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BELGIAN NATIONAL REPORT ON DRUGS 2013

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

Els Plettinckx | Jérôme Antoine | Peter Blanckaert | Johan C. H. van Bussel

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Belgian national report

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Els Plettinckx

Jérôme Antoine

Peter Blanckaert

Johan C.H. van Bussel

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Summary

Drug policy: legislation, strategies and economic analysis

The Belgian drug policy focussed in 2012 and the first semester of 2013 mainly on the control of new psychoactive substances (NPS). Firstly, a Royal Decree was published which added 15 NPS to the list of controlled substances in Belgium. Secondly, a bill to adapt the Belgian Drug Law of 1921 is discussed during the same period in parliament. In this bill, the Belgian legislator has opted for a generic criminalization of the NPS. The Bill includes a provision that the conditions and regulations of the information exchange will be regulated in detail in a Royal Decree. This Royal Decree will include, amongst others, the obligation for laboratories and for experts to send their information (anonymous data regarding the composition and the use of substances) to the Belgian Early Warning System on Drugs (BEWSD) in an automated way. A final element of the Bill is the criminalization of the preparatory actions in the case of drug production and drug trafficking. An other interesting development is the preparation of a new Royal Decree on opioid substitution treatment (OST) to avoid medical shopping as well as to map the prescriptions and characteristics of OST clients. In addition to these legal developments, the Belgian federal government developed a 1) new global and integrated national alcohol policy and 2) a national action plan for an integrated HIV policy. In Flanders, a steering group was set up to prepare the transfer of some of the competences related to the drug policy from the federal to the federate levels in the framework of the 6th state reform.

Drug use in the general population and sub-groups

In 2011, two school surveys including questions on cannabis use, were conducted in Belgium. One survey was conducted in the Flemish community and one in the German speaking community. Both studies indicate that about one third of the oldest school students used cannabis at least once in their lives. Higher lifetime prevalences of cannabis use were found in students following art education programmes and students with an apprenticeship compared to students of general, technical or professional educational programmes. The lifetime prevalence of substance use other than cannabis among the oldest school students in the Flemish community was 5.5% for amphetamines, 5.2% for ecstasy, 5.1% for cocaine and 1.0% for heroin. Research in the nightlife scene indicates a slightly different picture with the highest last year prevalence in the Flemish community for cannabis (32.4%), followed by ecstasy (16.8%), cocaine (13.6%), and amphetamines (8.1%). In the French community, however, the respondents are asked about the last month use. The results confirm the popularity of cannabis

use at first place (35.8%) with amphetamines at the second place (8.8%), followed by cocaine (5.8%).

Prevention

Most of the regulations and activities reported last year are still used in drug prevention. Universal prevention has been strongly encouraged during the past few years in primary and secondary schools as well as in higher education. Teachers in secondary schools of the Flemish community are supported by 'De Sleutel' in order to implement drug prevention programmes in classrooms, using the European programme "Unplugged". The number of contacts (telephone + e-mails) in both the Flemish and the French community increased in 2012. In order to reach more younger people, the 'Druglijn' launched an online chat service. Beside this, also online self-tests and self-help tools were created on their website. Most of the selective prevention projects, targeting at-risk groups, families and settings, were continued in 2012. In November 2012, the first Quality Night event in the Flemish community was organised by the association for alcohol and other drug problems (VAD) and 'Modus Vivendi' at 'I Love Techno'. Since 2012, mental health centre 'Eclipse' coordinates the project 'Mighties' in the framework of Early intervention. This project aims to develop an interactive psycho-educational tool. During the year 2012, five different campaigns were organised in order to adjust perceptions about and raise the awareness of drinking alcohol during adolescence, the use of cannabis among minors (between 15 and 18years old), being a child of substance abusing parents and substance use during pregnancy.

Problem drug use

The average age of injecting drug users in contact with syringe exchange programmes is increasing. The vast majority of the participants reported non-concurrent polydrug use. Opiates were the primary injected drug of choice (44.9%), followed by stimulant drugs (36.0%) and drug cocktails (18.7%). Injecting cocaine use and smoking freebase cocaine is increasing. In total, 15% of the participants in a syringe exchange programme reported to have had at least one drug overdose the last year. Another indication of problem drug use (PDU) is daily substance use. The survey within the party scene in the French community shows that 3.8% of the respondents injected at least once in their lives, 1.8% injected during the last month and 0.9% injected during the event. The survey within the party scene in the Flemish community reveals that 6.6% of the respondents use cannabis on a daily basis. Daily use of ecstasy (0.0%), amphetamine (0.3%), cocaine (0.7%) and heroin (0.2%) are much lower.

Drug-related treatment: treatment demand and treatment availability

A total number of 6004 clients entered treatment in 2012. 29.1% of these clients started a treatment for the first time in their life. 40.0% of the clients were registered in outpatient centres, 37.6% in inpatient centres and 22.4% in low-threshold agencies. The main illicit substances for which clients went into treatment were opiates (in 33.4% of the treatment demands) and cannabis (32.5%). The frequency of drug use often differs. The percentage of clients who have ever injected one substance is high among opiates users (42.0%) whereas this prevalence amounts to 17.0% for stimulant users, 9.0% for users of hypnotics and 4.0% for cannabis users. 17351 clients were registered in the OST database in 2011. 12.0% of the clients was receiving buprenorphine and 88.0% methadone.

Health correlates and consequences

A percentage of 0.5% of the persons newly diagnosed with HIV are probably attributable to injecting drug use. Additionally, a specific study about infectious diseases (hepatitis C (HCV), hepatitis B (HBV) and HIV) was conducted in 2011-2012 among current injecting drug users (IDUs). The results show a HCV prevalence of 43.3%; a HBV prevalence of 3.7% and a HIV prevalence of 2.3% among the participants who injected during the last 12 months. In 2012, the incidence rate of tuberculosis (TBC) has decreased to 8.9 registered cases per 100,000 persons years, which is the lowest incidence rate since 2001. The majority of IDUs reporting about their risk behaviour indicated not having shared injecting equipment with someone else during the last four weeks. Nevertheless, 42.3% of the respondents are still sharing needles and syringes. The Belgian national poison centre received 216 enquiries about intoxications related to illicit substance use during 2012. The majority (25.0%) of the intoxications were related to cannabis and their derivatives, 18.5% to cocaine and 13.9% to amphetamine, speed and central nervous system (CNS) stimulants. A decrease of psychiatric comorbidity of patients entering treatment facilities of ‘De Sleutel’ in the Flemish community is noted in 2012. Nevertheless, psychiatric comorbidity is still very common (48.6%) among illicit substance users. The first Belgian drug-related infectious diseases (DRID) study gives more detailed information about the correlation between dependency and psychiatric disorders. A strong correlation can be noted between opioid dependence on the one hand and generalized anxiety disorder and attention deficit disorder on the other hand. In 2009, 127 drug-induced deaths were observed in Belgium of which 68 in the Flemish region, 19 in Brussels and 40 in the Walloon region.

Responses to health correlates and consequences

In 2012, 3,500 admissions were registered for the pilot project for the crisis intervention and case management of clients with a joint substance use and mental health crisis. In order to monitor high-risk substances, NPS and to prevent (lethal) intoxications, toxicological laboratories are obliged to provide the results of toxicological analyses to the BEWSD. In 2012, 16 “official” warnings were sent by the BEWSD to the network to give information about amongst others NPS, casualties caused by 4-Methylamphetamine (4-MA), high dosed MDMA tablets or MDMA tablets containing piperazines. The needle exchange programmes in Belgium have a recuperation rate of 99.9% in the Flemish Community and 86.5% in the French Community. This is an increase compared to last year. Nevertheless, an evaluation study in the Flemish community revealed that 14.8% of the IDUs dispose their injecting equipment in an unsafe manner. As a consequence, efforts to stress the importance of syringe recuperation stay important.

Social correlates and social reintegration, the Brussels low-threshold case

Social exclusion among clients visiting the low-threshold drug services in Brussels is very common. The availability of housing in Brussels is very low. Consequently, 21.0% to 30.0% of the clients visiting low-threshold centres (project Lama and MSOC/MASS Brussels) are living in an unstable housing situation. As health insurance can only be attributed to people with a fixed address, 9.0% to 29.0% of the clients do not have access to health insurance. Only a very low percentage of the clients is working on a regular basis (21.0% to 24.0%). The proportion of people receiving a salary is as consequence low (4.0% to 17.0%). The proportion of clients with a high education level is similar (5.0% to 17.0%). A large proportion (25.0% to 55.0%) of clients in the low-threshold centres have already been in prison as well.

A survey carried out among homeless people visiting emergency shelters in Brussels showed that one third of them have a problematic consumption pattern of (il)licit substances. Specific efforts to support drug users in Brussels in finding housing and earning money are offered by ‘Transit’, ‘Lama’ and ‘Modus Vivendi’. Transit has a shelter centre with 21 beds with a mean length stay of 13 days. The centre has also 8 studio flats. These flats are rented at low prices and must be linked with a reinsertion and rehousing planning. The housing project "Hestia" of Lama makes 6 apartments available that are rentable for 1 year. Modus Vivendi allows marginalized drug users to have access to paid work by recruiting them for prevention activities.

As 5.0% of the clients who are visiting the low-threshold drug services in Brussels are registered in another treatment centre, the psycho-social workers are supporting the mobile psycho-social teams in order to reconnect the drug user to the health care network.

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

The federal police registered 35031 drug law offences in 2012. 69.8% of the drug law offences were related to the use and possession of drugs. 69.9% of these drug law offences are related to cannabis, 7.6% to (meth)amphetamine, 2.9% to ecstasy, 6.3% to heroin and 9.8% to cocaine or crack. 86.6% of all blood samples collected by the local and federal police in the framework of driving under the influence of drugs, were analysed by National Institute for Criminalistics and Criminology (NICC) in 2012. In 55.6% of the cases cannabis was involved, in 22.1% of the cases amphetamine, in 19.2% of the cases cocaine and in 4.8% of the cases opiates. A global increase of new mandates of alternative sanctions in relation to drug law offences is noted. Nevertheless, a slight decrease is found for the years 2011 and 2012. Probation stays the alternative measure with the highest number of new mandates each year. 4.5% of all cases entering the prosecution system of first line courts in 2012 is drug or doping related. The majority of these cases are leaving the prosecution system without consequence. When court level attended to drug and medication related cases in 2011, only 615 drug and medication related cases were suspended. The drug and medication related sentences have increased slightly, whereas the drug and medication related suspensions have decreased over the last seven years. Moreover, one out of four incarcerations is due to a drug-related offence. The PhD-study on the effect of detention on patterns of legal and illegal drug use of dr. Vandam indicates that illegal drug use is common in prison, since illegal substances are easily available and highly visible. 60.0% of all respondents used illegal substances during the past three months of their detention. 43.0% of all respondents indicates polydrug use. 2.0% of all respondents injected sporadically illegal drugs during detention.

Drug markets

The Belgian federal police reported 34862 seizures in 2012. The majority of all seizures were again related to cannabis (72.5%). 12.9% was related to cannabis resin, 56.4% was related to herbal cannabis and 3.2% was related to cannabis plants. The mini-plantations (6-49 plants) continue to rise. 9.6% of the seizures were related to cocaine, 7.6% to (meth)amphetamine, 5.6% to heroin and 2.9% to ecstasy. Most illicit amphetamine laboratories in Belgium have switched from using BMK as precursor to alphaphenylacetoacetonitrile (APAAN) as pre-precursor. Two APAAN conversion labs, as well as one ecstasy lab, two GHB labs, one lab for

the creation of tablets and one lab for the production of legal highs, have been seized and shut down in 2012. The average prices for 1 gram of cannabis (herbal or resin) varied between €9 and €10. The average price of one gram of heroine is about €28. The average price of cocaine varied between €50 and €60 and for speed between €8 and €11. The average price of one ecstasy tablet in Belgium was around €5. Prices for LSD remained stable in the French community (€8), but decreased in the Flemish community to €3 per trip. Average THC levels of 13.7% for herbal cannabis and 17.2% for cannabis resin were reported. A lot of the speed on the Belgian market was contaminated with 4-MA in 2012, which brings the average purity at 19.4%. An ecstasy tablet contained on average 86mg MDMA base. However, highly-dosed tablets (containing > 130mg MDMA) were frequently reported. The reported average purity for MDMA powder was 61.3% and for cocaine 59.1%. The average heroin concentration was only 13.3%.

Note

As this publication is designed for online use, references to specific websites are made by using hyperlinks. You only have to click on the part of the sentence where the cursor ( ) changes into .

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

Chapter 1: Drug policy: legislation, strategy and economic analysis

Vander Laenen F. & De Ruyver B.

1. Introduction

In 2012 and 2013, the implementation of the Common Declaration of January 25th of 2010 of the Inter-ministerial Conference (B.S./M.B. 15.04.2010) continued.

In this Common Declaration, the integral and integrated Belgian drug policy is grounded and institutionalized (Federal Government 2001). This concept is the core of the Belgian drug policy. The global and integrated drug policy is based upon the following pillars: 1) prevention; 2) early detection and early intervention; 3) treatment (including risk reduction for problem drug users) and 4) repression for producers and traffickers.

The development of the Belgian drug policy is executed in close cooperation with the people in the work field, i.e. the bottom-up approach (which has been one of the strong characteristics of the Belgian drug policy (De Ruyver, Vander Laenen and Eelen 2012)), and it is supported, as much as possible, by objective data. These data are, among others, collected and provided by scientific research activities.

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

2. Legal framework

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

A Royal Decree on new psychoactive substances is published

On April 12th, 2013, a new Royal Decree regarding NPS was published. It modifies article 2 of the Royal Decree of January 22nd of 1998 to regulate certain psychotropic substances enabling Belgium to organise the control of these substances, from their production, over the import and export up and until their use. This new Royal Decree adds 15 NPS to the list of controlled substances in Belgium. Several synthetic cannabinoids (a.o. 5F-UR-144), 4-

methylamphetamine (4-MA) and 5-IT are included. These fifteen products are substances that are currently not being controlled by the international UN-drug conventions.

A Bill to adapt the Belgian Drug law of 1921 is discussed in parliament

The goal of this Bill is to criminalize the illegal production of and trafficking in the so-called NPS. In 2012, 71 NPS were reported in Belgium. Since 2005, the Belgian Early Warning System on drugs (BEWSD) notified the EMCDDA about 47 NPS. These numbers illustrate the important position of Belgium in the supply side of NPS in Europe. Based on this situation, the Belgian Minister of Public Health requested the General Drugs Policy Cell to prepare a strategic note. This note was approved by the Inter-ministerial Conference on May 15th of 2012 who instructed the preparation of a Bill to change the Belgian Drug law of 1921.

The Bill was approved by the Belgian Council of Ministers on April 26st of 2013 and submitted for discussion in the collective commissions for justice and public health of the Belgian Parliament. The aim is to submit and vote the new law in Parliament before the end of 2013.

The Bill opts for a change in the Belgian Drug law with regard to NPS because the existing law falls short with regard to these substances. The existing legal framework does not differentiate between different substances that are being developed for the market and that require criminalization. Moreover, the drug law does not succeed to keep pace with the development of NPS in the field. By the time an individual substance is prohibited, the producers have already slightly changed the molecular structure of the substance, without changing its chemical basic structure. As a result, the Drug law needs to be updated once more (and the process continues ad infinitum).

To stop this inefficient legal situation, the Belgian legislator has opted for a generic criminalization of the NPS. The details of this criminalisation will be outlined in a Royal Decree. The provisions in the Royal Decree will allow for the criminalization of individual substances and of groups of substances with a partially common structure.

This criminalisation is accompanied by a transparent exchange-of-information system on the substances that circulate on the market, including NPS. With regard to the latter, the Bill includes a provision that the conditions and regulations of the information exchange will be regulated in detail in a Royal Decree. This Royal Decree will include, amongst others, the obligation for laboratories and for experts to send their information (anonymous data regarding the composition and the use of substances) to the BEWSD in an automated way. A new

element is that the obligation will be extended to the results of analyses that are part of a judicial investigation, which is information that - at present - falls under the secrecy of the investigation.

A third and final element of the Bill is the criminalization of the preparatory actions, i.e. the materials and techniques used, in the case of drug production and drug trafficking. This part of the Bill will target synthetic drugs as well as cannabis production. With regard to cannabis production, the Bill wants to tackle the activities and methods used to increase both the quantity and the quality of the cannabis production process and to shield the production from the outside world and thus from detection by law enforcement.

A new Royal Decree on opioid substitution treatment is prepared

Currently, two Royal Decrees determine the conditions of opioid substitution treatment (OST) in Belgium. In 2004, a Royal Decree on OST was adopted in order to implement the law of 2002. In 2006 a Royal Decree was adopted modifying to a large extent the 2004 Royal Decree on OST. In 2009, a workgroup was being assigned under the guidance of the Federal Agency of Medication and Health Products (FAMHP) in order to conduct an evaluation of the different aspects of the Royal Decree as well as to develop recommendations for its improved implementation. In 2010, the General Drugs Policy Cell stressed the importance of the development of a registration system to avoid medical shopping as well as to map the prescriptions and characteristics of OST clients.

In 2011, the current Minister of Public Health and Social Affairs ordered the development of a new Royal Decree. The FAMHP and the Federal Public Service Health developed a proposal for this decree with guidelines for the treatment with substitute drugs taking into account the outcomes of the scientific research ‘Analysis and optimization of OST in Belgium’ (Vander Laenen et al. 2013). The new Royal Decree, which will replace the Royal Decrees of 2004 and 2006, is to be operational by the Spring of 2014.

3. National action plan, strategy, evaluation and coordination

3.1. National action plan and/or strategy

The development of a global and integrated national alcohol policy

In January of 2001, the Belgian federal government approved the first federal policy note on drugs in the Belgian political history. This policy note focused on illicit drugs, although attention was paid to alcohol as well in particular in the actions relating to substance use prevention and to driving under the influence of substances.

In 2008 the Health Ministers signed a joint declaration concerning a National Alcohol Action Plan (NAAP) (2008-2011). In December of 2012, the 2008 declaration was expanded and updated. One of the main reasons for this update is the concept of a global and integrated policy concerning the harmful use of alcohol. The Inter-ministerial Conference Drugs, consisting of Ministers with a broad range of authorities from both the federal and the federate level, compiled a draft of a NAAP 2014-2018 (General Policy Cell Drugs 2013). This policy must encompass aspects such as economy, publicity, price, education and employment.

The mission of the NAAP 2014-2018 is to reduce the harmful use of alcohol in Belgium.

The future NAAP takes the Global strategy of the World Health Organisation (WHO) to reduce the harmful use of alcohol (2010) and the European action plan to reduce the harmful use of alcohol 2012-2020 (2011) as a starting point. The NAAP is structured around the same ten activity domains as the Global strategy. These domains are 1) leadership, awareness and commitment; 2) Health services' response; 3) Community action; 4) Drink-driving policies and countermeasures; 5) Availability of alcohol; 6) Marketing of alcoholic beverages; 7) Pricing policies; 8) Reducing the negative consequences of drinking and alcohol intoxication; 9) Reducing the public health impact of illicit alcohol and informally produced alcohol and 10) Monitoring and surveillance.

In June of 2013, a draft version of the NAAP with 28 policy measures was available on the website of the Federal Public Service of Health, Food Chain Safety and Environment. Different stakeholders as well as the general public had one month to comment on the measures in order to broaden the (community) support for the policy outlined in the draft Action Plan. Moreover, the draft Action Plan is reviewed by three academic international experts (Dr. Lars Møller, WHO; Prof. Dr. Jürgen Rehm, Centre for Addiction and Mental Health; Prof. Dr. Peter Anderson, Institute of Health and Society, Newcastle University).

The final version of the NAAP will be signed by all Ministers of the Inter-ministerial Conference Drugs in December 2013.

In view of the fact that the use of illicit drugs together with alcohol has been frequently established (EMCDDA 2009), from a health perspective, an integration of the Belgian alcohol and illicit drug policy (plans) is a policy option that is worth investing in (Vander Laenen 2012).

A national action plan for an integrated HIV policy

In September of 2012, the Health Ministers initiated the development of a national HIV-action plan 2014-2019. This action plan was developed in close cooperation with the experts from the field (from Belgium as well as from UNAIDS).

The three general aims of the action plan are 1) to limit the number of new HIV infections; 2) to stimulate access to prevention, screening, treatment and 3) to reduce all forms of stigma and discrimination.

Throughout the report, (intravenous) drug users are identified as one of the target groups for the national HIV-policy. Moreover, harm reduction strategies for drug users are identified as one of the most important strategies to limit the risks associated with drug use.

The actions 21 to 26 of the plan are focussed on intravenous drug users. Action 22 for instance stresses the need for improving access to needles and prevention material and for the establishment of drug consumption rooms. Action 24 is aimed at developing a comprehensive legal framework with regard to public health and risk reduction for drug users. The actions 27 to 31 discuss actions towards prisoners. Worth noting here is action 29, aimed at reducing the stigmatisation of drug using prisoners.

In October of 2013, this plan was signed by the competent Ministers of the Inter-ministerial Conference Public Health and presented by the Belgian Minister of Public Health.

The recent development of a national HIV-plan presents the opportunity to – further – develop an integrated policy. It is positive to see that the link with (intravenous) drug use is clearly made throughout the HIV action plan (WHO, UNODC and UNAIDS 2012). In the long(er) term, it would be worthwhile investing in a national global health oriented policy plan, consisting of a framework with overarching goals, working principles and actions, and of targeted actions (for specific targets groups or goals).

The 6th state reform

The 6th state reform in Belgium, which is in full preparation in 2012 and 2013, will transfer some of the competences with regard to drug policy from the federal level to the federated levels. Important actors from the specialised drug treatment field will become part of the competences of the federate levels (the low threshold medical social treatment centres, day care centres, crisis intervention centres and therapeutic communities, to name the most important drug specific actors).

In Flanders, a steering group was set up to prepare this transition. An extended report was compiled with an overview of the current situation. All initiatives in the field of prevention, early intervention, treatment, harm reduction for alcohol and drugs were listed. Their aims, capacity and financial regulations were described. The overview resulted in a number of constraints and priority concerns for the near future. In addition, the work field developed alternative roads to a new Flemish Addiction approach. Two options were described in a so-called 'Green paper' regarding the position of the drug addiction work field after the transition to the federated levels: on the one hand, an integration of the drug addiction work field within the mental health sector and on the other hand an option in which the addiction field remains a separate entity, as is - for the most part - the case today, that continues to cooperate with many different actors in society involved in drug policy (mental health and health departments, justice and police, education, work force, youth work, welfare sector, etc.). The Green paper was presented to the Flemish minister of Health and will be integrated in a global so-called Green book that outlines the options for a comprehensive state reform in 2014.

In view of these important shifts in drug-related competences and the preparations accompanying these changes, new political and policy initiatives by the federate levels are deferred.

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

3.2.1. Federal level

In 2013, the Belgian Federal Science Policy Office initiated a call for proposal for scientific studies, to further execute the Common Declaration of January 25th of 2011. This call included four topics for which research proposals could be submitted: 1) Social cost of licit and illicit drugs in Belgium; 2) Consensus building on minimum quality standards, and standards of excellence, in illicit drug demand reduction; 3) Threat of illegal cannabis plants for the population in general and intervention personnel in particular; 4) Non-thematic project in support of the integral and integrated drug strategy in Belgium (topic to be decided on by the research team). By the end of 2013, the studies that are selected, based upon on international scientific review, will be notified. The execution of the studies will start in the beginning of 2014.

3.2.2 Federate level

The Flemish Working Group on tobacco, alcohol and drugs is an advisory body to the Flemish minister of Health. In 2012, the group formulated an advice on the organisation of an early intervention for drug problems in Flanders. A discussion paper was prepared concerning the prevention approach towards people with a low socio-economic status. This paper was translated into a list of priority at-risk target groups for prevention. The advisory group also prepared a document on the effects of price setting for alcohol and tobacco.

As a continuing goal, the working group monitors the execution of the Flemish Action Plan on tobacco, alcohol and drugs.

4. Economic analysis

In 2011, the public expenditure for both licit and illicit drugs was studied in the framework of the research project ‘Drugs in figures III’ (Vander Laenen, De Ruyver, Christiaens and Lievens 2011), the measurement concerned the public expenditures for the year 2008. This scientific study also developed a scenario, allowing the federal, regional and local authorities to estimate their drug-related public expenditures. The manual describes which methodological steps have to be taken for data collection and processing. This instrument allows to monitor the Belgian drug policy in the future.

Following this study, the federal and federate governments reached in 2012 an agreement to analyse the public expenditures on drugs on a yearly basis. The data collection and analysis is coordinated by the Federal Public Service Health, Food chain safety and Environment. In

September 2013, the data analysis for the period of 2012 was not available yet. So far, the budget for pilot projects financed by the Federal Department of health for 2012 (table 1.1.) and the for the projects by the Federal Addiction Fund for 2012 (table 1.2.) can be presented.

Table 1.1. Budget pilot projects financed by the Federal department of health, €, Belgium, 2012

Pilot Project	Budget (€)
Project 'coordination and care'	374,177
Project 'crisis intervention units and case-management'	3,469,023
Evaluation of the project 'medically controlled supply of diacetylmorphine (TADAM)'	Scientific evaluation (296,742.0 (15.05.2011 until 15.05.2012) ; 276,506.1 (16.05.2012 until 30.09.2013) Treatment (940,400)
Project 'dual diagnosis'	917,976

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

Table 1.2. Budget funded projects by Federal Addiction Fund, €, Belgium, 2012

Institution	Title of the project	Budget (€)
CHU BRUGMANN	Evaluation, prise en charge et soutien à la prise en charge des adolescents souffrant d'une assuétude: approche familiale multi dimensionnelle (INCANT)	120,000.0
CAD Limburg	alcoholhulp.be + cannabishulp.be	123,500.0
Centre ALFA	Jeunes et consommation	54,950.0
Interstices CHU St Pierre	Projet Liaison Alcools	72,000.0
Comptoir	Consultations médicales gratuites et dispensaire de soins infirmiers pour usagers de drogues	43,180.0
De Kiem	Implementatie van een cocainespecifiek behandelingsprogramma CRA + vouchers	94,131.0
DE KIEM	Ambulante hulp aan drugverslaafden binnen de regelgeving van Alternatieve Gerechtelijke Maatregelen, proefzorg en drugsbehandelingskamer	36.609,0
DE SLEUTEL	Versterken van kwantiteit en kwaliteit in de preventie, vroegdetectie en hulpverlening	69,205.0
D.U.N.E.	Renfort de l'offre de soins du comptoir d'échange de seringues et travail de rue de Bruxelles-Capitale	72,000.0
Ellipse	CASA : Projet d' accompagnement à domicile de personnes souffrant ou ayant souffert d'assuétude(s)	75,930.0
IDA	Projet national d'information et sensibilisation : -16 pas d'alcool	72,809.0
IDA	Intervention spécifique sur les problèmes d'alcool dans les services des urgences	79,530.0

IDA	IDA-web: uitbreding van vlaams en ontwerp van franstalig interactive platform voor professionelen en intermediairen	25,200.0
MASS Bxl- Fédasil	Projet de collaboration FEDASIL et LAMA - M.A.S.S. - Interstices C.H.U. Saint-Pierre	59,599.0
Interstices Bruxelles	Bruxelles-cannabis … Vers la formation d'un réseau spécialisé	43,300.0
KOMPAS	Crisishulp aan huis	62,603.0
LA CAHO asbl	Implémentation d'un projet de sevrage à domicile de personnes alcoolo-dépendantes	140,500.0
LES PETITS RIENS	Synersanté	130,000.0
MSOC Gent	Opvang van opiaatafhankelijken in de eerstelijnsgezondheidszorg	49,455.0
MSOC Gent	Klinisch Casemanagement en intervisie voor hulpverleners voor drugverslaafde zwangeren en drugverslaafde ouders met jonge kinderen	40,005.0
MSOC OOSTENDE	Outreachende, geïntegreerde en pro-actieve begeleiding van drugafhankelijke ouders met jonge kinderen via A(ssertive) C(ommunity) T(reatment)	79,950.0
Het Verhuis-Siddartha (MSOC Vlaams Brabant	Opvoedingsondersteuning aan druggebruikende ouders en hun kinderen in Vlaams-Brabant en deskundigheidsbevordering van de laagdrempelige hulpverlening aan druggebruikende ouders en hun kinderen in Vlaanderen	66,447.0
NAMUR ENTRAIDE SIDA	Développement d'un pôle infirmier et médical dans le comptoir l'Echange	67,190.0
PopovGGZ	Optimalisatie van de zorg voor mensen met een verstandelijke beperking en een verslavingsprobleem	74,880.0
Psychiatrisch Centrum OLV	Psychiatrische thuisbegeleiding voor jongeren (16-35j) met een psychotische stoornis in combinatie met middelenmisbruik (alcohol, drugs)	52,805.0
Réseau Hépatite C	Accompagnateur social au profit de l'asbl Réseau Hépatite C – Bruxelles	21,776.0
PZ Sint Camillus	Projectvoorstel intensieve outreach voor het opvolgen van personen met een alcoholafhankelijkheid	110,788.8
ULB & Collaborateur (5 partenaires)	Benzodiazépines : Formations de médecins généralistes et d'autres intervenants de santé	78,475.0
VAD	Kwaliteitsbevordering in de verslavingszorg	46,852.6
VAD	Vroeginterventie door middel van groepswerking met jongeren die riskant of beginnend problematisch gebruiken	96,500.0
BOGOLAN	Projet d'accompagnement des parents usagers de drogues vers le lieu de vie de leur enfant	38,640.0
CAD LIMBURG EN CGG KEMPEN	Online drughulp (online hulpverlening met cocaine, speed, ecstasy, GHB)	60,500.0
CGG ECLIPS	Mighties :ontwikkelen van concrete psycho-educatiev methodieken en materialen toepasbarr in vroeginterventie en jongerendrughulpverlening	53,820.0
FREE CLINIC	DokA-jongerenproject Antwerpen : ontwikkeling van een brief motivational interventions-model met artsenconsultatie voor risicojongeren en middelengebruik binnen een laagdrempelig in looppunt	111,692.0

HOPITAL NEURO_PSY SAINT MARTIN	Prise en charge globale et intégrée à visée de réinsertion de jeunes adultes présentant un double diagnostic d'assuétudes et de comorbidités psychiatriques	134,500.0
IPSA-APB-SSPF	Sensibiliseren en opleiden van apothekers over geneesmiddelen en alcoholconsumptie en hen motiveren hun patienten hiervover aan te spreken	98,058.5
PELICAN	Site internet d'aide en ligne pour personnes alcooliques et leur entourage: information et programme d'accompagnement thérapeutique en ligne avec ou sans thérapeute	175,000.0
OCMW ANTWERPEN	Netwerk Herstel Antwerpen	49,250.0
TRANSIT LAMA	Table ronde autour d'une scène ouverte	60,000.0
VAD	Materiaalontwikkeling modulair aanbod motiverende gesprekvoering	56,510.0

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

Acknowledgements

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

van Bussel, JCH., Dedonder, E. & Déjoze, M.

1. Introduction

In Belgium, there is no recurring general population survey specifically dedicated to drugs and drug use. General population data on drug use is mostly derived from the Belgian Health Interview Survey (BHIS), the Belgian branch of the European health interview survey initiative (EHIS) launched by Eurostat. The BHIS covers a broad range of health topics such as health status, life style, prevention, medical consumption, etc. (Brunekreef et al. 1989;Demarest et al. 2001;Van der Heyden et al. 2010a;Van der Heyden et al. 2010b). As a result, only a few questions on substance use are included in the BHIS. At the request of the Belgian Federal Science Policy Office (BELSPO), Decorte and colleagues investigated the feasibility of a recurring survey on drug use in the Belgian general population (Decorte et al. 2009). Based on this report, the research and scientific information sub-cell of the General Cell Drugs Policy has set the implementation of a recurring national population survey on drugs and drug misuse as one of its priorities.

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

In this chapter, we describe the results of two recent school surveys (the school survey of the association for alcohol and other drug problems (VAD) - VAD Leerlingenbevraging; and a cannabis survey in the German speaking community) and two surveys in the party scene (the VAD Research in nightlife settings and the “Drogues Risquer Moins” project coordinated by Modus Vivendi).

2. Drug use in the general population

The most recent results of the BHIS with a self-completion module on psychoactive substance use are those of the 2008 wave (Gisle 2010a; Gisle 2010b; Van der Heyden, Gisle, Demarest, Drieskens, Hesse, and Tafforeau 2010a; Van der Heyden, Gisle, Demarest, Drieskens, Hesse, and Tafforeau 2010b). The results of this national general population survey (N= 11026 for the drugs section; 15-64y) are described in detail in the 2011 Belgian Annual Report (Deprez et al.

2012). In 2013, the Scientific Institute of Public Health (IPH) implemented the data collection of the next wave of the BHIS. Different from previous waves, the 2013 BHIS used the Computer-assisted personal interviewing (CAPI) method for the face to face part of the questionnaire, although drug use is still surveyed with the self-completed part. The questionnaire still contains the substance related items of the 2008 survey, being 1) the lifetime, last year and last month cannabis use; 2) frequency of last month cannabis use; 3) the age of first time cannabis use and 4) the last year use of cocaine, amphetamines, ecstasy, LSD, heroin, methadone, buprenorphine and legal highs. Results of the 2013 BHIS are expected in the second half of 2014.

Noteworthy is that the prevalences found in general population surveys, such as the BHIS, are probably underestimated (especially for drugs other than cannabis) (Degenhardt and Hall 2012). Marginalized people (homeless, prisoners, institutionalized persons) are excluded from the sample because invitations to participate to the study are send to households by surface mail (Van der Heyden, Gisle, Demarest, Drieskens, Hesse, and Tafforeau 2010a; Van der Heyden, Gisle, Demarest, Drieskens, Hesse, and Tafforeau 2010b). It is also highly likely that "hard" or “severe” users do not accept to receive the interviewer and/or do not take the time to complete the questionnaire.

3. Drug use in the school and youth population

3.1. Drug use among Belgian school students

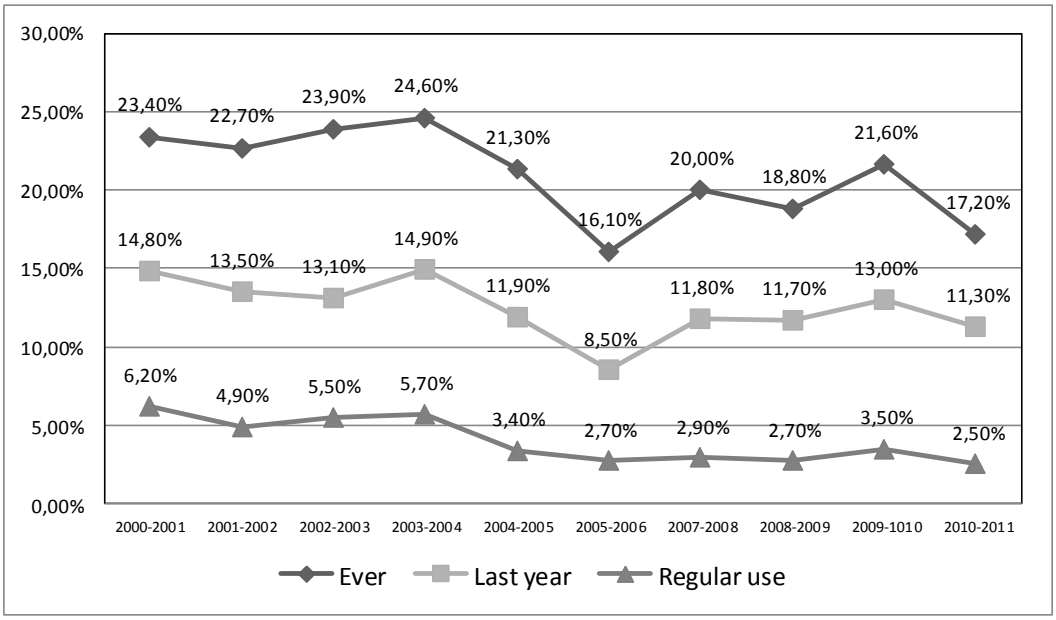
In Belgium, several large-scale surveys (using self-completion questionnaires) are conducted among school students of the Flemish and French Community. The Health Behaviour in School-aged Children survey (HBSC) is conducted every 4/5 years (1985/86, 1989/90, 1993/94, 1997/98, 2001/02, 2005/06) (Favresse and de Smet 2008; Godin et al. 2008; Hublet et al. 2006). The European School Survey Project on Alcohol and other Drugs (ESPAD) was conducted in 2003. The Flemish School Survey Project on Alcohol and other Drugs (VLASPAD: Vlaams schoolonderzoeksproject naar alcohol en andere drugs) was conducted in 2007 and 2010, (Lambrecht et al. 2004) and the school survey of the VAD is conducted on an annual basis among Flemish school students since 2000/01 (Kinable 2011).

As for the most recent school year 2010-2011, only the survey of the VAD was conducted (Melis 2013). In total, 25,301 students from 48 schools were contacted in this survey. Out of this group, a sample of 7,320 students was selected.

3.1.1. Cannabis

The prevalence found for cannabis use in the 2011 VAD school survey confirm the trend found in previous Belgian studies (Godin et al. 2011; Kinable 2011; Lambrecht and Andries 2013; Lombaert 2011). The study shows that more than one third (35.8%) of the oldest school students (17-18y) used cannabis at least once in their lives. About one fifth (22.9%) of this age group also used cannabis during the last 12 months. Both the lifetime and the last year prevalence are about 10 times higher compared to those found in the youngest age group (12-13y). Overall, a slight decline in the use of cannabis in the school population was found since 2000-2001. Since 2005-2006, ever and last year cannabis use is increasing again slightly. However, there is a stabilization of regular use to around 3.0%. (See Figure 2.1).

Figure 2.1. Ever, last year and regular use of cannabis in school students, %, Flemish community, Belgium, 2000-2011



Source: Melis, 2013

The mean age at which school students used cannabis for the first time was 15 years. Interestingly, higher prevalence (except for the daily use of cannabis) of cannabis use were found in students following art education programmes compared to students of general, technical or professional educational programmes. Students of professional education programmes indicated a higher prevalence (2.0% vs. 1.0%) of daily cannabis use.

The most frequently reported reasons to use cannabis were “sociability”, “relaxation”, and “curiosity”. Important reasons not to use cannabis were: 1) “don’t need it”; 2) “cannabis is dangerous”; 3) “it is unhealthy” (Melis 2013).

In addition to the above mentioned recurring large scale school surveys, an interesting school survey on cannabis use was conducted in the German speaking community (Déjoze 2011). The survey covered eleven of the twelve secondary schools of the German speaking community in Belgium. The target group of this survey consisted of 398 students of the 4th to the 6th grade of general, technical and professional orientation as well as students of the 1st up to the 3rd degree within an apprenticeship. The cannabis consumption as well as the degree of knowledge of this substance has been measured.

The study shows that 30.0% of the students had at least consumed once in their lifetime cannabis. Noteworthy are the very big differences related to the type of education programmes: the prevalence in the “classical” education (general, technical and professional) is 27.0% while it is 39.1% among the students with an apprenticeship. Two hypotheses aim to explain these results. The first one draws our attention to the amount of time physically spent in class. While one group goes to school on a daily basis (general, technical and professional education), the other one just spends 2 days a week at school (education within an apprenticeship). The second hypothesis directs our attention to the fact that only the apprentices (except student-jobs) get a salary.

The “once in a lifetime” prevalence is higher among boys (37.0%) than among girls (21.5%). The study also shows a statistically significant difference between the more urban northern region of the German speaking Community (Eupen) and the more rural southern region (Sankt-Vith). The respective prevalence’s are 38.4% and 24.9%. 83.7% of the experimental consumers, pretend having discovered cannabis with a friend and 66.0% of the students affirm knowing someone that consumes this drug. The reasons for first consumption are “curiosity”, "to chill” and “for the fun”.

