e.g. health, health representations, promotion in the Province of Hainaut (South of the country) (Observatoire de la Santé du Hainaut (OSH)). Exposure to and/or experimentation of drugs among youngsters was surveyed.
Three age-groups were investigated: 10 (5th year of primary school), 13 and 16 years old (respectively 2nd and 5th year of secondary school). The results show globally that boys are more exposed (to the vicinity of a drug user, to a proposal, to an experimentation) than girls. The exposure also increases with age. These results are similar to conclusions of other studies.
This study hasn't been repeated since 2004.

10.1.b Production, sources of supply and trafficking patterns within the country as well as from and towards other countries

It is still reported by police services that the level of national trafficking is essentially engaged in polydrug trafficking (Vanhyfte 2005).
The phenomenon of multi-drugs trafficking (several drugs in one transport) - especially towards the United Kingdom - became apparent in 1999. Belgium is the last embarkation point for these lorries combining cannabis, amphetamines, cocaine and heroin for the British market.

➢ **Heroin**

The trafficking of heroin to, through and from Belgium is not very clear. Latest information indicates that criminals who are active in heroin trafficking meet in Belgium and make their deals but the heroin isn't smuggled towards Belgium. The heroin comes from Turkey or Afghanistan and is smuggled to Germany or The Netherlands which spread the heroin

through Europe. If the heroin comes to Belgium we see that it is mostly traded for XTC: the heroin comes in from Turkey and the courier takes back XTC to Turkey.

- **Cocaine**

Since a couple of years, police notices that the trafficking routes of cocaine have changed. This is of course due to severe control on the old trafficking routes; the traffickers search new ways to get the cocaine to Europe. Instead of a direct smuggle from South-America to Spain or The Netherlands we see a detour to Western Africa. From there the drugs are brought to Europe directly or with a stop in Northern Africa.
Cocaine is smuggled by air and sea whereas the sea transports contain large amounts of cocaine and the air transports consist of couriers smuggling in corpore and in their luggage.

- **Cannabis**

Large-scale Moroccan hashish importation in Belgium and the Netherlands is organised since almost 10 years by Moroccan criminal groups. Products are transported by a variety of transports means (car, minibus, camper, coach, lorry and containers).
We also notice that more cannabis plantations that are discovered by the police. This doesn't mean that there are more plantations than before but it is clearly an indication than the information flow has improved.

- **Synthetic drugs**

The number of discovered laboratories remains stable since the beginning of the new millennium. After the uprising at the end of the 90's we can say that the situation hasn't worsened. Still the problem is accurate because of the dangers that are implied with drug laboratories (fires, explosions, damage to nature…), so awareness and good police research are required.

- **Precursors PMK and BMK**

Precursors PMK and BMK found in Belgian illegal laboratories come usually from China. It seems that those precursors are distributed in Belgium by Chinese criminal organisations installed in The Netherlands. Transport from China is organised on deck cargos of soybean, oil …to Rotterdam, Bremen or Antwerp. Precursors are not paid cash but are exchanged against XTC tablets or MDMA powder, then exported by Chinese organisations to Canada and Australia (no trace of financial transactions and commerce is more profitable). Many chemical substances used in the production of synthetic drugs are easy to buy in Belgium as they could be used for legal applications. On the contrary, in The Netherlands some precursors are not freely available so Dutch traffickers cross the border to buy large quantities of those in Belgium. Actions to inform chemical companies and distributing ones on the risk of chemical misuse have been carried-out by police services.

Moreover, the aspect of **waste management** is more often taken into account in the police's investigations. Indeed, producers of MDMA are confronted to huge wastes which they usually dump in the natural environment.
Belgian XTC tablets and amphetamines are exported to the US, Canada, UK and recently also to Australia, for large quantities concealing cargos are used.

- **GHB**

GHB came up as a popular drug and seems to be produced at small scale in so-called "kitchen laboratories".

10.2. Seizures

10.2.a Quantities and number of drug seizures

Increased security controls in airports might be a discouraging factor for traffickers and could explain why less seizures are performed in Belgian airports. This seems to be confirmed in other countries. However, new destination countries for drugs exportation by air seem to appear: Mexico, Brazil and South-Africa (Vanhyfte 2005).
Large yearly variations exist in the quantities seized in Belgium. There is not always a clear-cut explanation for these yearly variations. One large seizure can for example influence the figures, as can certain international law enforcement actions or stock piling of drugs.
Concerning cannabis, an increase in the seized quantities can be observed for cannabis plants: whereas in 2004 federal police and customs seized 67814 plants, this number increases to 83113 plants in 2005 and finally to 110368 plants in 2006. This evolution is in line with the increasing media coverage of discovered cannabis plantations in Belgium. No clear trend for cannabis resin and herbal cannabis can be identified (Standard table 13; 2007).
The quantity of seized heroin stops its rising trend in 2006: 142kg were seized in 2004, over 270kg in 2005 and 175.5kg in the year 2006. For cocaine, a similar trend can be observed with 3522kg seized in 2004, and more than its two-fold in 2005 with 9228kg. In 2006, 3945.8kg of cocaine were seized by the federal police and customs (Standard table 13; 2007).
For other illegal substances, no clear trend can be observed.

10.3. Price and purity

10.3.a Price of drugs at street level

Table 34 contains information on the prices of illegal substances collected by the police services for 2005 and 2006.

Table 34: Mean price* in Euros at street level of some illegal substances: Belgium, 2005-2006 (standard table 16, 2007)

DRUG	2005	2006
Cannabis resin (per gram)	6.0 (2.5-20.0)	6.65 (2.0-18.66)
Cannabis leaves (per gram)	5.75 (2.5-17.0)	5.38 (1.0-13.33)
Heroin brown (per gram)	24.7 (9.0-50.0)	n.a.
Cocaine powder (per gram)	50.3 (25.0-100.0)	48.04 (20-75)
Amphetamines powder (per tablet)	9.85 (5.0-20.0)	8.53 (3.61-20.0)
'XTC' (per tablet)	4.2 (0.3-20.0)	3.31 (0.5-10.0)

* Minimum and maximum price are given in parentheses.

According to the Police data, all prices – except for cannabis - seem to have decreased between 2005 and 2006.

In 2004, within the framework of the Belgian national Report on drugs, a data collection about prices at street level of different drugs through outreach work and syringes exchange desks in French Community has been settled. These data have been collected by health workers from needle exchange programmes, by street workers and health workers in recreational settings in different cities of the **French Community**. This initiative was continued in 2005 and 2006. Table 35 shows the results of this mini survey.

Table 35: Mean price in Euros at street level of some illegal substances: Belgium, 2005-2006 (standard table 16, 2007)

DRUG	2005	2006
Cannabis resin (per gram)	5.5 (2.8-10.0)	6.8 (1.5 – 20.0)
Cannabis herb (per gram)	5.7 (2.0-10.0)	6.3 (2.0-15.0)
Heroin (per gram) • **Brown** • **White**	 28.7 (10.0-50.0) 68.0 (44.0-230.0)	 33.2(10.0 – 75.0) 31.4 (15.0-70.0)
Cocaine powder (per gram)	50.5 (35.0-125.0)	48.4 (20.0-75.0)
Crack (per gram)	24.0 (3.0-45.0)	30.9 (5.0-60.0)
Amphetamines powder (per gram)	7.8 (1.0-12.0)	10.9 (5.0-30.0)
'XTC' (per tablet)	5.2 (3.0-10.0)	6.2 (1.0-20.0)
LSD (per dose)	8.8 (1.5-17.5)	8.9 (1.0-20.0)

According to these figures, prices seem to have risen for all substances in 2006 except for white heroin (though some biases might exist for this substance). Concerning the other products, a few things should be considered when reading this table. The price per gram must be taken into account with other criteria.

➢ **Cannabis**

In Brussels, one pack contains 0.8 g of cannabis and in south Wallonia, the 3 grams lump costs 20 €. Let us note that the price varies a lot according to quantity and place of purchasing. For example, the cannabis is less expensive in Dutch Coffee Shops.

➢ **White heroin**

White heroin is almost not available in Belgium.

➢ **Brown heroin**

In Brussels, one pack contains 0.6 to 0.8 g of heroin. Packs of 0.3 gr.-0.5 gr. (25€) often in lump or marbles shape (+/- 1/3 gr. for 10€) were also found on the market.

Punctually and locally, a fall in the heroin price (10€ for one pack) is noticed. One should put this observation into perspective according to the pack weight, the product quality and the dealer.

- **Cocaine**

Globally, a weighed gram costs 50€ but cocaine is often sold in small packs of 0.6 to 0.8 g and in lump or marbles shape (+/- 1/2 for 25€).

- **Crack**

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

- **Ecstasy pills**

The mean price for a pill of XTC is 6€. However, the price varies a lot according to the quantity of pills. For example in Brussels, by 1000, a pill of XTC is sold 0.35€, 1€ if bought by 100, 2.5€ by 50. This explains why drug users often buy large quantities of XTC.
In some places, an XTC pill in the form of crystal is sold for 10€.

- **LSD**

Comparatively to ecstasy pills, LSD is rarely consumed in the streets (used in blotting paper or gelatine form). LSD and XTC are more often used in night life (parties, clubs).

10.3.b Purity at street level and composition of drugs/tablets

Table 36 shows the results of analyses performed on substances seized by police services and customs and reported through the Early Warning System. It concerns both seizures at user's level as well as seizures from large drug traffics. Some of these seizures are done at the national airport. At that level, the seized drugs present usually high levels of pure substance because they have not been cut yet.

Table 36: Mean purity of some illegal substances (%), Belgium, 2005-2006 (standard table 14, 2007)

DRUG	2005*		2006*	
	Number of cases**	**Mean** (Minimum-maximum)	**Number of cases****	**Mean** (Minimum-maximum)
Cannabis resin * **	46 (42)	13.76 (0.6-27)	92 (72)	8.1 (0.1-22.5)
Cannabis herb* **	112 (81)	10.3 (0.2-26)	64 (52)	6.7 (0.1-20)
Heroin ** **	149 (78)	19.96 (1.8-71)	83 (64)	30 (0.7-99)
Cocaine	318 (191)	61.9 (0.17-89.27)	378 (319)	52.7 (0.1-97.5)
Amphetamine	204 (137)	20.41 (0.51-73.38)	210 (116)	15 (0.1-73.4)
Methamphetamine	11 (3)	1.68 (0.24-3.69)	23 (8)	2.3 (0.2-47.5)
Ecstasy (mg of MDMA base per tablet/unit)	150 (101)	56.04 (1.43-154.44)	155 (112)	31.1 (3.6-140)

* the percentages are not weighted because the exact amount of sample on which the analysis was done is not known.
** Between brackets is the number of cases on which the mean, min and max are calculated.
*** % THC content.
**** brown and white heroin.

Compared to the Δ^9-THC-levels of 'nederwiet', the levels found in Belgium are a bit lower but still much higher than those of marihuana from other foreign countries. In Belgium, sources of seized cannabis are unknown but the seized samples are probably partly 'nederwiet' (most of the samples are seized in trains from the Netherlands) and partly other foreign marihuana. A study by Van Tichelt showed similar results. Regarding the hashish, Δ^9-THC-levels are comparable with levels of foreign hashish. Few hashish samples were found with Δ^9-THC-levels between 35% and 49%. Those must be 'nederhash' samples (Van Tichelt et al. 2005).

PART B. Selected issues

CHAPTER 11.
Public expenditures

Sara Van Malderen
Dr. Freya Vander Laenen
Prof. Dr. Brice De Ruyver

11.1. Introduction

In 1998, one of the recommendations of the Belgian Parliamentary Working group on drugs was that policy evaluation on the drug issue is essential. Following these recommendations, the Belgian federal government issued a drug policy note in 2001, stating the importance of the study of public expenditure on drugs because it is an essential element in policy evaluation (Federal Government, 2001). Another argument for studying public expenditure was inspired by the complex Belgian state structure with sometimes separate and sometimes overlapping competences in the drug field. Therefore, insight is needed into the policy funding on the different competency levels.
In Belgium, the state is organised on three levels: the upper level comprises the Federal State, the Communities and the Regions; the middle level is occupied by the Provinces; and the lower level is that of the Municipalities. The Federal State is competent for law enforcement and for some aspects of health policy. The Communities and the Regions are competent for prevention policy and some aspects of health policy. The middle level, occupied by the Provinces, is more or less a coordinative level. At the local level the Municipalities are responsible for the coordination of the local drug policy, mostly with the means obtained from the upper level.
A first study on public expenditure was executed between 2001 en 2003 (De Ruyver et al., 2004). To refine the methodology used, aimed at collecting more detailed data and to develop a methodology usable and comparable at EU-level, a follow-up study on public expenditure was executed between 2005 and 2006 (De Ruyver et al., 2007).

