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BELGIAN NATIONAL REPORT ON DRUGS 2001

Commissioned by
the European Monitoring Centre for Drugs and Drug Addiction
Lisbon



The present Report,
and additional information on the activities of the BIRN
are available
on the Belgian Focal Point Web site

REITOX Belgian Focal Point

at

<http://www.iph.fgov.be/reitox>

Publisher
Scientific Institute of Public Health
D / 2002 / 2505 / 01
Printed
at the Scientific Institute of Public Health

REITOX Belgian Focal Point
Epidemiology Unit
Scientific Institute of Public Health
Ministry of Social Affairs, Public Health and Environment
Wytmanstreet 14, B - 1050 Brussels
Brussels, Belgium

This report was coordinated and written by the staff of the Focal Point (Patrick Leurquin, Edith Leus, Emmanuelle Robert, Francis Sartor, Sandrine Sleiman, Denise Walckiers) and the staff of Sub-Focal Points (Fabienne Hariga, Sofie Köttgen, Fred Laudens, Ellen Vandenbussche, Mark Vanderveken).

Acknowledgements

This report was made possible thanks to the contribution of many public and private professionals, health professionals and social workers who participated in the data collection despite the large workload of their activities with patients with drug problems. Their essential contribution is gratefully acknowledged.

Acknowledgement is due to the Sub-Focal Points teams, ensuring the daily work of data collection and the transmission of the information to the Focal Point. Special thanks to Sheila GOYENS (REITOX Focal Point) for her linguistic and administrative support.

We would like to especially thank for their very active contributions (by alphabetical order):

BASTIN P.(Infor Drogues)

DAL M. (Prospective jeunesse)

DERUYVER B. (Universiteit Gent)

DE WINTER Ch., LEBRUN V. and VANHYFTE C. (Federal Police Drug programme)

GEIRNAERT M. (VAD)

GILLARD C. (Ministry of Justice)

RAES V. (De Sleutel)

SASSE A. (IPH - AIDS surveillance)

TECCO J. (Université Libre de Bruxelles)

VANDENBOSCH B. (General Pharmaceutical Inspectorate/Ministry of Public Health)

WANLIN M. and DE SAINT HUBERT B. (FARES/VRGT)

WILLEKENS M. (Federal Police)

Call for contribution and comments

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

EMCDDA MANAGEMENT BOARD (European Monitoring Centre for Drugs and Drug Addiction)

Belgian members :

Willy BRUNSON
Directeur Général
Administration de la Communauté française de Belgique
Bd Léopold II, 44
B - 1080 BRUXELLES
Tel : 32-2/413.26.02; Fax : 32-2/413.26.13
e-mail : Willy.Brunson@cfwb.be

Claude GILLARD
Conseiller Juridique
Administration des Affaires pénales et criminelles
du Ministère de la Justice
Bd de Waterloo, 115
B - 1000 BRUXELLES
Tel : 32-2/542.67.74; Fax : 32-2/538.83.75
e-mail : Claude.Gillard@just.fgov.be

EMCDDA SCIENTIFIC COMMITTEE (Belgian member)

Joris CASSELMAN
Koning Leopold III laan 14
B - 3001 HEVERLEE
Tel : 32-16/40.02.81;
Tel/Fax (privé) : 32-16/46.32.09
e-mail : Joris.Casselmann@law.kuleuven.ac.be

MINISTERS involved in health problems related to drugs (from June 1999 onwards)

Mevrouw Magda ALVOET
Minister van Consumentenzaken, Volksgezondheid en Leefmilieu (Minister for Health of the federal government)

De Heer Jos CHABERT
Minister van Volksgezondheidszorg van het Brussels Hoofdstedelijk Gewest
(Minister for Health of the Region of Brussels-Capital)

Monsieur Thierry DETIENNE
Ministre des Affaires Sociales et de la Santé de la Région Wallonne (Minister for Health of the Walloon Region)

Monsieur Didier GOSUIN
Ministre de la Santé de la Région de Bruxelles-Capitale (Minister for Health of the Region of Brussels-Capital)

Madame Nicole MARECHAL
Ministre de la Santé et des Affaires Sociales de la Communauté française de Belgique
(Minister for health of the French Community of Belgium)

Herr H. NIESSEN
Minister der Deutschsprachigen Gemeinschafts (Minister of the German-speaking Community)

De Heer Frank VANDENBROUCKE
Minister van Sociale Zaken en Pensioenen (Minister for Social Affairs of the federal government)

Mevrouw Mieke VOGELS
Minister van Welzijn, Gezondheid en Gelijke Kansen, Vlaamse Gemeenschap
(Minister for Health of the Flemish Community)

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Belgian National Report on Drugs 2001

SUMMARY

Four parts compose The Belgian National Report 2001. The Part I deals with **national strategies** (Chapter 1); the Part II gives an overview of the **epidemiological situation** (Ch. 2 to 7); the Part III is related to **demand reduction interventions** (Ch. 8 to 10) and the Part IV presents **key issues** including polydrug use (Chapter 11), successful treatments (Chapter 12) and finally drug users in prison (Chapter 13).