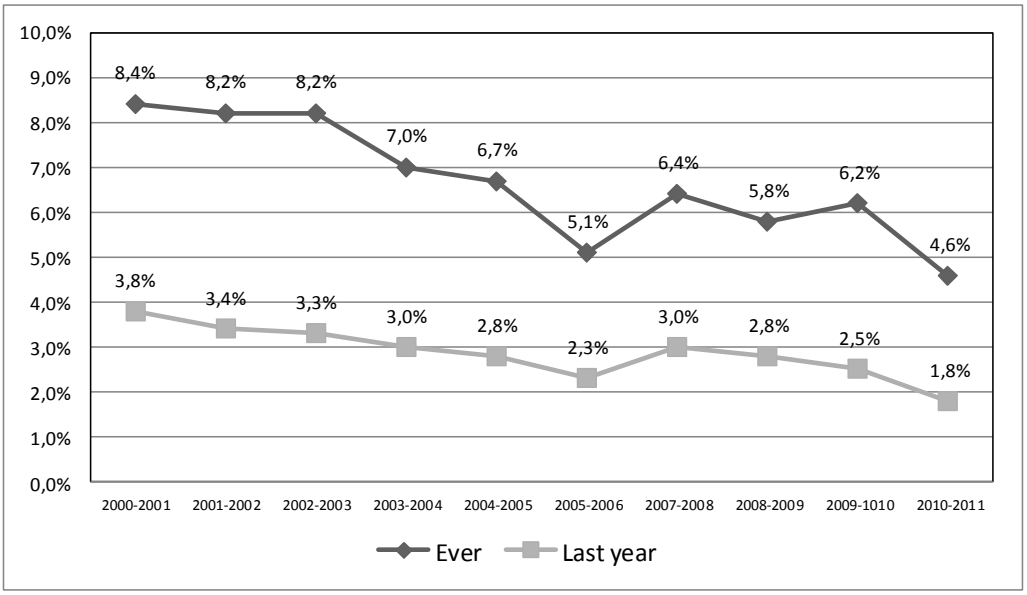
What’s really interesting is that students agree that cannabis consumption can have a negative influence on school performance, their personality, motivation (in general), sleeping rhythm and love life. Nevertheless, they imagine these consequences happen only at regular or daily consumption.

Finally, it was noticed that the students seem to know little about the drug law (except that the consumption is illegal for minors). It is important to notice that 57.0% of the students don't know where to learn more about it. The most often cited source is the web. To get a better idea how the students think about cannabis, the authors of the survey asked their opinion about legalizing cannabis. The result was that 76.0% spoke against legalization. However, when they asked the same question and proposed answers modulated with neutralization techniques (Sykes and Matza, 1957), only 58.8 % were against it. Just by being confronted to this new formulation of the question, 17.2% of the students seem to change their mind. This exercise meant to show how easy it is to persuade students and the danger this could bring.

3.1.2. Other illicit psychoactive substances

Results of the Flemish school survey shows that the use of illicit psychoactive substances other than cannabis is rather limited in the population of school students (Kinable 2010). The highest lifetime prevalence's among the oldest school students (17-18y) of the Flemish Community were reported for amphetamines (5.5%), ecstasy (5.2%) and cocaine (5.1%). A lifetime prevalence of heroin use was found about 1.0% among the oldest school students (Melis 2013). For the school years 2000-2001 until 2010-2011, we see a general decrease in the lifetime and last year prevalence for the use of psychoactive substance other than cannabis. (see figure 2.2) (Melis 2013).

Figure 2.2. Ever and last year use of illicit psychoactive substances other than cannabis in school students, %, Flemish community, Belgium, 2000-2011



Source: Melis, 2013

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

4.1. Drug use in recreational settings in Belgium

Several reports of Belgian student surveys (Kinable 2010; Lombaert 2011; Rosiers et al. 2011) highlighted the fact that recreational and nightlife settings like pubs, clubs, parties, etc. are preferred settings for the use of illicit substances. However the gap in drug use between dance music lovers and those who do not like this music narrowed. Music lovers are still more likely to use (frequently) illicit drugs in comparison with people who do not like dance music (Van Havere et al. 2011; Van Havere et al. 2012). The (patterns of) use of psychoactive substances and the characteristics of users in these settings are therefore regularly monitored in the Flemish and the French Communities by, respectively, the VAD research in nightlife settings and the risk reduction project ("Drogues Risquer Moins") coordinated by Modus Vivendi (Rwubu and Hogge, 2013). The methodological approaches of these monitors are significantly different and were described in detail in previous Belgian Annual Reports (van Bussel and Antoine 2012). In preceding years, the prevalences of substance use in both communities fluctuated to some extent. Changes in the coverage of number, type and location of recruitment settings could have contributed to this fluctuation, especially in the French Community (Rwubu and Hogge, 2013).

In 2013, a report about illicit drug use in the Flemish nightlife scene conducted during 2012 was published by the VAD (Rosiers 2013). In total, 618 party people, selected at dance festivals, rock festivals and clubs in the Flemish Community, filled in a questionnaire on their drug use including the use of cannabis, ecstasy, cocaine, amphetamine, GHB, LSD, hallucinogenic mushrooms, heroin, mephedrone and ketamine.

Like for the previous waves of the VAD research in nightlife settings, cannabis (32.4%) was the most popular illicit drug (last year prevalence), followed by ecstasy (16.8%), cocaine (13.6%), and amphetamines (8.1%). Compared to the 2009 wave of this study, a sharp decrease of more than 8.0% was found for the last year prevalence of cannabis use. Interestingly is that in 2012, ecstasy changed again places with cocaine to become the second most commonly used drug by party people (Rosiers 2013).

Table 2.1. Frequency of substance use in the party scene (N=618), %, Flemish Community, Belgium, 2012.

Substances	Ever	Once a month or less	More than once a month	Once a week	More than once a week	Daily
Cannabis	58.8	11.9	6.4	2.3	5.1	6.6
Ecstasy	29.0	11.2	3.5	1.7	0.5	0.0
Cocaine	27.0	9.1	2.8	0.8	0.2	0.7
Exalting medication	16.8	3.3	1.2	0.7	0.7	2.3
Speed	20.7	3.6	2.5	1.3	0.3	0.3
Smart products	20.1	4.9	2.1	0.2	0.3	0.2
Hypnotic- or sedative medication	15.6	3.2	0.8	0.2	0.0	1.0
Ketamine	11.3	2.0	0.8	0.5	0.3	0.2
LSD	12.9	2.8	0.7	0.2	0.0	0.0
GHB	10.0	2.7	0.2	0.2	0.0	0.2
Poppers	14.6	1.8	0.3	0.3	0.2	0.2
Psilo's/paddo's	17.4	1.5	0.2	0.5	0.0	0.0
Mephedrone	2.3	0.7	0.0	0.0	0.2	0.0
Heroine	2.3	0.3	0.0	0.2	0.0	0.2

Source: Rosiers, 2013

Overall, the prevalence of frequent use (once a week or more) of cannabis estimated in 2012 (14.0%) is about half of the estimate of 2003 (31.5%). As for the type of party setting, Rosiers (2013) did not find differences in the frequency of illicit drug use between attendees of clubs and dance events. In contrast, a significant higher use was found for attendees of dance events compared to the attendees of mainstream (rock) festivals.

For 2012, data are also available through "Drogues Risquer Moins" project in the French Community. It is a joint action of more than 30 associations active in recreational settings, coordinated by Modus Vivendi (Rwubu and Hogge 2013). Professionals and jobistes provide information and advice to users and those who are interested. The primary objective of the accompanying survey (paper questionnaire; in 2012 N = 3155, mainly between 15 and 25 years old) is to verify whether the harm reduction activities apply well to the targeted audience. The survey is therefore not representative of the whole party scene and, thus not interpretable as prevalence data (Rwubu and Hogge 2013).

Compared to the first survey in 2001, the proportion of respondents that have used any illegal substance at least once in the past month was substantially decreased (2001: 61.0%; 2012: 35.8%). Cannabis is by far the most used illicit psychoactive substance in the recreational settings in the French community. In 2012, the 'current' cannabis use was 30.1% (Rwubu and

Hogge, 2013). Amphetamines were the second most used illicit substance, with 8.8% of the outgoing respondents reporting the use of amphetamines in the month before the survey was conducted (Hogge, personal communication). The use of cocaine powder dropped from 14.0% in 2009 to 5.8% in 2012. The reported last month use of crack, ketamine, tranquillizers or sedatives, LSD and GHB is rather stable since 2007 (Rwubu and Hogge 2013).

Acknowledgements

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Chapter 3. Prevention

Casero, L. & Laudens, F.

1. Introduction

The Federal Government does not hold responsibility for the prevention policy, which is managed by the Community and Regional governments. The association for alcohol and other drug problems (VAD) and the social-psychological centre (SPZ) are the coordinating structures in respectively the Flemish and German community. The socio-epidemiological observatory for alcohol and drugs in the Federation Wallonia-Brussels (EUROTOX) is the monitoring centre for alcohol and drugs in the French community.

1.1. Activities

FLEMISH COMMUNITY

Monitoring data from the Ginger programme give a good overview on the alcohol and drug prevention activities (Rosiers et al. 2013). Ginger is an online registration programme for prevention activities in the field of alcohol and illegal drugs. The programme gives an overview of the kind of activities, the sector where they are carried out and their reach. In 2012, 89 prevention workers took part in this annual registration. In total 6111 valid alcohol and drug prevention activities were registered.

This registration programme reveals that prevention is mainly oriented towards actors in the educational and health sector. In the educational sector, seven out of ten activities are organized in secondary schools. Prevention activities in these schools mostly consist of training students and teachers, and organizing consultation with teachers and the school board.

In the health sector half of the prevention activities takes place with the regional mental health centres. Two third of the activities in this sector focus on consultations with school boards and prevention sessions with pupils. Three out of four prevention activities are aimed at intermediary target groups, like professional prevention workers, health experts or teachers. When a prevention activity is addressed to a final target group it often concerns young people (e.g. training in schools, early intervention activities).

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

Six Flemish subsidized projects were running in 2012. The first project concerns the development of an interactive 1 session family-based prevention programme for parents of

teenagers (see section 3.2). In the second programme a website for parents is being developed with all kinds of educational issues concerning healthy eating, fitness, tobacco, alcohol and drugs (see section 3.2). The third project targets children of substance abusing parents. The project consists on the one hand of a training for professionals to respond to these children via help lines, mail and chat programmes (see section 3.3.1) and on the other hand of an awareness campaign towards children (see section 4.2). The fourth project concerns a pilot project “drug prevention for ethnic minority youth” uses a Rapid Assessment and Response (RAR) – methodology in order to organize tailored preventive actions towards youngsters of Turkish and Moroccan origin (see 4.1). The fifth project concerns an information campaign on the risks of tobacco; alcohol and drugs before, during and after pregnancy (see 6). The sixth project is an early intervention programme targeting youth with a developing problematic drug use.

1.2. Policy

FLEMISH COMMUNITY

Since 2006, the Flemish government formulated goals concerning the use of tobacco, alcohol and drugs (TAD) in a region-wide health conference with all the actors involved in prevention (Vlaams agentschap zorg en gezondheid 2006). In 2008 a Flemish Action Plan on TAD 2009-1015 was developed and accepted by the Flemish parliament. 3 structural (objective 1-3) and 4 strategic (objective 4-7) objectives were defined. These objectives are described in the previous annual reports.

Concerning the third objective (structural) (investment in registration, monitoring and evaluation) the measurement of indicators by the Flemish institute for health promotion (Vlaams Instituut voor Gezondheidspromotie en Ziektepreventie: VIGeZ) related to tobacco, nutrition and physical activity was expanded. Since 2012 alcohol and drugs are incorporated into the measurement. Data collection in schools and companies was done (using a questionnaire) in November/December 2012. Local governments were questioned early 2013. VAD is responsible for the data processing and reporting concerning alcohol and drugs. The collaboration between VIGeZ and VAD was formalized in an agreement.

The fourth objective (strategic) is to improve the impact of existing prevention activities. The Flemish government supported this objective by expanding the scope of prevention activities which now also includes companies and local governments. In 2012, the regional mental health centres that host prevention workers received extra funding to target these two new sectors. In 2013, this became part of the structural funding of the regional mental health centres.

On March 19th 2012 the Flemish Workgroup TAD finalized an advice in support of the sixth objective (strategic) to develop strategies for smoking cessation and early intervention for alcohol and drug problems. The recommendations in the advice states that these interventions form a structural part of a policy based approach. Young people are chosen as the most important target group and a variety of interventions are suggested which can be used in a cascade system. Interventions should be accessible, geographically well spread and form a part of a local coordinated network. There is also a need for training and intervision.

Preparatory work for an advice concerning vulnerable groups (seventh objective (strategic)) started in 2012. Two priority sectors were identified as important for targeting people with a low socio-economic status namely 1) secondary schools and 2) public welfare centres (OCMW). Too often existing prevention activities in secondary schools target the general section. Efforts are necessary to reach pupils in technical, professional, special and part-time sections. Public welfare centres are chosen because of their large presence and accessibility for vulnerable groups. In 2013 stakeholders in these two sectors will be consulted in order to finalize the recommendation.

On demand of the Flemish minister of Health the Flemish Workgroup TAD compiled a recommendation for price setting policies for tobacco and alcohol. The recommendation gives a short overview of the advantages and possible side effects in public health that can be obtained through a price increase. Practical and legal steps as well as strategic partners necessary for implementing this strategy, were identified.

At the end of 2012 a steering group guided the compilation of a Green paper for alcohol and drugs. The Green paper will be integrated in a global Green book that outlines the options for the sixth state reform in 2014 (see also chapter 1).

WALLONIA-BRUSSELS FEDERATION

Prevention actions in Wallonia-Brussels Federation are articulated around the concept of “health promotion” (WHO, 1986). The strategies of interventions are defined in the five-year programmes of health promotion, which are then translated into Operational community plans (PCO). The PCO determines the priority operational objectives for the priority problems of health. The aim is the improvement of the quality of life and the health of the persons. The current operational community plan has been extended until 2014.

The Minister of Health in Wallonia-Brussels Federation (FWB), launched in 2010 an evaluation of the health promotion sector (Evaluation des dispositifs de la politique de santé en Communauté française, 2011). Following this evaluation, the Minister presented in 2011 the orientations of the reform. Firstly, the revision of the legal health code (which will replace

the code of 1977) and secondly the creation of a public interest organization (OIP) which will pilot the health policy in FWB.

The final report of the project called "joint strategies in prevention and harm reduction actions in the French community" was published in November, 2012. The project coordinated by Eurotox, proposes, for 5 environments (street, prison, festive, school and family) an action plan (objectives and priority actions) as well as recommendations.

2. Environmental prevention

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

Measures to improve the protective school environment and enhance the school climate form an intrinsically part of most school-oriented prevention and health promotion programmes.

Structural measures used in programmes tackling substance use outside the school environment are more related with collaborations with external organizations concerning leisure and sport, free provision of water, etc.

2.1. Alcohol and tobacco policies

2.1.1. Alcohol policies

The Health Ministers signed in 2008 a joint declaration concerning a National Alcohol Action Plan (NAAP) (2008-2011). In December 2012 these Ministers decided that time has come to update and expand the joint declaration of 2008. The mission of the NAAP 2014-2018 is to reduce the harmful use of alcohol in Belgium (see also chapter 1).

A number of laws regulating price, penalties and age limits have a preventive goal. These laws were described in detail last year (Plettinckx et al. 2012).

On May 12th, 2005 the Federal Minister of Public Health signed a convention with the alcohol industry regulating the publicity for alcoholic beverages. The most important agreements of this convention are that no association can be made between alcohol consumption and social, sexual or professional success or positive physical or psychological effects; no publicity is allowed in social, health and professional settings; alcohol-related publicity is banned in media targeting minors; alcohol-related publicity may not target pregnant women of suggest the possibility of driving; publicity have to mention the baseline

'Enjoy, but drink in moderation'. A national council, with a self-disciplinary jury, can recommend to change or stop publicity in violation of this convention.

The law of December 10th, 2009 forbids selling, serving or offering, to youngsters under the age of 16, any beverage which contains more than 0.5% blood alcohol concentration (BAC) by volume. Serving, selling or offering spirits is only allowed to persons having reached the age of 18 years. Each person willing to buy alcohol can be asked to prove his/her age. Health inspectors of the federal administration and also the police reinforce this law and are allowed to fine offenders (B.S./M.B. 31.12.2009). A national awareness campaign supports this new legislation (see section 6)

In April 2009, a collective labour agreement came into force which obliges private organizations to develop an alcohol and drug policy in the workplace.

2.1.2. Tobacco policies

The law of December 10th, 1997 prohibits the advertising for tobacco and sponsoring by the tobacco industry. This law bans any communication or action which aims at promoting the sale of tobacco regardless the place, the used media support or used techniques (B.S./M.B.11.02.1998).

Since December 1st 2004 it is prohibited to sell tobacco to youngsters under the age of 16. Each person willing to buy tobacco can be asked to prove his/her age (B.S./M.B. 10.11.2004). The use of tobacco by youngsters under the age of 16 if not prohibited though. Since July 1st, 2011, smoking is forbidden in all enclosed public places including cafés, bars and nightclubs (B.S./M.B. 29.12.2009). It is however allowed to settle a smoking room or to smoke on the opened terraces. Health inspectors of the federal administration and also police reinforce the law and have the right to fine offenders.

WALLONIA-BRUSSELS FEDERATION

In 2012, the 5th Walloon plan "Without tobacco" has been launched by the Minister of Health of the Walloon Region. The accent is put on young smokers and vulnerable people.

2.2. Other social and normative changes

Social norms and normative believes regarding the use of alcohol in certain settings and by certain groups of people are changing. There is growing public recognition that alcohol consumption by youngsters can have detrimental effect on their development. In 2009 this recognition is translated in a number of new laws (see also 2.1.1.) regarding the selling, ordering or offering of alcohol to youngsters and alcohol publicity targeted at minors.

The public acceptability of driving under the influence (DUI) has also changed during the last decennium. The laws regulating DUI (legal limit = 0.5% BAC) exist for a long time (B.S./M.B. 27.03.1968). Since 1995 the Belgian Institute for Traffic Safety (BIVV) undertakes each year an international acclaimed awareness campaign built around the same concept ‘Go for zero’. As a result DUI is perceived the longer the more as a antisocial, unacceptable behaviour.

3. Universal prevention

3.1. School

FLEMISH COMMUNITY

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

Since 1999 VAD offers an instrument for schools to evaluate their drug policy at school, with the input of their pupils. The pupils questionnaire (Leerlingenbevraging) collects data of all the pupils of a school and renders an individual report with tips and tools to improve the drug policy of a school. In the school year 2011-2012, 68 schools and 39,999 pupils took part in this project.

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

‘De Sleutel’ trains teachers in implementing drug prevention programmes in their classrooms, like the European developed programme “Unplugged”. This life skills education, which is one of the end terms in primary schools that are set by the Flemish government, and the social influences approach has effective outcomes in the delay of the onset of drug use in the age range of 12 to 14 years (first grade). The programme is based on EU-Dap. ‘De Sleutel’ also developed a follow-up programme for second (14 to 16 years) and third grade (16 to 18 years).

In the last few years, more activities are being introduced in primary schools (with main focus on delay of onset of drinking) and higher education (universities and schools for higher education with focus on alcohol and binge drinking, cannabis and misuse of medication). For the third grade of primary schools VAD offers ‘FUN without alcohol’ (LOL zonder alcohol)

which is a package built around 8 lessons. The aim is to improve social skills and make pupils more resistant against group pressure (see also section 6).

WALLONIA-BRUSSELS FEDERATION

Actions in schools are in the FWB based on the following principles: analyse the demand and clarify the situation; adapt the action to the educational project and to the institution's resources; recognize the role of prevention to the adults in connection with the young people; act together and create a dynamic of participation; guarantee to all the respect for the confidentiality.

Since September 2007, nine support points at schools regarding prevention of the addictions (PAA) are operational in the FWB. Their mission is to strengthen links between the specialized network regarding prevention of addictions on the one hand and the school environment on the other hand. The Local Health Promotion centres (CLPS) are responsible for this project. For instance, in Brussels an inter-sectorial committee was created. Sectors and associations which participate in the meetings are, on one hand, the actors of the Brussels secondary schools and, on the other hand, the specialized structures such as the "family planning", the "help structures in open environment", the active services in prevention of drug addiction, the structures depending on municipal and regional powers.

In 2011, a pilot project called "Well-being Cells" (Cellules bien-être) was initiated in schools. This project joins the philosophical and theoretical continuity of the integrated approaches usually used in health promotion at the school. The association of three Ministries (Health, Education and Youth) in the implementation, and the multi-level organization of this project, are unique and new. This pilot project has been developed during two school years (in 2011-2012 and 2012-2013) and concerns 80 establishments of any level, any network of education and any school type (maternal and primary, secondary general, ordinary and specialized). Every school develops its own project according to its own priorities and constraints. Concretely, "the Well-being Cell" is a local coordination group of internal and external participants of the same school (directors, teachers, educators, members of the promotion teams, the pupils, etc), who are consulted regularly to help the director to define the lines of force of the school regarding well-being.

3.2. Family

FLEMISH COMMUNITY

Universal prevention initiatives for parents are mainly integrated at local level, in programmes of adult organizations. There are several programmes aimed at training parental skills. These programmes are open to all parents (not only parents with drug using children) and have a broad objective to develop “life skills”.

In December 2011, VAD started the development of an interactive 1 session family-based prevention programme for parents of teenagers (10 to 15 years). The focus of the project is the parenting of teenagers and the role of parents in preventing, delaying the onset of and/or reducing tobacco-, alcohol- and other drug use by their children. Parents are educated about parenting styles like an open communication pattern, disciplining, modelling, monitoring, etc. Specific attention is paid in the project to parents with a low socioeconomic status.

The project was tested in 2012 in a pilot study in 3 Flemish regions of which a process evaluation and a controlled pretest-posttest effect evaluation indicated that the intervention is successful (Maes and Dubuy 2013). This programme will be ready for implementation in September 2013. Trainer sessions have been planned for professionals in the alcohol and drug sector and professionals active in parenting support. From September 2013 on, there will also be the possibility for trainers to order the package online.

VAD is project partner of VIGeZ in developing a universal prevention project for parents of children and teenagers focusing on e-learning. Special attention is given to parents with a low socioeconomic status. The central focus revolves about 5 health themes in parenting: nutrition, physical activity (and sedentary behaviour), tobacco, alcohol and other drugs. The main goal is to involve parents in an interactive website (using movies and small tests) where they’ll find tips and tricks to handle these health related themes. For each theme the reader will find information on communication with their children, modelling, disciplining and information on the availability concerning the different topics. This online project started in December 2011. In the second half of 2013 a provisional test website will be evaluated by different focus groups of parents and professionals. After evaluation, the website will be launched in December 2013.

WALLONIA-BRUSSELS FEDERATION

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

Projects existing in Charleroi and the province of Luxembourg were described last year. In 2012, two new projects with the focus on family were developed in Liège by the non-profit association NADJA. The first one is called “Welcome-point for Relatives” (Point Accueil Parents). The relatives consult the association, for the vast majority, for teenagers or young adults presenting a problematic consumption pattern combined with alarming risk behaviours. Besides the frequent consumption, the symptoms such as absenteeism and unhooking (66.0%), degradation of the relation with the parents (60.0%), isolation, withdrawal (52.0%) and small criminal behaviour (fights 21.0%, deal 12.0%, verbal threats 12.0%, and violence 10.0%) are mentioned by parents as a motivation for a request. The second project is called “parental coaching”. 11 sessions were followed by 9 isolated mothers and 1 couple of parents. These parents benefited from 22 sessions of guidance in parallel. All these persons know a favourable evolution of the situation: resumption of the dialogue relatives - children, resumption of education or the professional activity, resumption of social activities, and significant decrease of the consumption and/or the risk behaviours.

3.3. Community

3.3.1. Helplines

The ‘DrugLijn’ and ‘Infor-Drogues’ are respectively the drug help lines for the Flemish and French Community. These services do not only operate a telephone helpline. Since a few years, both organisations provide also online services such as email, Skype and chat through their website.

FLEMISH COMMUNITY

The annual figures for the ‘DrugLijn’ (N=6,561) show a substantial increase of 814 contacts in 2012 as compared to 2011 (Evenepoel 2013). This is an overall increase of 14.0% as compared to the previous year. A large part of that is due to the growing number of online contacts. The number of e-mail-contacts (N= 3,100) increased for example with 72.0% in two years’ time. The number of telephone calls is still slightly higher (N= 3,323) but when the number of Skype calls (N=51) and the number of online chat contacts (N=87) are taken into account, the overall balance between telephone calls and online inquiries has grown to a 50/50-ratio. This evolution has been going on for a few years and illustrates that the ‘Druglijn’ has transformed itself from a telephone line into a multi-channel contact centre.

Nevertheless, the 'DrugLijn' is not an emergency helpline and is therefore not available 24 hours per day. Outside the staffed hours (Mon-Fri 10h00-20h00), 2043 callers reached the IVR (Interactive Voice Response system) which provides information on the opening hours and basic emergency advice. Apart from these figures, the 'DrugLijn' also received 428 hoax calls.

Cannabis is the drug which has always been mentioned the most at the 'DrugLijn'. The percentage of inquiries on cannabis remained stable in 2012 (see table 3.1.). The figures however showed a remarkable increase in the number of inquiries regarding alcohol. In online inquiries alcohol even became the most mentioned substance. The number of questions concerning cocaine remained stable whilst the number of inquiries about psychoactive medicines decreased (after a relatively strong increase between 2009 and 2010). Comparable to 2011 – and after many previous years of decline - the percentage for ecstasy increased. The percentages for drugs such as heroin and amphetamine show a decrease.

Table 3.1. Contacts of the drug help lines, by gender and substance, % and N, Belgium, 2011-2012

Characteristics	Infor-Drogues				Druglijn*			
	2011		2012		2011		2012	
	%	N	%	N	%	N	%	N
Number of contacts	100.0	4,347	100.0	3,422	100.0	5,747	100.0	6,561
Gender								
Males	52.0	2,260	45.0	1,540	41.1	2,362	39.5	2,591
Females	43.0	1,869	50.0	1,711	57.1	3,283	59.2	3,886
Unknown	5.0	218	5.0	171	1.8	102	1.3	84
Involved substances in contacts								
Cannabis	37.0	1,090	38.5	1,119	35.2	1,694	35.8	1,942
Cocaine	18.5	544	17.0	496	14.7	709	14.9	808
Ecstasy	2.6	77	1.6	47	3.9	188	5.6	303
Heroin	8.5	252	7.2	210	4.6	224	4.0	216
Alcohol	12.7	374	14.0	408	26.3	1,267	30.2	1,637
Psychoactive medicines	8.0	235	9.6	278	12.6	607	10.5	570
Crack**	1.8	54	2.0	58	N/A	N/A	N/A	N/A
Methadone	5.2	154	4.9	143	2.0	97	2.1	114
LSD	1.1	33	0.9	25	0.8	38	1.2	65
Amphetamine	1.5	45	2.0	59	8.9	427	7.2	393

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

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

Source: Infor-Drogues, 2012; Druglijn, 2012.

Thanks to the success of its online service, the 'DrugLijn' now reaches more young people than a few years ago. To increase its accessibility for young people, the helpline launched an online chat service in October 2012. Although the amount of chat sessions by the end of 2012 remained limited (N=87), the first results showed that this service succeeded in reaching more young male drug users. 42.0% of the chatters were younger than 20 years old. The helpline reaches older age groups and more women via the telephone line. This involves often partners and even more mothers of drug users.

Besides the chat service, the 'DrugLijn' has launched online tools for self-tests and self-help on their website. This section contains 9 online assessment tests (cannabis, cocaine, ecstasy, amphetamines, alcohol, gambling, benzodiazepines, gaming and internet) for adults and two similar test (cannabis, alcohol) for minors (-18 year olds). Apart from that, 6 knowledge tests are online available. 8,1336 self-assessment test and 3,1302 knowledge tests were filled in on the website in 2012. Finally 335 persons registered for the online cannabis and cocaine self-help programmes.

Additionally, the centres for alcohol and drug problems (Centra voor Alcohol- en andere Drugproblemen (CAD)) and Drug aid Kempen (Drughulp Kempen) are running an online treatment programme for cannabis. In 2012 the website counted 48842 visitors (of which 28767 were unique visitors). This resulted in 142 who registered for treatment. At the end of 2012 a new online treatment programme came online, targeting ecstasy, speed, cocaine and GHB.

WALLONIA-BRUSSELS FEDERATION

In 2012, the total number of calls received by the helpline Infor-Drogues reached 3,422. This represents a decrease compared to the previous year. Nevertheless, it has to be remembered that in 2010 and 2011 an important percentage of the calls were made by two callers who generated by themselves 19.0% of the total calls. The "real" number of callers for 2011 bordered 3,165. Taking 2009 as the reference year ("normal year") we observe an increase of 5.0% in 2012.

Among the total number of received calls, it is important to distinguish the notion of "call" and "request". Indeed, every received call does not generally limit itself to a single request. So, it is common that a single caller ask for several things during the same call (e.g. the information about a product, the explanations on the functioning of detoxification centres, councils, etc.).

The 'Infor-Drogues' helpline operate 24 hours a day and 7/7 days. Concerning the period of contact, three categories are distinguished in the registration system, namely during working hours (from 8:30 am till 6:30 am), during nights (from 6:30 am till 8:30 am) and during

weekends. In 2012, 61.0%, of the calls come in at working hours (2101 calls), 19.0% at nights (645 calls) and 19.0% during weekends (664 calls). These percentages remains stables compared to previous years.

Current target groups of the ‘Infor-drogues’ helpline are users, relatives and professionals. The percentage of callers categorized as "users" passed from 56.0% in 2011 to 37.3% in 2012. This can be explained by the huge number of calls made by “the two single callers”. The callers made by relatives are regaining importance with 52.2% of the total calls. 10.0% of the calls are made by professionals.

Concerning calls made by relatives, we noticed that mothers represent 50.0% of the callers. Partner represents 14.0% (207/1,482 calls), 11.0% of the callers are fathers (166/1,482 calls), 18.0% are other family members (267/1,482 calls) and 7.0% others (106/1,482 calls). These proportions have remained broadly unchanged over the past years.

In 2012, 282 professionals contacted the telephone line. The following professions are included into the professional category: the health care professionals (50.0%), the educational sector (24.0%), the professionals of the justice sector (4.0%), the journalists (13.0%) and the public authorities (9.0%).

Regarding the age of user's callers, the age group between 26-35 year old continue to be the most presented (28.9%) followed by the 36-50 years old group (22.9%). Among all age groups, males are overrepresented. This observation is a continuing trend from previous years. User's callers are essentially male, relative callers are mainly females.

As previous year, amongst those calls for whom the geographical origin was known, most were from Brussels (1,183), the Walloon region (899), Flanders (25) and from abroad (25).

The most frequently mentioned substances at the ‘Infor-Drogues’ helpline in 2012 were cannabis (38.7%), follow by cocaine (17.1%) and alcohol (14.1%). As previous year, we observed no real change in the percentage of the product(s) evoked during calls.

‘Infor-Drogues’ has an e-mail service (e-permanence) since 2005. The e-mail service allows people to formulate questions and receive the ‘Infor-Drogue’ answer in total confidentiality within 74 hours. The total number of e-mail contacts in 2012 was 153. This figure corresponds to 119 individuals. Concerning the products, cannabis is this year again the most frequently mentioned "problematic" product (in 41.2%). Cocaine and crack remain highly present with 15.5 %.

Table 3.2 shows the distribution of callers by age group. It is noted with caution (because of the high percentage of unknown data), that 'Infor-drogues' reaches less young people in comparison with the 'Druglijn'.

Table 3.2. Contacts of the drug help lines, by age category, % and N, Belgium, 2012.

Age (y)	Infor-Drogues		Druglijn	
	%	N	%	N
Under 18	0.3	11	9.8	460
18-25	5.9	203	23.2	1,092
26-35	24.0	821	22.8	1,076
36-49	33.6	1,150	27.7	1,306
50 and older	15.3	522	16.5	776
Unknown	20.9	715	0.0	0
Total	**100.0**	**3422**	**100.0**	**6561**

Source: Infor-Drogues, 2012; De Druglijn, 2012

3.3.2. Local alcohol and drug Policy

FLEMISH COMMUNITY

In 2011 VAD launched a stepping-stone method to create an integral and inter-sectoral-based policy of alcohol and drugs in communities or cities in the Flemish community. This method consists of 7 steps, uses the local network and partners and a local analysis to implement actions concerning rules and regulation, structural measures, information and sensibilisation and early intervention and access to primary healthcare and welfare services. This process of a local alcohol- and drug policy in Flemish communities or cities is supported by regional and local prevention workers.

From 2014 on, all Belgian cities have to work within a new framework of rules, the so-called Policy and management cycle for cities and social welfare organizations (Beleids- en BeheersCyclus voor steden, gemeenten en OCMW's (BBC)), to compose their policy plans for the coming term. In order to stimulate and assist cities to include the alcohol and drug topic in these plans, VAD developed three information sheets: one on alcohol, one on cannabis and one on other illegal drugs (which are available on the website). The different information sheets have the same structure and contain information on theme related figures; how to make an analysis of the local alcohol and drug situation; how to formulate policy goals and action plans; the importance of local collaborations and different (preventative) materials for dealing with alcohol and drugs on a local level.

VAD developed also a protocol and guidance for mystery shopping research on alcohol. The protocol is called 'local monitor alcohol and youngsters' ('lokale monitor alcohol en jongeren'). Local prevention workers can use this protocol to perform test purchasing in order to investigate whether or not sellers of alcoholic beverages cling up to the legislation on

selling alcohol to minors. For this, they work together with 15 and 16 years old youngsters visiting supermarkets, night shops and other local stores to find out whether it is possible for them to buy alcoholic beverages. The monitor can be used to check if sellers of alcoholic beverages are familiar with the legislation or whether they need more information on the legislation on selling alcohol to minors. It can also be used to evaluate the effects of preventative actions on this theme. For each city in which the test purchasing took place, VAD prepared a tailored made report.

4. Selective prevention in at-risk groups and settings

4.1. At-risk groups

FLEMISH COMMUNITY

The didactic package 'Alcohol and cannabis, no nonsense' - developed in 2011 - ('Alcohol en cannabis zonder boe of bah') is a package tailored to young people with a mild mental handicap. It offers an effective way to make them more aware of the effects, risks and consequences of alcohol and/or cannabis use. In 2012 the package was ordered 29 times. The package was downloaded 569 times during that year as well.

CAD, which operates exclusively in the province of Limburg, developed a programme 'straffe stappen' targeting youngsters in special needs education. They also have a programme for people with a mental handicap. Both programmes were developed in 2009-2010 and financed by a provincial development fund (Limburg Sterk Merk).

VAD coordinated between September 2011 and February 2013 a pilot project 'drug prevention for ethnic minorities'. The general objective was to develop a methodology to organise preventive actions towards ethnic minority youth in the future. Specific objectives were 1) to carry out preventive actions in 3 regions (Limburg, Antwerp and Ghent), 2) capacity building with prevention workers and professionals working with ethnic minorities in using the developed methodology, 3) make an inventory of existing preventive tools and promote these (together with the new methodology) through the internet. A RAR was chosen and adapted during the project. Youngsters with a Turkish background were chosen in the province of Limburg and the city of Antwerp and youngsters with a Moroccan background in the city of Ghent. 13 preventive actions were carried out In the 3 regions after undertaken a RAR. The adapted RAR and actions can be found on the website of VAD.

WALLONIA-BRUSSELS FEDERATION

“Snowball operations” is a peer prevention programme coordinated by the non-profit association Modus Vivendi. The programme aims to engage the active participation of drug users (the so-called jobistes) in the prevention and harm reduction activities. This programme has the advantage to accumulate the provision of prevention and information initiatives to the most marginalized people with a data collection about the evolution of the knowledge and the attitudes of drug users regarding AIDS, hepatitis and other risks linked to drug used.

A questionnaire is used to evaluate the implementation of the programme, to follow the evolution of the consumptions, to identify the risk-takings, new tendencies, etc.

From March 2012 to February 2013, six snowball operations have been organised in the French community. Two operations were organised in Charleroi, 2 in Liège, 1 in Brussels and 1 in Namur. One of them was specifically organized by women (in Liège, with the cooperation of a local partner: Espace P). In total, 384 questionnaires were collected. On average, 7 male and 2 female jobistes were involved during these operations.

Table 3.3. Snowball operations, number of contacts and jobistes, French community, Belgium, 2005-2012

Year	N contacts	N jobistes	Total Snowball	Type of Snowball operations*
2005	1,047	39	4	Cannabis
2006	357	11	2	Hepatitis C - Bulgarians Turkish-speaking men in the male prostitution
2007	618	17	3	Squat « Collectif 123 »
2008	648	N/A	3	N/A
2009	674	64	7	N/A
2010	597	58	6	N/A
2011	134	13	2	N/A
2012	384	40	6	1 specifically focussed on women

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

Source: Modus Vivendi, personal communication, 2013.

Since 2006, the Snowball operations are also organised in prison. If the expenses of these operations are assumed by the Federal Public Service Justice, the whole work supplied of the projects is subsidized by the French Community Wallonia- Brussels. Besides all the objectives inherent to the method of the classical snowball surveys, the operations organised in prison include additional objectives such as to assign a mission to prisoners, to approach the risk reduction under the angle of prison reality, and to make the professionals sensitive of the necessity of organising projects of risk reduction in prison.

In 2012, four snowball operations were organized in prison. One in Berkendael, Brussels (5 jobistes, 8 contacts); one in Jamioulx, Charleroi (10 jobistes, 50 questionnaires collected) and two in Arlon, Luxembourg (20 jobistes, 134 contacts). In total, 192 questionnaires were collected in all prisons.

4.2. At-risk families

FLEMISH COMMUNITY

'Bubbels & Babbels' is an ongoing prevention project in Antwerp focusing on the problems of children of (ex)drug dependent parents. The project offers comprehensive coordinated services to decrease the harmful effects of drug addiction on children, families and the community.

'Bubbels & Babbels' provides case management to clients. The family is engaged both in identifying and meeting its own goals, so that the traditional case management approach of simply arranging services is expanded significantly. The case manager assists families in developing their goals, identifying their needs, and obtaining these services. In 2012 18 families showed interest in the service. 12 of those started effectively with the case management.

VAD coordinated in 2012-2013 a project targeting children of substance abusing parents. The first part of the project concerned an awareness campaign (see 6). In the second part trainings were organized for professionals who often are in contact with the target group. More specific collaborators working for the helpline "DrugLijn" and the Children and Youth telephone (Kinderen en Jongeren Telefoon) as well as professionals working in low threshold youth welfare organizations were among the targeted professionals.

Since 2012 ADIC VZW offers OP+ which is a drug free withdrawal programme for drug abusing parent(s) and their children (0-6 years). The parent(s) participate in an intense structured programme during which the children are in kindergarten.

3 Medical and Social Care Centres (MSOC/MASS) offer low-threshold services with a specific focus on children of drug users. The premise is that drug use complicates the parenting role of parents.

WALLONIA-BRUSSELS FEDERATION

Various projects are implemented in FWB over the past years. The paragraphs below summarise two interventions namely the "Parenthood" Service of the non-profit association ALFA based in the province of Liège and “Parenthood-Addiction” situated in the public hospital of the Public Centre of Welfare in Brussels. The "Parenthood" Service of the non-profit association ALFA was set up in 1994. The project is implemented by a psycho-social and medical team. The main objective of this project is to allow or to maintain harmonious relations between addicted parents and their children.