This contribution is based on the most recent study, “drug policy in figures II” (De Ruyver et al., 2007).
Because of the developed expertise throughout the years, this contribution will focus on the methodology used. The second part of the contribution will briefly present some research results.
With regard to studies on public expenditure, it is important to realize that these studies are predominantly meant for and used by people responsible for the coordination of policy and in particular drug policy. If a study on public expenditure is to support policy makers, the presentation of results must be sufficiently transparent.

11.2. Methodology

In this part the methodology used for the estimation of public expenditures on drugs in Belgium is explained in order to contribute to the development of a uniform and standardised methodology for estimating public expenditures in the EU Member States.
Three crucial elements, allowing for or hampering comparison with other international studies, are discussed: (1) the inclusion of expenditures, (2) their classification and (3) their measurement (Moore, 2006). A similar use of these three elements in the study of public expenditures will allow for a comparison between countries.

11.2.a Included and excluded expenditures

Before analysing the public expenditures on drug policy, it has to be clear how public expenditures are defined, which expenditures are included and which expenditures are beyond the scope of this analysis.

11.2.a.1 Public expenditures, private expenditures, external expenditures, social cost and cost-effectiveness

The key element in public expenditure is the public authorities' financial contribution to the drug policy.
The analysis proceeds from the perspective of the different public authorities competent for aspects of the drug policy. In **public expenditure** studies, only public funding is included. Neither private expenditures nor external expenditures are included. **Private expenditures** are expenditures made by private organisations non subsidized by public authorities and personal expenditures such as expenditures for the purchase of drugs. **External expenditures** are expenditures borne by society, such as expenditures due to loss of productivity, absenteeism on the work floor, early death as a result of drug use and the cost for society due to drug-related crime and drug-related nuisance.
Public expenditures are an *element* of the social costs on drugs. Together with private and external expenditures they constitute the total social cost on drugs in a given society.

Table 37: Social cost study versus public expenditure study

SOCIAL COST STUDY		
(1) Public expenditures	***(2) Private expenditures***	***(3) External expenditures***
Expenditure by public authorities on drug problem/policy	Expenditures of drug users Expenditures made by non subsidized private organisations	Total of indirect expenditures at expense of society
PUBLIC EXPENDITURE STUDY		
(1) Public expenditures	***(2) Private expenditures***	***(3) External expenditures***

Table 38: Included and excluded expenditures

Sectors	Included expenditures	Excluded expenditures
1. Prevention	Streetcorner work, Safety & Prevention contracts, prevention workers (regions)	Educational support
2. Treatment	Treatment, guidance, crisis centre	Treatment of infections by contaminated needles
3.Law enforcement	Public expenditures for investigation and prosecution violations of drug laws and drug-related crime	Theft committed by drug users
4. Other	Non sector-related research and policy	Expenditures purchase drugs

Studying public expenditures gives an insight into policy activities and reflects policy choices but it does not suffice to evaluate the **effectiveness of drug policy measures**. Nevertheless, knowledge of the amount and the repartition of public expenditures is a crucial element of cost-effectiveness studies.

11.2.a.2 The concept of public expenditure as used in the study

The expenditures included in the study are defined as ***'public expenditures by Belgian public authorities on policy actions expressly and directly aimed at the issue of illicit drugs'.***
Expenditures of the federal government as well as the expenditures coming from the regional, provincial, municipal authorities and depending public services are included. To estimate a member state's financial contribution on drugs it is recommended to exclude expenditures made by inter- or supranational institutions, such as research financed by the EMCDDA and the European Commission, or at least to separate these expenditures from national expenditures on drug policy.

Direct expenditures are public expenditures expressly labelled for concrete policy actions in the field of drugs and are as such identifiable in the public budgets. Indirect expenditures are not explicitly labelled for drug policy actions as such, although the drug policy indirectly benefits from it; e.g. expenditures for educational support, expenditures for the support of vulnerable populations and expenditures on urban renewal.

In the Belgian study the principal requested to limit the study expressly to ***illicit drugs***. However there are good arguments to enlarge the scope of future studies to include licit drugs (EMCDDA, 2006) so that insight can be gained in all drug-related expenditures.

11.2.b Classification of public expenditures: who finances what?

After a clear understanding of the concept of public expenditures and included expenditures, insight is needed into who finances what. Therefore, public expenditures on drug policy have to be classified on a national level according to the competent public authorities and according to the different policy sectors. In order to be able to compare data on an international level it is necessary to use the same classification.

11.2.b.1 Classification of public expenditures according to competent public authorities

In every member state the repartition of competences in the field of drug issues differs. Research on public expenditures cannot be dissociated from the specific state and governmental structure. Therefore it is essential to inventory which public authorities are responsible for which policy areas in the field of drugs. Furthermore, public services and subsidised private actors (NGO's) involved in the drug policy have to be included in the inventory as well.

11.2.b.2 Classification of public expenditures according to different policy sectors

To classify public expenditures, the purpose the expenditure is intended for has to be the starting point (Reuter et al., 2004). Based on this purpose, public expenditures are classified into different policy areas or sectors, mostly 'prevention', 'treatment', 'harm reduction' and 'law enforcement'. This classification has to allow for international comparison while at the same time taking into account the specific nature of the drug policy pursued in a particular country.
In the Belgian study, three sectors, **'prevention'**, **'treatment'** and **'law enforcement'** were used.
In international studies a fourth **'harm reduction'** sector is used as well (Moore, 2006; Reuter, 2006; Rigter, 2006; Ramstedt, 2006) although it is not always feasible to separate harm reduction aspects from a treatment programme (Reuter, 2006).This is for instance the case for low threshold methadone maintenance programmes.
In the Belgian study public expenditures on harm reduction are not presented as an independent sector but allocated to the sector 'treatment', although one has to admit that not all harm reduction measures are linked to treatment. A stand alone needle exchange programme, for instance, is mainly preventive in nature.

Some expenditures are difficult to classify under one of the previously mentioned sectors. Therefore a fourth **'other'** sector was created in the Belgian study. This is merely a **'rest'** sector or category for expenditures that cannot be classified under the sector 'prevention', 'treatment' or 'law enforcement'. Which specific public expenditures will be classified under this rest category will depend on the specific nature of a country's drug policy. In any case, this sector is solely intended for non-assignable expenditures. Under no circumstances can expenditures beyond the definition of public expenditures (cf. social cost), be categorized under the sector 'other'.

Examples of public expenditures aimed at drug-related 'prevention' are street corner work, prevention work, initiatives to prevent drug-related nuisance and epidemic diseases.

Examples of public expenditures aimed at drug-related 'treatment' are drug treatment and guidance for drug users (especially in hospitals), projects aimed at harm reduction (be it that not all harm reduction measures are linked to treatment, cf. supra) and reintegration programmes (employment) for (former) drug users.

Public expenditures classified under the sector drug-related 'law enforcement' are expenditures for the control of violations of the drug legislation by police, customs and judicial authorities.
Examples are expenditures for personnel such as policemen working in drug investigation units, customs officers specialized in drug trafficking and magistrates dealing with drug cases.

Examples of public expenditures classified under the sector 'other' or rest category are expenditures for local drug coordinators, expenditures on non-sector related research and policy and the yearly financial contribution to the Pompidou Group of the Council of Europe.

11.2.c Collection of financial data: top-down and bottom-up approach

To collect the financial data, two methods of analysis are used: a top-down and a bottom-up approach. The top-down method starts from the resources made available by the different public authorities involved in the drug policy. The public authorities' drug budgets are collected and analysed. This **"top-down approach"** starts with an analysis of the funding sources of the private, (NGO) and the public organisations. In the calculation, only the public financial resources are taken into account. More specific, the budgets on drug policy of the Belgian Federal Government Departments are retrieved as well as the drug-related expenditures of the Communities and Regions, of the Provinces and of Municipalities.[24]
The second method of analysis, the **"bottom-up approach"** starts from the activities in the work field and traces the money flow back to the public authorities' funding.
The advantage of this double method is that it makes verification possible; the data gathered on the basis of the top-down approach can be double-checked and completed with the data retrieved from the project actors in the field.[25]

11.2.d Calculation of public expenditures

After the data collection, processing can begin. Before calculating public expenditures on drug policy, one has to realise that expenditures on drug policy are often embedded in policy projects with broader objectives. Therefore, it is important to look beyond labelled drug-related expenditures. If the expenditures are part of a broader project, the expenditures aimed at the policy of illicit drugs have to be isolated. This allows for an estimation of the labelled drug-related expenditures and the non-labelled drug-related expenditures.

11.2.d.1 Calculation of explicitly labelled drug-related expenditures

When expenditures are exclusively used for drug policy on illicit drugs, no additional calculation is needed. The obtained results are labelled drug-related expenditures. Examples are the budget for the aftercare of drug users, the budget for research on drug prevention and expenditures on treatment programmes for drug users in prison.

11.2.d.2 Calculation of non-labelled drug-related expenditures: the use of a repartition key and of a unit expenditure

The collected financial data will also include expenditures intended for broader policy domains than just illicit drugs. To calculate the non-labelled drug-related expenditures included in a general budget it is necessary to apply a "*repartition key*" to the obtained amount.
The use of a repartition key is for instance required in the case of health promotion. To isolate the public expenditures for the illicit drugs from this budget, the number of projects for the prevention of illicit drugs is divided by the total number of projects. This calculation produces a percentage that reflects the part of the projects for illicit drugs.

[24] In the budget analyses use is made of 'ordinance credits'. These are expenditures foreseen and also actually spent. Sometimes, means are foreseen in governmental documents but eventually not spent in practice.

[25] Through surveys, projects actors in the different sectors are asked for received expenditures and the public authority responsible for its payment.

This repartition key method guarantees that all resources deployed besides personnel, including overhead, equipment and operation, are assigned to the policy actions taken (WHO, et al., 2000).
A disadvantage of using a repartition key (e.g. number of drugs clients/ total number of clients) is that it implicitly assumes that the expenditure for each unit is the same for all activities (e.g. that the expenditure for a drug user is equal to the expenditures for other clients). Differences in the expenditure per unit of activity are ignored (Ramstedt, 2002). It is therefore essential to study whether the investments in terms of working hours for the treatment of drug users and other clients are comparable.
In practice, the appropriate repartition key for illicit drugs may be determined in different ways: on the basis of information from registration systems, annual reports, contacts with the work field…
In some cases no financial data are available, neither from a top-down, nor from a bottom-up approach. In this case it is impossible to apply a repartition key. A calculation on the basis of *"unit expenditure"* is needed here. In the Belgian study, this type of calculation is used to measure the public expenditures for the hospitalization of drug users in a non-drug specific service. The average expenditure for hospitalization per day is multiplied by the average number of days a drug user is hospitalized.
Unlike the repartition key, this approach does not present problems of variability. However, in the Belgian study, this method was only used to calculate the expenditures on treatment in hospitals. After all, for the determination of a unit expenditure the researcher is depending on the institutions/actors involved, leading to a possible contestation of the reliability of the data. Secondly, the determination of unit expenditures is restricted to expenditures on personnel, contrary to repartition keys that include all types of resources.

11.2.e Feasibility of the implementation of the methodology for other countries

The implementation of this methodology firstly requires knowledge of the unique state and governmental structure and knowledge of the competences of the different authorities involved in the drug policy. The differences and diversity of competences among member states however, is no impediment to make use of the methodology. The financial data can be collected by the top-down approach, ideally combined with the bottom-up approach, depending upon available time and means and accessibility to data. Moreover, every member state can classify the drug budget into the proposed sectors to allow for international comparison and to allow for an estimation of public expenditures in the field of drugs in the European Union.

11.3. Results

11.3.a Limitations

The nature of the results has been influenced by three crucial factors.
Firstly, there is the divergent means of funding of the various administrations. Expenditures associated with law enforcement, for example, are primarily situated at the Federal level, while expenditures relating to prevention are dispersed over different competency levels. This will undoubtedly affect the analysis of public expenditures.
Secondly, the quality of the research results depends directly on both the availability and the quality of the basic data. This in turn depends on the registration systems that the departments and institutions apply. A lack of uniform and comparable registration systems further complicates matters.

Thirdly, the calculation of public expenditures is based on estimations and calculations, so one should always take into account a certain margin of error.

11.3.b Conclusions

In Belgium, over 50% of public expenditures on dealing with the drug problem go to law enforcement (Table 39 and Figure 13). The 'treatment' sector accounts for approximately 40% of public expenditures on dealing with the drug problem. The sector 'prevention' is dealt with less than 4%. Expenditures that cannot be categorised under one of the three main sectors, included in the rest sector 'other', are negligible, amounting to only 0.36%.