In January 2000, the Council of ministers of the Belgian government approved a policy note for a new drug policy (modifying the law of 1921 controlling the production, trade and use of drugs). This note covers illegal and legal drugs. The Belgian Parliament still has to vote the amendments to the current law.

The main points of this note are :

- global and integrated approach;
- evaluation, epidemiology and research;
- prevention;
- health care, harm reduction and reintegration;
- repression.

NATIONAL STRATEGY : A GLOBAL APPROACH

The Belgian **legislation** does not distinguish the applied penalties neither according to the types of drugs ("hard" or so-called "soft" drugs), nor to the quantities of the seized drugs. Only the concepts of possession, group use and trafficking are considered and are applied by the judicial authorities according to criteria applicable to each individual case. Nevertheless in 1997, the Parliament and the Council of Ministers adopted the conclusions of a working group on the drug problem : the law enforcement on drugs was consequently adapted specifying e.a. that the **penal justice** must be an 'ultima ratio' in case of serious public nuisance.

Some changes were initiated. Between an approach strictly repressive and at the opposite a full tolerance policy, a third way should exist called 'normalisation' policy. The policy priorities were redefined: prevention and reduction of drug use, decrease of the number of new drug users, protection of the community and its members who are facing the drug phenomenon and its consequences, provision of care to drug users and readiness to guarantee them a better life despite their drug use.

The policy of Internal Affairs is embedded in a **crime prevention** philosophy. A financial framework to support the municipalities with a high criminality rate was created. Those municipalities have to set up projects aiming at drug treatment and prevention.

In the Communities and Regions a growing effort is made to get a **global prevention**: the focus is mainly health and welfare oriented. Several evolutions are clear: development of a policy plan, increasing education and expertise of prevention workers, improved co-ordination of prevention activities from a health perspective, further development of local crime prevention initiatives with focus on drug prevention, enlarged provision in training, community approach. Many organisations and municipalities have developed prevention and/or care and cure activities in different fields: social services, workplaces, youth organisations, schools, peer groups, harm reduction, leisure time.

Treatment is offered by three types of services : inpatient centres (e.g. psychiatric centres, therapeutic communities, crisis intervention centres), outpatient centres (centres for mental health, day care centres, medico-social care centres, low threshold services) and primary care (general practitioners, welfare organisations, etc.). There is a tendency to lower the admittance level of the treatment centres. The focus of treatment has been broadened: not only abstinence but also harm-reduction and methadone maintenance.

KEY ACTORS

The Belgian political structures required an **interministerial conference** (different departmental staffs) in order to co-ordinate the different departments involved in the drug issue. There are a lot of key actors on the one hand at **federal level** : the Ministry of Justice, the Ministry of Foreign Affairs, the Ministry of Internal Affairs, the Ministry of Social Affairs and Public Health, and the Ministry of Finances, and on the other hand at **federate levels** : the communities and regional governments (Flemish, French and German-speaking Communities, Brussels-Capital Region).

Belgium is an observer at the United Nations Narcotics Commission and has ratified **international conventions** on narcotics, psychotropic substances and illegal trafficking. Belgium is among the UNDCP contributors (United Nations Drug Control Programme). The aspects of repression and supply reduction are an exclusive federal competence. Community and regional governments also have **international relationships and collaborations**: EMCDDA, WHO (as national counterparts of European alcohol action plan / WHO-Europe), Pempidou working groups, European Union projects (Intereg-, Euregio-, Multicity- projects).

The **Belgian Focal Point**, located at the Scientific Institute of Public Health, is the Belgian representative in the REITOX^a network settled down by the EMCDDA. The BIRN (Belgian Information Reitox Network) was created in 1995 and links the National Focal Point with the 4 Sub-Focal Points : **ASL** (Arbeitsgemeinschaft für Suchtvorbeugung und Lebensbewältigung) for the German-speaking Community, **EUROTOX** for the French Community, **CTB-ODB** (Concertation Toxicomanies Bruxelles - Overleg Druggebruik Brussel) for the Brussels-Capital Region, **VAD** (Vereniging voor Alcohol en andere Drug problemen) for the Flemish Community.