The target population of the project is threefold. First of all, parents and future parents who are drug addicted or presenting a drinking problem (among which those of less than 25 years). Secondly, children of addicted parents from 0 to 18 years old, living with the family or placed at a host family and thirdly relatives of the children such as grandparents, uncles and aunts and host families themselves. The team also works with various structures that play an important role in these complex situations of parenthood and drug addiction. 96 addicted parents were followed by the service from November 2011 till October 2012. 178 children between 0 and 18 years old came in contact with the service. Among them, 15 children were specifically followed.

“Parenthood-Addiction” (“Parentalité-Addiction”) is an active service within the framework of a public clinic. The project targets specifically pregnant women and addicted parents and involve all the members of the family. This multidisciplinary team aims offering a coherent and reassuring framework to the drug addicts mothers. The mean age in 2012 is situated at 31 years (between 22 and 44 years old). 8 mothers consumed methadone (57.1%); 7 cannabis (50.0%), 3 cocaine (21.4%), 8 multiple addiction (57.1%), 12 tobacco (85.7%), 1 opiates (7.1%) and 1alcool (7.1%). The project also has an appropriate space “the Alizes” which allows the families to meet each other. In 2012, the number of adults coming to “the Alizes” increased by 57.5%, and by 12.0% for children, what represents an increase (adults + children) of 45.0%. (adults welcomed in 2012: 1607 ; children : 437 and total people in 2012: 2044). In 2012, the Parenthood - addiction team followed 79 families and accompanied 14 births.

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

FLEMISH COMMUNITY

In 2011, VAD joined forces with the Brussels based harm reduction organization Modus Vivendi to extend the Quality Nights label (which replaces the partywise project) to Flanders. In 2012 the label (we call it charter in Flanders) was adapted to the specificities and habits of the Flemish party scene. In October 2012 the Quality Nights Charter was officially launched

in Antwerp starting up with nine new clubs. In November 2012, a try-out of the Quality Night concept was done at a major Techno event 'I Love techno' in Ghent. This was a great success. More info about Quality Nights can be found below in the section about 'Wallonia-Brussels federation and on the website.

Peer support was introduced in Flanders in the mid 2000 as a promising new method to work on risk minimization in the nightlife in Flanders, first by 'Breakline' and later by 'Vitalsounds'. During the years both projects became stronger, more experienced, better equipped and they managed to develop a crew of experienced and motivated peers. In 2010 'Vitalsounds' and 'Spiritek' (Lille, France) started an interregional project, funded by the European commission. Due to this project 'Vitalsounds' expanded its working area to the province of West Flanders and half of the province of East Flanders. In 2011 both 'Breakline' and 'Vitalsounds' developed a new website to inform party people about health risks in nightlife settings. Both project are also active via social media such as Facebook. Both projects cooperate since 2012 closely with Quality Nights to create a healthy and safer nightlife in Flanders.

WALLONIA-BRUSSELS FEDERATION

The Label «Quality Nights» aims to reduce the risks related to partying (health, addictions, return at home, conflict/violence, noise pollutions, sexually transmitted infections, etc.) and works in collaboration with the evening organizers, the owners and their staff on the party environment.

In Wallonia the programme is part of the project entitled " Project of political Statement of Walloon Region 2009-2014: an energy shared for a sustainable, human and united society". This project aims, among others, to boost the information and prevention activities in recreational settings in order to make youth aware of the risks relating to drug use.

To guarantee the coherence of the project, a global evaluation plan was developed and implemented with the support of local operators. It allows collecting all the information relative to contacted and labelled sites and the implementation of compulsory and optional criteria (the aim is to verify that labelled sites have met the obligations they agreed to undertake when they were selected). 37 places were certified in 2012. The overall objectives of the project have been, in 2012, to spread the partnership in order to extend the label in the provinces of Namur and Liège. Another objective was to develop and to spread communications tools.

Harm reduction activities in recreational settings are still performed by two types of projects: "Drugs, taking less risks (DR-) ("Drogues Risquer moins") and "Mobile Team".

Every year Modus vivendi is present at big summer festivals with a “Mobile Team”. This mobile team organises harm reduction actions in festive environment through needle exchange, drug testing and the distribution of brochures, condoms, flyers, water, etc.

Five festivals were covered by the project in 2012. Relax zones were organized during three festivals: Esperanzah, Dour and Tribes Gathering in Gouvy. 198 people were welcomed in the relax zones. The average age of the people taking care in the relax zones is 23, 5 years (min. 14 - max. 60), which is comparable with previous years. These figures confirms that the problems are met by a relatively young public, who are often less used to manage their consumption and their limits. The majority of the people welcomed in the relax zones are men. In 2012, women's proportion is approximately 30.0%, what was not any more the case in 2009 and 2010. Also in 2012, most of the people (52.5%) arrived at the relax zone on its own initiative, 27.6% via Red Cross or 9.9% of them with a friend and 3.3% via a jobiste. The most people (66.7%) mentioned fatigue as main reason of admission. 32.8% of the people are going to a relax zone because of being cold, being disoriented (18.7%), having fears (9.6%) or because of nausea (9.1%). In 2012, 81.7% of the persons, who answered the questionnaire (N=186), told to have consumed at least one psychoactive substance during the event. Even if the percentage of the alcohol decreased in 2012, it continues to be the most mentioned product. Ecstasy stays in the second position, followed by cannabis which both increased by 10.0%.

“Drugs, taking less risks” is a harm reduction information desk at festive places since 2001. It approaches all types of products (legal and illegal) and different consumption habits (occasional, entertaining, regular, problematic, compulsive, etc.). It seems that the attendance of the information desk is especially motivated by “the curiosity", “the availability of free condoms", “the search for general information” or "the desire to discuss". The people are mainly between 18 and 25 years old and males and females are equally represented.

In comparison with the indications of the mobile team, alcohol continues to record the highest percentage (92.4% “during the life ", 68.9% "during the last four weeks" and 57.2% "during the event"). Tobacco and cannabis have the second and third place. The fourth and fifth place are for speed/amphetamines and hallucinogenic mushrooms, followed by cocaine and ecstasy/MDMA. Poly drug use (except tobacco) during the event amounts to approximately 20.0% in 2012.

5. Indicated prevention

FLEMISH COMMUNITY

5.1. Screening and brief intervention

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

To facilitate screening and early intervention the ASSIST instrument, developed by the World Health Organization, was translated into Dutch (Claessens and Defillet 2010). The instrument exists in a paper version and an electronic version. A separate manual was developed for health care services and for welfare services to take the specific characteristics of these settings into account.

The objective of the ESBIRTES project is to identify and develop effective tools for Screening Brief Interventions and Referral to Treatment (SBIRT) for young adults presenting problems related to (poly)drug use at the Emergency Departement (ED). The development of an electronic tool took place in 2011-2012. This European project was implemented in 2012 in Belgium, the Netherlands, Hungary, Spain and United Kingdom.

After being treated for their acute health problem, all clients meeting the inclusion criteria are screened. The screening can result in 3 different outcomes: low risk, moderate risk and high risk. Clients who score in the low risk range receive a brief motivational advice and a link to local/national drug information website(s). Moderate-risk-clients are referred to an online self-help module. Clients in the high risk range receive a brief motivational advice to find professional help. Those who are not motivated for a referral to treatment will be directed to the self-help module. For more information, please refer to the website.

5.2. Early intervention

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

The concept of group intervention and individual brief intervention for adolescents , based on psycho-education, feedback and motivational interviewing (Claessens and Raskin 2010) was introduced in 2008 and further implemented in addiction treatment centres in 2011 and 2012. The counsellors were supported through training and intervision. The referring services

(schools, juvenile care…) can assess risk level and need for referral with the screening instrument SEM-J (Baeten et al. 2009). Community drug prevention workers are also important in providing early interventions for substance use. Their training needs were assessed and a specific training was developed. This training will be implemented in 2013.

Since 2012, mental health centre Eclips coordinates project Mighties. This project aims to develop an interactive psycho-education tool. The tool will be used by professionals working in drug related treatment and early intervention who are targeting youngsters. It will visualize how behaviour results from a competition between different interacting internal processes as a reaction on external stimuli. Drug use is influenced by rational and conscious considerations as well as automatic, often unconscious processes. The tool will represent visually the processes that take part in our brain and that result in behaviour. The professional and youngster will analyse together experiences and behaviour in different situations. The basic idea is to make clear to youngsters that there exists a compromise between 'I am my brain' and 'I do something because I decide to do so'. The pilot version of the tool is tested in 2013. The implementation is foreseen in 2014. In a next phase the tool will also be used in drug prevention.

5.3. Self-care and self-help

The DrugLijn-website contains a section with a number of online assessment-tests and online self-help-programmes for cannabis and cocaine users. CAD also has two websites (cannabishulp and drughulp) with online assessment-tests and online self-help-programmes for cannabis, ecstasy, speed, cocaine and GHB (see 3.3.1.), with a possibility to online counselling through chat.

6. National and local media campaigns

The '-16 no alcohol, -18 no liquor' campaign is a national initiative in support of the new legislation (see 2.1.1.). The objective is to inform shop assistants, youngsters and parents about the new law and to instruct shop assistants how to enforce the new law. In 2011 and 2012 220,000 stickers with the message '-16 no alcohol, -18 no liquor' were distributed in 14,000 retail shops and 60,000 stickers were distributed in 20,000 bars. An instructional video for the checkout staff in retail shops was developed and distributed in 10 out of the 12 big supermarket retailers.

FLEMISH COMMUNITY

On February 28th 2012, VAD launched a cannabis campaign targeting youngsters aged 15 to 18 years. The main aim was to reinforce and encourage the non-use of cannabis. The campaign message 'music/laughing/football is my drug' implies that 4 out of 5 youngsters

never use cannabis and they still have fun. The campaign message was printed on postcards and wristbands. Intermediary persons and organizations (teachers, youth organizations,…) could order for free a package with a number of postcards and wristbands. The target group was reached using a Facebook competition, ads in magazines and newspapers. On the DrugLijn-website, a separate section was devoted to the campaign. Youngsters who use cannabis could perform the new self-test for cannabis on the early intervention section of the website (see also section 3.3.1.). The Flemish minister of Health decided also to carry out a major cannabis campaign in Flanders in 2013. Preparations for this campaign started early 2013 and the campaign will be launched in autumn.

Students are a difficult and critical group to reach with a classic awareness campaign that merely points out the dangers or disadvantages of certain behaviours. VAD wanted to correct the wrong perception that all student are heavy drinkers. In March 2012 students in a university town were invited to a party hosted by a famous DJ and were offered 5 free barrels of beer. Students were ignorant that the beer contained no alcohol. After the party students were informed concerning the alcohol level of the beer and were interviewed. The interviews and some recordings shot during the event were compiled into a small movie which received 35,376 views on YouTube in 2012.

On October 29th 2012 an awareness campaign targeting children of substance abusing parents was launched. The campaign is one part of a broader project (see also 4.2.). The campaign was built around a movie depicting the live of a small girl whose mother is addicted. The movie received 20,326 views on YouTube in 2012. The view count of the campaign page on Facebook was 63,381 (up until June 2013). Together with the movie two booklets (‘If your parent drinks’ and ‘If your parent uses drugs’) were re-launched.

VAD, VIGeZ and the family oriented welfare organization ‘Kind & Gezin’ launched an information campaign on the risks of tobacco, alcohol and drugs before, during and after pregnancy at the 25th of October 2012. A poster and leaflet were developed with the baseline ‘the best onset starts with a stop’. The campaign was promoted through waiting rooms of general practitioners (GPs), gynaecologists, pharmacies and the facilities of ‘Kind & Gezin’. Ads were run in a number of magazines.

Acknowledgements chapter 3:

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Chapter 4. Problem drug use

Plettinckx E.

1. Introduction

In this chapter, aspects of problematic drug use following EMCDDA's current definition as 'injecting drug use or long duration or regular use of opioids, cocaine and/or amphetamines', are presented. The prevalence of injecting drug use in Belgium is estimated using the HIV multiplier method, combining data from the national AIDS/HIV register with estimates of the HIV-prevalence rate among injecting drug users. Characteristics of the injecting population are investigated through a yearly survey at syringe exchange in the Flemish Community (Windelinckx 2012). Indications of problematic drug use, of which some do not strictly follow the EMCDDA case definition of problematic drug use, among persons visiting recreational settings within the French community were obtained through the survey 'Drogues Risquer Moins' (Modus Vivendi).

2. Prevalence and incidence estimates of problem drug use

2.1. Indirect estimates of problem drug use

2.1.1. HIV-multiplier method

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

2.1.2. Data sources

National HIV/AIDS register

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

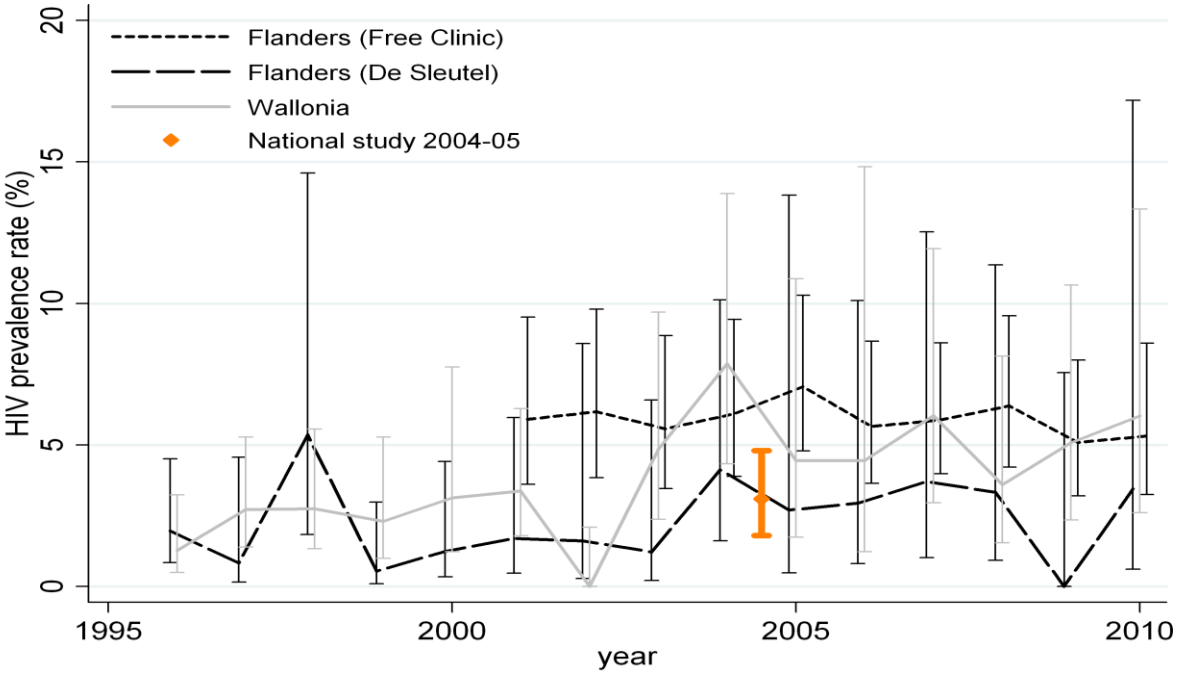
For each confirmed HIV-positive test, a standardized form is sent to the patient's clinician to collect additional information on 1) nationality; 2) residence; 3) sexual orientation; 4) probable mode of HIV transmission (homo- and heterosexual transmission, transmission through blood transfusion or through injecting drug use (IDU) and mother-to-child transmission) and 5) CD4 count at time of HIV diagnosis. Unfortunately, the standardized forms are not always fully completed returned to the IPH, resulting in missing risk factor information. Cases which developed AIDS are subject to follow-up. Each year, data is collected on last consultation and possible death. The non-AIDS cases are not subject to follow-up.

Sero-behavioral prevalence study

In Belgium, a sero-behavioral study among drug users in contact with drug treatment facilities or who were imprisoned was carried out in 2004-05 (Plasschaert et al. 2005). In total, 1005 drug users in treatment and 117 incarcerated drug users (15-40 years) enrolled at 65 different drug treatment facilities and 15 different prisons geographically dispersed over Belgium. Of the drug users in treatment and in prison, 57.0% (n=573) and 68.4% (n=80) respectively, declared to have injected drugs at least once during their life. Intravenous blood samples were taken to determine the HIV- as well as the Hepatitis B (HBV) and C (HCV) status of the participants. The HIV-seroprevalence among injecting drug users (IDUs) in treatment and in prison was estimated to be 2.8% (95%CI: [1.5;4.2]) and 5.0% (95%CI:[0.2;938]), respectively. These prevalence were not significantly different (p-value= 0.30), yielding an overall estimated prevalence of 3.1% (95%CI: [1.8;4.8]) (see figure 4.1.).

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

Figure 4.1. HIV-prevalence rates among injecting drug users and 95.0% Wilson's confidence intervals by year and source, %, Belgium, 1995-2010



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

An update of this figure is foreseen for 2014.

3. Data on problem drug users from non-treatment sources

3.1. Injecting drug users in contact with syringe exchange in the Flemish community

Data on IDUs frequenting the syringe exchange programmes located in the Flemish Community are collected using a structured, voluntary, anonymous questionnaire since 2001 (Windelinckx 2013). Every IDU contacting one of the syringe exchange programmes is asked to fill in a questionnaire, based on the Injecting Risk Questionnaire (IRQ) (Stimson et al. 1998) and additionally containing items on health status, drug use and access to health care. From 2006 onwards, a revised and improved questionnaire is used. The results described below are not considered to be representative for all IDUs in the Flemish community, since the number of IDUs not in contact with these programmes is believed to be substantial. 64.3% of the participants to the study indicated to know at least one IDU not in contact with the syringe exchange programmes.

In 2012, a total of 227 IDUs filled out the questionnaire. The age of the participants ranged from <20 to 56-60 years, with an average age of 36.6 years. Compared to previous year, the average age of the IDUs is increasing. The majority of the participants were male (80.2%). Almost 31.4% of the IDUs live in an unstable environment (homeless, squads, etc.). The vast majority of the participants reported non-concurrent polydrug use (on average 2 different types of drugs injected, on average 4 different types of drugs used). Opiates (44.9%) were the primary injected drug of choice, followed by stimulant drugs (36.0%) and drug cocktails (18.7%). Compared to previous years, injecting cocaine use (2010: 40.1%, 2011: 47.2%, 2012: 58.0%) continues to increase. Amphetamines are more frequently injected compared to last year (2010: 41.0%, 2011: 35.4%; 2012: 41.0%), whereas methadone remains stable (2010: 4.6%, 2011: 8.7%, 2012: 8.0%). Smoking of freebase cocaine was reported by 50.5% of the participants, which is an increase of 5.0% in comparison with 2011. Up to 50.5% of the participants reported to be initiated into IDU before the age of 21 years, which is also an increase of 5.0% in comparison with last year. 65.2% reported to be injected by someone else during first injection. In total, 14.5% of the participants reported to have had at least one drug overdose the last year and 15.7% (20.5% in 2011) reported never having been in treatment. Similar as previous years, the main concern of the researchers was the young age at initiation into IDU, with 9.9% of the participants being even younger than 15 years when injecting the first time. The age of the IDUs frequenting the syringe exchange programmes was much higher, indicating that the majority of the IDUs is already (unsafely) injecting for several years before getting in contact with risk and harm reduction programmes.

3.2. High risk drug use within the party scene

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

Daily drug use in nightlife settings is investigated through the survey in recreational settings within the Flemish Community. From 2003 up to 2009, the research rotates every two years between qualitative research targeting professional workers and quantitative research (survey research) targeting users (Rosiers 2010). From 2012 onwards, the survey will be repeated every three years. Table 4.1 contains the prevalence of daily substance use by year and substance of the most recent survey conducted in 2011 (Other results of this study are described in chapter 2) (Rosiers 2013).

Table 4.1. Daily substance use in nightlife settings, %, Flemish community, Belgium, 2003-2011

Daily substance use (%)	Year				
	2003 (N=645)	2005 (N=670)	2007 (N=775)	2009 (N=607)	2011 (N=618)
Ecstacy	0.5	0.8	1.5	0.0	0.0
Amphetamine	0.8	0.6	1.1	0.2	0.3
Cocaine	0.6	0.6	2.1	0.3	0.7
Heroine	0.0	0.5	0.0	0.2	0.2
Cannabis	20.0	11.6	12.6	6.8	6.6

Source: Survey in recreational settings, VAD, 2013

The prevalence of daily use of ecstasy, amphetamine, cocaine and heroin are very low within the party scene. In 2007, these prevalence (except heroine) were slightly higher compared with the estimates of the remaining years. A declining trend of daily cannabis use was observed. In 2003, the prevalence of daily cannabis use was as high as 20.0%, declining to 6.6% in 2011 (Rosiers 2013).

Indications regarding IDU and polydrug use can be obtained on the basis of the annual survey within the party scene in the French Community (“Drogues Risquer Moins”, Modus Vivendi, courtesy of Eurotox) (see also Chapter 2). The survey aims at verifying whether the harm reduction activities apply well to the targeted audience and is therefore not representative for

the whole party scene. Nevertheless, time trends as given in Table 4.2 might be cautiously interpreted. The lifetime and last month prevalence of IDU were stable over the years, fluctuating around 3.8% and 1.8% respectively. Polydrug use was fluctuating the past years, but seems to decline slightly since 2010, with 12.7% (in 2010) to 7.2% (in 2012) of the visitors indicating to use at least three different products, alcohol included, during the event.

Table 4.2: Injecting drug use and polydrug use during events
within nightlife settings, %, French community, Belgium, 2006-2012

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

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

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

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

Antoine, J.

1. Introduction

This chapter deals with drug-related treatment issues in Belgium. First, the last developments of the legal and policy aspects of treatment and the different sources of financing for specific projects are expounded. In the second part, an overview is provided of the different available treatment facilities and important related specific projects. Finally, a description is given of the population in treatment, based on the Treatment Demand Indicator (TDI) and the opioid substitution treatment (OST) register. An analysis of the data of the past two years enables a first report of observed trends.

2. General description, availability and quality assurance

2.1. Strategy/Policy

The strategy for the treatment of drug users in Belgium is based since 2010 on the joint statement of the inter-ministerial Conference on Drugs named “A global and integrated drug policy in Belgium” (B.S/M.B. 15.04.2010). The main recommendations are: 1) the promotion of a global support strategy starting from a health approach and integrating other dimensions; 2) the availability of treatment as well as support and aftercare; 3) the provision of a large choice of facilities, specifically dedicated to drug users or global health care and well-being services; 4) the balanced geographical repartition of the settings based on an estimation of the needs; 5) the availability of drug-free treatment, withdrawal treatment, OST, harm reduction, reintegration and post-cure; 6) the promotion of integrative treatment with attention to dual diagnosis, employment, housing, psychosocial problems; 7) the development of collaborative care networks, offering general and specific treatment approaches; 8) the training of new health care workers in order to avoid waiting lists and 9) the promotion of case management focussing on individual support in specific groups.

OST in Belgium is regulated by two Royal Decrees from 2004 (B.S./M.B. 30.04.2004) and 2006 (B.S./M.B. 21.11.2006). A study by Vander Laenen and colleagues pointed out that there is a need for a solid legal framework for substitution therapy, optimizing the current regulation (Vander Laenen et al. 2013). Three focus groups were organized (a total of 21 participants) to formulate policy recommendations and to identify good practices, in order to optimize the organization of OST in Belgium on a structural level. In this respect, the participants of the focus group in Flanders suggested to link a Ministerial Circular to the Royal Decrees, establishing the tasks and responsibilities of the different providers. In 2011,

the current Minister of Public Health and Social Affairs ordered the development of a new Royal Decree. The Federal Agency for Medicines and Health Products (FAMHP) and the Federal Public Service Health developed a proposal for this decree in June 2012. In December 2012, the Royal Decree proposal was submitted to the privacy commission and will be operational in the near future.

The registration of people entering treatment for a drug-related problem (TDI) also requires adaptations in the near future. The current official document describing the TDI registration in Belgium (B.S./M.B. 03.05.2006) is no longer compatible with the new European TDI Protocol V3.0. adopted in 2012 (EMCDDA 2012). New variables have been added to the current registration and some clarifications were made about the case definition; both are to be integrated in the Belgian TDI protocol as well. The coordination committee of the Belgian TDI registration met in 2012 and 2013 to implement this protocol at a national level. A new document has been approved by the inter-ministerial conference on health on September 30th 2013 and should be implemented in the treatment facilities from 2015 onwards.

Since 1980, the National Institute for Health and Disability Insurance (NIHDI) is financing specialized centres for drug-users through specific conventions. These centres are playing an important role in the treatment for drug-users in Belgium in both quantity and quality. Throughout the years, they developed a great expertise and tested different treatment options thanks to the flexibility of the convention (Institut national d'assurance maladie-invalidité (INAMI) 2000). They offer a large selection of reimbursed treatment types to drug users (29 centres, with more than 5000 clients entering treatment a year).

The addiction fund, which is financed by the NHIDI and organized by the Federal Public Service of Health, has been created in 2006 with an annual budget of €3,000,000. The purpose is to respond to health problems in relation with addiction in an innovative way. A large number of the financed projects are related to treatment such as the installation of medical consultation for drug users in specific places, treatment of particular categories of clients (youngsters, pregnant women, etc.), online treatment, home care, etc.

In addition, four pilot projects are financed by the cell Drugs of the Federal Public Service of Health for a total of €6,000,000. These pilot projects are all related to treatment and concern 1) coordination and care; 2) crisis intervention units and case management; 3) medically controlled supply of diacetylmorphine and 4) intensive treatment of persons with dual diagnosis.

The Belgian federal science policy (Belspo) also finances research programmes to support the federal drugs policy document since 2002. Seven projects have been financed in 2012.

Among those, three are related to treatment, namely 1) demand for drug treatment in primary care, 2) best practice in children and youngsters and 3) analysis and optimization of OST.

2.2. Treatment systems

2.2.1. Availability and diversification of treatment

In Belgium, there is a large variety of treatment or help facilities for persons with drug-related disorders. The main objective of these services for drug-users is the promotion of quality of life in terms of global health (physical and psychological) and in terms of welfare and respect of the autonomy of the client. (Institut national d'assurance maladie-invalidité (INAMI) 2000; Vanderplasschen et al. 2002; Vereniging voor Alcohol- en andere Drugproblemen v.z.w. 2011b).

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

Health care facilities available for specialized treatment are described below. More specific information is also provided through the IDA-Web website, which is the web platform for professionals on alcohol and drugs.

*MASS/MSOC: S*ocio-sanitarian hospitality houses which are low-threshold ambulatory centres offering mainly an individual support based on the harm-reduction model, e.g. medical and social support, OST. In addition, they often coordinate needle exchange programmes.

Day centres: These centres are targeting problematic users, occasional users and their relatives by the organisation of individual or group treatment sessions. A total abstinence of the user is not required but he/she cannot be under influence during the sessions. They offer medical (OST included), psychosocial, administrative and legal support.

Centres for mental health: The objective of these centres is a total abstinence or a reduction in consumption of the user by individual, group and family sessions. They pursue mental health recovery and can also handle more complex problems such as dual diagnosis. Some centres for mental health have also a specific offer oriented on addiction problems.

Semi-residential psychiatric treatment: These are psychiatric day-clinics where a client can be admitted after a residential treatment programme. Prevention of relapse is the main focus next to offering psychosocial support and guidance of the user in his/her social and societal reintegration.

Crisis centres: These low-threshold residential centres were often created from an existing therapeutic community. Clients in crisis can be admitted for a short period including group or individual sessions, in order to pursue detoxification from physical dependence and to motivate the client for future treatment.

Psychiatric unit in a general hospitals: Short time admissions with an aim at detoxification, observation, diagnostic opinion and motivation for future treatment. No substance consumption is permitted during the stay.

Psychiatric hospitals: These hospitals generally include a detox or specialized treatment unit for crisis intake, screening, detox, social reintegration and aftercare. The client has to be in complete abstinence.

Therapeutic communities: These entities provide long-term admission programmes in which clients can mainly enrol in group sessions on substance abstinence and reintegration of the client in the society by the respect of community life rules.

Some specific projects are currently being developed to target particular topics on treatment aspects.

Cannabis use disorder in troubled youth - The INCANT project

Noticing a lack of evidence-based programmes to treat heavy cannabis use in Europe, government representatives from Belgium, France, Germany, The Netherlands, and Switzerland decided to have U.S.-developed multidimensional family therapy (MDFT) tested in their countries in a trans-national trial, called the International Need for Cannabis Treatment (INCANT) study.

INCANT was a 2 (treatment condition) × 5 (time) repeated measures intent-to-treat randomised effectiveness trial comparing MDFT to Individual Psychotherapy. Data were gathered at baseline and 3, 6, 9 and 12 months thereafter. Participants (n=450) were adolescents from 13 to 18 years old with a recent cannabis use disorder. Three primary outcomes were assessed 1) treatment retention; 2) prevalence of cannabis use disorder and 3) 90-day frequency of cannabis consumption.

Cannabis use disorder was responsive to treatment. MDFT exceeded individual psychotherapy in decreasing the prevalence of cannabis dependence. MDFT is applicable in Western European ambulatory settings, and may show moderately greater benefits than individual psychotherapy in youth with more severe substance use (Rigter et al. 2012; Rowe et al. 2013).

Heroin-assisted treatment - The TADAM project

The first heroin-assisted treatment in Belgium was conducted in Liège between January 2011 and January 2013. The "Treatment Assisted by Diacetylmorphine" study (TADAM) is an open-label randomised controlled trial comparing heroin-assisted treatment with the existing oral methadone treatment on 74 clients. The TADAM project originated from a claim by the public services of the city of Liège, supported by methadone centres, that a new heroin-assisted treatment could help heroin addicts where methadone treatment is unsuccessful. The introduction of the TADAM trial was recommended in Liège owing to the significant number of heroin addicts and to the availability of the methadone treatment. The results will be published end 2013 (Demaret et al. 2011; Demaret et al. 2013).

Crisis intervention units and case management

People with substance related-disorders are often admitted through emergency units in hospitals. However, these admissions encounter many difficulties. This pilot project aims to develop a correct admission for these people and to implement the case manager profile. The operational objectives are that, after a limited 5 days intensive treatment, the client is at least stabilized and that, in collaboration with a case manager, the patient is referred to other appropriate ambulant or residential services. The function of the case manager is to guarantee the continuity of care. Five units are participating in Flanders (Antwerp, Ghent, Genk, Leuven, Bruges), three in Wallonia (Liège, Namur, Mons) and one in Brussels. The study concludes that there is a need for this kind of short duration admission for people in a crisis situation. Firstly, a broader definition of the concept 'crisis situation' is needed. Secondly, a tool that helps with assessment, intervention, planning and after care, specifically oriented on crisis management, can also be very useful. Thirdly, a network between treatment services working within the care pathway of the client is also important. Concerning case management, there is a demand for a unique model in the crisis units, for guidelines and for the completion of some basic functions before the case management comes into play. Case management can be seen as a link between the formal and informal care pathway (Bruffaerts et al. 2010).

Intensive treatment of clients with dual diagnosis

The project 'intensive treatment of clients with dual diagnosis' was launched in 2002 in two dual diagnosis units (Psychiatrisch Centrum Gent-Sleidinge and Intercommunale de Soins spécialisées de Liège). This specific project offers an intensive and integrated residential treatment for clients suffering from problematic substance use in combination with a psychotic disorder. First of all, results show that an intensive and integrated treatment of young adults with a dual diagnosis provides more positive results on psychological

functioning, quality of life and the general functioning in short or long term compared to the classic treatment. Another important finding is that the therapeutic effect after one year of standard treatment has decreased more compared to the integrated treatment. Tools have also been established for the evaluation of ambulatory care, before or after the stay in hospital (Sabbe et al. 2008; Morrens et al. 2011). This project is prolonged until December 2013. The results from this research have been confirmed by an audit done by the Collaborative Antwerp Psychiatric Research Institute (CAPRI) from the University of Antwerp in 2012.

2.2.2. Organisation and quality assurance

The VAD review of evidence based treatment guidelines

The Flemish regional focal point, the association for alcohol and other drug problems (vereniging voor alcohol- en andere drugproblemen: VAD) developed an overview of evidence-based guidelines for the treatment of alcohol or drug-related problems. These guidelines are evaluated critically on their methodology, intelligibility and presentation, possibility of use, flexibility and independence of the authors (Vereniging voor Alcohol- en andere Drugproblemen v.z.w. 2011a). This work builds on a research project (Pham et al. 2005), from which the findings were published in a monograph (Autrique et al. 2007) including a list of reviewed guidelines. The new reviewed guidelines, published in 2011 and 2012, concern mainly the treatment of clients with a dual diagnosis (Snoek et al. 2012).

Analysis and optimization of substitution treatment - The SUBANOP project

The SUBANOP-study started with the aim to gain more insight in and optimize current practices of OST in Belgium. Although OST has been applied on a large scale for more than 15 years now, research on this topic is limited. A centralized and comprehensive database which allows to map the providers of OST and to monitor evolutions in treatment demand and practices over time is needed. It is also necessary to collect more information on the characteristics and support needs of persons participating in OST. The combination of treatment-related data (e.g. dosage, type of medication and treatment regimen) with client data may provide important information regarding the question which clients benefit most from (e.g. treatment with buprenorphine and what their support needs are). Finally, additional research is advised regarding the nature and type of psychosocial support that opiate dependent persons require (Vander Laenen et al. 2013).

Best practice guidelines in children and youngsters - The ADAPTE-Youth project

The overall aim of this project is the development of best practice guidelines for the detection, prevention and treatment of substance abuse in children and youngsters between the age of 12 to 25 years, using the ADAPTE process (Hannes et al. 2011).

First, an epidemiological study has been conducted focussing on a) the prevalence of problematic alcohol and drug use in the Belgian population of children and youngsters and b) the prevalence of parental problematic alcohol and drug use. Secondly, a web-based survey has been conducted to identify and describe all Belgian organisations, target groups and stakeholders involved in drug- and alcohol detection, prevention or treatment. The results of this survey will be used to identify potentially important stakeholders that can be involved in the process of the adaptation of existing, international guidelines to a local context.

The research group will apply a stepwise approach focussing on the assessment of the quality of existing guidelines, their consistency, their applicability and appropriateness for a Belgian context. A set of draft guidelines will be piloted in potential user groups and these insights will be used to finalize a best practice guideline(s) on the detection, prevention and treatment of alcohol and drug abuse in children and youngsters. The final best practice guidelines adapted to the Belgian situation are not yet available. This project is on-going and results are not yet available.

Demand for drug treatment in primary care - The UP-TO-DATE project

Despite a diversified ambulatory care offer, general practitioners (GPs) are seen as major players in detecting and managing problems related to (il)legal substance abuse. Similarly, occupational physicians are also expected to play a role in the field of addiction, as health and safety promoters in the workplace. In Belgium little is known about resources and strategies used by these health professionals when they are faced with this issue, nor what their interests or attitudes are. The questions that this study will ask are 1) what is the current demand for care in the front line; 2) to what extent are GPs involved in this problem and 3) what resources can they use to provide an appropriate response to all types of requests for treatment of substance abuse (Vanmeerbeek et al. 2012).

3. Access to treatment

3.1. Characteristics of treated clients

3.1.1. The treatment demand indicator registration

The (TDI) registration in Belgium is officially approved by the inter-ministerial conference on public health in 2006 (B.S./M.B. 03.05.2006). A national TDI protocol was adopted in 2010 based on the EMCDDA Protocol version 2.0 (Simon et al. 2000). The registration at national level has been launched on January 1st 2011 in specialized centres. The new European protocol 3.0 was adopted in 2012 to be implemented in EU member states (EMCDDA 2012). Substantial work has been done in Belgium in both 2012 and 2013 to implement this protocol and to write a new national protocol, which has been adopted in September 2013 and serves as a basis for the registration from 2015 onwards.

As from 2011, the specialized residential and ambulatory centres use an online form to encode their clients, or send their formatted file containing all records through a repository module. Around 100 specialized centres should participate in this TDI registration.

In addition, 25 hospitals also have been invited to test the TDI registration through a pilot-project running from august 2011 to august 2012. This project has been prolonged and is now working with 42 hospitals (around one fourth of all hospitals) till the end of 2013.

Prisons and GPs are not currently participating in this data collection.

3.1.2. Description of clients entering treatment

This section describes the clients entering treatment for their illicit drug consumption (alcohol excluded) during 2012 in the centres participating in the TDI registration in Belgium (clients that are in continuous treatment for a long duration are not included in the TDI registration). This year, 26 outpatient centres out of 72 (36.0%) participate in the data collection, 20 inpatient centres among 21 (95.0%), 36 hospitals from 42 participating (86.0%) in the pilot-project and 9 low-threshold centres (MASS/MSOC) on 9 (100%).

The total number of clients entering treatment in 2012 was 6004 for a total number of 8034 treatment episodes. Among those clients, 29.1% started a treatment for the first time in their life. A large part of the clients (40.0%) was registered in outpatient centres, 37.6% in inpatient centres (including hospitals) and 22.4% in low-threshold agencies. Table 5.1 shows the number of clients in treatment by main substance and by gender.

(clients who are in continuous treatment since a long time are not included in the TDI registration)

Table 5.1. Persons starting treatment, by main substance and gender, N and %, Belgium, 2012

Main substance	Male		Female		Total*	
	N	%	N	%	N	%
Opiates	1,619	34.3	386	30.3	2,006	33.4
Stimulants**	1,194	25.3	357	28.0	1,552	25.8
Hypnotics and Sedatives	154	3.3	185	14.5	339	5.7
Cannabis	1,662	35.1	291	22.8	1,954	32.5
Other substances	97	2.0	56	4.4	153	2.6
Total	**4,726**	**100.0**	**1,275**	**100.0**	**6,004**	**100.0**

* Unknown gender are also included

** Stimulants category includes cocaine + other stimulants such as amphetamine

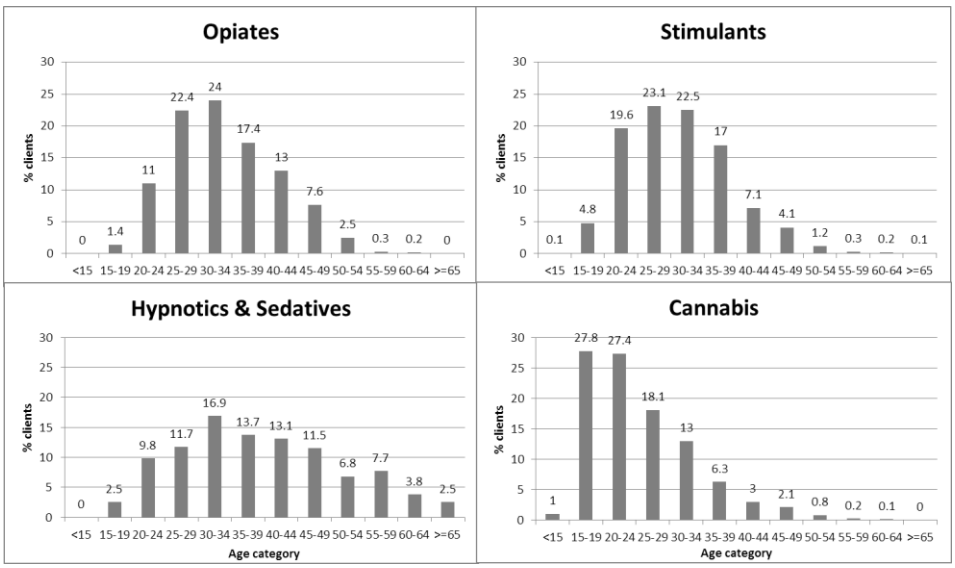
Source: BTDIR, 2012.