Table 39: Drug policy expenditures at the various government levels (2004)

k €2004	Prevention	Treatment	Law enforcement	'Other'	TOTAL
Federal	1635128	107801788	107478404	833521	217748841
Regions	8038053	9026432	37500	-	17101985
Provinces	536165	272690	-	-	808855
Towns & Municipalities	1141139	496642	59604214	235764	61477759
TOTAL	**11350485**	**117597552**	**167120118**	**1069286**	**297137440**

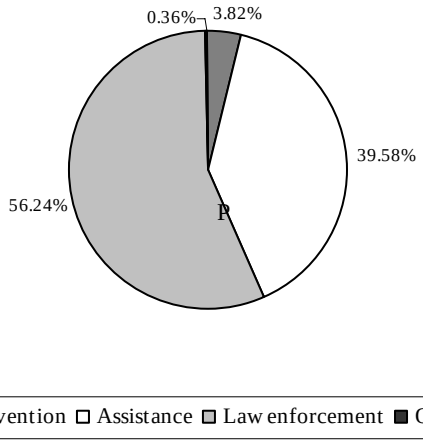

***Figure 13**: Visual representation of public expenditures for 2004*

In 2004, the total public expenditure on drug policy for all sectors combined was estimated at **€** 297137441. On 1 January 2004, Belgium's population stood at 10396421 inhabitants. This means that public expenditure on drug policy in 2004 amounted to € 28.57 per inhabitant.

Taking into account the level of spending per sector, this € 28.57 may be divided as follows:

Table 40: Distribution of public expenditure by sector

Sector (2004)	€ per capita
'Prevention'	1.09
'Treatment'	11.31
'Law enforcement'	16.07
'Other'	0.10
Total	**28.57**

Belgium's public expenditure on drug policy is substantially lower than that in the Netherlands and in Sweden. In the Netherlands, per capita public expenditure on drug policy for the year 2003 amounted to € 134.4 (Rigter, 2006). Sweden's per capita public expenditure on drug policy for the year 2002 amounted to € 101 (Ramstedt, 2006). A comparison with other studies on public expenditure is risky, because of the differences in the applied methodology.

In 2004, Belgium's Gross Domestic Product (GDP) amounted to € 289508500000 (289.5 billion euros), meaning that public expenditure on drug policy represented 0.10 % of the GDP.

11.4. National studies on drug-related public expenditures and experts

11.4.a National studies

De Ruyver, B., Pelc, I., Casselman, J., Geenens, K., Nicaise, P., From, L., Vander Laenen, F., Meuwissen, K., Van Dijck, A. (2004). *Drugbeleid in cijfers. Een studie naar betrokken actoren, overheidsuitgaven en bereikte doelgroepen* (Drug policy in figures, A study into the actors involved, public spending and target groups reached), Gent: Academia Press.
-> An English (20 p.) summary of this report can be downloaded on http://www.belspo.be/belspo/home/publ/pub_ostc/SoCoh/rSO01008_en.pdf

Bucquoye, A. (2006). Het drugbeleid vertaald naar 'centen' (Drug policy translated into 'money'), *Science Connection*, 12, juli 2006, p. 18-19; Downloadable on http://193.191.208.76/belspo/home/publ/pub_ostc/sciencecon/12sc1_nl.pdf

De Ruyver, B., Pelc, I., De Graeve, D., Bucquoye, A., Cornelis, L. en Nicaise, P. (2007). *Drugs in cijfers II : studie naar betrokken actoren, overheidsuitgaven en bereikte doelgroepen, vervolg studie / Drogues en chiffres II : etude des acteurs concernés, des dépenses publiques et des populations atteintes, Etude de suivi*. (Drug policy in figures II, A study into the actors involved, government expenditure and target groups reached), Gent : Academia Press.
-> An English (10 p.) summary of this report can be downloaded on http://www.belspo.be/belspo/home/publ/pub_ostc/Drug/rDR24r_en.pdf

11.4.b National experts

Prof. dr. B. De Ruyver
Ghent University
Department of Criminal Law and Criminology
Institute for International Research on Criminal Policy (IRCP)
Universiteitstraat 4 - 9000 Gent
Tel.: + 32 (0)9 264 69 47
Fax: + 32 (0)9 264 69 71
E-mail: brice.deruyver@ugent.be

Prof. Dr. B. De Ruyver was promoter to both Belgian studies on public expenditure (see 4.1).
He acquired many years of experience in scientific research relating to drug policy, criminal policy and international crime. He was coordinator or research partner for other research with regard to (several aspects of) drug policy as well.

A selection of references

- De Ruyver, B., Ponsaers, P., Lemaître, A., Macquet, C., De Wree, E., Hodeige, R., Pieters, T., Cammaert, F. en Sohier, C. (2007). Effecten van alternatieve afhandeling voor druggebruikers / Effets des mesures alternatives pour les consommateurs de drogues (Effects of alternative settlement on drug users), Gent: Academia Press.
- Ponsaers, P., De Ruyver, B., Lemaitre, A., Macquet, C., Pieters, T., Vaerewyck, W., Fincoeur, B. en Vander Laenen, F. (2005). Drugoverlast in de lokale context van acht Vlaamse en Waalse gemeenten. Naar een Monitor Integraal Lokaal Drugbeleid (Drug nuisance in the local context of eight Flemish and Walloon municipalities. Towards a Monitor Integral Local Drug policy), Gent: Academia Press.
- Geenens, K., Vanderplasschen, W., Broekaert, E., De Ruyver, B. en Alexandre, S. (2005). Tussen droom en daad: implementatie van case management voor druggebruikers binnen de hulpverlening en justitie, (Between vision and action: implementation of case management for drug users within assistance and justice), Gent: Academia Press.
- De Ruyver, B., Vermeulen, G., Vander Beken, T. and Vander Laenen, F. (2003). International Drug Policy, Status Quaestionis, Compendium of Articles, Antwerpen-Apeldoorn: Maklu.
- De Ruyver, B., Casselman, J., Meuwissen, K, Bullens, F. en Van Impe, K. (2000). Het Belgisch drugbeleid anno 2000: een stand van zaken drie jaar na de aanbeveling van de parlementaire werkgroep drugs, (The Belgian Drug Policy anno 2000: state of the art three years after the recommendation of the parliamentary working party drugs), Gent: Onderzoeksgroep Drugbeleid, Strafrechtelijk beleid en Internationale criminaliteit.
- De Ruyver, B. (1997). "Drugsbeleid vanuit een geïntegreerd perspectief" (Drug policy from an integrated perspective), Verslag namens de werkgroep belast met het bestuderen van de drugproblematiek, Gedr. St., Kamer, nr. 1062/3, P; 912-948.

Prof. dr. D. De Graeve
University of Antwerp
Departement of general economics
Prinsstraat 13 - 2000 Antwerpen
Tel. + 32 (0)3 220 41 70

Fax: + 32 (0)3 220 45 85
E-mail: diana.degraeve@ua.ac.be

Health Economics has been a research topic within the department of economics since the '70s. The department has gained an extensive research experience in economic analysis with respect to the health care sector in developed and less developed countries. Research topics include the financing and organization of care, the collection of costs of specific diseases or disorders and the economic evaluation of new drugs or technology. Often there is a multidisciplinary collaboration with a. o. physicians and sociologists.

A selection of references

- De Ridder, A., D Graeve D. (2006), Healthcare use, social burden and costs of children with and without ADHD in Flanders, Belgium. In: Clinical drug investigation, 26, 2, p. 75-90.
- De Graeve D, van Doorslaer E.., et al. (2004). Equity in the delivery of health care in Europe and the US.- In: Health economics: adding value to health care? / Brouwer W. (ed.), e.a., S.l., Dutch-Flemish Health Economics Association, p. 121-146
- De Cock R., Depoorter AM., De Graeve D., (2003), Total costs of health services for HIV/AIDS patients in Belgium. In: Shohov SP (ed) Advances in Psychology Research, 23, 45-59, Nova Science Publishers, New York.
- De Graeve D. en Kurz X. (2003), Economische evaluatie bij mentale stoornissen. (Economic evaluation of mental disorders) In: Dierick, M. [ed.], e.a., Handboek Psychofarmacotherapie , Gent, Academia Press, 2nd revised edition.
- De Graeve D., and Van Outri, T. (2003). Impact of health financing in Europe, in The World Economy, 26,10, p. 1459-1479.
- Van Doorslaer, E, Wagstaff, A., Van Der Burg, H., Christiansen, T., De Graeve, D., et. al. (2000). Equity in the delivery of health care in Europe and the US. Journal of health economics, 19, p. 553-583.
- De Graeve D. en Nonneman, W. (1996), Pharmacoeconomic studies: pitfalls and problems, International Journal of Technology Assessment in Health Care, 12, 1, p. 22-30.

11.5. Conclusion

The study of public expenditure on drugs will never be easy, simply because the drug phenomenon is complex and multidimensional, with social, security, health, economic, international and political components. Consequently, drug policy is complex too and inevitably, several Ministers and administrations are competent. In Belgium, matters are even more complicated. Belgian drug policy evolved in the work field for years before the Federal authority started developing a national policy; consequently, bottom-up and top-down driven policy co-exists and from time to time conflicts. Finally, Belgium has a complex state structure.

The importance of using a single, clear methodology, applied in a uniform manner can not be stressed enough, particularly when the comparison between different time-measurements and especially between different EU countries is the aim. A mere – small – change in methodology might erroneously lead to decide to either an increase or decrease of public expenditures, without any actual change in the budget.

Public expenditure studies reflect existing activities and policies in the field of the drug phenomenon. This estimation is a valuable policy indicator, as it enables to test the policy commitments of public authorities. A drug budget provides insight into the actual level of public expenditures in this field and into how these expenditures are composed or what the public authorities so-called 'policy mix' is. Consequently, the prevailing balance between the various sectors of illicit drug policy (prevention, treatment and law enforcement) also becomes visible. Furthermore, public expenditure studies are a starting point for cost-effectiveness studies and evidence based-policies.
In the Belgian federal policy document on drugs of 2001, prevention is said to be the priority in drug policy, followed by treatment and then by law enforcement as a last resort. In fact, with regard to public expenditure, the opposite becomes clear: the most substantial expenditures relate to law enforcement, followed first by treatment and then prevention (De Ruyver et al., 2004; De Ruyver et al., 2007).

Public expenditure studies do have their limitations too. They do not allow for a full policy evaluation. These studies are, in itself, no quality measurement of policy. To reach policy evaluation, an elaborated plan is needed, with clear statements on goals, operational action points, budgets and timeframes. This policy plan should ideally be evidence-based, based that is on epidemiological data about new trends in drug use and groups of (problem) drug users, on data about – insufficiently – reached target groups in prevention, early intervention and treatment and on evaluation and effectiveness studies. An element in policy evaluation then, is public expenditure, enabling public authorities administrations and the work field to evaluate whether public authorities 'put their money where their mouth is'.

References

Bucquoye, A. (2006). Drug policy translated into 'money'. Science Connection, 12, 18-19.

De Cock, R., Depoorter, A.-M., De Graeve, D. (2003). Total costs of health services for HIV/AIDS patients in Belgium. In SP. SHOHOV (ed.), Advances in Psychology Research (pp. 45-59). New York: Nova Science Publishers.

De Graeve, D. & Nonneman, W. (1996). Pharmacoeconomic studies: pitfalls and problems. International Journal of Technology Assessment in Health Care, *12* (1), 22-30.

De Graeve, D. & Kurz, X. (2003). Economic evaluation of mental disorders. In DIERICK, M. (ed.), Handboek Psychofarmacotherapie. Ghent, Academia Press, 2nd revised edition.

De Graeve, D., & Van Outri, T. (2003). Impact of health financing in Europe. The World Economy, *26* (10), 1459-1479.

De Graeve, D., van Doorslaer, E., et al. (2004). Equity in the delivery of health care in Europe and the US. In BROUWER W. (ed.), Health economics: adding value to health care? (pp. 121-146). Dutch-Flemish Health Economics Association.

De Ridder, A., D Graeve, D. (2006). Healthcare use, social burden and costs of children with and without ADHD in Flanders, Belgium. Clinical drug investigation, *26,* (2), 75-90.

De Ruyver, B. (1997). Drug policy from an integrated perspective. Report from the parliamentary working group responsible for the study of belast the drug problem. Gedr. St., Kamer, 1997, nr. 1062/3, P; 912-948.

De Ruyver, B., Casselman, J., Meuwissen, K., Bullens, F. en Van Impe, K. (2000). The Belgian Drug Policy anno 2000: state of the art three years after the recommendation of the parliamentary working party drugs. Ghent: Research group Drug policy, Criminal Policy and International Crime.

De Ruyver, B., Vermeulen, G., Vander Beken, T. and Vander Laenen, F. (2003). International Drug Policy, Status Quaestionis, Compendium of Articles. Antwerpen-Apeldoorn: Maklu.

De Ruyver, B., Casselman, J., Pelc, I. (2004). Drug policy in figures. Study of the actors involved, cost price calculation and population reached. Ghent: Academia Press.

De Ruyver, B., Pelc, I., De Graeve, D., Bucquoye, A., Nicaise, P., Cornelis, L. (2007). Drug policy in Figures II. *Follow-up research into the actors, public spending and reached target groups.* Ghent: Academia Press.

De Ruyver, B., Ponsaers, P., Lemaître, A., Macquet, C., De Wree, E., Hodeige, R., Pieters, T., Cammaert, F. en Sohier, C. (2007). Effects of alternative settlement on drug users. Ghent : Academia Press.

EMCDDA, (2006). 'Annual report 2006: Selected issues' [online]. Available: http://issues06.emcdda.europa.eu/download/sel2006-en.pdf

FEDERAL GOVERNMENT (2001). *Policy* document of the Federal Government concerning the drug problem. Brussel: Federal Government.

Geenens, K., Vanderplasschen, W., Broekaert, E., De Ruyver, B. en Alexandre, S. (2005). Between vision and action: implementation of case management for drug users within assistance and justice. Ghent: Academia Press.

Moore, T.J. (2006). What is Australia's "drug budget"? The policy mix of illicit drug-related government spending in Australia. Victoria: Turning Point Alcohol and Drug Centre.

Ponsaers, P., De Ruyver, B., Lemaitre, A., Macquet, C., Pieters, T., Vaerewyck, W., Fincoeur, B. & Vander Laenen, F. (2005). Drug nuisance in the local context of eight Flemish and Walloon municipalities. Towards a Monitor Integral Local Drug policy. Ghent: Academia Press.

Ramstedt, M. (2002). Estimating drug policy expenditures in Sweden. Stockholm: Centre for Social Research on Alcohol and Drugs.

Ramstedt, M. (2006). What drug policies cost. Drug policy spending in Sweden in 2002. Addiction, *101*, 330-338.

Reuter, P., Ramstedt, M., Rigter, H. (2004). Developing a Framework for Estimating Government Drug Policy Expenditures. Lisbon: EMCDDA Report, European Monitoring Centre for Drugs and Drug Addiction.

Reuter, P. (2006) What drug policies cost. Estimating government drug policy expenditures*. Addiction, 101,*315-322.

Rigter, H. (2006). What drug policies cost. Drug policy spending in the Netherlands in 2003. Addiction*, 101,* 323-329.

Van Doorslaer, E, Wagstaff, A., Van Der Burg, H., Christiansen, T., De Graeve, D., et. al. (2000). Equity in the delivery of health care in Europe and the US. Journal of health economics*, 19,* 553-583.

WHO, UNDCP, EMCDDA, (2000). Workbooks Evaluation of Psychoactive Substance Use Disorder Treatment. Workbook 5: Cost Evaluation.

CHAPTER 12.
Vulnerable groups of young people

Pascale Jamoulle
Fred Laudens
Bahija Lamkaddem

Since few quantitative studies or field works are centred on specific groups as defined in the EMCDDA guidelines, the amount of available data on vulnerable groups of young people in Belgium is limited.

This chapter will present in a first section some quantitative data available for the Flemish Community and, in a second part, an anthropological point of view from the French speaking part of the country will be exposed.

12.1. Data available in Flanders

12.1.a Profile of main vulnerable groups

- **Children living in care institution**

In 2004 in Flanders, 17428 minors were living in care institutions (VRIND, 2006). The number of minors admitted to these institutions is growing each year (in 2000 15476 minors were admitted). The demand for places exceeds the capacity of these institutions.

- **Youth in families with drug and/or alcohol use**

In Flanders no data are available on the number of children growing up in families with at least one parent having an alcohol- or drug problem (Coolen & all. 2002). Nevertheless, international research indicates that at least 1 child in 10 has a parent with an alcohol addiction. Children of Alcoholics (COA) are a vulnerable group because of the intergenerational transmission of alcoholism (through both genetic and environmental factors).

- **Party goers**

There exists no reliable estimation of the number of party goers in Flanders or Belgium. A profile of party goers in Flanders can be obtained through a research on drug use in night life settings conducted in 2005 (Van Havere, 2006). 702 respondents recruited in 3 clubs and on 3 events completed the questionnaires. 67.9% of the respondents were male and 32.1% were female. 92.0% of the respondents indicated they were heterosexual with the remainder more or less equally divided between homosexual and bisexual. Mean age of the respondents was 22 years and 8 months (M=22.7- SD= 5.4). Few respondents were older than 30 years.

- **Ethnic minorities**

There are no data available on the number of minors in ethnic minorities. The total number of immigrants in Belgium is estimated at 1,447,094 (Perrin, 2005). The number of people who stay in Belgium illegally are estimated at 200,000-300,000.

- **Global well-care**

In Flanders in 2005, 19,069 clients contacted ambulatory youth services (Steunpunt Algemeen Welzijnswerk, 2007).

12.1.b Drug use and problematic drug use among vulnerable groups

➢ **Drug use in services for special youth assistance**

In 2002 VAD conducted an extensive need assessment in services for special youth assistance (Baeten & all. 2003). Services for special youth assistance is a generic name for a diverse set of services such as accompaniment-homes, day care-centres, home care services, observation & orientation centres.
178 persons working in services for special youth assistance returned their questionnaire. The majority of the clients in these services are boys. The mean age of the clients is 13.4 years.
Respondents could indicate how often they are confronted within their service with problems regarding alcohol, medication, cannabis, other illegal substances and gambling. Respondents are confronted rather often with youngsters having problems with cannabis. 44.9% of the respondents are confronted often or always with clients with problematic cannabis use. 38.8% indicate that they are sometimes confronted with clients with problematic cannabis use. Only 16.3% of the respondents have (almost) never had any youngsters with problematic cannabis use.
31.4% of the respondents have (almost) never been confronted with clients with alcohol problems. The majority (58.3%) sometimes sees clients with alcohol problems and 1 out of 10 (9.7%) often has clients with alcohol problems.
38.7% of the professionals working with youngster have (almost) never seen clients with problems relating to illegal drugs (not cannabis). Almost half (45.7%) has sometimes clients with illegal drug problems (not cannabis). 15% are often confronted with clients having illegal drug problems (not cannabis).

The data of the need assessment also reveals a rather strong correlation between the frequency of problematic use of different legal and illegal drugs as indicated by the respondents. Respondents who are often confronted with clients with problematic alcohol use, are also often confronted with clients with problematic use of cannabis and other illegal drugs.

The severity of problem use (both legal and illegal) depends also on the type of service. Problematic drug use among clients of day care-centres is rather exceptional. Most clients with problematic drug use are seen in observation and orientation centres. Accompaniment -homes and home care services fall in between.
18.4% of the respondents believe that problems concerning drug use are important compared to other problems that clients have in general. For 56.3% problematic drug use is rather important compared to other problems among youngsters. Only 2.3% indicate that problematic drug use is not important considering other problems that clients have.
Most respondents (60.8%) believe that there is a relation between the problematic drug use of the youngsters and problematic drug use of their parents. 57.1% of the respondents indicate that parents' behaviour lowers the threshold for drug use of their children. For 20.9% of the respondents youngsters doesn't learn the right coping behaviour.

➢ **Drug use in night life settings**

The results on drug use data are taken on 1368 respondents who completed questionnaires in two separate surveys (2003 and 2005) in 3 different night life settings. This allows a time-analysis.
Almost half of the 1368 respondents used an illegal drug during the last year. The most used illegal drug is cannabis but the last year use of cannabis has decreased between 2003 and 2005 from 48.5% to 38.4%. More specifically the group of regular users of cannabis has decreased from 31.4% to 20.6% between 2003 and 2005. Still, even in 2005, 11.6% of the respondents used cannabis on a daily basis.

The second most used illegal drug is XTC: 1 out of 6 respondents (15.8%) took XTC during the last year (survey 2005) versus almost 1 out of 5 respondents (18.8%) that took XTC the last year in the 2003 survey.
Cocaine is the third most used illegal drug: 13.3% last year users in 2005 and 11.5% last year users in 2003.
Speed is almost exclusively quoted as 'used ever, but not during the last year' and in comparison with 2003 the use of speed has decreased (2003: 9.7% last year users; 2005: 7.0%). The use of GHB, Ketamine and Viagra is very limited in the studied population.
Almost half of last year users in the 2005 survey regularly combined alcohol with an illegal drug and 1 out of 4 combined different illegal drugs. The same pattern of combined use is found in the 2003 survey.
The last year users of illegal drugs take their drugs mainly while going out and in the company of friends. Cannabis and cocaine are also used before and after going out. Four out of five users buy their drugs by themselves and mainly not while going out but before.

- **Drug use in services for vulnerable youngsters**

VAD conducted in 2002 a qualitative research in 5 services working with vulnerable youngsters (De Donder, 2003). Two services work with autochthonous youngsters, two services with allochthonous youngsters (Turkish and Moroccan) and one service with both autochthonous and allochthonous youngsters. In total 22 youngsters were interviewed (12 girls and 10 boys). The youngest interviewee was 13 years and the oldest was 23 years. The mean age of youngsters was 18 years and 12 youngsters were of allochthonous decent.
In services working with allochthonous youngsters it appears to be much more reluctance among youngsters concerning the use of legal and illegal drugs. This could be attributed to the influence of the Islamic religion with its strict rules concerning the consumption of legal or illegal drugs.
When asked about their attitude towards drug consumption, few youngsters seem to have problems with the use of cigarettes. Moderate use of alcohol is possible. Youngsters however disapprove alcohol intoxication, especially if this causes interpersonal problems. The attitude towards the use of illegal drugs is more disapproving. Half of the youngsters disapprove the use of illegal drugs. The other half believes that illegal drug use is possible on condition not to exaggerate. What is not accepted is being in a state of intoxication in the service.
Half of the youngsters use cigarettes or alcohol. The proportion on non-smokers is higher in allochthonous services. In the latter there is almost no use of alcohol. Illegal drugs are used by a number of youngsters on an occasional basis. The most used illegal drug is cannabis. One youngster uses XTC and speed and one youngster has currently problems because of drug use. A number of youngsters indicate they had problems in the past because of drug use.
The most mentioned motives for using drugs are: “to forget problems”, “for pleasure”, “for the kick” and “out of curiosity”. Social pressure is only implicitly admitted.

12.2. Reflection based on ethnographical field studies (Hainaut and Brussels)

12.2.a The social manufacture of vulnerable groups

The socio-economic casualization, the spatial segregation and the lack of prospects exacerbate the risk-taking behaviours of young people. In the working-class districts living and housing conditions have deteriorated. Conditions of access to council housing in Belgium are such that they concentrate the most vulnerable populations in housing estates or blocks of council flats. Access priorities are worked

out based on a system of "precariousness points". Being a single parent family, on social benefits, with dependent children, having experienced emergencies, etc., all allow for points.
Once the housing has been allocated, rent is calculated according to the household income and is constantly readjusted. When they find (declared) work, people living on a housing estate often leave because the rent becomes too expensive. These public policies concentrate the most casualized people in a same place and the pauperization and stigmatization of their living place is humiliating for the inhabitants.
Practices linked with drugs allow gangs of youths to assert themselves in front of the other young people and adults. Risk-taking shows the youths "*making their mark*" and with that they restore their pride and honour and that of their neighbourhood by reversing the condemnation related to social relegation and the shame it leads to.
The cross-acquaintance networks of these young people lock them in as well as protect them. The need for recognition through drugs, deals and risk-taking behaviour is at the core of questioning one's identity amongst young people in precarious situations.

Troubled home ties, the absence of dialogue, conflicts, breakdowns, jobless parents often precipitate immoderate use of psychotropic substances (medicines, alcohol, other drugs, etc.) in families. The relationships between men and women, the roles and family models change very quickly; it induces happy developments but also existential suffering, communication difficulties and a weakening in the practice of the parental functions.
There is an increase of single mothers isolated by economic difficulties. Nowadays in Northern societies the family circle seldom gets involved in child rearing, which may leave mothers quite isolated in the upbringing of their children. When there is no separation marker – a third person – the single parent may waiver between an authoritarian attitude with his or her children – one particularly hard to live with for teenagers – or one which is too close, too possessive which may hinder the autonomy of the young person.
With fathers disqualified or marginalized, mothers unable to cope, and parental functions not taken over by the family circle, the borders between the generations may get muddled. Some mothers tend to increasingly transfer the authority to the child; most of the time the eldest one who gets more and more power in the family circle. This "parentalizing" of children weighs on the risk-taking and marginalization behaviours. It often worsens jealousy and rebellion between brothers/sisters who believe that the sharing of affection and power within the family is unfair. The child with parental responsibilities supports and runs his or her family. They find it hard to integrate the limits drawn by the grown-up world into theirs because they lack the support from this grown-up world. This distorted attitude towards the law weakens them in the long run, particularly with regards to their school and social integration. Young people look for other guides then. When they find them out on the streets, they follow their peers into taking one risk after another.

Violence in the family and in married life also combines itself to produce risk-taking behaviours. Children elaborate effective defence strategies to face violence. This can involve cutting themselves as a result of their heightened emotions and they tend to find social relationships based on domination/submission as normal. Other very young children drift away from any structuring parental ties and often they get shifted between foster families and institutions. They behave more and more riskily (running away, poly-consumption, etc.) When their call remains unheard, they may end up on the streets.