The main illicit substances for which a client started treatment were opiates (in 33.4% of the treatment demands) and cannabis (32.5%). The other substances were stimulants (25.8%) and hypnotics and sedatives (5.7%).

The proportion of women in treatment is 21.2% but the variations are widely depending on the main substance. This proportion is much more important for hypnotics and sedatives (54.6%) than for cannabis (14.9%). For opiates and stimulants, the proportion of women in treatment is around 20.0%.

Figure 5.1. represents the age distribution of clients in treatment by primary illicit drug. Clients in treatment for hypnotics are the oldest with an mean age of 39 years. On the opposite, clients in treatment for cannabis are the youngest (mean age of 25 years). The mean age for opiates users is 34 years and 31 years for stimulant users. 23 clients (0.4% of the treated population) are less than 15 years old. The majority are cannabis users.

Figure 5.1. Age distribution of clients in treatment for substance use, by primary drug, %, Belgium, 2012



Source: BTDIR, 2012.

The client's profile is also different according to the main substance used. Table 5.2. describes the addiction profile of clients by main substance.

Table 5.2. Consumption profile (last 30 days) of persons in treatment, by main substance, Belgium, 2012

Variables	Opiates	Stimulants	Hyp. & Sed.*	Cannabis
% ever injected	42.0	17.0	9.0	4.0
% daily consumers	61.0	34.0	73.0	51.0
% only 1 substance	18.0	24.0	47.0	44.0
% first treatment	12.0	24.0	23.0	40.0
Mean age (y) at first use	22.0	20.0	26.0	16.0

*Hypnotics and sedatives

Source: BTDIR, 2012.

The percentage of clients who have ever injected one substance is high among opiates users (42.0%) whereas this prevalence amounts to 17.0% for stimulant users, 9.0% for hypnotics users and 4.0% for cannabis users.

The frequency of use of the main substance is also very different. Only one third of the stimulant users (34.0%) uses the product every day during the last 30 days but almost three out of four (73.0%) persons who are using hypnotics and sedatives are daily consumers.

More than 3 out of 4 opiate (82.0%) and stimulant (76.0%) users report also other substance use (including alcohol), whereas this proportion is 53.0% for hypnotics and 56.0% for sedatives and cannabis users.

Only a small proportion of opiate users enters treatment for the first time (12.0%). This proportion doubles for stimulant users (24.0%) and for users of hypnotics (23.0%). The proportion of cannabis users who are in treatment for the first time is much higher (40.0%).

On average clients started using cannabis for the first time when they were 16 years old. The age of first use is higher for stimulants (20y), opiates (22y) and hypnotics (26y).

3.1.3. Description of the opioid substitution treatment register

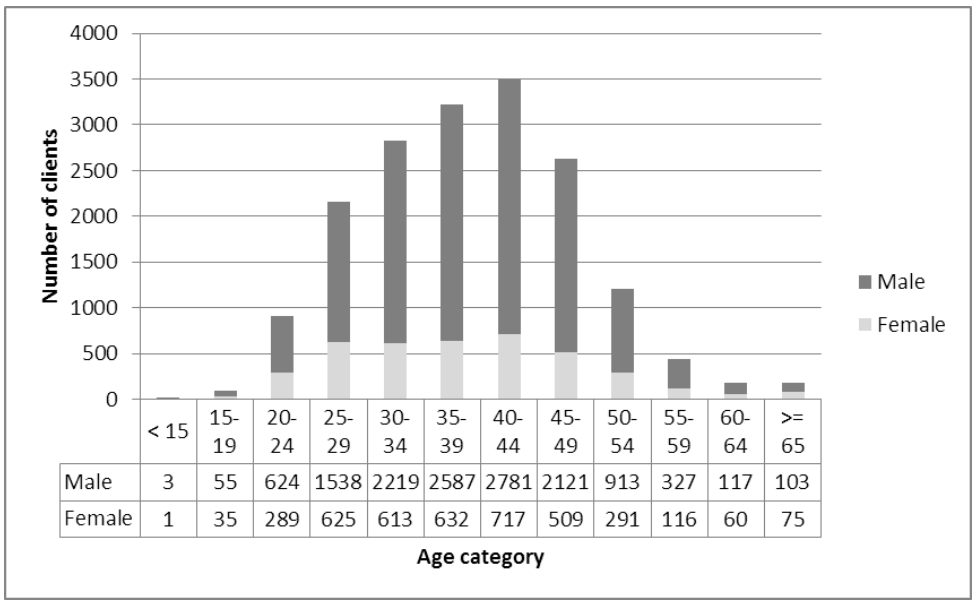
Since April 2009, prescriptions for methadone and buprenorphine are registered in the Pharmanet-system (registering the consumption of medial drugs) of the National Institute for Health and Disability Insurance (NIHDI). The objective of this registration is to avoid multiple prescriptions and allow warnings among concerned practitioners as requested by the Royal Decree of March 19th 2004 (B.S./M.B. 30.04.2004). This database contains information from public pharmacies, hospital pharmacies and specialized centres. OST provided in prisons are not included in this database.

3.1.4. Description of clients in opioid substitution treatment

In 2011 17351 clients were registered in the OST database. 12.0% of them received buprenorphine and 88.0% received methadone.

Figure 5.2 describes the profile of clients in OST. The proportion of women receiving OST is 23.0% which is similar to the proportion of women registered in the TDI database (21.0%). The mean age of clients in OST is 38 years.

Figure 5.2. Age distribution of persons in substitution treatment, by sex, N, Belgium, 2012



	< 15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	>= 65
Male	3	55	624	1538	2219	2587	2781	2121	913	327	117	103
Female	1	35	289	625	613	632	717	509	291	116	60	75

Source : Substitution registry, 2012

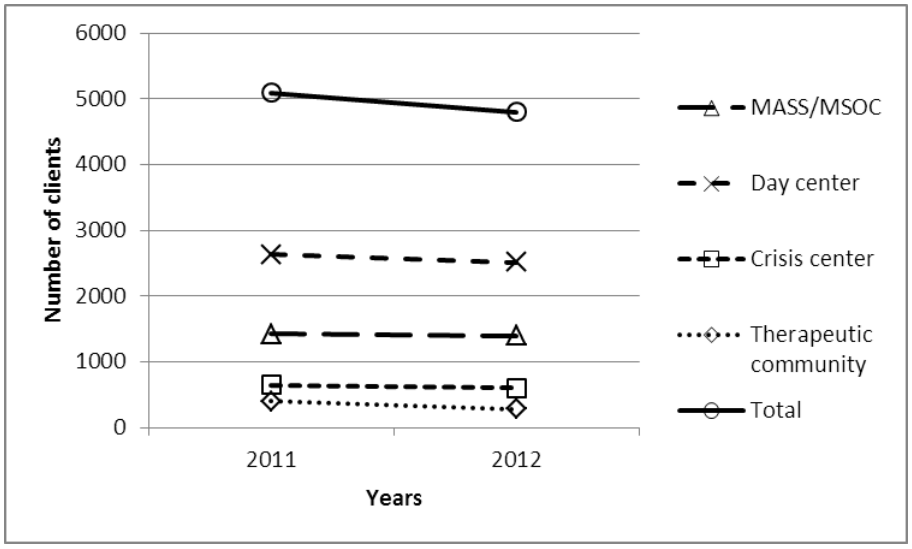
3.2. Trends of treated population and treatment provision

3.2.1. Clients in TDI register

In order to assess the trends of the population in treatment the analysis was restricted to a subset of centres, having a convention with the NIHDI, that are more constant in their participation in the TDI registration. The 27 centres (11 in Flanders, 10 in Wallonia and 6 in Brussels) with a NIHDI convention are obliged to register the TDI and therefore have the most complete and comparable data through years. The same number of units are reporting every year. These numbers are used to study trends but are not representative for the whole population in treatment. As the new TDI registration started in 2011, only 2 years are available for trend analysis.

The absolute numbers of treatment episodes reported in the different types of programmes are illustrated in the Figure 5.3. A slight decrease of around 300 treatment episodes (5.9%) between 2011 and 2012 is observed. This change appears in every type of programme; low-threshold centres, day centres, crisis centres and therapeutic communicates show a decrease of respectively 1.8%, 4.3%, 6.1% and 29.9.

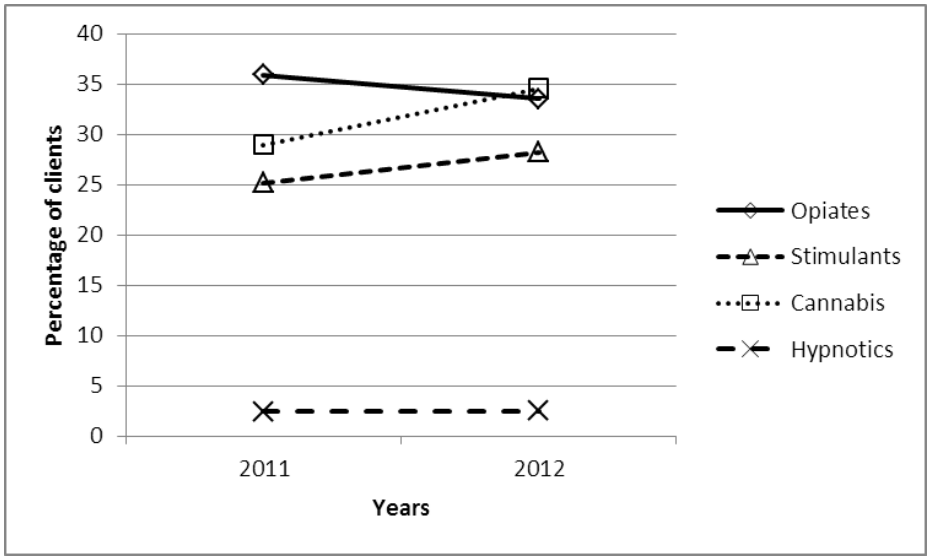
Figure 5.3. Evolution of the number of clients entering treatment in the specialized centres with a NIHDI convention, N, Belgium, 2011-2012



Source : BTDIR, 2012

The evolution of the percentage of main substance treated through the years is presented in Figure 5.4. The percentage of opioid users in treatment decreases from 36.0% to 34.0%. In contrast, the percentage of cannabis users is increasing from 29.0% to 35.0%. The proportion stimulant users is also increasing from 25.0% to 28.0% and the proportion of clients using hypnotics and sedatives remains stable at 2.0%.

Figure 5.4. Evolution of the percentage of main substance by clients entering treatment in the specialized centres with a NIHDI convention, N, Belgium, 2011-2012

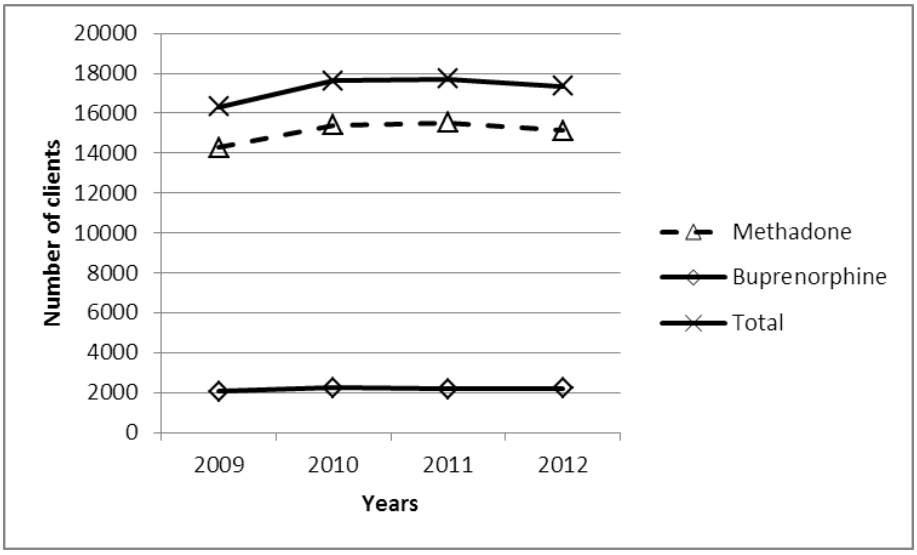


Source : BTDIR, 2012

3.2.2. Clients in substitution treatment

The trends of total number of clients in OST (Figure 5.5) can be observed from 2009. The relative increase from 2009 to 2012 is 6.3%. This proportional increase is lower for methadone (6.1%) than for buprenorphine (8.2%).

Figure 5.5. Evolution of the number of persons in substitution treatment, N, Belgium, 2009-2012



Source : Substitution registry, 2012

Acknowledgements chapter 5:

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Chapter 6. Health correlates and consequences

Plettinckx E.

1. Introduction

In this chapter, the health consequences of illicit drug use in Belgium are described. Regarding drug-related infectious diseases (DRID), data from national registers (HIV/AIDS and tuberculosis (TBC) register) and from diagnostic testing in drug services (ST9) are summarized. Behavioural data were collected by Spuitenruil Vlaanderen (Windelinckx 2013) and Modus Vivendi (socio-epidemiological observatory for alcohol and drugs in the Federation Wallonia-Brussels, Eurotox). Data from the National Poison Centre were used to provide information on drug-related emergencies. In addition, Psychiatric comorbidity was described based on the EuropASI, used as part of the intake interview at treatment centres from De Sleutel. Finally, information on drug-induced deaths was obtained using the National Mortality Register and the general mortality registers (GMR) (ICD-10, Selection B) of the Flemish and Brussels Capital region.

The first national DRID study was conducted during 2011-2012. This study tried to get insight in DRID diagnosis, risk behaviour and psychiatric comorbidity among injecting drug users (IDUs) at national level. These three topics are described in this chapter.

2. Drug-related infectious diseases

2.1. HIV/AIDS and viral hepatitis

2.1.1. National HIV/AIDS register

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

In 2012, 4 persons newly diagnosed with HIV, reported intravenous drug use as the probable mode of HIV transmission, yielding a percentage of 0.5% of the persons newly diagnosed with HIV being probably attributable to injecting drug use (IDU). Potentially as a result of reporting delay, no new AIDS diagnoses related to IDU were reported for 2012. It is clear that the percentage of IDUs among persons newly diagnosed with HIV are much lower compared to the

beginning of the HIV epidemic in the mid-eighties. Moreover, the HIV prevalence among IDUs is decreasing every year since 2007. No clear time trends were observed regarding the proportion of IDUs among the newly diagnosed AIDS cases. However, with exception of the onset of the HIV-epidemic, the proportion of IDUs among AIDS-cases was found to be systematically, although not significantly, higher than the proportion of IDUs among the HIV-cases, indicating that IDUs are more rapidly developing AIDS compared to non-IDUs. It is hypothesized that this is due to the higher hepatitis co-infection rate among IDUs compared to non-IDUs and/or due to differences in treatment compliance.

2.1.2. HIV diagnostic testing among ever-IDUs

The prevalence rate of HIV seropositivity among ever-IDUs in treatment was obtained based on serological data. Serological data among ever-IDUs, however, is only available for the Flemish region. The prevalence estimates are based on test results of blood screening collected through 'De Sleutel' (an institution of several ambulatory and residential treatment centres located throughout the Flemish region). Previous years, prevalence estimates were also collected through Free Clinic (an outpatient clinic located in Antwerp). Nevertheless, recent data about 2012 provided by Free Clinic is not available yet. De Sleutel collects serological information for clients entering treatment. Nobody of the clients entering treatment in 2012 (N=36) was found to be HIV seropositive. An overview of the prevalence rates for the period 2006-2012 is provided in Table 6.1, showing moderately fluctuating prevalence rates without clear time trends.

Table 6.1. HIV seropositivity among ever-injecting drug users in treatment (De Sleutel), % and N, Flemish community, Belgium, 2006-2012

HIV diagnostic tetsing		**Year**						
		2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
HIVab	%	2.9	3.7	3.3	0.0	3.4	8.3	0.0
	N	68	54	60	47	29	48	36

* prevalence rates based on self-reporting

Source: ST9P2_2007-2013_BE

2.1.3. Hepatitis diagnostic testing among ever-injecting drug users

The hepatitis prevalence rates among ever-IDUs in treatment was obtained analogously to the HIV prevalence rate described above. An overview of the hepatitis B (HBV) and C (HCV) prevalence rates for 2006-2012 are given in table 6.2. Regarding Hepatitis B, 3.0% of the clients tested positive for HbsAg in 2012, 11.0% for antiHBc and 33.0% for antiHBs. Regarding Hepatitis C, 17.0% of the clients tested positive for HCVab in 2012. Comparing these results with previous years does not reveal significant time trends.

Table 6.2. Hepatitis B and C infections among ever-injecting drug users in treatment (De Sleutel), % and N, Flemish community, Belgium, 2006-2012

Hepatitis diagnostic testing		**Years**						
		2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Hepatitis B								
HBsAg	**%**	0.0	0.0	1.9	0.0	0.0	4.3	3.0
	N	63.0	45.0	54.0	44.0	29.0	47.0	36.0
antiHBc	**%**	15.8	25.0	2.6	7.1	0.0	16.7	11.0
	N	38.0	28.0	38.0	28.0	22.0	36.0	28.0
antiHBs	**%**	12.3	11.1	18.4	25.0	20.0	25.5	33.0
	N	57.0	45.0	49.0	40.0	30.0	47.0	33.0
Hepatitis C								
HCVab	**%**	36.2	34.0	27.0	30.4	28.1	42.3	17.0
	N	69.0	53.0	63.0	46.0	32.0	52.0	35.0

Source: ST9P2_2007-2013_BE

2.1.4. National prevalence data on HIV, Hepatitis C and B among current injecting drug users

Until 2011, Belgium did not have national prevalence data for HIV, HCV and HBV among IDUs. Prevalence data for HIV, HCV and HBV are only available at local level. These local prevalence data differ mostly because of regional variation in prevention and harm reduction practices, client population and testing and reporting methods between the various centres (Bollaerts and van Bussel 2012). In order to have more comparable prevalence data, the EMCDDA and the University Mental Health Research Institute (UMHRI) in Greece developed guidelines to set up national DRID studies (Blystad and Wiessing 2010). These guidelines were used to conduct the first Belgian DRID study in 2011-2012. Participants were recruited through various low threshold drug treatment centres in Belgium by using the Respondent Driven Sampling (RDS) method. Anonymity was guaranteed throughout the study. After giving their official permission to participate to the study by signing an informed consent form, the participants were interviewed by the researchers (please refer to 2.3.3. and 3.2.1.4.) and were asked to deliver a saliva

sample between March and November 2012. The saliva samples were examined on HIV, HCV and HBV using Enzyme-Linked Immuno Sorbent Assay (ELISA) tests (Bollaerts and van Bussel 2012).

In total 180 IDUs participated to the study. All participants aged between 18 and 55 years old. The mean age of the participants is 36.6 year. Most of them were male (80.6%). The mean age of first IDU is 21.4 years old. 25.0% of the participants injected already before their 16th year of life. 21.1% of the participants injected only one substance during the last 12 months. The results of the ELISA tests (see table 6.3) indicate a high HCV prevalence of 43.3% [95%CI: 34.3 – 52.4] in 2012 among the participants who injected during the last 12 months. The prevalence of HBV (3.7%; [95%CI: 0.8 – 6.6]) and HIV (2.3%; [95%CI: 0.1 – 4.6) is much lower (Bollaerts and van Bussel 2012).

Table 6.3. HIV, hepatitis B and C infections among current (last 12 months) injecting drug users, %, Belgium, 2012

Diagnostic testing	Prevalence	
	%	% correction*
HIV		
anti-HIV (type 1 and 2)	2.3 (0.1-4.4)	2.3 (0.1-4.6)
Hepatitis B		
HBsAg	3.4 (0.7-6.0)	3.7 (0.8-6.6)
Hepatitis C		
Anti-HCV	38.6 (30.5-46.6) **	43.3 (34.3-52.4)

* Rogan-Gladen estimator: correction for testmisclassification
** xx (xx-xx): prevalence (95% confidenceinterval)

Source: DRID study (Bollaerts and van Bussel 2012)

2.2. Sexual transmittable infections and tuberculosis

2.2.1. National tuberculosis register

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

Since 1980, the national TBC incidence rate has declined rapidly, from 28.0 cases per 100,000 person years in 1980 to 9.5 cases per 100,000 person years in 2009. In 2010, an increase was observed with an incidence rate of 10.3 per 100,000 person for that year. In 2011, the incidence rate was same as in 2009, with 9.5 registered cases per 100,000 person years. In 2012, the incidence rate has decreased until 8.9 registered cases per 100,000 persons years, which is the lowest incidence rate since 2001. The highest incidences in 2012 were observed for Brussels (27.4/100,000), Antwerp (20.2/100,000) and Liège (22.5/100,000). Of the 987 cases registered in Belgium in 2012, 82.8% (N=817) had known risk factor of which 1.3% (N=11) was associated with intravenous drug use. However, the registration of the identified risk factors is disputable (Patrick de Smet, personal communication).

2.3. Behavioural data

2.3.1. Risk behaviour in injecting drug users in contact with syringe exchange in the Flemish region

Since 2001, data about risk behaviour among IDUs, who are using one of the syringe exchange programmes located in the Flemish Community, have been collected using a structured, voluntary, anonymous questionnaire (Windelinckx 2011). Every IDU contacting one of the syringe exchange programmes is asked to fill out a questionnaire which is based on the Injecting Risk Questionnaire (Stimson et al. 1998). This questionnaire contains additional items on health status, drug use and access to health care (Windelinckx 2013). An overview of the responses related to the IRQ is given in table 6.4.

In 2012, the majority of the participants (59.1%) reported not having shared injecting equipment with someone else during the last four weeks. Sharing needles and/or syringes with sexual partners is less common. 33.6% and 25.8% respectively of the participants reported having given or lent needles and/or syringes from a sexual partner. Sharing other injecting equipment during the last four weeks is more frequently reported: spoons (receptive: 41.6%), water (receptive: 45.5%) and filters (receptive: 35.1%). These results are in line with the results from 2010.

Table 6.4. Responses to the injecting risk questionnaire in needle exchange services, N and %, Flemish region, Belgium, 2012

Questions	N	Answers (%)			
During the last 4 weeks, …		**0**	**1**	**>2**	**Don't know**
How often have you shared injecting equipment?	225	59.1	14.2	18.2	8.5
How often have you given used needle/syringes to a sexual partner?	158	66.5	17.1	16.4	0.0
How often have you lent used needle/syringes from a sexual partner?	159	71.1	13.8	12.0	3.1
How often have you used a spoon that has already been used by someone else?	226	53.1	15.9	25.7	5.3
How often have you used a filter into which someone else had put a used syringe?	225	61.0	17.0	18.0	4.0
How often have you used the same water or bleach as someone else for flushing out?	224	47.8	21.9	23.6	6.7
How often have you injected with needles/syringes that had already been used by someone else?	209	77.5	14.4	6.0	2.0
How often have you filled your syringe from one that already been used by someone else (frontloading/backloading) ?	225	79.1	13.3	5.3	2.2
How often have you used old syringes that had been kept in the same container as someone else's old syringes?	221	72.8	12.7	9.1	5.4

Source: Spuitenruil Vlaanderen (Windelinckx 2013)

Similar as previous years, the percentage of participants who claimed not to have shared needles/syringes is higher compared to the percentage of participants who claimed not to have shared other paraphernalia. As such, the researchers conclude that the harm reduction campaigns of previous years, which focused on not sharing needles/syringes, were successful (Windelinckx 2013). However, drug users are less aware of the risk associated with sharing paraphernalia, probably explaining the very high Hepatitis C prevalence rates among IDUs. Future harm reduction campaigns will focus more on this type of risk behaviour.

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

Data on risk behaviour among IDUs recruited on the street in the French community is collected using "snowball operations" (opérations Boule de Neige), which has been organised by Modus Vivendi since 1993. The primary objective of these snowball operations is peer prevention and targeting hard-to-reach subpopulations. To this end, volunteering IDUs (jobistes) are trained (15-hours training) and paid to disseminate information on AIDS and hepatitis prevention and other harm reduction information among their peers.

The information on risk behaviour collected from surveys administered during these snowball operations, is summarized in Table 6.5 for the years 2006-2012. However, these results are not deemed to be representative for IDUs on the street in the French community, as the results are not corrected for their dependence on the social network of the 'jobistes' and because the questionnaire is mainly a contact tool for which the completion is not truly standardized. Moreover, the geographic coverage of snowball operations may vary from year to year depending on the supply and demand of harm reduction activities at local level. Nevertheless, the results indicate that injecting risk behaviour remains common among the recruited sample, with the last six month percentage of receptive needle/syringe sharing varying from 12.8% to 42.4% during the period 2006-2012. The time trends of these percentages are difficult to interpret due to the limits exposed above. Some drug users even reported having used needles/syringes found on the street during the last six months. Although the data do not allow conclusions on the extent and frequency of the risk behaviours, they clearly indicate that extreme injecting risk behaviour is not ruled out.

Table 6.5. Injecting Risk behaviour among street-recruited injecting drug users, Modus Vivendi (Opérations Boule de Neige), N and %, French Community, Belgium, 2006-2012

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

Source: Eurotox, 2007-2013

2.3.3. Risk behaviour in injecting drug users at national level

The first Belgian DRID study at national level in 2011-2012 provided not only analyses of saliva samples (please refer to 2.1.4. for more background information), but also provided information about risk behaviour among IDUs through qualitative interviews. The most important indicators are described in table 6.6.

In 2012, 42.3% of the participants reported having shared at least once paraphernalia with someone else during the last 30 days. 25.5% shared needles with at least one person and 23.5% did not use a sterile needle during the last injection. 57.8% and 61.1% respectively, reported to be tested for HIV or HCV. These figures indicate that IDUs are not screened as frequent as the EMCDDA guidelines recommend. Active IDUs have to be screened every 6 or 12 months (Blystad and Wiessing 2010). 78.0% of the drug injecting participants had sex during the last 12 months. Among them, only 22.0% used a condom (Bollaerts and van Bussel 2012).

Table 6.6. Overview of the infectious diseases related risk behaviour of injecting drug users participating to the DRID study, N and %, Belgium, 2011-2012

Topics injecting risk behaviour DRID study	**year**	
	2011- 2012 (N=180)	
Needle exchange	**Answer**	**%**
During the last 30 days, how many times did you share paraphernalia (injecting equipment such as spoon, filter, water, except needles) with someone else (partner included)?	0	55.5
	1-5 times	24.3
	More than 5 times	18
During the last 30 days, with how many people did you share paraphernalia (injecting equipment such as spoon, filter, water, except needles)?	0	54.2
	1-2	30.5
	More than 2	14
During the last 30 days, with how many people did you share syringes?	0	70.8
	1-2	21.5
	More than 2	4
During the last 30 days, how many times did you give, lend or sell used needles to someone else (partner included)?	0	89.5
	1-5 times	8.3
	More than 5 times	1
During the last 30 days, how many times did you inject with syringes already used by someone else (partner included)?	0	85.4
	1-5 times	13.2
	More than 5 times	1
How many times did you injected with the last syringe you used before throwing it away?	1 time	61.8
	2-5 times	35.1
	More than 5 times	3
Did you use a sterile syringe when you injected the last time?	Yes	82.6

Serological tests	**Answer**	**%**
When were you last tested for HIV (not taking into account the test of today)?	0-12 months ago	57.8
When were you last tested for antibodies against HCV (Hepatitis C) (not taking into account the test of today)?	0-12 months ago	61.1
Sexual behaviour	**Answer**	**%**
Did you have sex during the last 12 months?	Yes	78.3
With how many partners did you have sex during the last 12 months?	1-2	76.6
	2-5	15.6
	More than 5	7.8
Did you or your partners use a condom when you had sex the last time?	Yes	22
Did you have paid sex during the last 12 months? Paid sex means: having sex in exchange for money, drugs, food, shelter or other advantages.	Yes	9.9

*coding in accordance to 'DRID guidance module: example questionnaire for seroprevalence and behavioural surveys in injecting drug users.'

Source: DRID study (Bollaerts and van Bussel 2012)

3. Other drug-related health correlates and consequences

3.1. Non-fatal overdoses and drug-related emergencies

3.1.1. Telephone enquiries related to drug intoxications

Since 1963, the Belgian national poison centre has received more than 50,000 telephone enquiries each year related to acute or suspected poisoning by the general public and health professionals. In 2012, 345 calls were related to substance intoxications among adults (>14 years old) (Dr. Mostin, personal communication). In 58.5% of the cases (N=202), only one substance was involved. 216 questions were related to illicit substances. An overview of these substances is given in Table 6.7. The majority (25.0%) of the intoxications were related to cannabis and their derivatives, 18.5% to cocaine and 13.9% to amphetamine, speed and central nervous system (CNS) stimulants. These figures indicate that the number of cannabis- (2009: 34; 2010: 32; 2011: 50; 2012: 54) and cocaine- (2009:24; 2010:18; 2011:16; 2012:40) related enquiries have increased over the years.

Table 6.7. Illicit substances mentioned during telephone enquiries received by the Belgian national poison centre, N and %, Belgium, 2012

Illicit substances	Year	
	2012	
	N	%
Cannabis	54	25.0
Cocaine	40	18.5
Amphetamine/speed/CNS stimulants	30	13.9
Inhalants/solvents	17	7.8
Heroin/opiates	15	6.9
GHB/GBL	14	6.5
Ecstasy	14	6.5
Ketamine	3	1.4
Mushrooms/hallucinogenic plants	1	0.5
LSD	1	0.5
Other/unknown	27	12.5
Total	**216**	**100.0**

Source: National Poison Centre (Mostin, personal communication 2013)

3.2. Other topics of interest

3.2.1. Psychiatric comorbidity in drug users entering treatment in the Flemish region

As part of the intake interview, the European Addiction Severity Index (EuropASI), is administered to all clients entering treatment in one of the treatment centres of De Sleutel (Raes et al. 2004; Raes and Lombaert 2004). Based on the data collected through the EuropASI, the prevalence of comorbidity between drug use disorders and other mental illnesses (dual diagnosis) is estimated by cross classifying patients as mild (severity scores 0-3), moderate (severity scores 4-5) and severe (severity scores 6-9) on the life areas ‘alcohol and drug use’ and ‘psychiatric status’. Patients were then classified as ‘moderate dual diagnosis’ when they had moderate problems in both the substance misuse and the psychiatric domain, or when they had severe problems in one domain combined with moderate problems in the other domain. Patients were classified as ‘severe dual diagnosis’ when they had severe problems in both the substance misuse and psychiatric domains.

Table 6.8 summarizes the prevalence of the psychiatric comorbidity for the years 2006- 2012. These prevalences indicate a decrease of psychiatric comorbidity of patients entering treatment facilities of ‘De Sleutel’ in the Flemish community. The prevalence of patients entering treatment who are not confronted with psychiatric comorbidity increased in 2012 for the first time over 50.0%. Since 2006, the prevalence of severe dual diagnosis have never been so low as in 2012

(11.0%). Nevertheless, psychiatric comorbidity is still very common among illicit substance users (48.6%).

Table 6.8. Psychiatric comorbidity of clients entering treatment (De Sleutel), N and %, the Flemish Community, Belgium, 2006-2012

Psychiatric comorbidity	Year						
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Sample size (N)	631	639	651	814	581	668	670
Total prevalence (%) of dual diagnosis	51.8	52.9	49.6	50.6	53.8	53.9	48.6
% severe dual diagnosis	13.9	12.1	16.7	13.6	12.7	12.0	11.0
% moderate dual diagnosis	37.9	40.8	32.9	37.0	41.1	41.9	37.6

Source: De Sleutel (Lombaert, personal communication 2013)

3.2.2. Psychiatric comorbidity in injecting drug users (DRID study)

The interviews conducted during the first Belgian national DRID study in 2011-2012, as described in 2.3.3. focused also on mental health. The mental health of the participants was estimated by using the Mini International Neuropsychiatric Interview (MINI-)Plus (version 5.0.) (Sheehan et al. 1998). The study indicates that most current IDUs are characterized by a complex psychiatric profile. 22.2% of the participants have a high suicidal risk. The most common psychiatric disorders are: psychotic disorders (30.0%), posttraumatic stress disorder (16.1%), agoraphobia (15.6%), generalized anxiety disorder (13.9%) and attention deficit disorder with hyperactivity (11.1%). Table 6.9 describes the correlation between dependency and the psychiatric disorders mentioned above. We see a strong correlation between opioid dependence on the one hand and generalized anxiety disorder and attention deficit disorder on the other hand. The dependency of tranquilizers correlates with posttraumatic stress disorder. Dependency of alcohol correlates with both psychotic disorder and posttraumatic stress disorder. The linear regression analysis shows a positive relation between the number of dependency disorders and the number of psychiatric disorders (Bollaerts and van Bussel, 2012).

Table 6.9. Correlation between dependency on substances and other psychiatric disorders of injecting drug users participating to the DRID study, Belgium, 2011-2012

Psychiatric disorder	Dependency			
	Opioids	Cocaine	Tranquilizers	Alcohol
Psychotic disorder (current episode)	*-0.05 (0.83)	-0.13 (0.34)	0.07 (0.72)	***0.33 (0.014)***
Posttraumatic stress disorder (current episode)	-0.0 (1.0)	-0.0 (1.0)	***0.28 (0.046)***	***0.21 (0.018)***
Agoraphobia (current episode)	-0.1 (0.58)	0.02 (1.0)	-0.0 (1.0)	0.04 (0.82)
Generalized anxiety disorder (current episode)	***1.0 (0.009)***	0.19 (0.28)	-0.09 (0.64)	0.29 (0.06)
Attention deficit disorder with hyperactivity (lifetime)	***1.0 (0.027)***	0.15 (0.49)	-0.07 (0.79)	0.16 (0.31)
Suicide (current) - high risk	-0.08 (0.64)	0.15 (0.28)	-0.2 (0.17)	-0.22 (0.17)

***** xx (xx) : tetrachoric correlation (Fisher exact test for dependency, p-value)

Source: DRID study (Bollaerts and van Bussel, 2012)

4 Drug-related deaths and mortality of drug users

4.1. Drug-related deaths in the general population

In Belgium, national data on drug-induced deaths are available from the GMR. Since 1991, the Federal Public Service Economy – Directorate-general Statistics and Economic Information, centralizes the data from the death certificates coded by the competent administrations of the Flemish (for both the Flemish and the Brussels-Capital Region) and French (Walloon Region) Communities according to the International Classification of Diseases, Injuries and Causes of Death (ICD). The 9th edition (ICD-9) was used until 1997. From 1998 onwards, the 10th edition (ICD-10) was used. The mortality information is registered on the basis of residency (*de jure* information) as opposed to the region were the death occurred (*de facto* information). Data on drug-induced deaths among non-residents are available at national level. Nevertheless, recent national data are missing as a result of delays at the level of the Walloon and Flemish region. However, substantial progress has been made during the last years and the national mortality data are now available for the years 2004-2009.

Cases of drug-induced deaths were extracted from the 2004-2009 national mortality database using the EMCDDA “Selection B” case definition. According to this definition, cases are selected when the underlying cause of death was drugs psychoses, drug dependence, nondependent drug abuse, accidental poisoning, intentional poisoning and poisoning with undetermined intent due to opiates, cocaine, amphetamines and derivatives, cannabis and hallucinogens. The number of drug-induced deaths in Belgium by year and region are summarized in table 6.10. In 2009, 132 drug-induced deaths were observed in Belgium of which 73 in the Flemish region, 19

in Brussels and 40 in the Walloon region. Between 2004 and 2009, no clear time trends were observed for Belgium.

Table 6.10. Drug-induced deaths (15-64y), N, Belgium, 2004-2011

Region	Year							
	2004*	**2005***	**2006***	**2007***	**2008***	**2009***	**2010**	**2011**
Belgium	**74**	**105**	**86**	**118**	**146**	**132**	**NA**	**NA**
Flemish region	36	53	39	68	80	73	46**	NA
Brussels	14	16	25	29	22	19	18***	16***
Walloon region	24	36	22	21	44	40	NA	NA

Sources: * *GMR (selection B) 2004-2009 (Federal Public Service Economy – Directorate-general Statistics and Economic Information);* ** Flemish region: Vlaams Agentschap Zorg en Gezondheid; *** Brussels: Observatoire de la Santé et du Social de Bruxelles-Capitale

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Chapter 7. Responses to health correlates and consequences

Blanckaert, P. & Plettinckx, E.

1. Introduction

In this chapter, the recent preventive and health care responses to health correlates and consequences associated with the use of illegal psychoactive substances in Belgium are described. In particular, a description is given about crisis care services targeting drug users finding themselves in a state of acute psycho-emotional disequilibrium. Additionally, the Belgian Early Warning System on Drugs (BEWSD) and its regional partners are described. To conclude, the results of the syringe exchange programmes in Belgium are discussed.

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

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

For drug users finding themselves in a crisis ("a state of acute psycho-emotional disequilibrium" (Lewis and Roberts R. 2001)), limited capacity crisis care services are available in Belgium.

These can be divided into units linked to general hospital and emergency services, and crisis interventions in specialized drug treatment centres.

First, there is a national pilot project for the crisis and case management of clients with joint substance use and mental health crisis launched in October 2002 (Federal Public Service Health, Food Chain Safety and Environment). In 9 centres in the proximity of the emergency departments of general hospitals, crisis beds are offered with a maximum stay of five days. These centres are geographically dispersed around Belgium (Antwerp, Bruges, Brussels, Genk, Ghent, Liège, Leuven, Mons and Namur). Within these centres, special attention is given to continuing health care. From 2011 onwards, the centres register the number of admissions and the length of stay for every admission on a monthly basis. Correcting for missing registrations by single average imputation, the total mounts to 3500 admissions for the year 2012. The average length of stay was 3.6 days and the average occupation rate was 90.0% and 72.0% for the short interventions (< 4 hours) and night shelters, respectively (Katia Huard, Federal Public Service Health, Food Chain Safety and Environment, personal communication). This means a slight increase in the average length of stay (3.4 days in 2012) and a decrease of the occupation rate (93.0% for the short interventions and 75.0% for the night shelters in 2012).

Second, crisis intervention in specialised drug treatment centres exists in Belgium since 1980. The so-called Crisis Intervention Centres (CICs) accredited by NIHDI aim to offer

immediate short-term help to persons in crisis (detoxification), as well as encouraging and supporting them to seek continued treatment (motivation, orientation). In 2012, the average day capacity of clients available at the 8 CICs geographically dispersed over Belgium was 81 clients per day (Koen Deraedt, NIHDI, Personal communication). In these CICs, 945 treatment episodes were recorded for 2012, this in comparison with 961 treatment episodes in 2011 (Treatment Demand Indicator Register, 2012).

More than 20 psychiatric hospitals and psychiatric units in general hospitals offered crisis interventions to drug users as well in 2012.

2.2. Prevention and reduction of drug-related deaths

2.2.1. Prevention through the Belgian Early Warning System on drugs and peer support organisations

The BEWSD is coordinated by the Belgian Monitoring Centre for Drugs and Drug Addiction (BMCDDA) at the Scientific Institute of Public Health (IPH). The BEWSD is a partner of the European EWS Reitox network authorized by the EMCDDA/Europol. The functioning of the BEWSD was described in detail in the previous annual report (Plettinckx et al. 2012).

In Belgium, most of the information reaching the BEWSD results from the analysis of drug samples seized by Belgian law enforcement authorities (federal and local police services, customs, …), or the reporting of clinical or post-mortem samples, usually in a hospital setting.

Exact information on the contents of circulating street drugs in Belgium is usually not available. However, the seized drugs data provides a good approximation, made clear by the large numbers of new psychoactive substances (NPS: psychoactive substances not included in the 1971 United Nations Convention on Psychotropic Substances) that are detected each year in Belgium.

Whenever a high-risk substance or a new psychoactive substance is reported in Belgium, the BEWSD sends an EWS message to the network. Additionally, the BEWSD provides the toxicological laboratories in its network regularly with updated GC-MS libraries, to make sure the labs are capable of detecting the newest psychoactive substances.