Tensions between men and women have a strong impact on the life of young people in precarious situations. When the relationships between girls and boys fluctuate between denigration and hostility, they weaken.
The young men's chauvinism, tyrannical attitude towards girls, their tremendous need for recognition from other boys also arise from the pervading disqualification of men in families.
The ambiance in the coeducational spaces (families, schools, etc.) deteriorates in a context of discrimination and cultural stiffening.
Some brothers overrate their virility and their role in defending their sisters' honour. The "virilistic" codes oblige them to constantly disqualify women and more "effeminate" boys. When subject to this tyranny and disparagement, some girls develop a relationship with the rest of the world of dissimulation and rancour, or otherwise open attitudes of defiance fed by their anger and rebellion. Girls and boys may try to find consolation in psychoactive drugs to face repeated breaks, suffering and emotional violence.

School failure or the difficulties met within the school can cause great suffering to the children as well as to the families and the teachers. Precociously labelled as troublemakers, some youths enter into mutual casting-off processes. When punished and often as a result of heightened emotional reactions, they feel unfairly treated. Orientating youths "by default" and regardless of their wishes including dealing with the institutional 'defensive chain reactions' may catch up with them in a spiral of breaks with society. The status of a pupil who performs poorly at school is undermined and eventually he will look for other areas where he will acquire skills he deems important and social recognition. Dropping out of school, or being asked to leave is thus a major step in the marginalization processes and risk-taking behaviours.

"Street" school, poly-consumption and small trafficking nets put young people at risk. A growing part of the new generation confronted with fewer (legal) job opportunities and identity-issues plunge into illegality to have access to consumer goods, and to gain recognition. The informal economy provides an apparent protection and forms of learning to many youths failing at school. Small trafficking nets have become established in the districts, schools and parties. Taking part in deals means overly competitive relationships, domination, disrespect, mistrust, social adjustment and welfare break-up. Quality of life then deteriorates as well as mental health. "On the streets" talking about oneself or asking for help is viewed as weak and the grown-ups are viewed as "*finks*". Many fieldworkers feel helpless when faced with the devastating effects of the parallel economy. It disrupts family and neighbourhood links and tends to cancel out the institutional responses.

The conflicts between cultures, disorders resulting from life in exile and discrimination may worsen drug-related practices.
Affronts such as social exclusion (precariousness, going underground), disqualification of one's cultural family background, religion, and family in the host society as well as family conflicts may lead young people to the "street" culture. Because they face discrimination and their parents' disillusionment, they live their sense of double belonging which takes the form of double exclusion. When they no longer speak their parents' language and lose their cultural references, the inter-generational dialog dies out.
Fathers coming from a culture where the authority is collectively borne (such as some fathers in Africa) feel at a loss in front of the models of fatherhood in the country of refuge. In this case the father-son relationship is frontal, exhibiting dual-authority and particularly confrontational for men who have little experience in a forthright relationship with their children. Parents feel overtaken by the development

of the ways of life and of the change in techniques of rearing children. Because they are worried about immediate problems they sometimes call upon their children - more schooled than they are – to solve them. The teenager then develops skills which may undermine his parents' authority status.
An underground life, living in transit, with no means of support and no rights may cause a lot of damage to young people and their families. The most isolated undocumented migrants living without any protection or deprived of any offsetting course of action, confined in parallel worlds are in great danger of being exploited, racketed, and victims of human trafficking. In the best case they find a job under a fake identity in sweatshops where they remain all the time, or as "*skivvies*" in a day-labour job in a near-slave status for a survival salary. Some families have been subject to different kinds of violence in their country of origin (torture, political violence, breaks, and confinement). The violence they have suffered sometimes generates reactive and anxiety-deadening risk-taking behaviours.

A criminal background and imprisonment worsen the exclusion and marginalization processes. The criminalization of drug-taking is one of the reasons why youths lose trust in the institutions that should be there to assist them. On the other hand, legal measures taken in the context of immigration weaken families by strengthening exclusion and by doing so they encourage young people in precarious situations to go underground and continue to indulge their risk-taking behaviours.

Disaffiliation and the progressive falling apart of family ties may cause the excluded to end up wandering the streets or actually homeless. Resourceless, sometimes undocumented youths end up on the streets in extremely violent situations. The fieldworkers who meet them observe the development of worrying depressive states most probably because they cannot find any opening, any way out of their situation. Girls in particular are in danger because of their precarious way of life and the promiscuity of squats (exploitation, unwanted pregnancy, rape).
The selection is merciless and the violence is intensified on the streets. People quickly plunge into sanitary and social difficulties which may be extremely serious. They resort to drugs to make their condition bearable and to survival devices (begging, prostitution, etc.). Drugs and risk-taking behaviours ensure their survival.

12.2.b Social functions of drugs-related practices

Drug-induced behaviour differs according to the period of an individual's life, their personal experience and nature.

First of all, they are in an experimental area (see the horizontal axis in Figure 13). For most young people taking drugs and risks which are "off-centre" of the law allows them to remove social inhibitions, have fun, stimulate communication and sensory abilities. They may have an access to consumption and recognition from specific groups too by infringing the rules and taking part in the underground economy. Some of them however, repeatedly cross the limits of what is « acceptable » in an inordinate pursuit of provocation and danger *("tasting" their fear).*

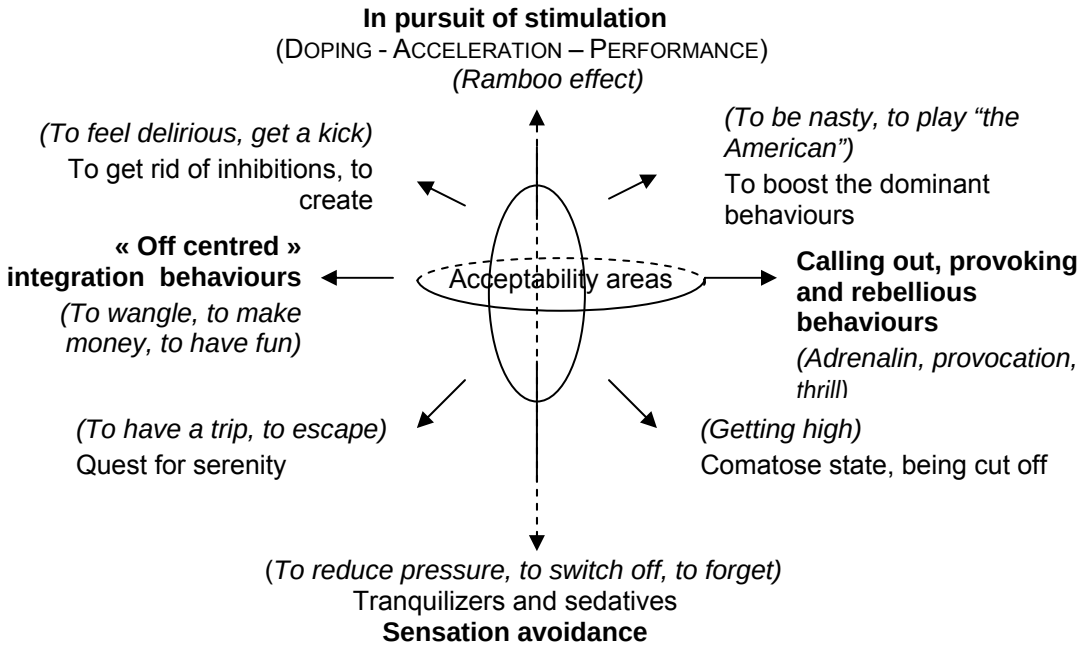

Figure 14: *Drug use patterns*

Drug-related behaviours are also used to regulate emotional tensions *(see vertical axis of Figure 14)*. When feeling bored or powerless, some individuals or groups take dope to get rid of their inhibitions, to hide their fears, to increase their performance, to be tough and to assert themselves in standing/reputation.
Conversely other types of risk-takers who feel anxious, under pressure, and inwardly injured manage their emotions by taking tranquilizers which help them not to feel anything any longer. Such a course of action once out of control physically and emotionally weakens them.
Young people at a specific age, under pressure from events, crises, an inextricable or unbearable situation, may translate their ill-feeling by trespassing on the limits, going repeatedly from one excess to another. Most of them however, regulate the risks on the whole because even though the group culture turns towards the pursuit of new experiences and infringements it may value self-control and a level-head. Compulsive risk-taking behaviours tend to ruin the youngsters and their family's good name. Many of them thus remain in the circle of "acceptable" risk-taking. They restrain their consumption, control the social relationships linked with drugs and develop strategies to avoid the most dangerous situations. Those who can rely on their relationships or their families learn by trial and error to regulate their relation to drugs by moderating the influences from their background. Others may become very destructive or self-destructive under such circumstances: they enter into a spiral of crime and/or getting high which produce recurring jeopardizing and casualization effects. When the "calling for help" behaviours are not heard and the social moderators are missing, drug-addiction, violence, vagrancy, etc. may become major sufferings.

12.2.c Conclusion: Prevention

As regards prevention, the better one knows the population one aims to help, the better one is able to. The important thing therefore is to move, to become acquainted with ethnicity to learn the codes and frames of reference of the persons in their various backgrounds; territorial, social, ethnic and cultural.
When meeting, it is essential first of all to develop relationships based on reciprocity and trust and to get involved in the relationship with the young and their families. To rely on the relationships and to give people the opportunity to express the tensions, claims and feelings of injustice means identifying their feelings and the effects of social suffering in particular.
The aim consists of mobilizing the creativeness of the persons and the groups, to support the social struggle, to help earlier, to reduce access time to resources, to improve access to services and support.

Nearness and accessibility
In the low-income areas, migrants, exiles, young people and families risk cumulative violence in institutions and ghetto suburbs. Once trust is impaired, it increases the time and distance to access the various devices. This gap has urged many professional fieldworkers to go closer and be available for local and distinctly preventive action.
They start with people's skills, their day-to-day experience, and their resourcefulness in the most decayed frames of life. In order to reduce the social and subjective distance, they spend time with the population they are concerned with; they get impregnated with their life styles; learn their codes, their allegiances, their difficulties and the solutions they find to deal with them. They get adapted to the rhythms of those who live precariously, the impermanence and the shortages they live with. This closeness is crosswise and may be applied in a clinic, in prevention, in social intervention, in investigations in the field, etc. It comes within the "clinic of the tie"[26] and it is applied where relationships have fallen apart: the bonds with the family and institutions, the ties of belonging and other social ties. The clinic of the tie questions our ability to give a meaning to the breaks, the toughening attitudes, and to patch up confidence and lasting relationships with them.

Banking on the people's resourcefulness and participation
Prevention relies on people's resourcefulness, their wish to express themselves and their expertise in overcoming difficulties. It may greatly help to develop the expressive abilities and the creative potential of the young and their families (writing, theatre, music, painting, sport, etc.). Everyone is endowed with – visible or hidden – gifts useful to express their personal story, to externalize the violence they undergo; gifts which may help them to regain confidence in their own capabilities, to control better their anger and to express it usefully. Working in prevention means that when you start from the cultural practices of the people and their wish to bear witness of their real life you promote citizenship and social change, e.g. inner-city rap music which allows many young people to express their anger, their wish for social justice, but with rhymes according to their own shared cultural and musical rules.

[26] *Cf.* Jean Furtos, Christian Laval (dir), *La santé mentale en actes. De la clinique au politique*, Erès, 2006, Jean Furtos, Contexte de précarité et souffrance psychique : quelques particularités de la clinique psychosociale, *Soins Psychiatrie*, n°204 et Marie-Rose Moro, « *Enfants d'ici venus d'ailleurs* », Hachette littérature/La Découverte 2002.

Taking a stand on reducing the risks of desocialization

By working at reducing the drug-related risks (RR), the fieldworkers have learnt to rely on the people's dignity, skills, and capacity to give, in order to create bonds with other people and to convey their experiences and skills. It has brought them to some kind of equal footing with those living precariously. It has shown that citizenship and responsibility towards others are far more efficient than fear as a preventative measure.

RR as a wide and crosswise concept of work has gradually made its way to the forefront. In the field of health promotion the idea has changed from that of "drug-addictions prevention" to that of "managing risk-taking behaviours". One question was how to transfer the competences gained in "health RR" for the purposes of prevention.

Many professional workers in prevention choose a position for RR of desocialization, in the general sense of the word, which aims at strengthening people's ability to protect themselves and protect their family. They focus on the global personality of the people in their day-to-day background and they start a dialog on the ways to reduce the risks as regards health, troubles with the law, and social or parental suffering.

The RR approach allows the fieldworkers to get in everywhere even in the most secluded, precarious environments to keep in touch with the most "*remote*" people. The motto: "*take care of yourself and of the others*" acts as a trigger and then as a "thickener" of the relationship. The RR is a process of relationship and citizenship; its messages passed round, its practices learnt via the relationship. It instils the rules of social exchange and reciprocity in places where sanitary and social practices have much deteriorated, and where the rules of self-respect or of respect of the other are very weak.

RR makes sense to people living in 'precariousness' because it is rooted in the values of the dominant culture as well as in those of the "street" culture. The young people must show self-control capabilities in their dealings and reduce the risks of their environment. The prevention activities focus on listening and discussing the issue of a correct assessment of the risk-taking taking place. The field interveners start from the insight which people have into the situations they go through. By understanding better their day-to-day life, their resources and their aspirations, the interveners can give them the appropriate pieces of information, and think together with them about practical ways to manage and control their behaviours.

Relying on biological and social parenthood

In an urban environment, particularly in families experiencing exile or conflicts, kinship is very often replaced by - or strengthened with - social parenthood[27]. The young and their families establish a privileged relationship of "nearly a family" with some chosen people around them. A godfather or a stepfather plays the part of a substitute father. A band of young people, a sports group, a religious community, a group of mutual help are as many sisters and brothers in the same condition. By protecting the young, the group provides him or her with a social basis, helps them to build up their identity and mental health and becomes their chosen family. His or her social ties fulfil many educational and socializational functions. The biological parents

[27] The social parenthood includes adult relationships as a whole that matter for an individual, his kinship « from the heart » whether symbolic or spiritual. It is made of chosen relationships depending on a privileged harmony. The individual may resort to it to face the ordinary needs of his life. See Maurice Godelier's remarks about this (*Métamorphoses de la parenté,* Fayard, 2004) and Michel Agier (*L'invention de la ville : banlieues, townships, invasions et favelas*, Archives contemporaines, 1999).

go on providing for his or her basic needs while the 'pals' (for example) are becoming more and more important in their life.
The more reduced their biological and social family, the more precarious is the youths' and the family's situation. Making the relationships with the extended family and the communities to which they belong easier, or adjusting them and trying to find privileged bonds among the "social" family of the young are the many easy interventions which may strengthen them significantly. There are multiple useful devices to allow people to fill up their social family: tenants associations, community or family centres, sports clubs or other socializing spaces which help the lonely persons to establish new relationships.
In a situation of parental inadequacy, the preventive approach proposes sharing parenthood. The parents are allowed to fulfil some parental functions or some aspects of passing on whilst the community also gives its contribution. A school, a day nursery, an uncle, a neighbour; these may partly take over. Developing the social kinship of the young allows these surrogates to diversify support and their references knowing that social taboos will have to be overcome in order to protect the children and relieve parents whose parental abilities are altered.

The transdisciplinary approaches
Elaborating a common preventive culture requires the organization and the support of thematic networks, interdisciplinary workshops and continuous crosswise trainings. Here are many means of fighting against the isolation of the professional workers helping them to share their difficulties and their resources. Sharing experiences, know-how and knowledge allows them to give better adapted answers to complex issues.
All these plans will play a growing part since the initial trainings still overlook the new social issues (risk-taking behaviours, violence resulting from exclusion, straying on the streets, etc.) and the new developments in the participative and collective methodologies for prevention (recognition process and empowerment[28], local social development, systemic approaches and actions at community level). The cross-sector trainings in this context contribute to establish a dialog, ties of trust and a common culture about how to tackle the problems.
It is essential to set an offer of social ties that are permanent when you support people. Unstable young usually experience repeated breaks, comings and goings between the different structures and their support framework is fragmented. Such meetings leave a trail which also teaches something; even if not recognized as such on the spot, they are milestones on the path of development.
Step by step, by trial and error, from breaks to reconciliation, the young "start moving". Their path is never straight; they experience ups and downs. One has to last at applying preventive actions, to rely on the time factor, not to walk out on people even if one does not get their immediate adherence. The ties-(re)building processes are slow; they take time and require permanence, whereas the issue about the stability of the substitutes and the social teams arises as far as many prevention projects are concerned. "*How do we build permanent things out of temporary things?*" is a question that many social workers ask themselves.

[28] Any approach based on the empowerment (recovering the power over one's life) is based upon the belief that the people – individually as well as collectively – possess the abilities (or are able to develop them) to gain access to – and control the resources they need for their well-being.

References

Agier, M., *L'invention de la ville : banlieues, townships, invasions et favelas*, Archives contemporaines, 1999.

Azocar, B ., Dorvillius E., Eschevaria P ., Jamoulle P., Joubert M, Serrano S. « Conduites à risques. Vivre, risquer, vibrer. Penser et agir en prévention », *Proximités*, juin 2007.

Baeten, I. & Rosiers, J. (2003). Alcohol- en druggebruik in de Bijzondere jeugdzorg. Vragen over aanpak en begeleiding 2002. Brussel: VAD.

Beaud, S., Pialoux, M., *Violences urbaines, violences sociale*, Paris, 2003.

Bouhnik, P., *Toxicos. Le goût et la peine*, La Découverte, 2007.

Bourgois, Ph. , *En quête de respect, le crack à New York*, Seuil, 2001 (1995).

Coolen, C., Koninckx, M. & Bijtebier, P (2002). Hulpverlening aan kinderen van alcoholisten. Gezinnen onder invloed – invloedrijke gezinnen. Brussel: VAD.

De Donder, E., Rosiers, J. & Van Den Berghe, E (2003). Thuis in vrije tijd. Een verkennend onderzoek over preventie van alcohol-en drugproblemen in jeugdwerkingen met maatschappelijk achtergestelde jongeren. Brussel: VAD.

Furtos, J., Laval, Ch. (dir), *La santé mentale en actes. De la clinique au politique*, Erès, 2006.

Furtos, J., « Contexte de précarité et souffrance psychique : quelques particularités de la clinique psychosociale », *Soins Psychiatrie*, n°204.

Godelier, M., *Métamorphoses de la parenté,* Fayard, 2004.

Jamoulle, P., *Des hommes sur le fil. La construction des identités masculines en milieux précaires*, La Découverte, Paris, 2005.

Jamoulle, P., *La débrouille des familles. Récits de vies traversés par les drogues et les conduites à risques*, De Boeck, 2002.

Jamoulle, P., *Drogues de rue, récits et styles de vie,* De Boeck, 2000.

Jamoulle, P., « *Les conduites liées aux drogues dans les zones de précarité*. Enquête de terrain auprès de professionnels »**,** *Psychotropes*, vol 2, n°3-4, 2001, p.11 à 29.

Joubert, M., Giraux-Arcella, P. (dir.), *Villes et Toxicomanies. De La connaissance à la prévention*, Eres, 2005.

Joubert, M. (dir.), Santé mentale, ville et violences, Eres, 2003.

Maurin, E., *Le Ghetto français. Enquête sur le séparatisme social*, Seuil, 2004.

Moro, M.-R., *Enfants d'ici venus d'ailleurs*, Hachette littérature/La Découverte 2002.

Paugam, S., *La disqualification sociale*, PUF, 1991.

Perrin, N. (2005). Evolutie van het aantal vreemdelingen in België. Gedownload op 3 september op http://www.diversiteit.be/NR/rdonlyres/33DF55F7-DE68-4F16-856C-F30CD587915B/0/NPevolutieaantalvreemdelingen2.pdf

Sauvadet, T., *Le capital guerrier. Concurrences et solidarité entre jeunes de cité*, Armand Colin, 2006.

Steunpunt Algemeen Welzijnswerk (2007). CAW monitor 2006. Berchem: Steunpunt Algemeen Welzijnswerk

Studiedienst van de Vlaamse Regering (2006). VRIND 2006. Gent: F-Twee uitgeverij

Van Havere, T. (2006). Partwise. Kwantitatief onderzoek naar trends in druggebruik in het uitgaansleven – 2005. Brussel: VAD

PART C. Bibliography, annexes

BIBLIOGRAPHY

Administratie Planning en Statistiek (2005). VRIND 2006, Vlaamse Regionale Indicatoren, Sociaal-Culturele context, APS, Brussel.

Administratie Planning en Statistiek (2006). VRIND 2007, Vlaamse Regionale Indicatoren, Sociaal-Culturele context, APS, Brussel.

Autrement (2005). Rapport annuel 2004.

Bayingana K, Demarest S, Gisle L, Hesse E, Miermans PJ, Tafforeau J, Van der Heyden J. (2006). Enquête de Santé par Interview, Belgique, 2004. Institut Scientifique de Santé Publique, Bruxelles.

Beutels, M., Van Damme, P., Aelvoet, W., Desmyter, J., Dondeyne, F., Goilav, C. et al. (1997). Prevalence of hepatitis A, B and C in the Flemish population. Eur. J. Epid., 13, 275-280.

Blanken, P., Hendriks, V., Fahrner, E.M., Gsellhofer, B., Kufner, H., Hartgers, C., Kokkevi, A., Pozzi, G., Tempesta, E., Uchtenhagen, A.. (1995). EuropASI Adattamento Europeo dello Addiction Severity Index, Boll. Farmacodip. e Alcol., XVIII, 2, 7-45.

Buy, S. (2005). Les stupéfiants: situation du phénomène dans l'arrondissement administratif de Bruxelles-Capitale 2002-2004. Police Fédérale, SCA, Bruxelles.

Calle, P.A., Damen, J., De Paepe, P., Monsieurs, K.G. & Buylaert, W.A. (2006). A survey on alcohol and illicit drug abuse among emergency departments patients. Acta Clinica Belgica. 61-4.

Casselman, J., Kinable, H.(2007). Het gebruik van illegale drugs. Multidimensionaal bekeken.VAD-UGA, Kortrijk-Heule.

Collectif (2005). Réduction des risques et testing de pilules: Etat des lieux en Communauté française. Carnet du risque N°45. Modus Vivendi, Bruxelles.

Colpaert, K., and De Clercq, T. (2003). Implementing the "Treatment Demand Indicator" in Belgium: registration of drug users in treatment. IPH/IHE REPORTS Nr. 2003-018. Scientific Institute of Public Health, Epidemiology Unit, Brussels.

Colpaert, K., Vanderplasschen, W., Van Hal, G.& Broekaert, E. (2005). Gedeelde Cliënten, gedeelde zorgen?! De alcohol- en drughulpverlening in de provincie Antwerpen in kaart. Orthopedagogische Reeks N°20, Universiteit Gent, Gent.

Crombé, C. (2006). Stedenfondsverslag 2006: Antwerpen: SODA.

Currie, C., Roberts, C., Morgan, A., Smith, R., Settebulte, W., Samdal, O., and Barenekow Rasmussen, V. (2004). Young people's health in context. Health Behaviour in School-aged Children (HBSC) study: international report from the 2001/2002 survey. Health Policy for Children and Adolescents, 4, 1-248.

De Bock, M. (2004). Groepswerkingter ondersteuning van ouders met druggebruikende kinderen: Grood, eenleidraad voor begeleiders. VAD-berichten, 3, 7-9.

de Bruijn, L, Smits, D. (2002). Drugverslaafden met jonge kinderen. Draaiboek voor opvoedingsondersteuning bij drugverslaafde ouders in een ambulante setting. VAD, Brussel.

De Cuyper, R. (2003). Een pragmatisch en patiëntgericht zorgtraject voor dubbele diagnose-patiënten (psychose-toxicomanie). Sleidingen.

De Ruyver, B., Pelc, I., De Greave, D., Bucquoye, A., Cornelis, L. & Nicaise, P. (2007). Drugs in Cijfers II. Studie naar de betrokken actoren en bereikte doelgroepen. Academia Press: Gent.

Deblaere, P. (2003). Drogues et sécurité routière: conduite sous influence, l'approche belge.

Decorte, T. (2005). Ecstasy in Vlaanderen. Een multidisciplinaire kijk op synthetische drugs. Acco, Leuven.

Decorte, T., Kaminski, D., Muys, M. et al. (2005). Problematisch gebruik van (illegale) drugs : onderzoek naar de operationalisering van het concept in een wettelijke context : eindrapport - L'usage problématique de drogues (illégales) : recherche concernant l'opérationnalisation du concept dans un contexte légal : rapport final . Academia Press, Gent.

Derluyn, I., Vanderplasschen, W. & Broekaert, E. (2000). Drugverslaafden met jonge kinderen. Een exploratief onderzoek naar modellen en opvoedingsondersteunende methodieken bij de hulpverlening aan drugverslaafde ouders met jonge kinderen. VAD, Brussel.

Derluyn, I., Calle, D., Vanderplasschen, W. & Broekhaert, E. (2002). Drugverslaafde ouders met jonge kinderen. Concept- en methodiekontwikkeling voor opvoedingsondersteuning in de residentiële setting. VAD, Brussel.

EMCDDA, Pompidou group. (2000). EMCDDA Scientific Report.Treatment demand indicator, Standard protocol 2.0. EMCDDA, Lisbon.

EOS Gallup Europe (2004). Young people and drugs. Flash Eurobarometer 158, Brussels.

Espace P (2006). Evaluation du programme de vaccination gratuite contre l'Hépatite B, Espace P 1998-2005.

Evenepoel, T. (2005a). Informeren en sensibiliseren in het uitgaansleven: Campagnes als exponent van een globaal preventieconcept (VAD-De DrugLijn). in T. Decorte: Ecstasy in Vlaanderen. Een multidisciplinaire kijk op synthetische drug. Acco, Leuven.