An overview of the messages sent by the BEWSD to the network is presented in table 7.1. The informative messages, specifically targeted at the toxicological laboratories, are not included in this table.

Table 7.1. Overview of the EWS warnings sent by the BEWSD, Belgium, 2012

Month	Drugs involved	Description
March	pFPP	Detection of pFPP in 'ecstasy' tablets in Belgium
March	AM-2233, AM-694, JWH-307, WIN48,098	Informative message regarding the seizure of 4 synthetic cannabinoids in Belgium
March	MDMA + pentobarbital	Alert after detection of MDMA powder cut with pentobarbital
April	4-methylamphetamine (4-MA)	Alert and press communication after reported deaths due to consumption of speed contaminated with 4-MA
May	mCPP	Warning for MDMA tablets containing also mCPP
July	Heroin/anthrax	Warning for heroin contaminated with B. anthracis in Europe (relay of EMCDDA alert)
August	Sufentanil	Possible circulation on the illicit market of stolen Sufenta® vials
August	JWH-081	Reported intoxication with JWH-081
September	MDMA	Warning for high dosed MDMA tablets
September	5-IT	Warning regarding the high number of casualties reported in Sweden
October	Methiopropamine	Intoxication with methiopropamine reported
October	5-IT – AMT	Analytical challenges in analytically differentiating between 5-IT and AMT
October	MDMA – mCPP	Warning for high dose MDMA tablets and tablets containing mCPP
November	5-APB, 4-MeO-PCP, 5F-UR-144	Informative message regarding the detection of these NPS in Belgium
December	MDMA	Warning for high dosed MDMA tablets
December	4-MA	Another reported casualty after the consumption of speed contaminated with 4-MA

Source: Database BEWSD, 2012.

Most warnings sent by the BEWSD in 2012 involved high dose MDMA tablets, or MDMA tablets containing piperazines; also, the casualties caused by 4-MA were a major event in Belgium in 2012 (a more detailed description of the Belgian response is given in 2.2.2). Furthermore, some warnings were sent to the network concerning NPS detected in Belgium.

The warnings sent out by the BEWSD are relayed further to workers in-the-field by the regional focal points VAD and Eurotox in order to prevent (additional) casualties. VAD and Eurotox also use internet fora, where drug field workers can post messages regarding developments or dangerous trends observed among drug users. Table 7.2 provides an overview of the information messages disseminated in 2012 by the regional focal points Eurotox and VAD. Also specific harm reduction and peer support projects like Vitalsounds, Breakline and Quality Nights are included in table 7.2. These projects work mainly around harm reduction “in-the-field”, and can frequently be found at parties and festivals. Their main goal is to provide scientifically correct and usable information regarding drugs and drug use (e.g. safe sexual behaviour, and avoiding auditory damage). They give advice to party goers and distribute flyers and other harm reduction materials (e.g. sniffing tubes, condoms, etc.). Quality Nights is a health promotion label which aims at reducing risks pertaining to nightlife scenes by collaborating with party promoters and organizers, providing harm reduction advice (e.g. the free distribution of water at parties or festivals). Vitalsounds and Breakline are besides harm reduction projects, also peer support projects. The behaviour of peers may induce drug users to use drugs in a safer way. Moreover, peers are equally matched people with the same lifestyle. In this position, peers can give advice and support from their own experience (Kinable 2006). As most overdoses occur when others are present, peers can be helpful in preventing overdose deaths in the party scene by the recognition of symptoms and providing an adequate response (EMCDDA 2013).

Table 7.2 shows that harm reduction/prevention projects and organisations, focussing on prevention in specific sub-populations (e.g. young people in the party scene: Quality Nights, Vitalsounds, Breakline), tailor the information sent out by the BEWSD to their specific target audience. As an example, the harm reduction project Vitalsounds only published the warnings with a direct impact on their audience on their website, in this case the warnings with regard to highly dosed MDMA tablets.

Table 7. 2. Overview of information distributed by VAD, Eurotox, Vitalsounds, breakline and Quality Nights, Belgium, 2012.

Author	Method	Month	Psychoactive substances involved	Description
Vitalsounds	Website message	January	3-amino-1-phenylbutane	Warning for the appearance of this substance in Belgium
Eurotox	Yahoo group – EWS alert	March	MDMA/Pentobarbital	MDMA powder contaminated with pentobarbital
VAD	Forum message – EWS alert	March	MDMA/Pentobarbital and synthetic cannabinoids	Warning message regarding MDMA contaminated with pentobarbital/Informative message: synthetic cannabinoids
Quality Nights	Harm reduction flyer – Website message	March	MDMA/Pentobarbital	Harm reduction message about MDMA contaminated with pentobarbital
Vitalsounds	Website message	March	MDMA/Pentobarbital	Warning for MDMA contaminated with pentobarbital
Eurotox	Yahoo group – EWS alert	April	4-MA	Alert after the deaths related to 4-MA use
VAD	Forum message – EWS alert	April	4-MA	Alert after the death of 3 recreational amphetamine users (speed contaminated with 4-MA)
Quality Nights	Harm reduction flyer – Website message	April	4-MA	Warning of speed contaminated with 4-MA
Vitalsounds	Website message	April	4-MA	Warning of speed contaminated with 4-MA
Vitalsounds	Website message	May	mCPP	Warning for MDMA tablets containing mCPP
Eurotox	Yahoo group – EWS alert	July	Heroin/anthrax	Relaying of the EMCDDA alert regarding heroin contaminated with B. anthracis

VAD	Forum message – EWS alert	July	Heroin/anthrax	Relaying of the EMCDDA alert regarding heroin contaminated with B. anthracis
Eurotox	Yahoo group – EWS alert	August	Sufentanil	Warning with regard to possibly stolen vials of Sufenta®
VAD	Forum message – EWS alert	August	Sufentanil	Warning regarding possible circulation of stolen Sufenta® vials
VAD	Forum message – EWS alert	September	5-IT	Warning regarding the high number of 5-IT deaths in Sweden
Eurotox	Yahoo group – EWS alert	September	MDMA	Warning for high-dosed MDMA tablets
VAD	Forum message – EWS alert	September	MDMA	Warning regarding high-dose MDMA tablets
Quality Nights	Harm reduction flyer – Website message	September	MDMA	Warning regarding high-dosed MDMA tablets
Breakline	Website message – Flyer Quality Nights	September	5-IT and MDMA	Warning regarding to deaths related to 5-IT use in the UK and Sweden and high dosed MDMA tablets in Belgium
Vitalsounds	Website message	September	MDMA	Warning regarding high-dosed MDMA tablets
Eurotox	Yahoo group – EWS alert	October	mCPP/MDMA	Warning for high dosed MDMA tablets and tablets containing mCPP
Vitalsounds	Website message	October	mCPP/MDMA	Warning for high dosed MDMA tablets and tablets containing mCPP
Vitalsounds	Website message	November	MDMA	General warning for the circulation of high dosed MDMA tablets
Breakline	Facebook message	November	MDMA	General warning for the circulation of high dosed MDMA tablets
Eurotox	Yahoo group – EWS alert	December	4-MA	Another death where 4-MA was detected post-mortem
VAD	Forum message –	December	4-MA	Warning after 4-MA related death in Belgium

	EWS alert			
Vitalsounds	Website message	December	4-MA	Warning regarding another death after 4-MA use

Source: VAD EWS forum; Eurotox Yahoo group; VAD/Eurotox EWS alerts; Quality Nights and Vitalsounds and Breakline websites.

The BEWSD regularly (at least once a month) disseminates "informative" messages regarding NPS found in Europe or Belgium. Likewise, when appropriate, the BEWSD sends out GC-MS library updates to its network of toxicological laboratories; these updates are a great tool to ensure the laboratories in Belgium remain up-to-date in their potential to identify the several NPS that are seized on Belgian territory. However, these BEWSD messages have little to no relevance for the regional focal points and harm reduction organisations in Belgium. As a result, the target audience for these informative messages are only the laboratories in Belgium. In 2012, 71 NPS were reported to the BEWSD by the participating laboratories, mostly novel synthetic cannabinoids and cathinone derivatives.

A quality system was developed for the BEWSD, to improve the impact of the BEWSD-communications towards the different partners, and EWS-messages were streamlined and categorized according to severity/perceived threat. To categorize the EWS messages, and to improve the clarity and intended target audience of the messages sent by the BEWSD, a "roadmap" was developed, including different "levels" of alerts.

Messages distributed by the BEWSD are divided into 4 categories (levels). Categories are indicated in the subject line of the alerts (BEWSD alerts are sent by e-mail to the network), followed by the topic of the specific alert (e.g.: [BEWSD Informative]: Detection of a NPS in the UK). This makes it easier for the network to differentiate the messages according to urgency.

The categories used by the BEWSD include 1) informative messages: non-urgent communication regarding the appearance of NPS in neighbouring countries or in Belgium itself, without direct impact on public health. Not necessarily analytically confirmed information; 2) alert level 1 messages: appearance of a NPS or a dangerous composition of classic illicit drugs, without casualties however, in Belgium or the EU. Information is analytically confirmed; 3) alert level 2 messages: same as alert level 1, except that intoxications have been reported in Belgium or Europe, or casualties have been reported in other EU countries (not Belgium); 4) alert level 3 messages: same as alert level 2, but casualties or dangerous trends with direct impact on public health have been reported in Belgium.

In most cases, there is no direct communication to the general public. In exceptional circumstances (e.g. a level 3 alert) a warning to the general public can be made by informing the press. In 2012, the press was directly informed by the BEWSD (in coordination with the Ministry of Public Health) only once (after the deaths due to speed contaminated with 4-MA).

As part of the BEWSD quality system, and to prevent distribution of the possible sensitive information contained in the BEWSD-messages, in 2012 a disclaimer was added to all messages sent by the BEWSD, to avoid sharing of this information beyond the BEWSD professional network.

Also, the BEWSD website was updated to include an “EWS warning” section, which is accessible to the general public. This section of the website contains the EWS alerts, stripped of all sensitive and identifying information. It is mostly used to warn the public with regard to highly dosed MDMA tablets for example. Also, a discussion section, which is not accessible to the general public, was added, where professionals in the (harm reduction) field can post and discuss info regarding new patterns of consumption, or the appearance of NPS on the user drug market.

2.2.2. The legal response to the 4-Methylamphetamine casualties in Belgium

Considering drug-related deaths, in 2012, again at least three people died after the consumption of ‘speed’ (amphetamine) contaminated with 4-methylamphetamine (4-MA). In 2011, already 3 people died after the ingestion of contaminated speed, bringing the total number of people that died after the consumption of 4-MA in 2012 in Belgium to at least six.

4-MA was originally developed as an appetite suppressant, but development was halted due to side effects. It has recently resurfaced as a new psychoactive substance in Europe, and is mostly found together with amphetamine. Around 11.5% of tested speed samples of Dutch origin were positive for 4-MA. In Belgium, 4-MA was also found in speed samples. In 2011 and 2012, several fatal incidents after amphetamine use were observed in Belgium, the United Kingdom and The Netherlands.

Taking into account the total number of drug-related deaths in Belgium (around 100 people every year), it was decided that the casualties due to 4-MA use were a reason for serious concern. Hence, for the first time in Belgium, a national risk assessment procedure was initiated, assessing the risk of 4-MA for the general population, and for the (young) party population in particular. Representatives of the federal Ministry of Health, the National Institute for Criminalistics and Criminology (NICC), the regional focal points (VAD and Eurotox), toxicology experts and emergency physicians from the large university hospitals were included in this risk assessment group, as well as representatives from the BEWSD and the IPH.

In all reported victims, toxicological analysis confirmed the presence of 4-MA, in addition to amphetamine. The observed blood amphetamine levels were too low to be fatal. Contrary to amphetamine, which displays noradrenergic and dopaminergic activity, 4-MA also shows serotonergic activity. The observed toxicity is most likely the result of the combined dopaminergic activity of amphetamine and the serotonergic activity of 4-MA. In addition, the presence of 4-MA may have dampened the psychoactive effects of amphetamine by attenuation of the amphetamine-induced dopamine release, potentially inclining users to ingest higher doses of contaminated speed. Slower metabolism of 4-MA and its MAO-inhibiting properties could also have contributed to the unusual high toxicity of 4-MA (Blanckaert et al. 2013).

A BEWSD warning message was sent to emergency departments, clinical and toxicological laboratories, and regional focal points, who disseminated the message further to health care workers in the field.

Furthermore, several recommendations for surveillance and communication were made (Blanckaert 2012):

- Since there was probably an underestimation of reported deaths/intoxications due to the use of 4-MA, initiatives should be taken to improve surveillance in these cases. Emergency department physicians should be aware of the symptoms specifically caused by 4-MA (especially hyperthermia) in cases presumed to be 'just' amphetamine intoxication, and if *in-house* screening for 4-MA is not available, blood samples should be forwarded to clinical laboratories that are equipped to perform these analyses.
- Specific detailed information regarding the 4-MA/amphetamine toxidrome (and the treatment options) should be sent to all emergency departments in Belgium, and to the professional and scientific societies (emergency physicians, forensic pathologists, toxicological laboratories), including that in amphetamine intoxications, co-intoxication with 4-MA should be considered.
- A specific communication strategy to reach the exposed public (press, festival organizers, etc…) should be developed. The fact that 4-MA is not yet illegal in Belgium should be taken into consideration. The message should warn for the contamination of an illegal drug (amphetamine) with a potentially lethal compound. Also, the dangers of concomitant use of these 'speed' mixtures with legal medication (e.g. antidepressants such as selective serotonin reuptake inhibitors) should be emphasized.
- 4-MA will be added to the list of controlled substances in Belgian Law (K.B./A.R. 22/01/1998-99-85 "Reglementation of psychotropic substances").

In Belgium, the press was informed of the circulation of contaminated speed, and several press interviews were given, emphasizing the risks of consumption of contaminated speed. Since it was unclear whether producers of the contaminated speed knowingly synthesized 4-MA, a secondary goal of these press releases was to raise awareness about the contamination issue with illicit manufacturers.

The results of the Belgian risk assessment were used to place 4-MA under an emergency schedule in The Netherlands (resulting in the banning of 4-MA within 24 hours). Moreover, on the European level, a formal risk assessment on 4-MA was performed, advising the member states to put 4-MA under legal control as soon as possible. In Belgium, 4-MA was listed as a controlled substance in the beginning of 2013.

3. Prevention and treatment of drug-related infectious diseases

3.1. Needle exchange

To reduce the spread of infectious diseases and other health risks, syringe exchange programmes distribute sterile injecting material and additional prevention material among injecting drug users (IDUs) and collect used needles.

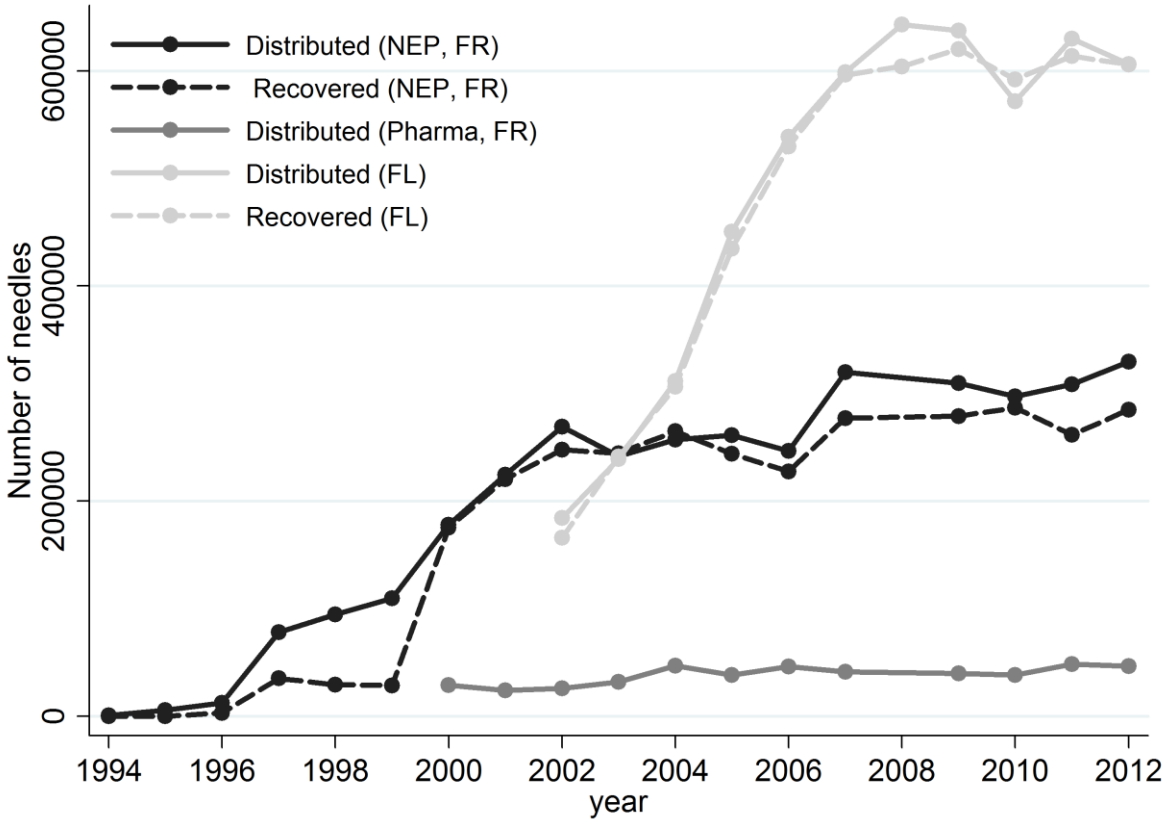
In the Flemish community, the syringe exchange programme, which started in 2001, has been carried out by one regional and five provincial coordinators (one per province in Flanders), working at the Medical and Social Care Centres (MSOC/MASS) for drug users. The provincial coordinator builds networks of health care professionals and pharmacists, who help him to distribute the sterile injecting material (including syringes, filters, ascorbic acid, spoons (Exchange©), alcohol swabs, flasks of injectable sterile water, foil, bicarbonate, and containers to recover syringes). Sterile injecting material was distributed by 41 needle exchange services, dispersed over 28 cities and villages within the Flemish community in 2012. In addition, 31 pharmacies, dispersed over 12 cities and villages, are also contributing in the syringe exchange programme in the Flemish community. 606,349 sterile syringes were distributed in 2012 (see also ST10_2013_BE_03), and 605,833 were returned, resulting in a recuperation rate of 99.9%.

In the French Community, the needle exchange programme is coordinated by Modus Vivendi since 1994. In 2008, the needle exchange project was reorganised, resulting in a lack of data for that year. Since 2008, sterile injecting equipment has been offered through 16 official fixed-site and mobile services (with accreditation). In 2011, a new needle exchange service was initiated in Mons, which brings the total to 17 needle exchange services located in 8 cities (Arlon, Brussels, Charleroi, Ciney, Dinant, Liège, Mons and Namur) in 2012. On top of this, more than 10 other services distribute sterile injection equipment. However, the number of sterile syringes distributed within these services is unknown. Finally, a network of

pharmacists participating in the “Stérifix” project distributes “Stérifix” kits at the cost of € 0.5 (including two syringes, two alcohol swabs, two dry post-injecting swabs, two spoons, two flasks of injectable sterile water and harm reduction information).

In the French community, 329,576 sterile syringes were distributed through the 17 official fixed-site and mobile services (see also ST10_2013_BE_02) and 285,056 were returned, resulting in a recuperation rate of 86.5%. In addition, 23,225 Sterifix kits were produced and dispatched in the pharmacies participating to the Sterifix project in French community. As each kit contains 2 syringes, 46,450 syringes were then dispatched to IDUs through this project in 2012. However, there is no information available on the number of syringes effectively sold through this network. The degree of urbanization and the fact that the number of distributed needles in the Sterifix project and the pharmacies in the French community are not exactly known, may result in a lower number of registered distributed sterile syringes in comparison with the Flemish community. Moreover, the needle exchange services are dispersed among more cities and villages in the Flemish community which can influence the number of distributed sterile syringes in a positive way since this increases the accessibility of the needle exchange services. Compared to last year, the number of distributed needles slightly increased in the French community whereas it declined in the Flemish community (Figure 7.1.). The recuperation rates are increasing again for both communities (Figure 7.2.). Nevertheless, attention to stress the importance of syringe recuperation to reduce the risks (e.g. needle accidents) for the general population stays important.

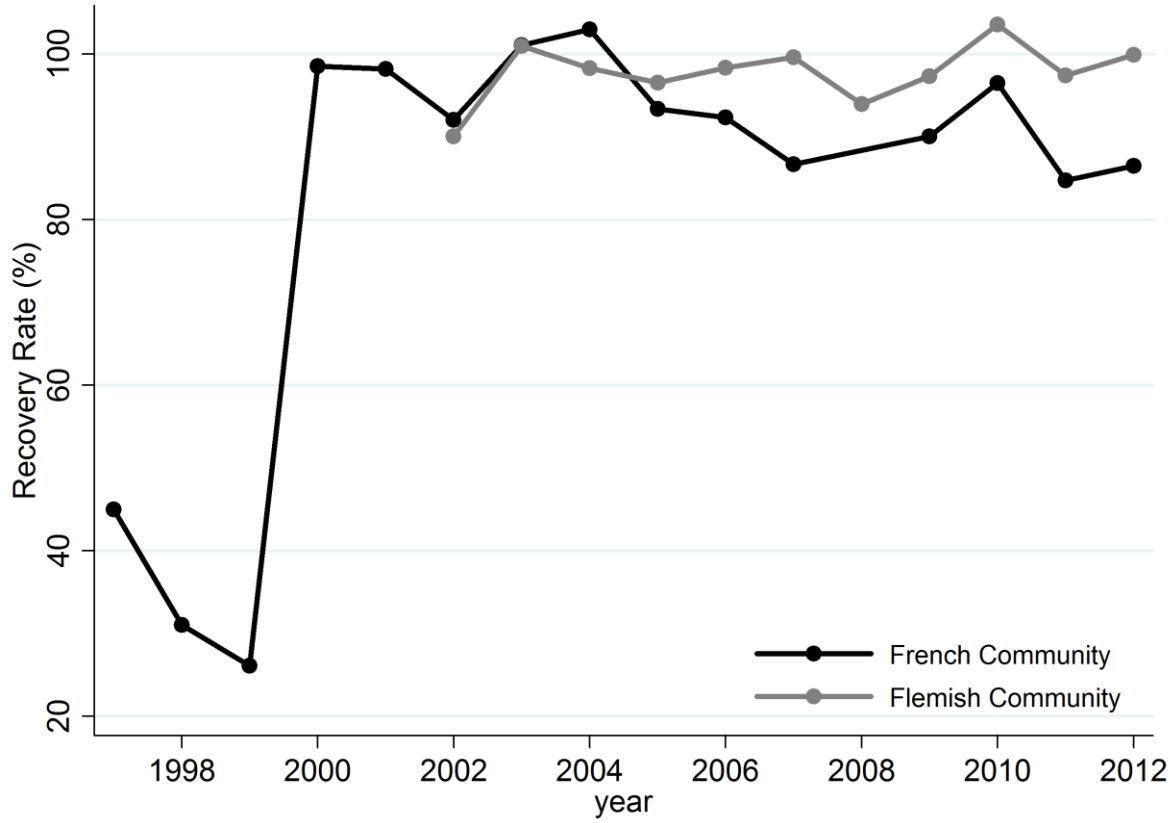
Figure 7.1. Syringes distributed and recuperated in the Flemish and French Community by needle exchange programmes and by pharmacists (Stérifix project), N, Belgium, 1994-2012



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

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

Figure 7.2. Recuperation rate of the syringes distributed by needle exchange programmes in the Flemish and French Community, %, Belgium, 1994-2012



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

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

The effectiveness of the syringe exchange programme in Flanders is evaluated on a yearly basis by means of the voluntary, anonymous questionnaire. A detailed description of the methodology used can be found in chapter 6, section 2.3.1. Several questions about drug use, such as risk behaviour, the use of the syringe exchange programme and pharmacies to get or buy clean syringes, health situation, drug treatment and specifically crack use, are asked to the users of the Flemish syringe exchange programme. 227 valid questionnaires were filled out in 2012. The results indicate that, next to the needle exchange programmes, pharmacists play an important role in distributing injecting material, with 65.0% of the IDUs in the needle exchange programme also visiting pharmacists to obtain injecting material. Many used needles were properly returned, however, 14.8% of the IDUs indicate to engage in unsafe disposal of their injecting equipment (e.g. throwing needles unprotected into the garbage or on the street) (Windelinckx 2013). More results of this questionnaire, specifically about risk behaviour, are discussed in chapter 6 (Section 2.3.1.).

4. Responses to other health correlates among drug users

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

Acknowledgements chapter 7:

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Chapter 8: Social correlates and social reintegration, the Brussels low-threshold case

Antoine, J.; Husson, E.; Theizen, L.; Goessens, M. & Wérenne, J.

1. Introduction

This chapter focuses on social correlates and social reintegration from the point of view of the low-threshold centres in Brussels: Project Lama, MSOC/MASS Brussels and Transit. These low-threshold centres support the most excluded drug-users who don't fit the traditional care network.

Brussels, the biggest city (1,140,000 inhabitants at 01.01.2012) and capital city of Belgium and Europe, brings together the most vulnerable groups of people (e.g. asylum seekers). More than one fourth of the inhabitants (28.3%) in Brussels are living with an income less than the poverty risk threshold. The unemployment rate is 31.2% among young people (<25y). The poverty challenges for the city will increase due to the economic crisis and the demographic evolution foreseen (Observatoire de la Santé et du Social de Bruxelles-Capitale 2012).

The objectives of this chapter are 1) to picture the socio-economic status of clients entering the low-threshold centres in Brussels, 2) to describe the challenges encountered by these centres in their daily work and 3) to present some initiatives launched to reintegrate drug-users.

First, a description of the centres considering their specific objectives and their capacity will help to understand the availability of services for clients. Second, a description of the socio-economic status of persons going to these centres will picture the social exclusion among drug users. Third, a description of drug use among groups of people (e.g. visiting emergency shelters or prostitutes) can assess the drug problems among excluded groups. Finally, an overview of existing projects helping these marginalized population in terms of housing, work or after-prison reintegration will complete this picture on the Brussels situation.

2. Description of the centres

2.1. Centre Transit

The centre Transit opened in 1995 on demand of the Brussels Capital-Region in the context of the security plan, which was financed by the Federal Public Service Interior. Transit works on the basis of two modalities: 1) an ambulatory centre and 2) a short-time residential centre (20 beds). Clients can come 24h/7d to the low-threshold centre without any condition and will be oriented to the day-centre or to the residential centre. They can consult different services such as socio-administrative support for paperwork and official documents. Clients can also develop a life project with the support of this centre (Goessens 2012). The activities have been progressively extended towards syringe prisoners, exchange, housing, etc.

2.2. Project Lama

Project Lama exists since 1983. It was the first centre for drug users in Brussels that prescribes opioid substitution treatment (OST) in the context of an ambulatory urban context. Since 1990, Lama applies a harm-reduction and low-threshold approach. Now, the centre has 4 treatment locations and one initiative of six supervised flats (Hestia).

Lama offers social and sanitarian support for drug users in difficulty or in a vulnerable situation. The centre guarantees a low-threshold access with a high therapeutic objective. They benefit from a convention with the National Institute for Health and Disability Insurance (NIHDI) for two of their locations and have also an agreement with the French community commission of Brussels to carry out specific tasks such as care, networking, training, etc.

‘Lama’ support different kinds of projects, such as the project under discussion of drug consumption rooms, social support or "Housing first". The centre participates to policy as well, as it is involved in the different federations. Moreover, the centre is involved in many scientific projects such as 1) a OST study (Vander Laenen et al. 2013) and 2) a study about hepatitis C (Gerkens et al. 2012a; Gerkens et al. 2012b). ‘Lama’ has also 30 years of experience in training medical doctors, social workers and paramedical staff (Husson, Personal communication, 2013).

2.3. MSOC/MASS Brussels

The MSOC/MASS of Brussels (Social Sanitarian Hospitality House) is financed by NIHDI and is specialized since 1999 in the needs of marginalised drug-users who do not fit into the 'classic' health system due to social, psychological or mental reasons. The objectives are focussing on four main areas:

1) An increased contact with this hidden fringe of drug-users who escape the existing health services. The increased knowledge of the target population and the experiences will enable to adapt services to the existing needs.

2) Harm reduction linked to the use of illegal drugs and improvement of the quality of life. They pay particularly attention to the sanitarian, social and psychological needs of the patients, in order to reach a minimal degree of self-help. Once the basic needs are as much as possible achieved, the increase in quality of life will be reached through social activities and training.

3) High level re-education in order to provide the possibility to enter into a process of rehabilitation and to rediscover the ability to make something in their life and eventually to refer the patient to a specialised institution.

4) After a strict evaluation of the capacities, a reorientation to the existing net of services of the patient to a more 'traditional' programme offered by general practitioners (GPs), medical and specialised centres (Theizen, Personal communication, 2013).

2.4. The low-threshold dialogue

Within the *low-threshold dialogue*, the 3 centres mentoined above are gathering clinical support through transversal working groups. The *dialogue* is a place for reflexion on social and health policies that have to match the actual evolution of social demand. This networking has been created to improve care access for the most destabilized drug users, to improve the quality of work, to improve the fluency of communication, to facilitate work and to innovate via original social initiatives. This network is trying to strengthen links with regional or municipal authorities to improve the support of drug users regarding their needs.

This network is working particularly on partnerships with other associations such as Modus Vivendi (harm reduction and prevention for drug users), Dune asbl (harm reduction and street work for drug users), Hepatitis C network (harm reduction and prevention for people concerned with hepatitis C), SMES (mental health and social exclusion network), Doctors of the world (low-threshold care for homeless people), etc. (Husson, Personal communication, 2013).

2.5. Client's profile and capacity

These 3 low-threshold centres are supporting more than 2000 clients every year. The table 8.1 shows their client's profile and their capacity.

Table 8.1. Clients profile and capacity of the 3 low-threshold centres, Brussels, Belgium, 2012

Variable	Project Lama TDI clients	MSOC/MASS Bxl All clients	Transit All clients
Client's profile			
Mean age (y)	39.0	39.0	38.0
% <30 years	18.0	35.0	23.0
% women	17.0	14.0	14.0
% >20 years addiction	25.0	26.0	43.0
% Currently injecting	5.0	15.0	30.0
% Daily consumer	58.0	36.0	83.0
% Opiates users	81.0	96.0	79.0
Capacity			
# clients 2012	887.0	600.0	632.0
# contacts 2012	23,204	20,156	33,505
# workers (FTE) 2012	27.5	17	39

Source: BTDIR, 2012; Theizen, Personal communication, 2013; Goessens, Personnal communication, 2013

The mean age is relatively similar between the 3 centres (38/39 years). Though, the proportion of young people (<30 years) varies significantly. The MSOC/MASS Brussels supports a larger proportion of young people (35.0%) compared with ‘Transit’ (23.0%) and ‘Lama’ (18.0%).

Clients visiting these centres have a relatively long addiction history. One fourth (25.0%) of the clients of Lama are more than 20 years dependent, 26.0% of the clients of MSOC/MASS and 43.0% of the clients of Transit.

The proportion of currently injecting clients is relatively low in ‘Lama’ (5.0%) and MSOC/MASS (15.0%) but is a bit higher in ‘Transit’ (30.0%). The main substance causing problems are in general opiates (around or more than 80.0% of the clients in the three centres). A team of 83.5 persons vouch for 75,000 contacts each year.

Another observation made in these centres is the polydrug use profile of the clients. Most of them are using more than one substance. Illegal drug consumption often goes together with alcohol and/or medicines bought at the black market or misused from original therapeutic objectives.

3. Social exclusion and drug use

3.1. Social exclusion among drug users

Socio-economic characteristics of people visiting these 3 low-threshold centres will be described through either the treatment demand indicator (TDI) database (new treated persons entering the facility during the year 2012) or the complete database of people in treatment (including also long-term treated persons). These data are presented separately for these three centres due to their specific objectives described earlier.

3.1.1. Living situation

The living situation of clients is presented in table 8.2. The first possibility is that the client has a fixed residence. Secondly, clients are possibly living in variable places or on the street. A third possibility is that they are institutionalized in prison or medical facility.

Table 8.2. Living situation of clients visiting the 3 low-threshold centres, %, Brussels, Belgium, 2012

Variable	Project Lama TDI clients	MSOC/MASS Bxl All clients	Transit All clients
Living situation			
Stable	68.0	65.0	15.0
Variable	21.0	27.0	85.0
Prison/Institution	11.0	8.0	N/A

Source: BTDIR, 2012; Theizen, Personal communication, 2013; Goessens, Personnal communication, 2013

In Project Lama and MSOC/MASS Brussels, the percentage of people who don't have a fixed housing varies between 21.0% and 27.0% but at Transit, where the focus is mostly on housing, this percentage is 85.0%. This unstable housing situation is also often linked with social isolation of the people as showed by the TDI register. Around 60.0% of those living in variable environments are also living alone.

These numbers have to be put in parallel with the difficulty to access housing in Brussels. High rental prices, increase of bad quality or overpopulated apartments as well as a long waiting list for social housing are some of the problems faced by the Brussels inhabitants (Observatoire de la Santé et du Social de Bruxelles-Capitale 2012).

3.1.2. Working situation, income and education level

The three variables concerning the working situation, income and education level of clients are presented in table 8.3.

The variable ‘working situation’ illustrates in three large categories if the clients is working on regular basis, on occasional basis or is not working at all. The variable ‘income’ shows

whether the client receives work revenues, social incomes or other. The education level is also an important variable for a future reintegration on the work market and can be distinguished by none or primary, secondary, higher and other education.

Table 8.3. Working situation, income and education level of clients visiting the 3 low-threshold centres, %, Brussels, Belgium, 2012

Variable	Project Lama TDI clients	MSOC/MASS Bxl All clients	Transit All clients
Working situation			
Regularly	21.0	24.0	N/A
Occasional	33.0	31.0	N/A
Not	46.0	45.0	N/A
Income			
Work	17.0	9.0	4.0
Unemployed/pension	15.0	27.0	14.0
Social benefits	36.0	21.0	52.0
Other *	32.0	43.0	30.0
Education			
None/Primary	28.0	26.0	69.0
Secondary	59.0	57.0	24.0
Higher	13.0	17.0	5.0
Other **	/	/	2.0

* Not economically active, incomes from family, no incomes
** e.g. secondary education for adults and evening classes

Source: BTDIR, 2012; Theizen, Personal communication, 2013; Goessens, Personnal communication, 2013

These data show that only a very low percentage is working on a regular basis (21.0% to 24.0%). The percentage of people receiving a salary is anecdotal (from 4.0% to 17.0%). Slightly more than one fourth of the population in treatment in 'Lama' (26.0%) and MSOC/MASS (28.0%) have an education level not higher than primary school. In Transit this percentage is higher (69.0%). This is 12.0% in the general population in Brussels. The proportion of clients with a high education level (5.0% to 17.0%) is much lower than the percentage of the general population in Brussels (32.0%) (Observatoire de la Santé et du Social de Bruxelles-Capitale 2012).

This shows that these centres are faced with a very precarious population that has very few perspectives regarding the economic crisis and other barriers they have to face (criminal records, low education level). Unfortunately no substantial energy is put in the employment problem in these centres due to other more urgent problems to solve such as health or housing issues.

3.1.3. Nationality

The distribution of the nationality of the clients visiting the centres is presented in table 8.4. This variable reflects only information about the official nationality, information about the ethnic origin is not available. These data are compared with the data about the general population of Brussels collected by the National Institute for Statistics (NIS) in 2011.

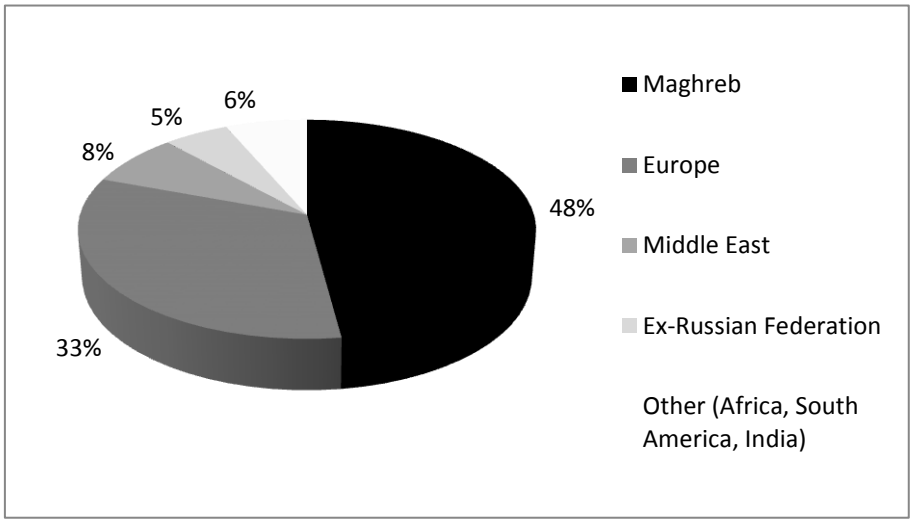
Table 8.4. Nationality of clients visiting the 3 low-threshold centres and in the Brussels population, %, Brussels, Belgium, 2012

Variable	Project Lama All clients	MSOC/MASS Bxl All clients	Transit All clients	Brussels general population NIS data 2011
Nationality				
Belgian	50.0	35.0	60.0	67.0
EU	18.0	29.0	10.0	19.0
non-EU	32.0	36.0	30.0	14.0

Source : Husson, Personal communication, 2013; Theizen, Personal communication, 2013; Goessens, Personnal communication, 2013; NIS, 2011

At Project Lama and Transit, 33 different nationalities were represented according to the categories shown in Figure 8.1. This distinction was not possible for MSOC/MASS Brussels.

Figure 8. 1. Groups of foreign nationalities among people in treatment in Project Lama and Transit, %, Brussels, Belgium, 2012.



Source : Husson, Personal communication, 2013; Fanelli, Personal communication, 2013

The proportion of non-Belgian clients varies between 65.0% in MSOC/MASS and 40.0% in Transit. These high values of non-Belgian clients are similar for the last three years, with a tendency to higher values specially with migrants from the EU.

These people are in a situation of high vulnerability because of the little or no social reintegration perspectives in Belgium. The absence of social protection exposes them to social and health risks.

The proportion of the various nationalities visiting treatment centres show a similar pattern as the general migration phenomenon due to economic crisis. Belgium inflow percentage is slightly higher than the OECD mean. There is a trans-European migration that has changed and evolved (OECD 2013). Firstly, new groups of migrant workers appear from Poland, Romania, Bulgaria. Secondly, asylum seekers are more numerous, coming from Afghanistan, Iran, Pakistan and Russia. A third group is composed with illegal residents. This type of users is particularly prone to social risks and cumulative lack of social protection and vulnerability. It is important to note the vulnerability of these groups, particularly young users, who are living in precarious situations (Chobeaux and Aubertin 2013).

The high rates of foreign patients compel institutions to find regularly new tools to ensure access to care. Therapeutic treatment also involves the establishment of communication tools. Centres make use of interpreters during sessions to communicate with patients. Access to care is precarious because of the limits of social rights that are granted, especially for EU nationalities. It makes therapeutic treatments less effective and increases health risks.

Since 2012, new legal guidelines allow Public Centres for Social Welfare to limit access to health care and emergency medical assistance for EU nationalities during the first three months of obtaining a temporary residency permit (Medimmigrant 2013).

3.1.4. Prison stay

A former prison stay is an additional barrier for future reintegration, in particular in the professional circuit. Table 8.5. shows the proportion of clients having already been to prison.

Table 8.5. Prison experience of clients visiting the 3 low-threshold centres, %, Brussels, Belgium, 2012

Variable	Project Lama TDI clients	MSOC/MASS Bxl All clients	Transit All clients
Prison experience	25.0	55.0	30.0

Source : BTDIR, 2012; Theizen, Personal communication, 2013; Goessens, Personnal communication, 2013

A large part of the clients (25.0% to 55.0%) in low-threshold centres have already been to prison. Even if there is no information about the reason for this prison stay, this high proportion shows that the drug users are frequently exposed to illegal activities, mostly in order to meet their consumption needs. A former prison client may also need extra

administrative support for the client regarding the health insurance affiliation or a judicial redemption process.

3.1.5. Health insurance

The health insurance is a basic guarantee for a person to have access to health care. The affiliation situation of clients for 2012 is presented in table 8.6. The most social excluded people, are limited in the services they can consult.

Table 8.6. Health insurance affiliation status of clients visiting the 3 low-threshold centres, %, Brussels, Belgium, 2012

Variable	Project Lama All clients	MSOC/MASS Bxl All clients	Transit All clients
Health Insurance			
Insured	70.0	71.0	63.0
To sort out	9.0	13.0	8.0
No access	16.0	9.0	29.0
Other	5.0	7.0	0.0

Source: Husson, Personal communication, 2013; Theizen, Personal communication, 2013; Goessens, Personnal communication, 2013

In the treatment centres Lama and MSOC/MASS Brussels, between 9.0% and 16.0% do not have access to the health insurance. As the health insurance can only be attributed to people with a fixed address, these persons are mainly homeless people or migrants. Between 72.0% and 95.0% of clients in this category don't have the Belgian nationality.

A large part also (between 9.0% and 13.0%) has to sort their health assurance affiliation out. These are mainly released prisoners who have to arrange their assurance again.

Even clients who are insured need administrative support. This means only that these clients are registered to a mutual fund but that not everything is already arranged to be effectively insured.

This shows the consequent work of the social workers to follow up and to organise the various situations of clients in a continuous way (often every year).

3.1.6. No use of other treatment facilities

The mobility of clients into the specialized health care network can also be a way to see if these people are able or willing to use the complete care offer. Only 4.4% among the clients from Project Lama or MSOC/MASS Brussels who are registered in the TDI database in 2011 and 2012, were found to be registered in another treatment centre before or after their stay in these low-threshold agencies. Among these clients, 66.0% were found in second line

specialized facilities (specialized outpatient facility, specialized residential centre), 25.0% in hospitals and 9.0% in low-threshold centres in another city.

It is apparently difficult for drug users to move into the traditional health care network. Most of the precarious and marginalized drug users are often excluded from these facilities due to their global situation.

3.2. Drug use among socially excluded groups

3.2.1. Homeless people

During the winter period 2012-2013, a survey was carried out among homeless people during medical consultations in two emergency shelters in Brussels hosted by the non-governmental organisation ‘Doctors of the World’ (van Egmond 2013). The objectives of this survey were to document the client's access to health care and housing, their health and mental health condition and their consumption of psychoactive substances with a focus on benzodiazepines.

In total, 143 people answered these questions. 126 men and 17 women between 18 and 66 years old from different nationalities. Most of them are from Belgium (38.0%) and from Maghreb countries (31.0%).

The results concerning the consumption of psychoactive substances showed that one third (33%) of the homeless people had a problematic consumption with substances (including alcohol). Among them, 21% reported daily consumption of hypnotics and sedatives, 11.0% of cannabis and 4.0% of opiates. One third of all respondents (34.0%) also declared to need professional help for their consumption.

This survey shows that among a socially excluded population such as homeless people, an important proportion (more or less one third) has consumption problems, mainly with alcohol and tranquilizers.

3.2.2. Sex workers

In 2011, a study took place among female sex workers in Belgium with the objective to study among others their drug consumption (Decorte et al. 2011). This study was not only conducted in Brussels but in the whole country. In total 528 women were questioned during a face-to-face interview from Antwerp (122), Brussels (116), Charleroi (89), Ghent (101) and Liège (95). They were working in different places (street, windows, bar, private or escort).

The lifetime prevalence of illicit substance use was 58.5% for cannabis, 45,1% for cocaine, 26,7% for amphetamines, 15,5% for heroin and 8.0% for crack.

To assess the problematic use of drugs, questions were also asked about the injecting status and frequency of use. More than 10.0% of the respondents had already injected drugs and 14.6% used the substance at least once a week during the past month. On the basis of the Severity of Dependence scale, 30.0% of the sampled women were effectively dependent on at least one substance (Gossop et. Al, 1995).

4. Social reintegration

4.1. Housing

In Brussels, two projects of transitory housing for drug users are existing and seem to be complementary.

Transit has a shelter centre with 21 beds with a mean length stay of 13 days. This is a short duration community living environment supervised by social workers. The centre has also 8 studio flats. These flats are rented at low prices and must be linked with a reinsertion and rehousing planning. 28 people benefited from these housing services in 2012. The mean length of stay is 69 days and 93.0% of the residents found a housing solution after their stay. Among which 43.0% found a personal housing (Goessens 2012).

Lama has also developed a housing project called "Hestia" (mentioned already in 2.2). It allows the users to find stability and a lasting accommodation. There are 6 apartments rentable for 1 year. At the end of this period, around 50.0% of the people turn into an independent housing solution.

The federal public service for social integration has the objective to start a new initiative inspired by the approach "housing first" in 5 big cities including Brussels. The objective is to better respond to the demand for a quick access to housing for homeless people. Treatment, sobriety or the ambition to change are not included in the conditions to get access to a housing initiative. This initiative is still in debate (SPP Intégration sociale 2012).

4.2. Work and finances

Modus Vivendi is active in harm reduction activities and is recruiting drug users in Brussels (and the Walloon region) for their prevention activities. These drug users are trained to use harm reduction principles and are incited to meet other drug users in order to pass preventive messages. These people are paid for this job. This initiative allows marginalized people to have access to a paid work (Modus Vivendi 2013).

Initiatives of sheltered workshops specific for drug-users such as "Buro Actief" in Flanders (Free Clinic 2013) or "Entreprise de formation par le travail" in Wallonia are not existing in Brussels (Autrement asbl 2013).

4.3. Social relations

The network of Psycho-social workers has been created in Brussels to investigate the need to support care centres with a mobile psycho-social team for people combining social instability and mental disorders. The objective is to reconnect the drug user to the health care network. Ten social workers took part to this project and collaborate to improve it. A lot of the supported people had a drug use problem (42.0%). Some points of interest, such as a low-threshold access to mental health specialists and the lack of access to housing solutions for people combining multiple problems, have been identified (Slimbrouck 2012).

The creation of a first drug consumption room is also in debate in Brussels. These kind of places have also a social role. It is a place for social contacts, advices and basic care for drug users. This can be an opportunity to come into contact with the most marginalized drug users (Baufay 2012). The low-threshold dialogue carried out a research piloted by Transit with the support of local authorities in the Ribeaucourt district in Molenbeek (Brussels) (Kirzin et al. 2012). Results are speaking in favour of this kind of structure. Currently many members of the civil society as well as health and specialized professionals are supporting this project through a call set up by the low-threshold dialogue and the federation of drug users centres. They hope that the political and judicial contacts, they are currently supporting, will have a positive influence on the opening of drug consumption rooms in cities that are confronted with "open drug scenes" such as Brussels. Finally, they hope that these environments will be implemented as recommended by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA 2004), and will find their place in Belgium.

4.4. Reintegration after prison

Since 2011, an agreement has been concluded between the prisons in Brussels and Transit concerning a follow-up of the treatment after a prison stay. Transit visit the prisoner before release in order to give the agreement to follow-up the medical drug treatment of the prisoner after his/her prison stay. When the prisoner is released, information about the addiction treatment in prison is transmitted directly to Transit and the prisoner receives OST for the next 72 hours. This allows the patient to receive medication while looking for a new treatment centre outside prison (Meurant 2013).

Another support for persons who are released from prison is the "exit kit" which contains 2 lunch vouchers, a train card, a pen, condoms and a regional plan. This is not specific for drug users but allows the most destitute people to survive during a couple of days (Broux 2013).

Cap-iti, another centre in Brussels, helps people who are released from prison to become more socially integrated. They help them to get social and administrative rights, to find a

place to live or an address for the inscription at the commune. Nevertheless, ex-prisoners can also consult Cap-iti in order to get support during the procedure of judicial redemption. In total 335 persons asked for this specific support in 2012 (C.A.P.-I.T.I.asbl 2013).

Acknowledgements chapter 8:

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

Plettinckx E.

1. Introduction

A new national safety plan was implemented in 2012 by the federal minister of interior and justice. This plan prioritises different aspects of the competences of the local and federal police in Belgium. These priorities are very important because the Belgian police is one of the principal actors regarding drug-related crime. As drug-related crime is usually only detected by proactive activities of law enforcement, the Belgian police and the customs are the first actors who are involved in these activities. As such, their priorities and tasks have an effect on the different levels of the criminal justice system. The resources allocated to reach these priorities probably have an impact on the data collection and may explain some evolutions.

The drug-related priorities for the period 2012 – 2015 are 1) drug dealing; 2) import and export of cocaine; 3) the production and trafficking of synthetic drugs and cannabis; 4) and driving under the influence of alcohol and drugs (Turtelboom and Milquet 2012).

According to these priorities, this chapter first provides an overview of the drug-law offences (which include dealing, import, export and production of illegal drugs) and the offences related to driving under the influence of illegal drugs (both the statistics of police and customs are included).

Second, an overview is given of the possible reactions in order to prevent drug-related crime and reoffending.

Third, the number of new drug-related mandates, which are entrusted to the houses of justice and registered in the database of the houses of justice in the framework of alternatives to prison, are provided.

Fourth, the drug-related cases entering and leaving the (youth) prosecution level are analysed. This information is collected by the statistical service of the public prosecutor through the consultation of the database of the public (youth) prosecutors. The use of these administrative databases implies some limitations because of the lack of uniformity of the registration of the data in the different judicial districts. Additionally, this registration system is not systematically adapted to the changes in the youth protection law (College van procureurs-generaal, 2013).

Fifth, the number of drug-related sentences and suspensions are discussed, followed by a more detailed analysis of drug-related imprisonments and the prison population.

The last section will give a description about the availability of illicit drugs and (problem) drug use in Belgian prisons, which is based on a PhD study of dr. Vandam. New information about responses to drug-related health issues in prison and reintegration of drug users after release from prison, which is based on the biannual prison survey “Drug use in Belgian prisons: monitoring of health risks” is not available yet. At the moment, the University of Ghent is analysing the data collected in the survey. The results are expected to be ready in 2014.

2. Drug-related crime

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

2.1. Drug law offences

The Belgian federal police publishes statistics to allow policymakers to set priorities. These figures are based on reports of both the local and federal police and describe various crimes (Federale Politie - CGOP / Beleidsgegevens 2013). Table 9.1 describes the total number of offences in relation to the total number of drug law offences committed during the period 2006-2012. In 2011, a total of 1098391 criminal offences were registered, of which 41959 drug law offences (use, possession, dealing, trafficking, or production of drugs), yielding a rate of 3.8%. These figures suggest a decline in the share of drug-related offences over the years (from 4.0% in 2006 to 3.6% in 2012). The share of drug-related offences was the highest in 2008-2009.

Table 9.1. Drug law offences in relation to the total number of law offences, N and %, Belgium, 2006-2012.

Offences	Year						
	2006	**2007**	**2008**	**2009**	**2010***	**2011**	**2012****
Total (N)	1,010,888	1,022	1,029,214	1,052,917	1,058,203	1,098,391	524,305
Drug-related (N)	40,422	44,597	46,206	47,798	42,201	41,959	18,653
Drug-related (%)	4.0	4.4	4.5	4.5	4.0	3.8	3.6

* Individual drug use is since 2010 only counted as drug possession, before this was often counted both as use and possession

** 2012 data is only related to the first semester of the year.

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

Drug law offences are a concept covering different categories such as use, possession, import and export, trade, production and trafficking of illicit drugs (European Monitoring Centre for Drugs and Drug Addiction 2007). The Belgian federal police reports every year about these different categories (Federale Politie - CGOP / Beleidsgegevens 2013). Both the numbers and prevalences for the years 2006-2012 are described in table 9.2. As individual drug use is registered as possession of drugs since 2010, drug use and possession are reported together. These figures report an increase of the total amount of drug law offences from 2006 until 2009. From then on, the total number of drug law offences is decreasing again. Nevertheless, the drug law offences globally increased slightly from 40422 in 2006 to 41959 in 2011. This evolution is mainly determined by the evolution in drug law offences related to the use and possession of drugs, which include about 66.0-70.0% of all drug law offences. The share of drug law offences related to trade varies between 13.0% and 15.0% over the years. Import and export related drug law offences varies between the 12.0% and 13.0% of all drug law offences. The proportion of drug-related production, however, increased from 1.6% in 2006 to 2.9% in 2012.

Table 9.2. Drug law offences by category, N and %, Belgium, 2006-2012

Drug law offences	Year													
	2006		2007		2008		2009		2010		2011		2012*	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Use and possession	28,201	69.77	31,506	70.65	32,581	70.51	33,552	70.20	27,973	66.29	28,419	67.73	13,024	69.82
Trade	5,559	13.75	5,880	13.18	6,065	13.13	6,701	14.02	6,340	15.02	6,107	14.55	2,778	14.89
Import and export	5,520	13.66	5,842	13.10	6,081	13.16	5,684	11.89	5,064	12.00	4,843	11.54	1,621	8.69
Production	649	1.61	841	1.89	894	1.93	1,050	2.20	1,214	2.88	1,261	3.01	546	2.93
Other	493	1.22	528	1.18	648	1.40	811	1.70	1,610	3.82	1,329	3.17	684	3.67
Total	**40,422**	**100.0**	**44,597**	**100.0**	**46,206**	**100.0**	**47,798**	**100.0**	**42,201**	**100.0**	**41,959**	**100.0**	**18,653**	**100.0**

*2012 data is only related to the first semester of the year.

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

These figures show that the vast majority of drug law offences are related to the demand side, which is confirmed by strategic analysts working on drugs of the federal police. They are collecting on a regular basis detailed information about drug law offences by type of drugs. These analyses are producing more detailed, more complete (data for the complete year 2012) and more accurate results as data is extracted from the national database every two months (please refer to table 9.3). Moreover, drug use and drug possession is only counted once (as one single offence) as drug use always implies drug possession. Nevertheless, the local and federal police do not always know what kind of illicit drug is involved. Some seizures have to be analysed by a laboratory before it is known which substance is involved. In about 90.0% of the cases the federal police gets feedback about the results of these analyses. For these reasons, the total number of drug law offences mentioned in table 9.3 are lower than the total number of drug law offences in table 9.1 and 9.2.

The strategic analysts of the federal police report that almost 70.0% of these drug law offences were related to cannabis in 2012. 8.0% of the drug law offences are related to (meth)amphetamine, 3.0% to ecstasy, 6.0% to heroin, 10.0% to cocaine or crack and 3.0% to ‘other’ drugs (benzodiazepine, captagon, codeïne, GHB, ketamine, khat, methadone, morfine, opium and mushrooms).

Table 9.3. Drug law offences as main offence, by type of drug, N and %, Belgium, 2006-2012

Drug type	Year													
	2006		2007		2008		2009		2010		2011		2012	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Cannabis	22,640	63.9	25,044	65.2	26,348	65.3	27,344	70.9	25,711	70.4	24,211	72.8	24,490	69.9
(Meth)amphetamine	2,862	8.1	2,000	7.3	3,275	8.1	2,580	6.7	2,830	7.8	2,323	7.0	2,669	7.6
Ecstasy	1,921	5.4	1,796	4.7	1,607	4.0	798	2.1	593	1.6	738	2.2	1,030	2.9
Heroin	3,301	9.3	3,897	10.2	3,706	9.2	2,997	7.8	3,145	8.6	2,186	6.6	2,193	6.3
Cocaine/crack	3,569	10.1	3,683	9.6	4,042	10.0	3,879	10.1	3,234	8.9	2,819	8.5	3,427	9.8
Other	1,165	3.3	1,166	3.0	1,392	3.4	963	2.5	991	2.7	999	3.0	1,222	3.5
Total	**35,458**	**100.0**	**38,386**	**100.0**	**40,370**	**100.0**	**38,561**	**100.0**	**36,504**	**100.0**	**33,276**	**100.0**	**35,031**	**100.0**

Source: Federal police: ST11_2013_BE_01 / ST11_2008_BE_01

Although drug-law offences related to cannabis were increasing over the last years, most recent data reveals a slight decrease in 2012. (Meth)amphetamine related law offences are fluctuating over the years. Ecstasy related law offences seem to increase since 2011. Heroine related law offences are decreasing slightly over the past years. After a stagnation of four years, cocaine related law offences were decreasing in 2010 and 2011. The figures show that cocaine related law offences increased again the past year. The drug-related law offences classified as ‘other’ are increasing still in 2012. Also for 2012, a big part is related to N (please refer to Chapter 7, section 2.2.1. for more information).

2.2. Other drug-related crime

2.2.1. Driving under the influence of drugs

In the framework of the Road Safety Action Plan, the Federal Highway Police are organising controls in order to screen drivers for drug use. Since 2011, the Federal Highway Police only uses oral fluid screening tests. The first step of the procedure is a visual checklist. In case of positive indications of illicit drug use, an oral fluid screening test is conducted. In case of a positive test, a doctor will take a blood sample that is to be analysed in a laboratory (Ricour, Personal communication, 2011). In the period of January 2007 until September 2010, about 6.1% of all 'driving under the influence' (DUI) offences (N=9586) were detected by the federal highway police (Vlaminck 2012).

In 2012, 489 drivers were tested by the Federal Highway Police through this selective screening method (2898 hours of control). 24.7% of them tested positive for THC, cocaine, morfine, amphetamine and/or MDMA (B.S./M.B. 15.09.2009; Ricour, Personal communication, 2011). Consequently, 119 blood samples were taken in order to indicate the substances that were used. As we know that generally 6.1% of all DUI offences are detected by the federal highway police, we may assume that in total 1983 blood samples were collected both by the federal highway police and the local police in 2012. 1718 blood samples were analysed by the National Institute for Criminalistics and Criminology (NICC), which is 86.6% of the total. The other blood samples were sent to other laboratories in Belgium. Unfortunately, only a detailed overview of the analyses conducted by the NICC is available (table 9.4). Nevertheless, we can conclude that these results are representative for the rest of the analyses conducted by other laboratories, as this includes 86.6% of the total substances involved.

Table 9.4 shows that 13.0% of these samples were related to false positive oral fluid screening tests. In 55.6% of the cases cannabis was involved, in 22.1% of the cases amphetamine, in 19.2% of the cases cocaine and in 4.8% of the cases opiates.

Most analyses indicated only one substance. According to these results, 45,2% of the drivers were under the influence of cannabis only, 15.2% of the drivers used only amphetamine, 10,5 % were only under the influence of cocaine and 2.2% used only opiates. 13.7% of the analyses were related to poly-drug use.

Table 9. 4. Substances detected in blood samples after a positive oral fluid screening test, N and %, NICC, 2011-2012

Substances detected in blood	Year			
	2011		2012	
	N	%	N	%
Amphetamine	202	14.6	261	15.2
Amphetamine + cannabis	73	5.3	76	4.4
Amphetamine + cannabis + cocaine	7	0.5	11	0.6
Amphetamine + cannabis + cocaine + opiates	0	0.0	0	0.0
Amphetamine + cannabis + opiates	0	0.0	0	0.0
Amphetamine + cocaine	19	1.4	28	1.6
Amphetamine + cocaine + opiates	0	0.0	0	0.0
Amphetamine + opiates	1	0.1	4	0.2
Cannabis	726	52.5	777	45.2
Cannabis + cocaine	70	5.1	78	4.5
Cannabis + cocaine + opiates	2	0.1	5	0.3
Cannabis + opiates	3	0.2	9	0.5
Cocaine	124	9.0	181	10.5
Cocaine + opiates	11	0.8	27	1.6
Opiates	31	2.3	38	2.2
Below legal cut-off value	115	8.3	223	13.0
Total blood tests	**1,384**	**100.0**	**1,718**	**100.0**

Source: NICC, Personal communication, 2013.

3. Prevention of drug-related crime

Although not all drug users commit other crimes, drug use is often associated with (drug-related) crime (De Ruyver et al. 2008b). The presence of drug users in Belgian prisons is much higher in comparison with the general population (Daems et al. 2009). The prevalence of lifetime drug use in Belgian prisons is since 2003 equal to or higher than 50.0%. One out of three detainees in Belgium is incarcerated because of drug-related offences (Todts et al. 2007; Todts et al. 2009; Van Malderen et al. 2011). These findings encouraged researchers to investigate the influence of substance use to the participation in criminal activities. Researchers have shown that both current and previous (il)legal drug use increase the likelihood of

committing crimes (Lundholm et al. 2013; Lurigio 2000; Sinha and Easton 1999). Regardless of gender, (early) initiation into drug use is a risk factor for the onset, continuation and reinforcement of criminal activities (Lurigio 2000;Swan and Goodman-Delahunty 2013). Research shows that the consumption of alcohol and large doses of benzodiazepines trigger for example interpersonal violence (Lundholm, Haggard, Möller, Hallqvist, and Thiblin 2013). Drug and property crime, on the contrary, may be due to heavy marijuana use during adolescence (Green et al. 2010). As drug use is a risk factor for committing crimes, efforts to prevent or delay the onset and reduce the period of drug use is very important (Green, Doherty, Stuart, and Ensminger 2010; Odgers et al. 2008). Please refer to chapter 3 in order to have an overview of the environmental, universal, selective and indicated prevention initiatives applicable to Belgium.

Despite these prevention initiatives, people may continue to use drugs. Even incarceration cannot motivate some people to stop using drugs (please refer also to section 5). During the period 2006-2010, 30.0 to 36.0% of the Belgian prison population indicated to have used drugs during the current detention (Van Malderen, Pauwels, Walthoff-Borm, Glibert, and Todts 2011). For those offenders who are using drugs, drug treatment seems an effective means, not only to reduce illegal drug use but also drug-related crime and recidivism (Lurigio 2000; Vorma et al. 2013). Sheerin and colleagues verified the effectiveness of a methadone maintenance therapy programme in reducing crime in New Zealand. Their results showed a large reduction of the income derived from illegal activities (Sheerin et al. 2004). Other research suggest opioid substitution treatment (OST) in prisons, which reduces recidivism if the methadone dose reaches 60mg and the treatment duration lasts the entire period of imprisonment (Stallwitz and Stöver 2007).

In Belgium, the criminal justice system has the possibility to involve treatment at three levels, namely at prosecution level, court level and at the level of imprisonment. First of all, the criminal justice system has the possibility to impose alternative sanctions to drug using offenders. Judicial alternatives are applicable in various stages of the criminal justice system and include conditions which have to be met by the offenders. These conditions may be related to drug treatment (Defillet 2012). As a large number of homeless people, low educated people and persons without a job are involved in drug-related crime, the criminal justice system may also broaden their scope and insist on work, housing or education related conditions (whether or not in combination with drug treatment) (De Ruyver, Colman, and Vandam 2008b). Please refer to

section 4.1. of this chapter to read more about the use of the different categories of alternative sanctions by the Belgian criminal justice system.

Second, two 'referral-to-treatment' pilot projects, 'trial care' (Proefzorg) and 'drug treatment court' (Drugbehandelingskamer (DBK)) were implemented in the Judicial district of Ghent in 2005 and 2008 respectively (De Ruyver et al. 2008a; Vander Laenen et al. 2012). Both projects attend only drug-related crimes in order to redirect drug using offenders to treatment. The orientation to treatment follows rapidly after the crime. In most of the cases (except for the short version of 'trial care') drug using offenders are supported and supervised intensively by either a trial care manager or a liaison during treatment. The project 'trial care' is established at the prosecution level, the 'DBK' at the level of first line court. After quitting or successfully finishing the treatment period, feedback is given to the public prosecutor or magistrate in order to take the result of the treatment period into account during the settlement of the criminal file (De Ruyver, Colman, De Wree, Vander Laenen, Reynders, van Liempt, and De Pauw 2008a). A short description of the procedure of these two projects was given in Deprez and Van Malderen (2012). Both pilot studies were subject of an evaluation study. Both process evaluations turned out to be positive (De Ruyver et al. 2008a; Vander Laenen et al. 2012). Moreover, De Ruyver and colleagues revealed that the pilot project is effective in reducing recidivism (De Ruyver et al. 2007). Consequently, practitioners are highly motivated to improve the functioning of the projects and expend their implementation in the future (Vander Laenen et al. 2012). Every district has to verify whether the following elements are present or provided before implementing these referral-to-treatment initiatives: 1) both projects need to be included in the existing regional network of drug treatment initiatives (Colman et al. 2011); 2) the capacity of treatment must be sufficient (Colman et al. 2011); 3) providing sufficient financing to treatment (De Ruyver et al. 2008a); 4) all actors involved have to be aware of the existence of these projects (Colman et al. 2011); 5) the competences between justice and treatment have to be defined clearly (De Ruyver et al. 2008a); 6) coordination must be provided (Colman et al. 2011); 7) trial care managers and liaisons have to play a central role (Colman et al. 2011; De Ruyver et al. 2008a); 8) maintain the judicial pressure (e.g. make sure that the justice assistant is present in the DBK) (Colman et al., 2011); 9) dialogue with mutual respect for each other's professional secrecy, is necessary (De Ruyver et al. 2008a); 10) written information exchange brings more clarity (De Ruyver et al., 2008a); 11) give attention to all life domains (Colman et al., 2011); 12) provide sufficient feedback (Colman et al., 2011).

Third, drug using offenders in prison cannot be ignored. As a consequence, drug using offenders in detention in Belgium can make use of several drug-related health services, such as cognitive-behavioural interventions, OST, therapeutic communities and drug free programmes. More information can be found in the two last editions of the Belgian national report on drugs (Deprez et al. 2012; Plettinckx et al. 2012).

4. Interventions in the criminal justice system

The next paragraphs give an overview of the reactions of the criminal justice system in order to respond to drug-related crime. Section 4.1 gives an overview of the different categories of alternative measures which were followed up by the justice assistants of the houses of justice. Section 4.2 discusses the responses to drug-related offences when entering prosecution or court level.

4.1. Alternatives to prison

Alternative sanctions in general and for drug users in particular is stimulated amongst others by the interministerial conference on drugs (De Wree et al. 2009b; B.S. 15.04.2010). Research has shown so far that imprisonment does not have a deterrent effect on the commitment of crimes (Freiburger and Iannacchione 2011; McGrath and Weatherburn 2012; Nagin et al. 2009). Detention may not only increase drug use and crime but can also have negative effects on social, physical and psychic aspects of life (Hardy and Snowden 2010; Liebling and Arnold 2012; Nieuwbeerta et al. 2009; Schnittker and John 2007). Both national and international research demonstrate a positive effect of alternative sanctions on crime reduction and several life domains (Cid 2009; De Wree et al. 2009a; De Wree et al. 2009b; Spohn 2007). Especially if drug treatment is part of the alternative sanction (Lurigio 2000; Vorma et al. 2013). As a result, alternative sanctions are a more adequate answer on offences than imprisonment (Cid 2009; De Wree et al. 2009a). The most important advantage is that alternative measures can be geared to the individual situation and needs of each offender (De Wree et al. 2008; De Wree et al. 2009a). The prosecutor or judge has the possibility to propose (at prosecution level) or impose (at court level) in certain circumstances (ex. adult offender, maximum sentence of 5 years, …) an alternative measure. In this case, the offender will be referred to a justice assistant who is since 1999 responsible for the supervision and guidance of these alternative measures and works in one of the 28 houses of justice in Belgium. All guided mandates of the alternative measures are recorded in a general database of the houses of justice within the Directorate-General for Justice Houses (Burssens 2012). This registration is mandatory since 2005 (Devos

2009). The data analysis and quality service of the Directorate-General for the Houses Justice extracted in 2012 for the first time all mandates related to drug offences from the general database of the houses of justice. The analysis of new drug-related mandates between 2006 and 2012 shows that most of the clients are between 18 and 34 years old, are male, have the Belgian nationality and have a job. Table 9.5. gives a description of the number of new assignments related to drug offences at the houses of justice between 2006 and 2012. These figures indicate a global increase of new mandates of alternative measures in respect of drug law offences. Nevertheless, we find a slight decrease in the years 2011 and 2012. Alternatives to pre-conviction detention and mediation in criminal matters are the only alternative measures which are increasing the last three years with 2.0% and 3.0% respectively. Mediation in criminal matters includes, however, the smallest number of new mandates over the last years. Probation stays the alternative measure with the highest number of new mandates each year.

Table 9.5. New assignments at the houses of justice for drug-related crimes, N and %, Belgium, 2006-2012

Assignments	Year													
	2006		2007		2008		2009		2010		2011		2012	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Alternatives to pre-conviction detention	963	23.1	1,125	22.6	1,279	21.4	1,333	21.8	1,258	18.9	1,237	19.0	1,244	20.5
Probation	1,389	33.4	1,460	29.4	1,618	27.0	1,767	28.8	1,848	27.7	1,783	27.5	1,587	26.1
Autonomous work sentence	1,035	24.9	1,224	24.6	1,455	24.3	1,233	20.1	1,316	19.7	1,179	18.2	1,227	20.2
Electronic surveillance*	2	0.0	290	5.8	864	14.4	966	15.8	1,449	21.7	1,213	18.7	1,151	18.9
Penitentiary**	523	12.6	680	13.7	566	9.4	622	10.2	581	8.7	770	11.9	510	8.4
Mediation in criminal matters	251	6.0	193	3.9	208	3.5	207	3.4	220	3.3	295	4.5	362	6.0
Total	**4,163**	**100.0**	**4,972**	**100.0**	**5,990**	**100.0**	**6,128**	**100.0**	**6,672**	**1000**	**6,495**	**100.0**	**6,081**	**100.0**

* Although a national centre for electronic surveillance was implemented in 2000, electronic surveillance got only a legal basis in 2006 and is only legally entrusted to the houses of justice since 2007 (Burssens 2012;Devos 2009;Vanhaelemeesch 2012). This is the reason why the registered mandates does not exist or are very low for 2006.
** This is a collective term for conditional release, provisional release, posting of the government, limited detention and release on probation of internees.

Source: DG MJH Dienst - Data Analyse en Kwaliteit 14 februari 2013

4.2. Other interventions in the criminal justice system

Almost 32,000 drug or doping-related cases entered the prosecution system of first line courts in Belgium in 2012. This represents 4.5% of all cases. Table 9.6 shows figures about drug or doping-related cases entering the prosecution level of the last 7 years and indicate a decrease in the percentage of drug or doping-related cases since 2008.

Table 9.6. Drug/doping related cases in comparison with the total amount of cases entering the prosecution system of first line court, N and %, Belgium, 2006-2012

Cases entering prosecution system*	Year						
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Drug/doping related (N)	33,874	39,058	40,843	40,695	37,835	37,952	31,815
% drug/doping-related	4.6	5.6	5.7	5.6	5.2	5.2	4.5
Total	**741,436**	**703,341**	**712,329**	**724,422**	**729,354**	**731,007**	**707,470**

* both new and reopened cases

Source: Chamber of the Prosecutor General (Gegevensbank van het College van procureurs-generaal: Statistisch analisten 2013)

The prevalence of drug or doping related cases entering the youth prosecution system is two times higher than at the level of the prosecutor of first line court in 2012 (see table 9.7). 9.0% of all cases entering the youth prosecution were related to drugs or doping. This is the highest prevalence reported in the last 7 years and indicate an increases of 2.0% in comparison with 2011.

Table 9.7. Drug/doping related cases entering the youth prosecution system, N and %, Belgium, 2006-2012

Cases entering the youth prosecution system*	Year						
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Drug/doping related (N)	6,265	5,851	6,207	6,365	6,549	5,645	5,659
% drug/doping-related	8.4	7.1	7.4	7.9	7.9	7.1	9.0
Total	**74,491**	**82,305**	**83,840**	**80,178**	**83,014**	**79,249**	**62,626**

* both new and reopened cases

Source: Chamber of the Prosecutor General (Gegevensbank van het College van procureurs-generaal: Statistisch analisten 2013)

Table 9. 8 shows the closing decisions for drug and doping-related cases at prosecution level (youth prosecution is not included) in Belgium since 2006. Most (56.8%) of the drug or doping related cases at the prosecution system of first line court are still closed without consequence in 2012. The second most common closing decision in 2012 is the joinder (13.5%). The drug or doping-related cases which were handed over are less common in 2012 (third place) in comparison with the last 6 years. 12.7% of all drug or doping related cases were handed over in 2012. The prosecutor redirected 7.1% of the drug or doping related cases to a pre-trial chamber in 2012. This percentage remained stable over the past years. 5.8% of the cases were summoned immediately. An out of court settlement was paid in 3.7% of the cases and a mediation was only completed in 0.5% of the cases. These two last closing decisions turn out to be more often completed successfully in recent years.

Table 9.8. Closing decision for drug/doping related cases at prosecution system of first line court, N and %, Belgium, 2006-2012

Closing decision at prosecution level	Year													
	2006		2007		2008		2009		2010		2011		2012	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Without consequence	19,674	57.7	22,136	57.8	21,539	54.6	22,679	56.9	21,392	57.3	20,917	56.5	19,097	56.8
Handed over	5,058	14.8	5,983	15.6	7,217	18.3	5,877	14.7	5,303	14.2	5,879	15.9	4,254	12.7
Joinder	4,412	12.9	4,869	12.7	5,097	12.9	4,950	12.4	4,478	12.0	4,301	11.6	4,519	13.5
Out of court settlement paid	763	2.2	891	2.3	932	2.4	1,356	3.4	1,115	3.0	1,000	2.7	1,233	3.7
Mediation completed	97	0.3	116	0.3	114	0.3	113	0.3	123	0.3	100	0.3	156	0.5
Immediate summons	1,767	5.2	1,930	5.0	2,102	5.3	2,322	5.8	2,289	6.1	2,243	6.1	1,962	5.8
Pre-trial chamber	2,346	6.9	2,358	6.2	2,427	6.2	2,591	6.5	2,634	7.1	2,616	7.1	2,390	7.1
Total	**34,117**	**100.0**	**38,283**	**100.0**	**39,428**	**100.0**	**39,888**	**100.0**	**37,334**	**100.0**	**37,056**	**100.0**	**33,611**	**100.0**

Source: Chamber of the Prosecutor General (Gegevensbank van het College van procureurs-generaal: Statistisch analisten 2013)

The Service for Criminal Policy collects the information about the final judgements in all Belgian courts. The Service for Criminal Policy updated the database, which is published online, in 2012 with new figures of 2011. Additionally, the Service for Criminal Policy made an update of the previous years (2006-2010). The incompleteness of the figures for these years may be the result of either a delay in sending the 'judgement extractions' from the courts to the Central Criminal Registry or a delay in the registry in the Central Criminal Registry itself (Elke Devroe, personal communication). As consequence, table 9.9 shows the figures of drug or medication related sentences and suspensions in relation to the total numbers of registered sentences and suspensions for the years 2006 until 2011. Figures from 2000 until 2005 can be found in the previous national report on drugs (Plettinckx, Antoine, Blanckaert, Bollaerts, and van Bussel 2012).

Table 9.9. Sentences and suspensions of drug or medication-related cases, N and %, Belgium, 2000-2011

Final judgement at court level	Year					
	2006	2007	2008	2009	2010	2011
Sentences						
Total	**302,169**	**253,636**	**254,764**	**267,417**	**258,224**	**243,188**
Drug-related (N)	5,423	5,454	5,444	5,238	5,693	5,516
% drug-related	1.8	2.2	2.1	2.0	2.2	2.3
Suspensions						
Total	**14,850**	**12,966**	**10,223**	**9,813**	**10,198**	**9,609**
Drug-related (N)	1,038	882	637	572	590	615
% drug-related	7.0	6.8	6.2	5.8	6.1	6.0

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

The drug-related sentences and suspensions are fluctuating over time. Nevertheless, in global terms, the drug-related sentences have increased slightly from 1.8% in 2006 to 2.3% in 2011. The drug-related suspensions, in contrary, have decreased over the last seven years from 7.0% to 6.0%. Table 9.10 provides an overview of drug-related imprisonments compared to the total number of imprisonments between the years 2006 and 2011.

Table 9.10. Number of imprisonments, N and %, Belgium, 2006-2011

Number of imprisonments	Year					
	2006	2007	2008	2009	2010	2011
Total	**16,237**	**16,715**	**17,346**	**18,001**	**18,189**	**18,302**
Drug-related (N)	3,774	4,011	4,350	4,585	4,601	4,638
% drug-related	23.2	24.0	25.1	25.5	25.3	25.3

Source: Chronique de criminologie (Guillain and Deltenre 2012)

The above mentioned table indicates that most imprisonments (75.0%) are not drug-related. Nevertheless, the amount of drug-related imprisonments cannot be neglected. One out of four incarcerations is due to a drug-related offence. Moreover, the proportion of drug-related imprisonments in relation to all drug-related sentences is far bigger compared to the proportion of all imprisonments in relation to all sentences.

In 2011, 4638 imprisonments were carried out because of drug-related offences (table 9.10.). Although the total number of sentences gradually drops and the number of drug-related sentences remains fairly stable over the years (table 9.9), the number of drug-related incarcerations is increasing, with 2.0% since the year 2006 (25.0% of the total number of detentions in 2011 can be related to drugs). This increase seems to be a reflection of the yearly increase in the total number of detentions.

The total number of drug-related imprisonments is divided into two categories in table 9.11, namely the number of imprisonments because of a drug law offence on the one hand and the number of imprisonments because of a combined offence (drugs + other crime) on the other hand. This table shows that most of the drug-related imprisonments are due to 'drugs-only' offences (>75.0%).

Table 9.11. Number of drug-related imprisonments, N and %, Belgium, 2006-2011

Number of drug-related imprisonments	Year											
	2006		2007		2008		2009		2010		2011	
	N	%	N	%	N	%	N	%	N	%	N	%
Drugs only	2,871	76.1	3,166	78.9	3,423	78.7	3,600	78.5	3,5554	77.2	3,512	75.7
Drugs and other	903	23.9	845	21.1	927	21.3	985	21.5	1,047	22.8	1,126	24.3
Total	**3,774**	**100.0**	**4,011**	**100.0**	**4,350**	**100.0**	**4,585**	**100.0**	**4,601**	**100.0**	**4,638**	**100.0**

Source: Chronique de criminologie (Guillain and Deltenre 2012)

If we compare the number of imprisonments (table 9.10 – 9.11) with the prison population (table 9.12 – 9.13), it is noticeable that the number of detentions is higher than the number of prisoners (both total and drug-related). The prison population is affected by the number of detainees entering and leaving the Belgian prisons and the duration of stay (Guillain and Delterne 2012). These factors, together with the fact that one person can be incarcerated several times a year for a short period, can explain the lower number of the prison population in comparison with the number of imprisonments. Although both the total and the drug-related prison population is increasing over the years, the share of drug related detainees among the total prison population stays relatively stable (table 9.12).

Table 9.12. Prison population, N and %, Belgium, 2006-2012

Total prison population*	Year						
	2006	2007	2008	2009	2010	2011	2012
Total	**9,596**	**9,936**	**9,804**	**10,098**	**10,488**	**10,969**	**11,109**
Drug-related (N)	2,914	3,023	3,013	3,079	3,292	3,432	3,437
% drug-related	30.4	30.4	30.7	30.5	31.4	31.3	30.9

* This table describes the prison population on the first March of each year in the period 2006-2012

Source: Chronique de criminologie (Guillain and Deltenre 2012)

Table 9.13 provides a more detailed overview of the detainees in prison because of a drug-related offences. These figures show that the drug-related prison population consist mainly (>65.0%) of prisoners who committed not only drug law offences but also other offences.