Evenepoel, T. (2005b). Jaarverslag de DrugLijn, 2004. VAD, Brussel.

Federal Police (2003). Action Plan "Road safety action plan" Results after 5 months. Press release, Brussels.

Follon, M. (2003). STEM: Een stem voor thuisloze druggebruikers in Limburg. Een onderzoek naar de noden en behoeften van Limburgse thuisloze druggebruikers. CAD Limburg, Hasselt.

Fonds des Affections Respiratoires asbl. (2007). Registre de la tuberculose 2005. FARES asbl, Bruxelles.

Hariga F.(2000). Recherche –Action Dour 1999; Carnet du risque n°30. Modus Vivendi, Bruxelles.

Hariga F., Van Huyck C., Leclercq D., Allart M. Demez R.(2004). Equipe mobile de réduction des risques en milieu festif: Eléments d'évaluation - juin 2002 – sept. 2004; Carnet du risque N°44.. Modus Vivendi, Bruxelles.

Hariga, F. (1999). Rapport Boule de Neige 98. Modus Vivendi, Bruxelles.

Hariga, F., Przyluki, L., Van Lierde, J. (2002). CESC : Echange de seringues à Charleroi. Evaluation de la 1ère année d'activités. Carnet du risque n°40, Modus Vivendi, Bruxelles.

Hariga, F., Przyluki, L., Van Lierde, J. (2003). CESC : Dispositif d'échange de seringues à Charleroi : 2ème année d'activités. Carnet du risque n°43, Modus Vivendi, Bruxelles.

Hariga, F., Van Huyck, C., Lazarou, A. (1999). Rapport de recherche action Dour 1998. Modus Vivendi - Carnet du risque N°16. Bruxelles.

Hibell, B., Andersson, B., Bjarnasson, T., Ahlström, S., Alakireva, O., Kokkevi, A., Morgan, M. (Eds.), (2004) . The ESPAD Report 2003. Alcohol and Other Drug Use Among Students in 35 European Countries.The Swedish Council for information on Alcohol and Other Drugs (CAN), Council of Europe, Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (Pompidou Group),

Jamoulle, P. (2005). Des hommes sur le fil, La constitution de l'identité masculine en milieu précaire. La Découverte, Paris.

Jeanmart C. (2005). Des usagers de drogues et des familles. Analyse de trajectoires de recours en territoire transfrontalier franco-belge. Cnrs-Clersé-Ifrési, Lille.

Jossels G, Govarts E, Roelands M. (2007). Drug-Related Deaths - Flanders & Brussels, 1998-2004. Scientific Institute of Public Health, Brussels.

Kinable, H (2006). Bevraging van Vlaamse leerlingen in het kader van een Drugbeleid Op School. Summary report school year 2004-2005. Vereniging voor Alcohol- en andere Drugproblemen: Brussel.

Ledoux Y. (2005). Evaluation de la délivrance de méthadone en Belgique : rapport final. Academia Press, Gent.

Liesse, A., Piron, V., Rwubusisi, M., Hariga, F., Bastin, Ph., Dal, M. (2006). L'usage des drogues en Communauté française. Rapport Communauté française 2004-2005. Eurotox asbl, Bruxelles.

Lombaert, G. (2005). Risico- en protectieve factoren in verband met middelengebruik. Onderzoek bij 14- tot 18-jarige scholieren in de provincies West-Vlaanderen, Oost-Vlaanderen en Zeeland. (Risk factors and protective factors related to drug use. Study in 14 to 18 year old pupils in the provinces West-Vlaanderen, Oost-Vlaanderen and Zeeland.) Gent, De Sleutel, Department of Research and Quality Assurance.

M.E.G.A., dossier moniteur, BCR, programme Drogues-Prévention, 1998.

Maison d'Accueil Socio-Sanitaire (M.A.S.S.) de Bruxelles asbl. (2005). Rapport d'activités 2004 [online]. Available : http://www.mass-bxl.be/documents/RapportActicit%E92004.pdf

Matheï, C., Robaeys, G., Van Damme, P., Buntinx, F., Verrando, R. (2005a). Prevalence of hepatitis C in drug users in Flanders: determinants and geographic differences. Epidemiol Infect., 133(1), 127-136.

Matheï, C., Robayes, G., Van Ranst, M., Van Damme, P., Buntinx, F. (2005b). The epidemiology of hepatitis C among injecting drug users in Belgium. Acta Gastro-Enterologica Belgica, vol 68 (1): 50-54.

Mattick RP, Kimber J, Breen C, Davoli M. (2003). Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database of Systematic Reviews 2002, Issue 4.

Mendonck, K., Van Menxel, G. (2006). Tellus cliëntregistratie 2005, Berchem, Steunpunt Algemeen Welzijnswerk.

Mendonck, K., Van Menxel, G. (2007). Tellus cliëntregistratie 2006, Berchem, Steunpunt Algemeen Welzijnswerk.

Mignolet, D., Thys, P., Debu, B., Myncke, R., Vandekerckhove, B., Bernard, N., Van Ruymbeke, M. (2007). Habitat solidaire. Etude sur les possibilités de reconnaissance de l'habitat groupé pour les personnes en précarité sociale [online]. Available :http://www.politiquedesgrandesvilles.be/content/what/expertise development/knowledge-production/researches/07-0627_def-habitat_solidaire_fr.pdf

Ministère de la Communauté française, Direction Générale de la santé (2004). Programme quinquennal de la promotion de la santé 2004-2008, Bruxelles.

Modus Vivendi. (2007). Progress Report 2006.

Observatoire de la Santé du Hainaut. (2006). Tableau de bord de la santé 2006 [online]. Available :http://www.hainaut.be/sante/observatoiresante/publications/medias/Tableau_de_bord%20_de_%20la_%20sante_du_Hainaut_%202006_Full.pdf

Phenix (2005). Rapport annuel 2004.

Piette, D., Parent, F., Coppieters, Y. et al. (2003). La santé et le bien-être des jeunes d'âge scolaire. Quoi de neuf depuis 1994 ? Comportements et modes de vie des jeunes scolarisés et des jeunes en décrochage scolaire en Communauté française de Belgique de 1986 à 2002. Université Libre de Bruxelles: Ecole de Santé Publique, PROMES.

Plasschaert S, Ameye L, De Clercq T, et al. (2005). Study on HCV, HBV and HIV seroprevalence in a sample of drug users in contact with treatment centres or in prisons in Belgium, 2004-2005. Scientific Institute of Public Health, Brussels.

Police Fédérale (2004). Plan National de sécurité 2004-2007. Police Fédérale, Bruxelles.

Police Fédérale (2007). Rapport d'activités 2006 de la Police Fédérale [online]. Available : http://polfed-fedpol.be/pub/jaarverslag/pub_jaarverslag2006_fr.php

Ponsaers, P., De Ruyver, B., Lemaître, A., Macquet, C., Pieters, T., Vaerewyck, et al. (2005). Nuisances liées à la drogue dans le contexte local de huit communes wallonnes et flamandes: Vers un Moniteur de politique intégrée locale en matière de drogues. Academia Press, Gand.

Preumont, C., Bils, L. (2000). Evolution des données relatives à l'indicateur 'Demandes de traitement' pour les usagers de drogues illicites de 1993 à 1998 en Communauté française de Belgique. CCAD, Bruxelles.

Raes V., Tomás-Rosselló J. (2005) Monitoring treatment Outcome. EuropASI and TDI. Paper presented at 2005 Annual expert meeting of the Treatment Demand Indicator, EMCDDA, 22-23 september 2005

Raes, V., & Lombaert, G. (2004). Jaarverslag 2003. EFQM: focus op de zorgprocessen. De Sleutel, Dienst Wetenschappelijk Onderzoek en Kwaliteitszorg, Gent.

Raes, V., Lombaert, G. (2002). Jaarverslag 2001: een evaluatie volgens EFQM. Jaarverslagen. De Sleutel. De Sleutel, Merelbeke.

Raes, V., Lombaert, G. (2003). Jaarverslag 2002, Een evaluatie volgens EFQM. De Sleutel, Merelbeke.

Robaeys, G., Bottieau, E., Bourgeois, S., Brenard, R., Buntinx, F., Colle, I., De Bie, J., Matheï, C., Mulkay, J.P., Van Damme, P., Van Ranst, M., Verrando, R., Michielsen, P. (2005). Guidelines for the management of chronic hepatitis C in patients infected after substance use [online]. Available : http://www.basl.be/doc/HepC_Tox_guidelines.doc

Roelands, M., Govarts, E., Liesse, A., Raes, V., Van Deun, P., Witpas, A. (2007). Estimates of Problem Drug Use in Belgium based on treatment demand data. Presentation at the expert meeting on Problem Drug Use at the European Monitoring Centre on Drugs and Drug Addiction, October 11, Lisbon.

Rombouts, D. (2002). Druggebruik & Zwangerschap. Een praktische gids voor hulpverleners. Bubbels & Babbels, Antwerpen.

Rosiers, J. (2005a). Preventie van alcohol- en andere drugproblemen. Monitoring van activiteiten. Rapport 2004. VAD, Brussel.

Rosiers, J. (2005b). Ginger: vijf jaar alcohol- en drugpreventie in Vlaanderen. Monitoring van activiteiten 1999-2003. VAD, Brussel.

Rosiers, J. (2006). Ginger. Preventie van alcohol- en andere drugproblemen. Monitoring van activiteiten. Rapport 2005. VAD: Brussel

Sasse, A., Defraye, A. (2004). Epidémiologie du sida et de l'infection à VIH en Belgique. Situation au 31 décembre 2003. Institut Scientifique de la Santé Publique, EPI Report 2004-23, Bruxelles.

Scheers, M., Verstraete, A., Adriaensen, M., Raes, E., Tant, M. et al. (2006). Rijden onder invloed van psychoactieve stoffen. Academia Press, Gent.

Sesame (2005). Rapport annuel 2004.

Sleiman, S., Roelands, M. (2007). Belgian national report on drugs 2006. Scientific Institute of Public Health, Brussels.

SPF Justice (2007). Justice en chiffres 2007, Bruxelles.

SSMG-Réseau ALTO. (2005).Projets relatifs aux données statistiques. Rapport d'activités. Période de subvention du 1er avril 2004 au 31 mars 2005 [online]. Available : http://www.ssmg.be/new/files/IMP_Toxico_StatEffAlto.pdf

Stöver, H., Hennebel, L., Casselman, J. (2004). Substitution treatment in European prisons. Cranstoun drug services, London.

Todts, S., 'The Believe treatment program: effects on reoffending', Studiedag PSD, gevangenis Brugge, 8 september 2006.

Todts, S., Hariga, F., Pozza, M., Leclercq, D., Glibert, P., Micalessi, M.I. (2007). Usage de drogues dans les prisons belges. Monitoring des risques sanitaires 2006. Rapport final.

VAD (2007). Leerlingenbevraging, schooljaar 2005-2006. VAD, Brussel.

Van den Bogaerde, E., Van den Steen, I., Marchand, P.(2006). Veiligheidsmonitor 2006. Tabellenrapport, Federale Politie - Directie van de nationale gegevensbank, Brussel, 2007.

Van Der Biest, E., Walckiers, D. (2004). Early warning system on drugs at public health level in Belgium. Progress report, IPH EPI report n° 13, Brussels.

Van Havere, T. (2003). EWS map: Early Warning System, de informatiesnelweg tussen u en ons. VAD, Brussel.

Van Havere, T. (2004). Partwise. Kwantitatief onderzoek naar trends in druggebruik in het uitgaansleven - 2003. Brussel: VAD

Van Havere, T. (2006). Partywise: Kwantitatief onderzoek naar trends in druggebruik in het uitgaansleven - 2005. Brussel: VAD.

Van Huyck C., Hariga F. (2001). Recherche-Action sur la pertinence d'une intervention de réduction des risques dans les lieux de sorties bruxellois. Carnet du risque N°35. Modus Vivendi, Bruxelles.

Van Tichelt, K., Canfyn, M., Govaerts, C., Lenaerts, K., Piette, V., Parmentier, F. (2005). Δ^9-THC- concentraties in cannabis in 2003 en 2004, Wetenschappelijk Instituut Volksgezondheid, Brussel.

Vander Laenen, F. (2004). De Nieuwe Ministeriële Omzendbrief voor druggebruikers. Het vervolgingsbeleid laat er zich niet door leiden. Panopticon 25.

Vander Laenen, F., Dhont, F. (2003). Zalven en slaan. Een eerste analyse van de nieuwe drugwetgeving, Tijdschrift voor Strafrecht, 227 – 245.

Vander Laenen, F., Dhont, F. (2005). 'De vernietiging van artikel 16 van de Wet van 3 mei 2003 tot wijziging van de Drugwet van 24 februari 1921, Kroniek van een aangekondigde vernietiging'. Tijdschrift voor Strafrecht, jrg. 6, 1, p. 36-43.