Nevertheless, table 9.10 showed that most of the drug-related imprisonments are due to 'drugs-only' offences (>75.0%). This is the result of the number of provisional detentions for 'drug-only' offences. Guillain and Delterne (2012) indicate that 18.0% of all provisional detentions are related to drug-only offences, whereas only 6.0% of all convictions. The combined offences are more represented (31.0%) among all convictions. Detainees with a provisional detention are released relatively quickly. Prisoners who are convicted are staying in most cases for a long(er) period in prison. As such, detainees with a provisional detention are less represented in the prison population which result in a lower percentage of detainees imprisoned because of 'drugs-only' offences in the drug-related prison population.

Table 9.13. Drug-related prison population, N and %, Belgium, 2006-2012

Prison pop.	**Year***													
	2006		**2007**		**2008**		**2009**		**2010**		**2011**		**2012**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Drugs only	896	30.8	1,060	35.1	1,100	36.5	1,081	35.2	1,126	34.2	1,145	33.4	1,059	30.8
Drugs and other	2,018	69.2	1,963	64.9	1,913	63.5	1,995	64.8	2,166	65.8	2,287	66.6	2,378	69.2
Total	**2,914**	**100.0**	**3,023**	**100.0**	**3,013**	**100.0**	**3,076**	**100.0**	**3,292**	**100.0**	**3,432**	**100.0**	**3,437**	**100.0**

* This table describes the prison population on the first March of each year in the period 2006-2012

Source: Chronique de criminologie (Guillain and Deltenre 2012)

5. Drug use and problem drug use in prisons

This section provides a detailed overview concerning the availability of illicit drugs and (problem) drug use in Belgian prisons. Table 9.12 shows that 31.0% of the prisoners are currently in incarcerated because of drug-related offences. Nevertheless, this does not provide insight in the drug using patterns of prisoners in Belgium. In 2013, a PhD study about the effect of detention on patterns of legal and illegal drug use was finalised. This study gives a description of 1) the perception of prisoners of the availability of drugs inside two Belgian prisons and 2) (problem) drug use before, during and after detention. Simultaneously, the study examines the extent to which the results can be explained by the General Strain Theory (GST) of Agnew (Vandam 2013).

Dr. Vandam (2013) used a mixed method study design in order to maximise the strengths and to minimise the weaknesses of both quantitative and qualitative methods.
The quantitative part of the study consists of a three-wave panel study. This study design allows the researcher to follow the same persons during three periods of time. In 2009, 100 prisoners, which would be released soon, were selected from two prisons (Bruges and Ghent). Five prisoners were released from prison before the survey could be administered and four prisoners did not want to participate in the study. As a consequence, 91 prisoners gave informed consent to the researcher to be available for the study during, three and six months after detention. During these three periods, face to face structured questionnaires were conducted. During the first measuring period, the respondents were asked to answer questions about the period before and during detention. Although 91 prisoners gave their initial approval to be available for the study after release, the follow-up of these persons (due to several reasons) was not easy. The drop out remained limited thanks to several follow-up methods. 81.0% (N=74) of the respondents were interviewed again after three months and 74.0% (N=67) after six months.
The qualitative part of the study consists of half-open interviews in order to understand the individual experiences related to detention and drug use. The respondents were selected through a stratified purposeful sampling. Ten ex-prisoners were selected among the 67 respondents who took part in the last phase of the quantitative part of the study.

This limited contribution focusses only on the patterns of illegal (problem) drug use during detention. First, we describe the perception of the availability of illegal drugs inside prison. Second, this section provides an analysis of the patterns of illicit drug use during detention. Third, injecting drug use (IDU), poly drug use and daily drug use are considered as indicators of problem drug use (PDU) (Vandam 2013).

5.1. Availability of illicit drugs in prisons

The majority of the respondents have the opinion that most of the substances are easily available in prisons. 77.0% of the respondents indicate that illegal drugs are available inside prison. Respondents indicated during the open interviews that illegal drugs enters the prison through different manners such as visitors and prisoners after penitentiary leave. According to the respondents, drug use inside prison is tolerated by the prison staff under certain condition. This can cause additional problems for the prisoners in quitting illegal drug use during detention (Vandam 2013).

5.2. Drug use in prisons

Illegal drug use is common in prison, since illegal substances are easily available and highly visible. Respondents are using illicit substances during detention in order to relieve boredom, to forget their problems or because of usual practice. 60.0% of all respondents used illegal substances during the past three months of their detention. 56.0% of them are using cannabis, 18.0% heroin, 16.0% amphetamines and 3.0% cocaine. Although these prevalences remain relatively high, this study indicates a decline of 11.0% of illicit drug use during detention in comparison with the period before detention. Cannabis and heroin use decline with 8.0%, the use of amphetamines by 7.0% and cocaine use by 41.0%. Prison can be an environment which motivates drug users to stop using. A sort of eye-opener that prevents them from relapsing. Some respondents also indicate not to use or to use less during detention in order to eliminate or minimise the probability of detection. Other substances are avoided during detention, because prison is not the proper setting to use these substances. Nevertheless, it happens as well that respondents are using more frequently during detention because of peer pressure (Vandam 2013).

5.3. Problem drug use

PDU is considered here as injecting or intensive use of the substances described above, namely cannabis, heroin, amphetamines and cocaine.

2.0% of all respondents injected illegal drugs sporadically (less than weekly) during detention. This means that one out of ten respondents continues to inject drugs during detention. None of the respondents started IDU during detention. The respondents reported injecting only heroin or amphetamines in prison. The daily use of drugs and the use of more than one substance during detention is more common. Despite the fact that the number of daily users declines sharply, 25.0% of the illegal drug users are still using on a daily basis. 29.0% of the cannabis

users and 6.0% of the heroin users are using every day. Cocaine and amphetamines are not used on a daily basis during detention. 43.0% of the respondents use two or more substances during their stay in prison, of which 33.0% on a daily basis. 77.0% of the daily poly-drug users are using medication in combination with cannabis and 8.0% are combining medication with cannabis and heroin (Vandam 2013).

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Chapter 10. Drug markets

Blanckaert, P.

1. Introduction

This chapter provides an overview of the drug markets in Belgium. Data regarding drug markets in Belgium is provided by different partners (through e.g. questionnaires or surveys, police reports and laboratory data).

Information regarding drug seizures, the seized illicit drug laboratories, drug origin and trafficking is provided by the General Directorate of the Judicial Police, Direction of Crime against Persons (DGJ-DJP), Drug Programme. Data on drug seizures and the seized illicit drug laboratories in particular are extracted from the General National Database (GND), which gathers all police reports in Belgium, both at the local and at the federal level.

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

Information regarding the street prices of drugs in Belgium is based on two sources. The first source is the federal police, who routinely collects pricing information (e.g. during examination of a suspected dealer). The second source is the Observatoire Socio-épidemiologique Alcool-Drogues (Eurotox asbl, the regional focal point in the Walloon region), which collects price data in the French community on the basis of a questionnaire examined among drug users by harm reduction and prevention services.

Data with regard to the composition and purity of the classic illicit drugs circulating on the Belgian market, are provided by the Belgian Early Warning System on Drugs (BEWSD), which keeps a database of all reported analysed drug samples in Belgium. Most of the time, these drug samples are seized by police services. Sometimes, these drug samples stem from users themselves, submitted through a small scale local pill testing project in the Brussels region (Modus Vivendi). Specifically, the contents of tablets sold as ecstasy, potential (toxic) contaminants and cutting agents are discussed.

2. Availability and supply

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

Last year's data regarding perceived availability of drugs and exposure/access to drugs were obtained from the "Youth attitudes on Drugs" (The Gallup organisation) study. The study showed that Belgian young people could easily obtain cannabis. The perceived access to other drugs (cocaine, heroin, ecstasy) was found to be more difficult. A minority of young people have used so-called new psychoactive substances (NPS, also called "legal highs"), mostly obtained through a friend (The Gallup Organisation, 2011). No new data have been obtained since.

2.2. Drugs origin: national production versus imported

For cannabis, most seizures in Belgium originated from The Netherlands or Belgium itself. Seized cannabis resin remains an exception, as the most frequent country of origin is Morocco. Heroin is still mainly imported through Turkey. The most important country of origin for cocaine was Colombia. Comparable to previous years, amphetamine and ecstasy were mostly produced in Belgium or produced and imported from The Netherlands (Dommicent, personal communication, 2013).

A survey regarding cannabis cultivation was organized by Decorte et al (Decorte, Potter, Barrat, Malm, and Lenton, 2013). This consisted of a web survey, asking cannabis growers for their growing habits. Respondents were recruited amongst others through internet fora, radio, newsletters in print, events, cannabis grower websites, specialized cannabis magazines and universities.

In Belgium, a lot of students responded to the questionnaire (in total 1043 respondents). Clearly most respondents of this survey were regular or even heavy users of cannabis. Most of the respondents started their cannabis use between age 16 and 17. 80.0% of respondents smoked cannabis on the day of or in the week leading up to the questionnaire. The amount of "other drug use" was also high among cannabis growers. The median 'age of first grow' was 20 years. Most Belgian respondents had grown between 2 to 5 crops, which is an indication of a high proportion of quite inexperienced growers. Compared to their North-American counterparts, Belgians had a preference for growing outdoors. The number of mature plants grown per crop was similar for each country (in Belgium, a median of 3 plants), with most people growing a relatively small number of plants (Decorte, Potter, Barrat, Malm, and Lenton, 2013).

Among the reported reasons for growing, the most important factors were cost, provision for personal use and pleasure. Especially Belgians reported "pleasure" as one of the reasons for

growing cannabis. Over 50.0% of respondents also mentioned healthiness of product and avoidance of criminals as reasons for growing their own cannabis (Decorte, Potter, Barrat, Malm, and Lenton, 2013). The adaptation of the Opiate law in the Netherlands restricts since 2012 the easy access to the de-criminalized “coffee-shop” market for foreigners. This law added in 2012 two new criteria to the existing AHOJG-criteria, namely the criteria of private club and resident, which prohibits the entrance to coffee-shops for non-residents of the Netherlands (Snippe and Bieleman, 2012).

In this respect, it should come as no surprise that the vast majority of growers reported consuming at least part of their crops for personal cannabis use. Significant majorities gave away cannabis, and a minority swapped cannabis with other growers. Only 18.0% of Belgians reported selling cannabis for profit as opposed to selling to cover their own costs of growing (Decorte, Potter, Barrat, Malm, and Lenton, 2013).

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

Belgian federal police services provide information with regard to the trafficking patterns for drugs in Belgium.

For cannabis plantations, the number of seized plantations continues to rise each year (table 10.5). This is also evident from table 10.2, where the amount of seized herbal cannabis increased again in 2012. However, this is not reflected in the number of seizures related to cannabis, which decreased in 2012 (table 10.1). Most of the domestic cannabis production is destined for export to the Netherlands, where it is sold in “coffee-shops”. Furthermore, Belgium remains a trafficking country for cannabis resin.

When it comes to cocaine, Belgium remains a transit country for cocaine traffic from South-America to Europe, especially through the Antwerp sea port and the Brussels airport. This is reflected in the high amounts of cocaine seized in 2012 (table 10.1). It has to be noted that the size of the seized shipments continues to increase as well (table 10.2). In 2012, several multi-tonne cocaine seizures were made.

For amphetamines and MDMA, Belgium remains a main production country, together with The Netherlands; each year, a number of MDMA and/or amphetamine labs are seized (table 10.4).

One new very worrying development is the apparent positioning of Belgium as a transit/production country for NPS, mostly synthetic cannabinoids (see 3.3).

3. Seizures

3.1. Quantities and numbers of seizures of all illicit drugs

The quantities and numbers of seizures for the most common illicit drugs are data collected by and obtained from the Belgian federal police (GND). These data are presented in tables 10.1 and 10.2 respectively.

Considering the total number of drug seizures in Belgium (table 10.1), a decrease of 7.7% can be observed in 2012 (34,862 seizures) in comparison with 2011 (37,776 seizures). This decrease confirms the decreasing trend in the number of drug seizures, which started in 2009 (40,674 seizures) in Belgium.

The majority of all seizures in 2012 were again related to cannabis (72.5% of all seizures). The total number of seizures related to cannabis amounted to 25,283. These numbers are relatively stable compared to 2011. Nevertheless, the quantity of seized cannabis is less compared to previous years (cannabis resin and herbal cannabis 2010: 8,361 kg; 2011: 10,115 kg; 2012: 6,973).

For the third year in a row, the proportion of heroin seizures dropped significantly (8.9% of the total seizures in 2010; 5.8% in 2011 and 5.6% in 2012). The quantity of seized heroin kept decreasing in 2012 as well (from 140 kg in 2011 to 112 kg in 2012).

Contrary to the overall trend, the number of drug seizures related to cocaine increased from 8.6% of all seizures in 2011 to 9.6% in 2012. Record amounts of cocaine were seized in Belgium in 2012: over 19 tonnes were seized, more than double the amount of cocaine that was seized in 2011. Moreover, this is the largest amount ever seized in Belgium.

The proportion of amphetamine seizures remained relatively stable in comparison with previous year (7.1% in 2011 and 7.3% in 2012). The amount of amphetamine seized in 2012 dropped drastically compared to previous years: only 54 kilograms were seized (compared to 111.5 kg in 2011). Regarding to methamphetamine, there were no differences in the number of seizures and the amount seized between 2011 and 2012. Moreover, in general, methamphetamine seizures remained anecdotal (3 kg, 93 seizures, which is 0.3% of the total) in 2012.

The proportion of seizures related to ecstasy increased from 2.2% of all seizures in 2011 to 2.9% in 2012. However, only 26,874 tablets were seized (versus 64,384 tablets in 2011), concluding that more people were arrested with – in general – less ecstasy tablets in their possession.

Judging by the amount and the number of seizures, the appearance of LSD keeps diminishing. As such, LSD remains a marginal phenomenon in Belgium. In 2012, only 225

blotters were seized (a drastic decrease compared to the 838 seized blotters in 2011), spread over 44 seizures (78 seizures in 2011). This can potentially be explained by the appearance of 25I-NBOMe on the Belgian market, sold as LSD on blotters. However, for 2012, no seizure data on 25I-NBOMe were available.

For GHB, 507 seizures were made in 2012 where GHB was discovered (for a total of 76 liter, in line with the results from previous years).

For the more exotic drug Khat (Catha Edulis), in 2012, 70 seizures were made, for a total of 1298 kilograms of plant material. These data are comparable to the data obtained in previous years.

Table 10.1. Total quantities of seized drugs by substance, Belgium, 2006-2012

	Year						
Drug type	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Cannabis resin (kg)	8,054	58,544	1,529	18,659	3,153	5,020	1,338
Herbal cannabis (kg)	4,563	12,732	4,891	4,486	5,208	5,095	5,635
Cannabis plants (units)*	110,368	148,251	177,190	272,714	312,528	337,955	330,675
Heroin (kg)	154	548	63	275	386	140	112
Cocaine (kg)	3,946	2,470	3,851	4,605	6,844	7,999	19,178
Amphetamine (kg)	119	483	411	49	362	112	54
Methamphetamine (kg)	.	.	.	.	39	2	3
Ecstasy-type substances (tablets)	482,904	541,245	162,821	31,025	32,954	64,384	26,874
LSD (units)	120	1	.	.	3,924	838	225
GHB (liter)	.	.	.	104	24	82	76
Khat (kg)	.	.	.	1,685	1,018	1,128	1,298

* Change in methodology: since 2008 the capacity of cannabis plantations is reported instead of the actual seizure and the reporting of plantations is done directly to the DGJ-DJP instead of through the GND. The data from 2006 and 2007 are less reliable.
** GHB and Khat are only monitored by BMCDDA since 2009.

Source: Federal police: ST13_2009_BE_01; ST13_2013_BE_01.

Table 10.2. Number of drug seizures by substance, N and %, Belgium, 2006-2012

	Year													
	2006		2007		2008		2009		2010		2011		2012	
Drug type	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Cannabis														
Resin	5,546	16.2	5,870	16.0	4,921	15.3	6,206	15.3	5,048	13.1	5,156	13.7	4,500	12.9
Herbal	17668	51.5	19,196	52.4	16,831	52.3	22,274	54.8	21,485	55.6	21,784	57.8	19,672	56.4
Plants*	73	0.2	4,660	1.3	666	2.1	732	1.8	979	2.5	1,070	2.8	1,111	3.2
(Total)	(23,287)	(67.9)	(25,532)	(69.6)	(22,418)	(69.7)	(29,212)	(71.8)	(27,512)	(71.2)	(28,010)	(74.1)	(25,283)	(72.5)
Heroin	2,341	6.8	2,850	7.8	2,307	7.2	3,054	7.5	3,433	8.9	2,176	5.8	1,953	5.6
Cocaine	3,708	10.8	3,656	10.0	3,345	10.4	4,021	9.9	3,448	8.9	3,263	8.6	3,349	9.6
Amphetamine	2,933	8.6	2,767	7.6	2,646	8.2	2,944	7.2	2,912	7.7	2,699	7.1	2,548	7.3
Methamphetamine	.	.	.	.	.	.	.	.	64	0.2	91	0.2	93	0.3
Ecstasy-type	2,009	5.9	1,798	4.9	1,412	4.4	921	2.3	650	1.7	838	2.2	1,015	2.9
LSD	1	0.0	1	0.0	.	.	.	.	59	0.2	78	0.2	44	0.1
GHB**	.	.	.	.	.	.	473	1.2	503	1.3	544	1.4	507	1.5
Khat**	.	.	.	.	.	.	49	0.1	51	0.1	77	0.2	70	0.2
Total	**34,279**	**100.0**	**36,604**	**100.0**	**32,128**	**100.0**	**40,674**	**100.0**	**38,632**	**100.0**	**37,776**	**100.0**	**34,862**	**100.0**

* The cannabis plant seizures are underreported in the GND, especially for 2006. See Table 10.5 for a more accurate estimate of the cannabis plantations discovered since 2007

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

Source: Federal police: ST13_2009_BE_01; ST13_2013_BE_01

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

Data on the products used as drug precursors in Belgium are collected and reported by the Precursor Unit from the Federal Agency for Medicines and Health Products (FAMHP) and the federal police. An overview of drug precursors seized in the time period 2010-2012 is provided in table 10.3.

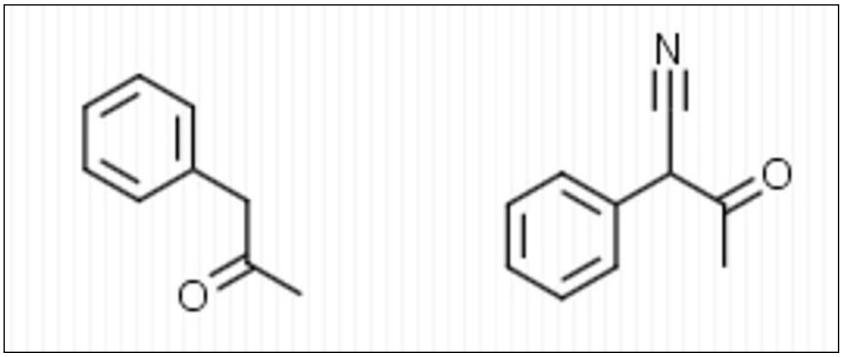
Table 10.3. Amounts of precursors seized, Belgium, 2010-2012

Substance	2010	2011	2012
1-phenyl-2-propanon (BMK)	5,125 l		503 l
Phenyl-2-nitropropene		1 kg	
N-methyl-L-alanine			1,150 g
Formamide	650 l	15 l	
Formic Acid	300 l	265 l	
Sodium hydroxide	987 kg	896.5 kg	5,875 kg
Safrole		9,000 l	
Gamma-butyro-lactone (GBL)	2 l	30 l	9 l
Alphaphenylacetoacetonitrile (APAAN)	1,500 kg	10 kg	8,763 kg

Source: FAMHP, data 2010-2013, personal communication; Dommicent, personal communication, 2013.

Contrary to previous years, there was a decrease in the amount of seized 1-phenyl-2-propanon (benzylmethylketon, BMK), the direct precursor for amphetamine synthesis. Only 500 litres were seized in 2012. In light of the decreasing amounts of seized BMK, of special note is the drastic increase in the amount of Alphaphenylacetoacetonitrile (APAAN) that was seized in Belgium in 2012. This implies that most illicit amphetamine laboratories in Belgium have switched from using BMK as precursor to APAAN as pre-precursor (please refer to figure 10.1 for their molecular structure). APAAN is converted into BMK, using a simple acidic hydrolysis reaction (using water and sulphuric acid). Subsequently, BMK is used in the synthesis of amphetamines (instead of directly using BMK compared to a couple of years ago).

Figure 10. 1. Molecular structure of benzylmethylketon (BMK, left) and alphaphenylacetoacetonitrile (APAAN, right).



This hypothesis is also supported by the fact that in 2012, two APAAN conversion labs have been seized and shut down (table 10.4). It has to be noted that APAAN still does not appear on the list of internationally controlled precursors. It is obvious from table 10.3 that APAAN should (and will) be included in a future update of the precursor-list in Belgium, considering the large amounts of seizures of product and the seized conversion labs.

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

Belgium and The Netherlands are well-known production countries for ecstasy and amphetamine. As a result, every year, a number of illicit ecstasy or amphetamine laboratories are seized. Nevertheless, also other illicit drug laboratories are seized. Table 10.4 gives an overview of dismantled synthetic drug labs between the period 2006 – 2012.

Table 10.4. Number and type of synthetic drug labs dismantled by police services, Belgium, 2006-2012.

	Year						
Lab type	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Labs for synthetic drugs							
Amphetamines		3	3	1	4	1	
Methamphetamine						1	
APAAN conversion lab							2
Ecstasy	1		1			1	1
Ecstasy + amphetamine	1						
LSD		1		1			
GHB			1		2		2
Unknown/unspecified combinations		4					
Other							
Creation of tablets			1				1
Production of Legal Highs							1
Total	**2**	**8**	**6**	**2**	**6**	**3**	**7**

Source: Dommicent, personal communication, 2013.

In 2012, no amphetamine nor methamphetamine labs were dismantled. This confirms the general trend in the decline of the number of illicit amphetamine labs over the past years. Nevertheless, two APAAN conversion labs in order to convert APAAN into BMK (used in the synthesis of amphetamine) were discovered for the first time. It is unclear whether amphetamine was ever produced at those seized locations. This establishes firmly the role of APAAN as pre-precursor for the synthesis of amphetamines in Belgium and is in line with the large amounts of APAAN that are seized by the federal police or customs department every year. Contrary to the situation in the states, Belgian (and most of the European Union) does not have a detectable methamphetamine problem. The tight control of the traditional

precursor for methamphetamine, (pseudo)ephedrine, might have something to do with this phenomenon.

One ecstasy lab was discovered, which is in line with previous years. This ecstasy lab also produced tablets containing PMMA. Two GHB labs were seized in 2012. These GHB laboratories (where γ-butyrolactone was converted to GHB through alkaline hydrolysis) were of the larger variety. The number of GHB labs in Belgium are probably underestimated since most GHB labs (for small scale production of GHB) are normal houses, kitchens and garages. One tablet-creating facility was seized; however, it was non-operational at the time of seizure.

Of special note in the type and numbers of synthetic drug labs dismantled in Belgium in 2012, is that one production/packaging facility for synthetic cannabinoids was seized by the federal police. The raw chemical cannabinoids were mixed with herbs to obtain a smokable product or “legal high”. The facility was found in a warehouse. Synthetic cannabinoids were purchased in the pure, raw powder or crystal form (mostly from Chinese laboratories) in kilogram amounts and were imported into Belgium. In the production facility, these chemicals were dissolved in solvents, and sprayed in a certain dosage on smokable non-psychoactive herbal material (e.g. Damiana leaf), using heavy equipment (e.g. a cement mixer). The chemical/plant matter mix was allowed to dry, after which it was packaged in doses (e.g. packages of 3.5 or 5 grams). The packages, with mostly a flashing and attractive design, were then exported to neighbouring countries as wholesale. A lot of these products ended up in online smartshops all over Europe (Dommicent J, Van Camp B, personal communication).

2012 was an absolute record year regarding the number of seized cannabis plantations (please refer to table 10.5). A modest increase of 3.8% was observed compared to 2011. In total, 1111 cannabis plantations were seized in 2012, of which six facilities were used for growing cannabis-cuttings (for later use in larger cannabis growing operations).

Table 10.5. Seized cannabis plantations, by plantation size, N and %, Belgium 2007-2012.

	Year											
	2007		**2008**		**2009**		**2010**		**2011**		**2012**	
Plantation size*	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Micro	66	16.8	136	21.1	138	18.7	211	21.8	190	17.9	172	15.6
Mini	130	33.1	219	33.9	227	30.8	312	32.2	376	35.4	453	41.0
Small	62	15.8	125	19.3	161	21.8	165	17.0	187	17.6	166	15.0
Middle sized	40	10.2	58	9.0	73	9.9	94	9.7	101	9.5	89	8.0
Large	44	11.2	63	9.8	67	9.1	104	10.7	119	11.2	142	12.9
Industrial	51	13.0	45	7.0	71	9.6	82	8.5	88	8.3	83	7.5
Total with info	**393**	**100.0**	**646**	**100.0**	**737**	**100.0**	**968**	**100.0**	**1,061**	**100.0**	**1,105**	**100.0**
No info**	73		20		1		11		9		6	
Total	**466**		**666**		**738**		**979**		**1,070**		**1,111**	

* Micro: 2-5 plants: Mini: 6-49 plants; Small: 50-249 plants; Middle sized: 250-499 plants; large: 500-999 plants, Industrial: >1000 plants

** including cannabis cutting sites and other plantations with unknown size.

Since 2008, the capacity of cannabis plantations is reported instead of the actual seizure; and the plantations are reported directly to the DGJ-DJP instead of through the GND. For 2007, the corrections on capacity of plantations could be done for only a part of the plantations. The percentages are based on the total number of plantations with known size.

Source: Dommicent, personal communication, 2013.

From table 10.5, it is clear that the number of micro plantations keeps decreasing compared to previous years. Contrary to this trend, the mini-plantations (6-49 plants) continue to rise in 2012. These are plantations that can be put up fast and nearly everywhere (basement, attic, rental houses, etc). Although, from all seized plantations, their proportions have always been the largest, the proportion of mini plantations increased from 35.4% in 2011 to 41.0% in 2012. Also the large plantations are increasing again since 2010.

The numbers of seized small, middle-sized and industrial plantations decreased slightly compared to previous years. The decrease of industrial plantations can be explained by the fact that criminal organisations tend to further “spread their risk”, and choose to grow multiple smaller growing operations as compared to one very large growing operation. The adaptation of the Opiate law in the Netherlands, restricting the easy access to coffee-shops for foreigners (also mentioned in 2.2), may be a second explanation (Snippe and Bieleman, 2012). In this respect, some Belgian users may have decided to grow cannabis for personal use instead of buying it in the Netherlands.

4. Price/purity

4.1. Price of illicit drugs a retail level

Several sources of information regarding prices of illicit drugs at retail level are available in Belgium. First, drug street price information is collected by federal police services. Federal police services collect price data for both the Flemish and the French community. This data is obtained during interrogation of suspected drug dealers and users. Second, Eurotox (based in the French speaking part of the country) collects price data for the French Community on the basis of a questionnaire examined among drug users by harm reduction and prevention services. An overview of the reported mean, minimum and maximum prices by drug type and region are provided in tables 10.6 to 10.10.

Average prices for cannabis products for the time period 2007-2012 are presented in table 10.6. Depending on the region and the data source, in 2012, average prices for 1 gram of herbal cannabis varied between 8.8 and 9.8 €/gram; for cannabis resin, average prices were 8.6 to 9.5 €/gram. Compared to the prices in 2011, these average prices represent a significant increase of 10.0% to 39.0%. The highest increase is seen for cannabis resin (16.0% to 39.0%). These price increases can be related to possible increases in the local demand for cannabis, due to the change in access to the coffee-shops in the Netherlands.

Table 10.6. Cannabis prices at street level, €, Belgium, 2007-2012

	Year																	
	2007			2008			2009			2010			2011			2012		
Drug type	**mean**	**min**	**max**	**mean**	**min**	**max**	**mean**	**min**	**max**	**mean**	**min**	**max**	**mean**	**min**	**max**	**mean**	**min**	**max**
Cannabis resin per gram																		
Eurotox, French community	6.8	1.5	20.0	8.7	0.6	16.0	8.2	1.5	20.0	7.7	2.0	20.0	8.0	2.0	25.0	9.5	2.0	28.0
Federal Police, French community	6.3	2.0	12.0	7.9	3.0	15.0	7.5	4.0	12.0	7.0	3.0	15.0	6.7	2.0	25.0	9.3	2.5	18.4
Federal Police, Flemish community	6.8	3.0	11.0	6.8	3.0	12.0	6.5	5.0	10.0	7.5	5.0	10.0	7.4	2.0	25.0	8.6	2.5	18.4
Cannabis herbs per gram																		
Eurotox, French community	6.3	2.0	15.0	9.2	1.0	20.0	8.1	3.0	15.0	8.3	3.0	20.0	8.1	2.0	25.0	9.8	2.0	20.0
Federal Police, French community	6.0	2.0	12.5	8.1	3.0	25.0	6.9	3.3	12.0	8.2	5.0	12.5	8.0	2.5	16.7	8.9	1.8	25.0
Federal Police, Flemish community	6.0	3.0	12.0	5.9	2.6	10.0	7.4	3.0	12.5	6.4	2.8	10.0	6.9	2.5	16.7	8.9	1.8	25.0

Source: Federal police: Dommicent, personal communication (ST16_2008_BE_03; ST16_2013_BE_01); Eurotox (ST16_2008_BE_02 – ST16_2013_BE_02).

Heroin prices at street level between 2007-2012 can be found in table 10.7. Compared to 2011 (which saw the highest price level for heroin in the past seven years), prices for heroin remained relatively stable or showed even a slight decrease (on average a decrease of 6.0 to 8.0%). This decrease is in contrast with previous years, where a sharp increase was observed. Average prices increased from about €24 in 2010 to €30 in 2011. This increase in previous years was explained by a potential shortage of heroin.

Table 10.7. Heroin prices at street level, €, Belgium, 2007-2012

	Year																	
	2007			2008			2009			2010			2011			2012		
Drug type	**mean**	**min**	**max**	**mean**	**min**	**max**	**mean**	**min**	**max**	**mean**	**Min**	**max**	**mean**	**min**	**max**	**mean**	**min**	**max**
Heroin unspecified per gram																		
Federal Police, French community	23.3	10.0	50.0	23.9	5.0	50.0	24.4	10.0	50.0	24.2	8.0	50.0	29.7	7.0	100.0	27.3	6.0	100.0
Federal Police, Flemish community	26.7	10.0	60.0	25.2	12.0	40.0	22.7	10.0	40.0	23.8	9.0	62.5	30.0	7.0	100.0	28.3	6.0	100.0
Heroin brown per gram																		
Eurotox, French community	33.2	10.0	75.0	24.6	10.0	52.0	26.4	10.0	50.0	23.4	8.0	70.0	24.5	6.0	75.0	24.7	6.0	100.0
Heroin white per gram																		
Eurotox, French community	31.4	15.0	70.0	24.2	20.0	30.0	33.9	12.0	80.0	.	.	.	.	.	.	.	.	.

Source: Federal police: Dommicent, personal communication (ST16_2008_BE_03; ST16_2013_BE_01); Eurotox (ST16_2008_BE_02 – ST16_2013_BE_02).

Prices for cocaine are shown in table 10.8. The crack phenomenon only exist in a few very large cities (e.g. Antwerp), hence, price data are only available for the French community until 2009. The maximum prices for cocaine increased in 2012 (€125-150 compared to €100 in 2011). Cocaine prices in the French and the Flemish community were comparable, only the price reported by federal police services was higher in the French community (about €60 compared to €50 in the Flemish community).

Table 10.8. Cocaine and crack prices at street level, €, Belgium, 2007-2012

	Year																	
	2007			2008			2009			2010			2011			2012		
Drug type	**mean**	**min**	**max**	**mean**	**min**	**max**	**mean**	**min**	**max**	**mean**	**min**	**Max**	**mean**	**min**	**max**	**mean**	**min**	**max**
Cocaine per gram																		
Eurotox, French community	48.4	20.0	75.0	49.9	25.0	81.0	53.0	25.0	120.0	49.7	20.0	100.0	49.9	20.0	100.0	49.4	15.0	150.0
Federal Police, French community	47.5	20.0	100.0	47.8	5.0	87.0	52.8	10.0	100.0	52.2	30.0	100.0	51.8	20.0	100.0	60.9	20.0	125.0
Federal Police, Flemish community	49.0	30.0	60.0	50.8	30.0	70.0	48.9	15.0	70.0	49.1	30.0	100.0	56.0	20.0	100.0	51.6	20.0	125.0
Crack per gram																		
Eurotox, French community	30.9	5.0	60.0	45.0	5.0	70.0	55.0	40.0	60.0	.	.	.	.	.	.	.	.	.

Source: Federal police: Dommicent, personal communication (ST16_2008_BE_03; ST16_2013_BE_01); Eurotox (ST16_2008_BE_02 – ST16_2013_BE_02).

Table 10.9 reflects the prices for amphetamine, or “speed” as it is called in Belgium. All sources (federal police services and Eurotox) report a significant increase in the price of speed in 2012 compared to 2011, ranging from 36.0% (Eurotox) to 11.0-17.0% (federal police services). Average prices for 1 gram of speed varied between €8.4 and 11.2. The reason for this price increase is unknown, although the fact that a lot of the speed in Belgium was severely contaminated with 4-methylamphetamine (4-MA) in Belgium in 2012 (see chapter 7) might have had an influence on pricing of amphetamines. Unlike other countries (e.g. the USA), Belgium does not have a relevant crystal meth problem. Methamphetamine is rarely seized in Belgium. Contrary to the use of methamphetamine, Belgium and The Netherlands have a tradition of amphetamine use.

Table 10.9. Amphetamine prices at street level, €, Belgium, 2007-2012

	Year																	
	2007			2008			2009			2010			2011			2012		
Drug type	**mean**	**min**	**max**	**mean**	**min**	**max**	**mean**	**min**	**max**	**mean**	**min**	**max**	**mean**	**min**	**max**	**mean**	**min**	**Max**
Amphetamine per gram																		
Eurotox, French community	10.9	5.0	30.0	9.5	3.0	20.0	11.6	2.0	40.0	9.6	2.0	40.0	8.2	2.0	25.0	11.2	4.0	25.0
Federal Police, French community	10.5	6.0	15.0	6.6	1.5	10.0	10.9	2.8	25.0	9.1	2.5	10.0	8.4	3.0	16.7	9.8	3.0	25.0
Federal Police, Flemish community	10.6	3.0	25.0	8.7	3.5	20.0	8.1	5.0	12.0	8.4	2.5	15.0	7.5	3.0	16.7	8.4	3.0	25.0

Source: Federal police: Dommicent, personal communication (ST16_2008_BE_03; ST16_2013_BE_01); Eurotox (ST16_2008_BE_02 – ST16_2013_BE_02).

The evolution of prices for ecstasy-tablets and LSD blotters between 2007-2012 are presented in table 10.10. Prices are given per unit (per tablet/paper trip). Depending on the source of the data, the average price of one ecstasy tablet has increased with about 15.0% in 2012 (compared to the prices in 2011) The average price of one ecstasy tablet in Belgium was around €5 in 2012. Minimum and maximum prices have not changed significantly.

Table 10.10. Ecstasy and LSD prices in euro at street level, €, Belgium, 2007-2012

	Year																	
	2007			2008			2009			2010			2011			2012		
Drug type	**mean**	**min**	**max**	**mean**	**min**	**max**	**mean**	**min**	**max**	**mean**	**min**	**max**	**mean**	**min**	**max**	**mean**	**min**	**Max**
Ecstasy per tablet																		
Eurotox, French community	6.2	1.0	20.0	6.1	2.0	20.0	6.2	1.0	25.0	4.7	1.0	15.0	5.1	1.0	15.0	5.6	0.4	20.0
Federal Police, French community	3.6	1.0	6.0	4.1	1.1	10.0	4.1	1.2	10.0	5.2	2.0	10.0	4.6	2.0	10.0	5.8	1.0	10.0
Federal Police, Flemish community	4.4	1.0	10.0	3.2	1.8	5.0	3.5	1.0	8.0	3.4	1.0	10.0	4.5	2.0	10.0	4.5	1.0	10.0
LSD per dose																		
Eurotox, French community	8.9	5.0	15.0	10.5	4.0	30.0	9.5	1.0	25.0	9.6	5.0	30.0	8.0	2.0	18.0	8.8	2.0	15.0
Federal Police, French community	7.5	5.0	10.0	8.3	6.5	10.0	.	.	.	.	.	.	.	.	.	10.0	3.0	10.0
Federal Police, Flemish community	9.2	7.0	10.0	.	.	.	10.0	10.0	10.0	12.0	12.0	12.0	11.8	7.0	15.0	3.0	3.0	10.0
* French community data from federal police include Brussels																		

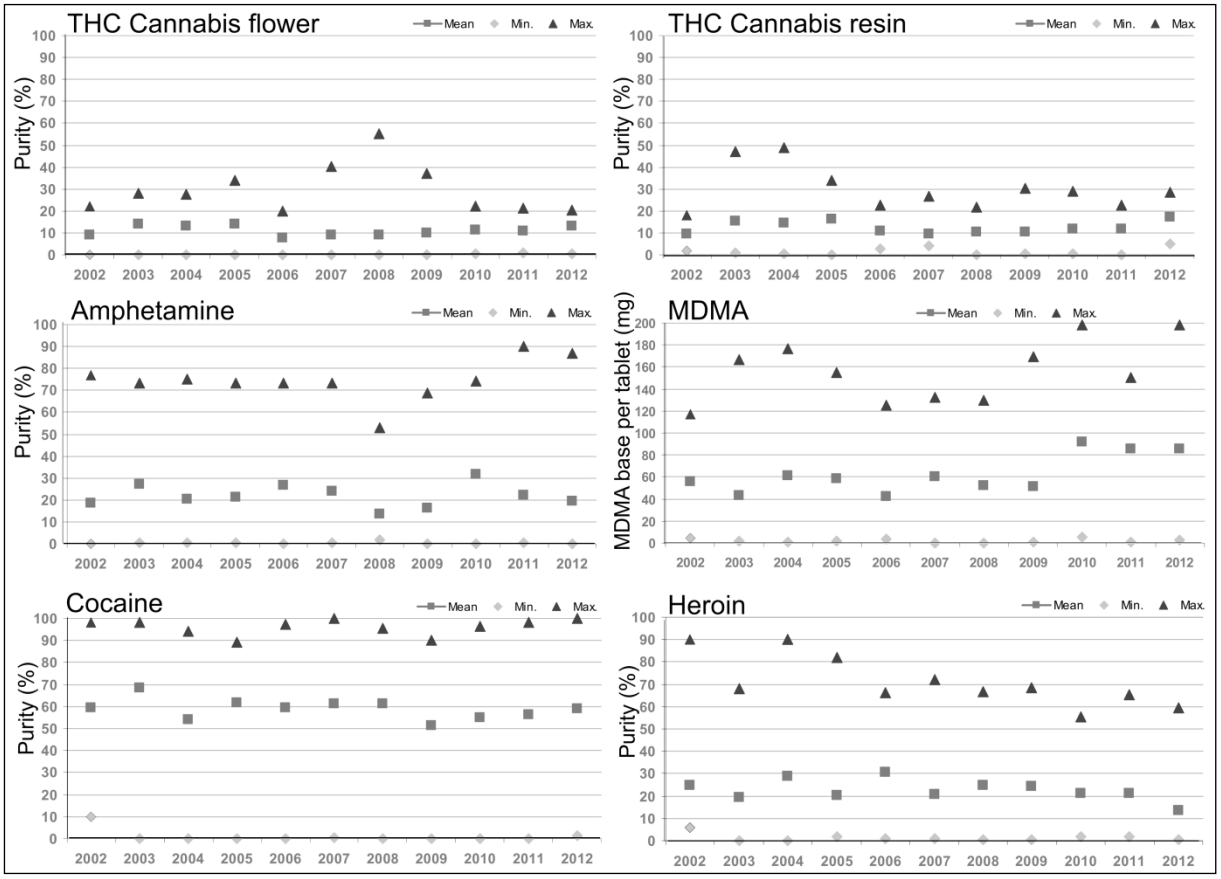
Source: Federal police: Dommicent, personal communication (ST16_2008_BE_03; ST16_2013_BE_01); Eurotox (ST16_2008_BE_02 – ST16_2013_BE_02).