Vanhyfte, C. (2005). Evoluties en tendensen op Belgische drugmarkt: Georganiseerde criminaliteit en drugtrafiek in 2004, Drugnews extra, n°9, Federale Politie, Brussel.

Vermeiren, R., Schwab-Stone, M., Deboutte, D., Leckman, P.E., Ruchkin, V. (2003). Violence exposure and substance use in adolescents: findings from three countries. Pediatrics, 111, 535-540.

Vlaamse Regering, Ministerie van Welzijn, Volksgezondheid en Gezin (2004). Beleidingsnota van Vlaams minister van Welzijn, Volksgezondheid en Gezin, 2004-2009.

Windelinckx, T. (2005). Evaluatie Onderzoek Spuitenruil Vlaanderen 2004. Free Clinic, Antwerpen.

Windelinckx, T. (2006). Evaluatie Onderzoek Spuitenruil Vlaanderen 2005. Free Clinic, Antwerpen.

Windelinckx, T. (2007). Evaluatie Onderzoek Spuitenruil Vlaanderen 2006. Free Clinic, Antwerpen.

Legislation References

Full texts may be found at the following web site (except when mentioned): http://just.fgov.be

- Koninklijk besluit (K.B.) **17 januari 2005** tot toekenning van financiële hulp aan bepaalde steden en gemeenten in het kader van een overeenkomst betreffende de preventie van druggerelateerde maatschappelijke overlast en de lokale coördinatie van initiatieven inzake drugverslaving, *B.S.*, 11 februari 2005, 4863-4865.
Arrêté royal (A.R.) 17 janvier 2005 accordant une aide financière à certaines villes et communes dans le cadre d'une convention relative à la prévention des nuisances sociales liées aux drogues et à la coordination locale des initiatives développées en matière de toxicomanie, *M.B.*, 11 février 2005, 4863-4865.

- Besluit **7 maart 2006** van de Regering tot vaststelling van de krachtlijnen inzake gezondheidspromotie voor de jaren 2006 en 2007, *B.S.*, 2 augustus 2006, 37620-37624.
Arrêté 7 mars 2006 du Gouvernement fixant les lignes de force en matière de promotion de la santé pour les années 2006 et 2007, *M.B.*, 2 août 2006, 37615-37619.

- Wet **20 juli 2006** houdende diverse bepalingen, *B.S.*, 28 juli 2006, 36940-37011.
Loi 20 juillet 2006 portant des dispositions diverses, *M.B.*, 28 juillet 2006, 36940-37011.

- K.B. **6 oktober 2006** tot wijziging van het koninklijk besluit van 19 maart 2004 tot reglementering van de behandeling met vervangingsmiddelen, *B.S.*, 21 november 2006, 62152-62155.
A.R. 6 octobre 2006 modifiant l'arrêté royal du 19 mars 2004 réglementant le traitement de substitution, *B.S.*, 21 novembre 2006, 62152-62155.

- K.B. **17 oktober 2006** tot wijziging van het koninklijk besluit van 29 juni 2003 betreffende het informeren van Belgisch Focal Point van het Europees informatienetwerk over drugs en drugverslaving, *B.S.*, 13 december 2006, 69305-69306.
A.R. 17 octobre 2006 modifiant l'arrêté royal du 29 juin 2003 relatif à la transmission d'information au Point focal belge du réseau européen d'information sur les drogues et les toxicomanies, *M.B.*, 13 décembre 2006, 69305-69306.

- K.B. **22 oktober 2006** tot wijziging van het koninklijk besluit van 22 januari 1998 houdende regeling van sommige psychotrope stoffen en betreffende risicobeperking en therapeutisch advies, *B.S.*, 6 december 2006, 67909-67910.
A.R. 22 octobre 2006 modifiant l'arrêté royal de 22 janvier 1998 réglementant certaines substances psychotropes et relatif à la réduction des risques et à l'avis thérapeutiques, *M.B.*, 6 décembre 2006, 67909-67910.

- Besluit **8 november 2006** van de Secretaris-generaal houdende de vaststelling van de lijst van verboden substanties en middelen, *B.S.*, 29 december 2006, 76189-76195.

- K.B. **7 december 2006** betreffende de strategische veiligheids- en preventieplannen, *B.S.*, 22 december 2006, 73821-73824.
A.R. 7 décembre 2006 relatif aux plans stratégiques de sécurité et de prévention, *M.B.*, 22 décembre 2006, 73821-73824.

- K.B. **28 december 2006** tot vaststelling van de nadere regels voor subsidiëring door het Fonds tot bestrijding van de verslavingen, *B.S.*, 09 februari 2007, 6523-6524.
A.R. 28 décembre 2006 fixant les modalités d'attribution du Fonds de lutte contre les assuétudes, M.B., 09 février 2007, 6523-6524.

- Ministerieel Besluit (M.B.) **15 januari 2007** betreffende de invoering van de strategische veiligheids- en preventieplannen 2007-2010, *B.S.*, 30 maart 2007, 18720-18758.
Arrêté Ministériel (A.M.) 15 janvier 2007 relatif à l'introduction des plans stratégiques de sécurité et de prévention 2007-2010, *M.B.*, 30 mars 2007, 18720-18758.

- M.B. **15 januari 2007** betreffende de invoering van de strategische veiligheids- en preventieplannen 2007-2010 - Erratum, *B.S.*, 7 mei 2007, 24148.
A.M. 15 janvier 2007 relatif à l'introduction des plans stratégiques de sécurité et de prévention 2007-2010 - Erratum, *M.B.*, 7 mai 2007, 24148.

- K.B. **9 april 2007** tot bepaling van de toekennings-, aanwendings- en controlevoorwaarden van de financiële toelage van de steden en gemeenten die begunstigde zijn van een strategisch veiligheids- en preventieplan, *B.S.*, 7 mei 2007, 24050-24076.
A.R. 9 avril 2007 déterminant les modalités d'octroi, d'utilisation et de contrôle de l'allocation financière des villes et communes bénéficiaires d'un plan stratégique de sécurité et de prévention, *M.B.*, 7 mai 2007, 24050-24076.

- Omzendbrief **23 mei 2007** ter verduidelijking van artikel 11 van het ministerieel besluit betreffende de invoering van de strategische veiligheids- en preventieplannen 2007-2010, *B.S.*, 11 juni 2007, 31540-34542.
Circulaire 23 mai 2007 explicative de l'article 11 de l'arrêté ministériel relatif à l'introduction des plans stratégiques de sécurité et de prévention 2007-2010, *M.B.*, 11 juin 2007, 31540-31542.

DATA BASES -WEBSITES

DATA BASES

Belgian Senate
http://www.senat.be

Moniteur Belge, Belgisch Staatsblad.
http://www.just.fgov.be/index_fr.htm

National Institute of statistics
http://www.statbel.fgov.be

FEDRA Federal Research Actions
http://www.belspo.be/belspo/fedra/pres_fr.stm

COFRAREF Publications of the Belgian French Community
http://www.cfwb.be/cofraref/

WEB SITES

Belgian Government
http://www.fgov.be

De Sleutel
http://www.desleutel.be

ESPAD
http://www.espad.org

European Institutions
http://www.europa.eu.int

Eurotox
http://www.eurotox.org/

Ghent University
http://www.UGent.be

HBSC
http://www.hbsc.org/

Federal Public Service Home Affairs
http://www.ibz.fgov.be

Federal Public Service Justice
http://www.just.fgov.be

Federal Public Service Public Health, Food Chain Safety and Environment.
http://www.minsoc.fgov.be

Federal Science Policy Office
http://www.belspo.be

Fedito Bruxelloise et Wallone
http://www.fedito.be

Flemish Institute for Health Promotion
http://www.vig.be

French Community-Health Department
http://www.cfwb.be/sante/index.html

Health Council
http://www.health.fgov.be/CSH_HGR/index.html

INAMI / RIZIV
http://www.riziv.fgov.be
http://www.inami.fgov.be

Infor Drogues
http://www.infor-drogues.be

Modus Vivendi
http://www.modusvivendi-be.org

MPG/ RPM
http://www.luc.ac.be/mpg/fr/Default.htm

Prospective Jeunesse
http://www.prospective-jeunesse.be

Scientific Institute of Public Health
http://www.iph.fgov.be/epidemio/drugs

Université Libre de Bruxelles
http://www.ulb.ac.be

Université de Liège
http://www.ulg.ac.be

University of Antwerpen
http://www.ufsia.ac.be/

University of Leuven
http://www.kuleuven.ac.be

Vereniging voor Alcohol- en andere Drugproblemen
http://www.vad.be

ANNEX 1 LIST OF STANDARD TABLES AND STRUCTURED QUESTIONNAIRES

Standard tables used:

02 (2007), 09 (2007), 11 (2007), 13 (2007), 14 (2007), 16 (2007), 19 (2007).

Structured questionnaire used:

23 (2004)).

ANNEX 2 LIST OF TABLES

ANNEX 3 LIST OF FIGURES

ANNEX 4 LIST OF ABBREVIATIONS

ALTO	Alternatives aux Toxicomanies
APES	Appui en Promotion et Education pour la Santé
ASBL	Association Sans But Lucratif (non-profit organisation)
ASL	Arbeitsgemeinschaft für Suchtvorbeugung und Lebensbewältigung
BASL	Belgian Association for the Study of the Liver
BELSPO	Belgian Science Policy
BIRN	Belgian Information REITOX Network
CAD	Centrum voor Alcohol- en andere Drugproblemen (Hasselt)
CAW	Centra voor Algemeen Welzijnswerk
CCAD	Comité de Concertation sur l'Alcool et les autres Drogues
CLPS	Centre Liégeois de Promotion de la Santé
COCOF	Commission Communautaire Française *(Communauté française à Bruxelles)*
CPAS/OCMW	Centre Public d'Aide Sociale / Openbaar Centrum voor Maatschappelijk Welzijn
CTB/ODB	Concertation Toxicomanies Bruxelles / Overleg Druggebruik Brussel
CFWB	Communauté française Wallonie Bruxelles
DIIS	Direction Interdépartementale d'Intégration Sociale
EDDRA	Exchange On Drug Demand Reduction Action
EFRO	European Funding for Regional Development
EFT	Entreprises de Formation par le Travail
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESPAD	European School Survey Project on Alcohol and Other Drugs
EuropASI	Europ Addiction Severity Index
EWS	Early Warning System
FARES	Fondation contre les Affections Respiratoires et pour l'Education à la Santé
FEDITO	Fédération Bruxelloise Francophone des Institutions pour Toxicomanes
FOREM	Services d'Information sur l'Emploi et la Formation
HBSC	Health Behaviour in School-aged Children
IHP	Initiative d'Habitations Protégées
INAMI/RIZIV	Institut National d'Assurance Maladie-Invalidité/RijksInstituut voor Ziekte- en Invaliditeitsverzekering
IPH/ISP/WIV	Scientific Institute of Public Health/ Institut Scientifique de la Santé Publique/ Wetenshappelijk Institut Volksgezondheid
IDU(s)	Intra-Venous Drug Use(rs)
IST/STI	Infection Sexuellement Transmissible/Sexually Transmitted Infection
MASS/MSOC	Maison d'Accueil Socio-Sanitaire / Medisch-Sociale Opvang Centra
MKG/RCM	Minimale Klinish Gegevens / Résumé Clinique Minimal
MPD/MPG/RPM	Minimum Psychiatric Data /Minimale Psychiatrische Gegevens / Résumé psychiatrique Minimal
MSP	Maison de Soin Psychiatrique
NICC /INCC	National Instituut voor Criminalistiek en Criminologie/ Institut National de Criminalistique et de Criminologie
ONE	Office de la Naissance et de l'Enfance
ONEM/RVA	Office National de l'Emploi/Rijksdienst Voor Arbeidsvoorziening
OISP	Organisme d'Insertion Socio- Professionnelle
OSH	Observatoire de la Santé du Hainaut
PDU	Problem Drug Use
PMS	Centres Psycho-Médico-Social
PPP	Plans de Prévention de Proximité
PSE	Promotion de la Santé à l'Ecole
PSI	Plans Sociaux Intégrés
REITOX	Réseau Européen d'Information sur les drogues et Toxicomanies / European information network on drugs and drug addictions
SAJ	Service d'Aide à la Jeunesse
SODA	Stedelijk Overleg Drugs – Antwerpen

SPJ	Service Provincial de la Jeunesse
SPZ	Sozial Psychologisches Zentrum
TBC	Tuberculosis
ULB	Université Libre de Bruxelles
UNDCP	United Nations International Drug Control Programme
ULG	Université de Liège
VAD	Vereniging voor Alcohol en andere Drug problemen
VDAB	Vlaamse Dienst voor Beroepsopleiding en arbeidsbemiddeling / Flemish Service for Employment Mediation
VRGT	Vlaamse Vereniging voor Respiratoire Gezondheidszorg en Tuberculosebestrijding
VRIND	Vlaamse Regionale Indicatoren
VUB	Vrije Universiteit Brussel
VVBV	Vlaamse Vereniging voor Behandelingscentra in de Verslaafdenzorg