Prices for LSD remained stable in the French community in 2012. In the Flemish community on the other hand, a drastic decrease of the average price for one LSD trip was observed: from €11.8 per LSD trip in 2011 to €3.0 per trip in 2012. The reason for this price fall is as of yet unknown. However, the appearance on the market in 2012 of other very cheap hallucinogens distributed on blotters (e.g. 25I-NBOMe and other derivatives) might have had an influence on the price setting of blotter trips in general.

4.2. Purity/potency of illicit drugs

Mean concentrations of the most common illicit drugs (cannabis, amphetamine, MDMA, cocaine and heroin) found on the Belgian drug market are presented in figure 10.2 for the time period 2002-2012. The BEWSD database is used for the calculation of these data. The database contains the results of all analysed drug samples reported to the BEWSD. These samples are mostly collected after a seizure of the Belgian federal police or customs services (both large and small seizures, at the dealer level and the consumer level respectively, are included). However, the results of a small amount of user-submitted samples are also included.

Figure 10.2. Substance concentration in seized drug samples, %, Belgium, 2002-2012



Source: Database of the BEWSD, ST14_2013_BE_01.

For herbal cannabis, an increase in the average THC concentration was observed in 2012, up from 10.7 in 2011 to 13.7% THC in 2012. For cannabis resin, this increase was even more pronounced. Average THC levels of 17.2% were reported. This is a marked increase compared to previous years (11.8% in 2011) and is the highest average concentration reported since 2002. Judging by the reported THC concentrations, these data seem to support the hypothesis that cannabis products are getting stronger every year.

Since 2010, the average purity of amphetamine powder continues to decrease, reaching an average purity of 19.4% in 2012 (average concentrations in 2011 and 2010 were 22.2% and 31.6% respectively). A lot of the speed on the Belgian market was contaminated with 4-MA in 2012 (Blanckaert et al., 2013).

The recovery of the MDMA market was confirmed in 2012. After a period of low quality, low dosed MDMA tablets, a rise in the average amount of MDMA base per tablet of ecstasy was found the last three years. In 2012, an ecstasy tablet contained on average 86mg MDMA base, which is comparable with 2011 (85.3mg) and 2010 (92.3mg). However, especially the high observed maximum dosages are a reason for concern. The BEWSD issued several alerts, warning for the circulation of high dosed MDMA tablets in Belgium and the Netherlands. Ecstasy tablets containing over 300mg MDMA have been reported in the Netherlands.

A relatively new phenomenon is the appearance of MDMA on the drug market in crystal or powder form (slang term: “molly” or “sand”). This form of MDMA is, like most other drugs in powder or crystal form, sold per gram. Reported average purity for MDMA powder in 2012 was 61.3%, which is comparable to the average concentration in 2011 (58.1%; however, in 2011, only 9 MDMA powder samples were analysed, versus 23 in 2012).

The purity of cocaine samples in Belgium is high and is on the rise since 2009. In 2012, average reported purity was 59.1%, a marked increase compared to 2011 (56.1%) and 2010 (55.0%). This high purity can be explained partially by the fact that each seizure at Brussels-airport have to be analysed (determined by the Public Prosecutor). The seized cocaine at Brussels-airport (4.3% of the total cocaine seizures in 2012) is imported directly from South America/ the Caribbean and is not yet adulterated. As consequence, these pure samples have an influence on the high average purity of seized cocaine in Belgium.

For heroin on the other hand, a marked decrease in purity was observed over the years. The average heroin concentration in 2012 was only 13.3%. In 2011 and 2010, a heroin sample contained on average 21.0% heroin.

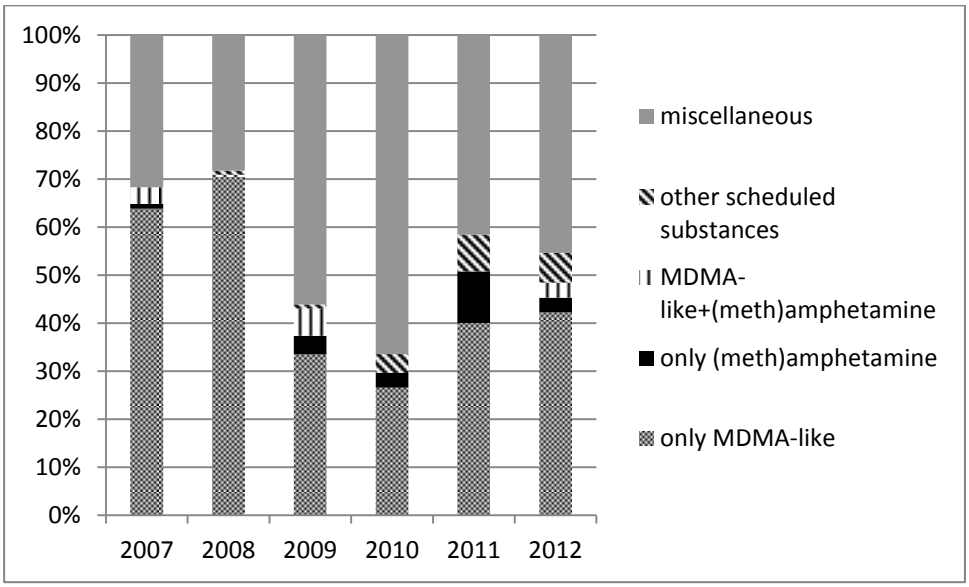
4.3. Composition of illicit drugs and drug tablets

Like the information obtained for purity of powders in 4.2, information on the composition of seized drug samples (tablets, powders and liquids) is available from the database of the BEWSD.

4.3.1. Tablets

Figure 10.3 represents a summary of the contents of tablets seized as illicit drug tablets for the time period 2007-2012. Only a few differences with the results of 2011 were observed: a decrease of the tablets containing only (meth)amphetamine and an increase in the proportion of tablets only containing MDMA. This, together with the increasing amounts of MDMA found in ecstasy tablets, is another sign of the recovery of the ecstasy market. Very few tablets were found in 2012 containing both MDMA and (meth)amphetamine.

Figure 10.3. Composition of illicit drug tablets, %, Belgium, 2007-2012



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

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

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

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

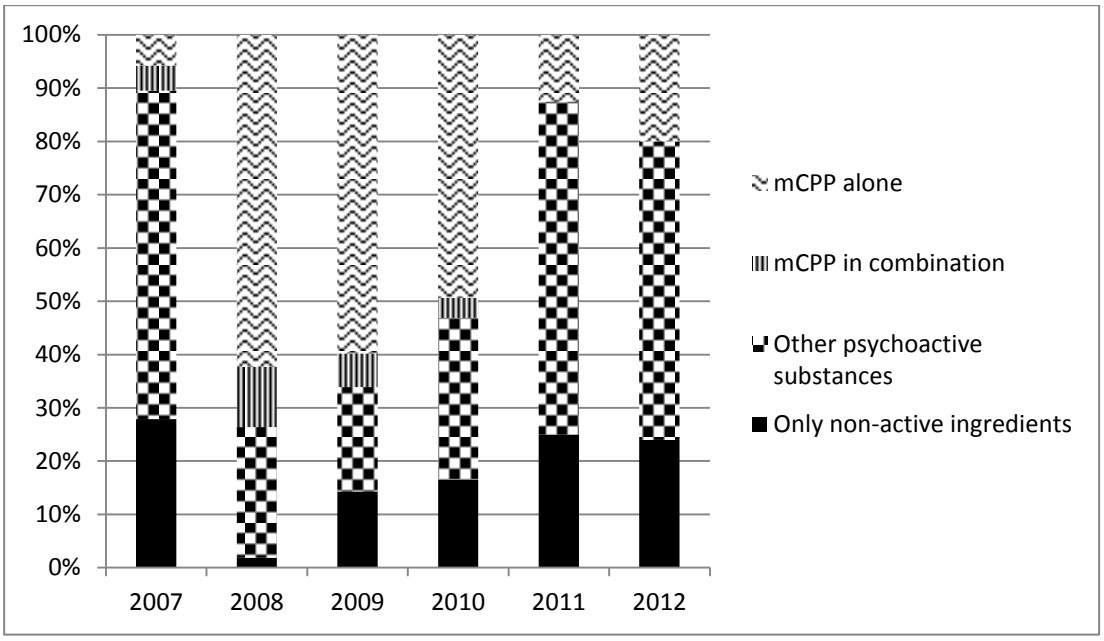
5 The category 'Others (scheduled substances)' refers to tablets containing other scheduled substances (than MDMA-like substances or (meth)amphetamine), alone or in association with MDMA-like substances and/or (meth)amphetamine, together with or without non-scheduled substances (e.g. mCPP, caffeine,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

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

Source: Database of the Belgian Early Warning System on drugs, ST15_2013_BE_01.

Tablets that were seized and analysed as “illicit drugs”, but where no scheduled or unscheduled psychotropic substances (e.g. tablets containing only lactose or other inert fillers), were not included in these calculations. They were also not included in the “miscellaneous” category. A detailed description of the composition of the tablets in the “miscellaneous” category is provided in figure 10.4.

Figure 10.4. Description of tablets category ‘miscellaneous’, %, Belgium, 2007-2012



The category “Other psychoactive substances” included mostly benzodiazepines (bromazepam, clonazepam, lormetazepam, but mostly flunitrazepam), antidepressants, tramadol and sulpiride.

Source: BEWSD database, 2013.

Not many differences in the composition of the ‘miscellaneous’ category were observed, compared to 2011. There was an increase in the number of tablets containing only mCPP. A substantial amount of tablets were analysed and found to contain pharmaceutically active, but non-psychoactive substances. These included hormonal agents such as clenbuterol, methandrostenolon and oxymetholone. Also observed were tablets containing erectile dysfunction therapy agents, such as sildenafil citrate. These non-psychoactive substances were not included in figures 10.3 and 10.4. The category “only non-active ingredients” includes tablets that only contain filler material (like lactose) or other (inorganic) inactive compounds.

4.3.2. Other product types

An overview of the adulterants/cutting agents and their mean concentration in amphetamine, cocaine and heroin powders can be found in table 10.10.

For amphetamine, in 2012, 4-MA was frequently found as contaminant. As explained earlier, several people have died due to this contamination. On average, it was present in 18.0% of analysed speed samples, in a mean concentration of 7.6%. Its presence in amphetamine samples is probably the consequence of a contamination of BMK (the precursor used for amphetamine synthesis) with 4-methyl-BMK. Currently, it is still unclear whether illicit amphetamine manufacturers are aware of this contamination. Other frequently encountered cutting agents include caffeine (71.0% of tested samples, mean concentration 54.0%). In some samples, fluoro-amphetamine or PMA were encountered.

Considering the high purity of cocaine in Belgium (see 4.2, figure 10.2), the low concentrations of adulterants and cutting agents in cocaine samples analysed in Belgium should come as no surprise. In 2012, levamisole was the most frequently encountered adulterant in cocaine samples (present in 47.0% of samples, mean concentration about 10.0%). Caffeine, hydroxyzine, lidocaine and phenacetine were also frequently encountered.

The most used cutting agent in heroin samples in Belgium was caffeine (present in 21.0% of samples in a mean concentration of 25.0%), together with acetaminophen (paracetamol, present in 20.0% of samples in a mean concentration of 46.0%). Monoacetylmorphine (MAM), noscapine and papaverine are impurities originating from the heroin manufacturing process and were present in 16.0 - 20.0% of tested samples, in relatively low concentrations (1.0 - 7.0%). Since 2012, dextromethorphan is more and more prevalent (7 out of 144 heroin samples).

Table 10.11. Adulterants/cutting agents found in seized drug powders, N and %, Belgium, 2012

Drug type	Adulterants	Samples (N)	% of samples	Mean adulterant concentration (%)
Amphetamine	4-MA	21	18.1	7.6
	BMK	6	5.1	/
	Caffeine	82	70.7	54.3
	Fluoro-amphetamine	6	5.2	3.4
	PMA	1	0.7	2.1
Cocaine	Levamisole	258	47.0	9.7
	Caffeine	83	15.2	5.3
	Phenacetine	85	15.5	19.9
	Hydroxyzine	50	9.1	3.8
	Lidocaine	40	7.3	4.0
	Diltiazem	18	3.3	5.3
	Benzocaine	9	1.6	12.3
	Acetaminophen	3	0.6	51.8
	Boric acid	3	0.6	/
Heroin	Caffeine	140	21.5	25.4
	Acetaminophen	132	20.2	45.7
	MAM	132	20.3	3.3
	Noscapine	133	20.4	7.0
	Papaverine	105	16.1	1.0
	Chloroquine	2	0.3	/
	Codeine	1	0.2	5.0

Source: BEWSD database, 2013.

Like previous years, amphetamine remains the least “pure” drug in Belgium, followed by heroin. Some common, relatively harmless substances were found (e.g. caffeine). However, potentially life-threatening substances (such as 4-MA) were also present. The observed impurities in heroin are mostly alkaloids derived from heroin manufacturing process. However, cutting agents to increase dealer profit (caffeine and paracetamol) are also involved. Cocaine is frequently cut with phenacetine, caffeine, hydroxyzine and lidocaine, to increase profit. Levamisole (and in some cases hydroxyzine and diltiazem) is added in the producing country (mostly South-American countries) to increase weight and improve the appearance of the cut cocaine. Also, it adds to the weight of freebase cocaine, since levamisole cannot be removed using an acid/base reaction to produce smokable cocaine or crack.

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AUTHORS AND CONTRIBUTORS

Antoine Jerome joined the Belgian Monitoring Centre for Drugs and Drug Addiction in 2011. He has a background as bioengineer and developed his knowledge and experience in epidemiology and statistics by joining the Epidemiology team of the Institute of Public Health on different topics as statistical support.

Blanckaert Peter joined the BMCDDA in 2012. After finishing his pharmaceutical studies at the Ghent University, he obtained the degree of PhD in analytical/organic/radiochemistry and wrote his dissertation with a main focus on *in vivo* imaging of serotonin 5-HT2A receptors in the brain, coupled to neurochemistry/pharmacology of neurotransmitters. He continued as a scientific researcher for two more years at Ghent University Hospital before taking up the position of coordinator of Belgian Early Warning System on Drugs at the Institute for Public Health.

Casero Lucia has a Master in pharmacy and joined Eurotox in 2007 as a coordinator after graduating with a Master in Public Health (MPH) from the ULB-UCL University. Additionally, she holds some complementary certificates in public health - in particular from the University Carlos III in Madrid and from the Tropical Institute of Medicine in Antwerp. Her career includes several years as coordinator and programme manager in Non-profit organizations.

De Donder Else is sociologist and works as a researcher for VAD since 1999. She coordinates the activities of the VAD research network on substance use.

Dejozé Michael graduated as Master in criminology from the University of Liège in 2011. He currently works at this university and is the project manager of EMROD, the euregional observatorium of delinquency. Next to contributing to several scientific expert groups like the "cellule drogues" of the University of Liège, the VITRA (Violence and traumata) and the CRIS (center of sociological research and intervention), he also works on the strategic support group "security" of the Euregio Meuse-Rhine, leads the euregional platform drugs and is a member of the Provincial Commission of Crime Prevention (Liège).

Goessens Muriel, Master in educational psychology, is director of the Centre Transit since 1995. She is also responsible for the syringe exchange programme (LAIRR) since 1999, responsible for the local drugs coordination in Brussels since 2001 and responsible for supervised flats. Next to this, she is also administrator of the Brussels federation of addiction centres and of the MSOC/MASS Brussels.

Hogge Michaël holds a Master degree in psychology. He worked as a researcher in the neuropsychology unit of University of Liège, and completed a PhD in Psychological Sciences before joining Eurotox in 2009 as scientific and epidemiological project manager.

Husson Eric holds a Master in economic and social policy. He works in the drug addiction sector since 1998 as a social worker in different structures (protected housing Brussels, Project Lama, the therapeutic community 'La Pièce' in l'Equipe asbl, MSOC/Mass Brussels, Transit asbl). He coordinates the Lama Project Anderlecht since 2010 and is responsible for the "low threshold network" since 2011. He is also visited Professor for the course "Social Work and Addiction" at the High School Louvain en Hainaut since 5 years.

Laudens Fred studied psychology and works for VAD since 1999. He is the liaison between VAD, as the Flemish regional focal point, and the IPH.

Plettinckx Els graduated as Master in criminological science at Ghent University in 2011. She worked as an internee for one year at the EMCDDA, after which she started working for the Belgian Monitoring Centre for Drugs and Drug Addiction and takes responsibility for the coordination of the Belgian annual report.

Prof. dr. Brice De Ruyver - Master in law (1978), Master in criminology (1978) and Doctor in criminology (1986) - is Professor at Ghent University attached to the Department of Criminal law and Criminology and Director of the research group 'Institute for International Research on Criminal Policy' (IRCP). Prof. De Ruyver participates in different international networks and has published on drug policy, organised crime, human trafficking, criminal policy and international policy regarding Justice and Home Affairs. He was and is promoter of several research projects (circa 70), amongst others for the European Commission and several Belgian federal government departments (Science policy, Justice, Interior, Foreign Affairs, Development Cooperation,…). Since April 2000 until March 2008 he was expert adviser to the Prime Minister in relation to security and the police reforms. Since 2002 he is member of the scientific committee of the EMCDDA (Lisbon). Since 2010 he is national drug coordinator.

Prof. dr. Freya Vander Laenen is Bachelor in social work (1993), Master in criminology (1996) and Doctor in criminology (2007). She is Professor at Ghent University attached to the Department of Criminal law and Criminology and member of the research group 'Institute for International Research on Criminal Policy' (IRCP).

Prof. dr. Vander Laenen participates in different international networks and has published on drug prevention, harm reduction, drug related crime, drug policy and on qualitative methodology in drug research.

Theizen Laurence completed her education as Master in association management at ULB. She is working in the drug addiction sector as social worker since 1995 (Project Lama, Médecins sans Frontières and MSOC/MASS Brussels). Since 2009 she is working as administrative director of the MSOC/MASS Brussels.

van Bussel Johan C.H. Ma, MSc, completed his PhD in biomedical sciences at the K.U.Leuven. In 2009, he joined the Operational Direction Public health and surveillance of the Scientific Institute for Public Health (IPH) and worked as a senior scientist for the European Community Health Indicators Monitoring programme (ECHIM). As of May 2010, Johan van Bussel is head of the Substance Use and Related Disorders research programme of the IPH and head of Belgian Monitoring Centre for Drugs and Drug Addiction, focal point of the European Information Network on Drugs and Drug Addiction (REITOX) of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

Wérenne Jerry has worked as general practitioner at Project Lama since 1991. He is medical director of this centre since 2005. He is also founder and administrator of the Hepatitis C network in Brussels and administrator of the of the Brussels federation of addiction centres.

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ALPHABETIC LIST OF RELEVANT DATABASES AVAILABLE ON INTERNET

This alphabetic list contains only specific drug-related databases (accessed on 18/10/2013). More general databases are provided on the BMCDDA-website.

Belgian Health Interview Survey (BHIS)

http://his.wiv-isp.be

Research programme in support of the federal drugs policy document (FEDRA)

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

Ginger

http://www.vadginger.be

IDA-web

http://www.ida-fr.be

http://www.ida-nl.be

ALPHABETIC LIST OF RELEVANT INTERNET ADDRESSES

This alphabetic list contains only specific drug-related websites (accessed on 30/08/2013). More general websites are provided on the BMCDDA-website.

Association for mental health care (Limburg)
www.vggz.be

Belgian Early Warning System on Drugs
ewsd.wiv-isp.be

Belgian Health Interview Survey
his.wiv-isp.be

Belgian Information Network on Drugs and Drug Addiction
bindda.wiv-isp.be

Belgian Monitoring Centre for Drugs and Drug Addiction
bmcdda.wiv-isp.be

Breakline
www.breakline.be

Broeders alexianen
www.alexianentienen.be

Cannabis aid
www.cannabishulp.be

Cannabis clinic
www.chu-brugmann.be

Centre for alcohol and other drug problems Limburg
www.cadlimburg.be

Centre for mental health care Kempen
www.cggkempen.be

Centre for mental health care Largo (mid and south-West Flanders)
www.cgglargo.be

Centre for mental health care Vagga (Antwerpen)

vagga.be

Centre L'oree

www.centreloree.be

De Druglijn

www.druglijn.be

De Sleutel (Flanders and Brussels)

www.desleutel.be

De Spiegel (Asse en Leuven)

drugshulpverlening.despiegel.org

Driving under the Influence of Drugs, Alcohol and Medicines (**DRUID)**

www.druid-project.eu

Drug addiction SEPSUD (Schaarbeek)

Drugsverslaving-SEPSUD

Drug aid

www.drughulp.be

Drugs in movement

www.drugsinbeweging.be

Drugs intervention centre Antwerp

www.adicvzw.be

Federal public service Health

www.health.belgium.be

Federal public service Justice

www.Justitie.belgium.be

Flemish Agency for Care and Health

www.zorg-en-gezondheid.be

Flemish school research project about alcohol and other drugs (**VLASPAD)**

www.vlaspad.be

Free Clinic

www.free-clinic.be

General Drugs Policy Cell

www.health.belgium.be

Go for zero

www.goforzero.be

Health Behaviour in School-Aged Children (HBSC)

http://www.hbsc.org

Infor Drogues

www.infor-drogues.be

International Cannabis Need of Treatment Project (INCANT)

www.incant.eu

Kompas VZW (West Flanders)

www.kompasvzw.be

Local health consultation and organisation

www.vlaamselogos.be

Mental Health Consultation platform (Brussels-Capital)

www.pfcsm-opgg.be

Modus Vivendi

www.modusvivendi-be.org

Municipal consultation drugs Antwerp

OCMW.antwerpen.be

Narcotics anonymous

www.na-belgium.org

National Institute of Criminalistics and Criminology (INCC)

Nicc.fgov.be

non-profit association for alcohol and other drug problems (VAD)

www.vad.be

Quality nights

www.qualitynights.be

Social psychological Centre in the German Community (SPZ)

www.spz.be

Socio-epidemiological observatory for alcohol and drugs in the French community (EUROTOX)

www.eurotox.org

SOS sobriety

www.sosnuchterheid.org

Therapeutic programme for drug users and their environment 'De Kiem' (Gent, Ronse/Geraartsberge, Gavere)

www.dekiem.be

Treatment demand indicator Belgium

tdi.wiv-isp.be

Trempoline: prevention and treatment of addiction

www.trempoline.be

University Scientific Institute for drug problems

www.uwid.be

Vital sounds

www.vitalsounds.be

LIST OF STANDARD TABLES AND STRUCTURED QUESTIONNAIRES SUBMITTED IN 2013*

ST/SQ	Full Title	Submitted by	Data provider	BAR chapter(s)
ST 2	ST2_2013_BE_01: Methods and results of school surveys on drug use, Belgium, 2012	BMCDDA	VAD	2
ST 5	ST5_2013_BE_01: Direct drug-related deaths/drug-induced deaths, Belgium, 2009	BMCDDA	General mortality Register	6
	ST5_2013_BE_02: Direct drug-related deaths/drug-induced deaths, Belgium, 2007			
ST 6	ST6_2013_BE_01: Evolution of direct drug-related deaths/drug-induced deaths, Belgium, 2007-2009	BMCDDA	General mortality Register	6
ST 9 P1	ST9_2013_BE_01: Methods prevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs), Flemish community, 2012	VAD	De Sleutel	6
ST 9 P2	ST9P2_2013_BE_01: Serology prevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs)_HCV Ab, Flemish community, 2012	VAD	De Sleutel	6
	ST9P2_2013_BE_02: Serology prevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs)_HIV Ab, Flemish community, 2012			
	ST9P2_2013_BE_03: Serology prevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs)_antiHBs, Flemish community, 2012			
	ST9P2_2013_BE_04: Serology prevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs)_antiHBc, Flemish community, 2012			
	ST9P2_2013_BE_05: Serology prevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs)_HBsAG, Flemish community, 2012			
ST 10	ST10_2013_BE_02: Syringe availability, French community, 2012	Eurotox	Modus Vivendi	7
	ST10_2013_BE_03: Syringe availability, Flemish community, 2012	VAD	Free Clinic	
ST 11	ST11_2013_BE_01: Reports of drug law offences, Belgium, 2012	BMCDDA	Federal Police	9
ST 13	ST13_2013_BE_01: Number and quantity of seizures of illicit drugs, Belgium, 2010-2012	BMCDDA	Federal Police	10
ST 14	ST14_2013_BE_01: Purity/potency at street level of some illicit substances, Belgium, 2010-2012	BMCDDA	Belgian EWS	10

ST/SQ	Full Title	Submitted by	Data provider	BAR chapter(s)
ST 15	ST15_2013_BE_01: Composition of illicit drug tablets, Belgium, 2010-2012	BMCDDA	Belgian EWS	10
ST 16	ST16_2013_BE_01: Price at street level of some illicit substances_self-reported data, French community, 2010-2012	Eurotox	outreach workers and syringes exchange desks	10
	ST16_2013_BE_02: Price at street level of some illicit substances_Police data, Belgium, 2010-2012	BMCDDA	Federal Police	
ST 24	ST24_2013_BE_01: Access to treatment, Belgium, 2012	BTDI	Belgian TDI	5
TDI	TDI_2013_BE_01: Characteristics of individuals starting in outpatient treatment for drugs by type of treatment, Belgium, 2012	BTDI	Belgian TDI	5
	TDI_2013_BE_02: Characteristics of individuals starting in inpatient treatment for drugs by type of treatment, Belgium, 2012			
	TDI_2013_BE_03: Characteristics of individuals starting in low-threshold treatment for drugs by type of treatment, Belgium, 2012			
SQ 25	SQ25_2013_BE_01: Universal prevention, French Community, 2012	BMCDDA	Eurotox	3
	SQ25_2013_BE_02: Universal prevention, Flemish Community, 2012	BMCDDA	VAD	
SQ 25M	SQ25M_2013_BE_02: Supplement on standardized programmes_Unplugged 1st grade, Flemish Community, 2012	BMCDDA	VAD	3
	SQ25M_2013_BE_03: Supplement on standardized programmes_Unplugged 2st grade, Flemish Community, 2012			
	SQ25M_2013_BE_04: Supplement on standardized programmes_Unplugged 3st grade, Flemish Community, 2012			
	SQ25M_2013_BE_05: Supplement on standardized programmes_LOL zonder alcohol, Flemish Community, 2012			
	SQ25M_2013_BE_06: Supplement on standardized programmes_Maat in de shit, Flemish Community, 2012			
SQ 26	SQ26_2013_BE_01: Selective Prevention, French Community, 2012	BMCDDA	Eurotox	3
	SQ26_2013_BE_03: Selective Prevention, Flemish Community, 2012	BMCDDA	VAD	

* ST's for which 'no new data' was reported are excluded from this list
Please refer to the EMCDDA statistical bulletin for an overview of the data in these Standard tables

LIST OF UNCITED BELGIAN RESEARCH

Alleva, L., Tirelli, E. and Brabant, C. (2013). Therapeutic potential of histaminergic compounds in the treatment of addiction and drug-related cognitive disorders. *Behavioural brain research,* 237, 357-368.

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Annex 1: List of abbreviations

Abbreviations	Explanation
ADAPTE-YOUTH	Adapting best practice guidelines for the detection, prevention and treatment of substance abuse in children and youngsters to a local Belgian context
ADIC	Antwerp Drug Intervention Centre
AHOJG	Geen Affichering; harddrugs; overlast; jongeren; grote hoeveelheden *(no advertising; harddrugs; nuisance; youth; big amounts)*
AIDS	Acquired Immune Deficiency Syndrome
ALFA	Aide Liégeoise aux Alcooliques et à leur Famille *(Help Liege to Alcoholics and their families)*
anti HBc	Hepatitis B core antigen
anti HBs	Hepatitis B surface antigen
APAAN	Alphaphenylacetoacetonitrile
ARLs	AIDS Reference laboratories
ASBL	Association sans but lucratif *(Non-profit association)*
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
BAC	Blood Alcohol concentration
BBC	Beleids- en beheerscyclus *(policy and management cycle)*
BELSPO	Belgian Science Policy
BELTA	Belgian Lung and Tuberculois Association
BEWSD	Belgian Early Warning System on Drugs
BHIS	Belgian Health Interview Survey
BIVV	Belgisch Instituut voor de VerkeersVeiligheid *(Belgian Institute for Traffic Safety)*
BMCDDA	Belgian Monitoring Centre for Drugs and Drug Addiction
B.S./M.B.	Belgisch staatsblad/ Moniteur Belge *(Belgian Official Journal)*
BTDIR	Belgian Treatment Demand Indicator Register
CAD	Centra voor Alcohol en andere Drugproblemen
CAP-ITI	Centre d'Accueil Postpénitentiaire et d'Information aux Toxicomanes Incarcérés
CAPI	Computer-Assisted Personal Interviewing
CAPRI	Collaborative Antwerp Psychiatric Research Institute

Abbreviations	Explanation
CAW	Centrum Algemeen Welzijnswerk *(Centre General Social Work)*
CD4	Cluster of differentiation 4
CGG	Centra Geestelijke gezondheidszorg *(Mental health centres)*
CGOP	Directorate of Operational Police Information
CHU	Centre Hospitalier Universitair *(Hospital university centre)*
CI	Confidence interval
CIC	Crisis Intervention Centres
CLPS	Centre local de promotion de la santé *(Local health promotion centre)*
CNS	Central nervous system
COCOM	Commission Communautaire Commune *(Common Community Commission)*
CRA	Community Reinforcement Approach
DBK	Drugbehandelingskamer *(Drug Treatment Court)*
DGJ-DJP	General Directorate of Judicial Police - Direction of crime against persons
DG MJH	Directoraat-Generaal Justitiehuizen *(Directorate-General for Justice Houses)*
DR-	Drogues Risquer moins *(Drug risk less)*
DRID	Drug Related Infectious Diseases
DUI	Driving Under the Influence
ED	Emergency Departement
EHIS	European Health Interview survey initiative
ELISA	Enzyme-Linked-Immuno Sorbent Assay
EMCDDA	European Monitoring Centre for Drugs and Drug Addictions
ESPAD	European School Survey Project on Alcohol and Other Drugs
EU	European Union
EuropASI	European addiction severity index
EUROTOX	Observatoire Socio-Épidemiologique Alcool-Drogues
EWS	Early warning System
FAMHP	Federal Agency for Medicines and Health Products
FARES	Fonds des Affections Respiratoires *(Fund of respiratory diseases)*
FWB	Federation Wallonia-Brussels

Abbreviations	Explanation
GC/MS	Gas Chromatography-Mass Spectrometry
GMR	General Mortality Register
GND	General National Database
GP	General Practionners
GST	General Strain Theory
HBsAg	Hepatitis B surface antigen
HBSC	Health Behaviour in School-aged Children
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HCV Ab	Hepatitis C virus antibody
HIV	Human Immunodeficiency Virus
HIV Ab	Human Immunodeficiency Virus Antibody
ICD (9 or 10)	International classification of diseases, injuries and causes of death (version 9 or10)
IDA	Information about drugs and alcohol
IDU	Injecting Drug use
INCANT	International Cannabis Need of Treatment project
IPH	Scientific Institute for Public Health
IRQ	Injecting Risk Questionnaire
IVR	Interactive voice response system
MAM	Monoacetylmorphine
MDFT	MultiDimensional Family Therapy
MDMA	3,4-Methylenedioxymethamphetine
MSOC-MASS	Maison d'Accueil Socio-Sanitaire - Medisch sociaal opvangcentrum *(Medical social care centre)*
NAAP	National Alcohol Action Plan
NEP	Needle exchange programme
NICC	National Institute for Criminalistics and Criminology
NIHDI	National Institute for Health and Disability Insurance
NIS	National institute for statistics
NPS	New Psychoactive Substances
OCMW	Openbare Centrum voor Maatschappelijk Welzijn

Abbreviations	Explanation
OECD	Organisation for Economic Co-operation and Development
OIP	Organization of Public Interest
OST	Opiate Substitution Treatment
PAA	Points d'appui assuétudes *(Addiction support points)*
PCO	Plan Communautaire Opérationnel *(Operational community plan)*
PDU	Problem Drug Use
PJP	Parquette Jeunesse/ JeugdParket *(Public Youth Prosecutor)*
PMA	Para-MethoxyAmphetamine
PMMA	PolyMethyl MethAcrylate
PZ-HP	Pschychiatrisch ziekenhuis – Hôpital Psychiatrique *(Psychiatric hospital)*
RAR	Rapid Assessment and Response
RDS	Respons Driven Sampling
RDT	Routine diagnostic testing
REA	Rechtbank eerste aanleg *(Court of first instance)*
SBIRT	Screening Brief Interventions and Referral to Treatment
SEM-J	Screeningsinstrument Ervaringen met Middelengebruik – Jongeren *(Screening instrument experience with substance use – youth)*
SIPAR	Système Informatique PARajudiciaire
SLCD	Surveys, Lifestyle and Chronic Diseases
SPZ	Sozial-Psychologisches Zentrum
SQ	Standard Questionnaire
ST	Standard Table
STI	Sexual transmittable infections
SUBANOP	Analysis and optimization of substitution treatment in Belgium
TAD	Tobacco, Alcohol and Drugs
TADAM	Treatment Assisted by DiAcetylMorphine
TBC	Tuberculosis
TDI	Treatment Demand Indicator
THC	Δ^9-tetrahydrocannabinol
UCL	Université catholique de Louvain
UK	United Kingdom

Abbreviations	Explanation
ULB	Université Libre de Bruxelles
UMRHI	University Mental Health Research Institute
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
UP TO DATE	Use of alcohol, illegal drugs, hypnotics and tranquilizers in the Belgian population
USA	United States of America
VAD	Vereniging voor Alcohol- en andere Drugproblemen *(Association for Alcohol and other Drug problems)*
VAT	Value-added tax
VIGEZ	Vlaams instituut voor gezondheidspromotie en ziektepreventie *(Flemish Institute for health promotion and disease prevention)*
VLASPAD	Vlaams schoolonderzoeksproject naar alcohol en andere drugs *(Flemish school research project on alcohol and other drugs)*
VRGT	Vlaamse Vereniging voor Respiratoire Gezondheidszorg en Tuberculosebestrijding *(Flemish Association for respiratory health and Tuberculosis control)*
WHO	World Health Organisation

(Italics) : English translation

Annex 2: List of tables

Annex 3: List of figures

Annex 4: List of full references of laws in original language

Belgian legislation

French

16 Mars 1968 - Loi relative à la police de la circulation routière (M.B. 27.03.1968).

10 décembre 1997 - Loi interdisant la publicité pour les produits du tabac (M.B. 11.02.1998).

19 mars 2004 - Arrêté royal réglementant le traitement de substitution (M.B. 30.04.2004).

19 juillet 2004 - Loi modifiant la loi du 24 janvier 1977 relative à la protection de la santé des consommateurs en ce qui concerne les denrées alimentaires et autres produits (M.B. 10.11.2004).

6 octobre 2006 - Arrêté royal modifiant l'arrêté royal du 19 mars 2004 réglementant le traitement de substitution (M.B. 21.11.2006).

31 juillet 2009 - Loi relative à l'introduction des tests salivaires en matière de drogues dans la circulation (M.B. 15.09.2009).

10 décembre 2009 - Loi portant des dispositions diverses en matière de santé (M.B. 31.12.2009).

22 décembre 2009 - Loi instaurant une réglementation générale relative à l'interdiction de fumer dans les lieux fermés accessibles au public et à la protection des travailleurs contre la fumée du tabac (M.B. 29.12.2009).

25 janvier 2010 - Une politique globale et intégrée en matière de drogues pour la Belgique: Déclaration Conjointe de la Conférence Interministérielle Drogues (M.B. 15.04.2010).

20 mars 2013. — Arrêté royal concernant le conditionnement, l'étiquetage et la délivrance des préparations magistrales et officinales contre la toux et le rhume (M.B. 12.04.2013).

Dutch

16 Maart 1968 - Wet betreffende de politie over het wegverkeer (B.S. 27.03.1968).

10 december 1997 - Wet houdende verbod op de reclame voor tabaksproducten (B.S. 11.02.1998).

19 maart 2004 - Koninklijk Besluit tot reglementering van de behandeling met vervangingsmiddelen (BS. 30.04.2004).

19 juli 2004 - Wet tot wijziging van de wet van 24 januari 1977 betreffende de bescherming van de gezondheid van de verbruikers op het stuk van de voedingsmiddelen en andere producten (B.S. 10.11.2004).

06 oktober 2006 - Koninklijk besluit tot wijziging van het koninklijk besluit van 19 maart 2004 tot reglementering van de behandeling met vervangingsmiddelen (BS. 21.11.2006)

31 juli 2009 - Wet tot invoering van speekseltesten op drugs in het verkeer (B.S. 15.09.2009).

10 december 2009 - Wet houdende diverse bepalingen inzake gezondheid (B.S. 31.12.2009).

22 december 2009 - Wet betreffende een algemene regeling voor rookvrije gesloten plaatsen toegankelijk voor het publiek en ter bescherming van werknemers tegen tabaksrook (B.S. 29.12.2009).

25 januari 2010 - Een globaal en geïntegreerd drugsbeleid voor België: Gemeenschappelijke Verklaring van de Interministeriële Conferentie Drugs (B.S. 15.04.2010).

20 maart 2013. - Koninklijk besluit tot wijziging van het koninklijk besluit van 22 januari 1998 houdende regeling van sommige psychotrope stoffen en betreffende risicobeperking en therapeutisch advies (B.S. 12.04.2013).

Annex 5: Index of Terms

H

K

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Wetenschappelijk Instituut Volksgezondheid
Institut Scientifique de Santé Publique

Directorate Public health and surveillance
Rue Juliette Wytsmanstraat 14
1050 Brussels | Belgium

www.wiv-isp.be

Editor
Dr Johan Peeters | General Director
Rue Juliette Wytsmanstraat 14
1050 Brussels | Belgium

Legal Depot
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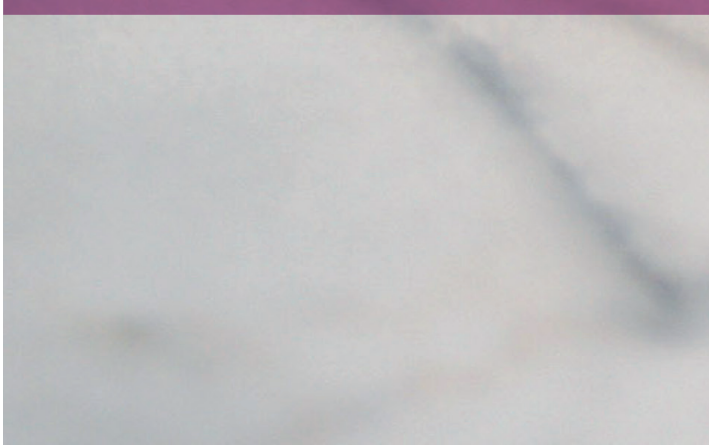

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