The Focal and Sub-Focal Points are getting in touch with a lot of partners from different fields (justice, police, toxicological laboratories, universities and other research centres, prevention and harm reduction organisations, therapeutic communities and other treatment actors...), exchanging information, collecting and analysing data and disseminating results, research reports, guidelines,....

SOURCES, AVAILABILITY AND QUALITY OF INFORMATION

Progressively the overview of the epidemiological situation on drugs is improving. The framework of the EMCDDA, the identification of priorities and related guidelines are a real support. Although monitoring systems and epidemiological researches have been carried out, the global description of the situation and the alterations in drug consumption and drug related problems remain incomplete. The school population is the group where drug use is the best documented. Regarding adults, treated patients, judicial and police activities, reliable data are necessary in order to assess the actual prevalence of drug use and particularly the problematic use.

Most of the school surveys are conducted by or in close co-operation with experienced research institutions or universities, repeating regularly surveys using the same methodology and the same tools, conducted in the framework of the WHO HBSC cross national survey. Little by little research teams produce comparable data for specific age groups. So at present comparisons can be made on the level of the Flemish Community between 1994, 1996 and 1998. In the French Community, the trends of the behaviour of youngsters from 1986 to 1994 (and 1998) have been analysed and published. A very large survey aiming to evaluate drug policy at school was conducted in 1999 in the Flemish Community.

Meanwhile more harmonisation between the other studies conducted in the different areas of the country is necessary. For example, the concept of 'regular' use is defined very differently in the various studies.

On the other hand, there is a competition of multiple geographically limited surveys making uneasy to carry out the large standardised HBSC surveys : indeed more and more schools do not agree to participate in the HBSC survey because of recent participation in a local school survey.

Information on the situation of drug use in the general adult population is partial but developing : since 1996, a CATI health monitoring survey has been started in the French Community (including questions on cannabis and cocaine) whereas a CATI survey was conducted in Flanders in 1995. The

^a REITOX : Réseau Européen d'Information sur les drogues et TOXicomanies / European network linking EMCDDA and National Focal Points for the exchange of information on drugs and drug addictions.

2001 national Health Interview Survey will include a few questions on cannabis and XTC use. There are very few surveys involving other subgroups (youngsters out of school, ethnic minorities,...); however the situation in prison is better documented despite the methodological constraints.

Further efforts should be made to realise local and national estimates on the prevalence of hard drug use. Also insight and detection of new trends in drug use is important. In general more research is needed aimed at the social context of drug use, mechanisms of drug (ab)use, ...

The data on deaths related to drug use from the National Institute of Statistics are still old dated and the number of overdoses provided by police services is not fully reliable. Information on infectious diseases (HIV, hepatitis B and C) is available : methodological aspects of these studies and harmonisation are under discussion.

The federate entities (Communities, Region of Brussels-Capital) each developed their own system of registration of treatment demands. One observes a progressive harmonisation and at least an increasing compatibility between registration systems for drug users used within traditional and even less traditional services e.g. low threshold services for methadone distribution or street corner work. Epidemiological data on the treatment demands are progressively harmonised but the coverage of the registration systems is not enough documented : this prevents from obtaining reliable figures at national level. Efforts should be continued in order to make possible general utilisation studies.

SOME RESULTS...

In the motivating framework of the collaborative European information network on drugs (REITOX) supported by the EMCDDA, methods for the collection of comparable and reliable information are being developed. Epidemiological key-indicators were selected. In 2000, several ad hoc working groups based on the experience and skills of the different partners met.

It is uneasy to summarize results as very often some restrictions should be mentioned and results should be considered with caution. The recent surveys confirm the increase of the use of recreative drugs among youngsters and probably also among adults.

According to school surveys, it appears that :

- around 12% of students aged 15-16 years experienced at least once cannabis during the last month;
- around 20% of students aged 17-18 years experienced at least once cannabis during the last month;
- the proportion of users of illicit substances is higher among boys than among girls;
- from 15-16 years of age onwards, cannabis derivatives are the products most used; before 1999, ecstasy was the second product most used and became in 2000 the third or the fourth; on the other hand hypnotics and amphetamines are more used than XTC;
- in terms of trends, the prevalence rates seem to be stabilized in all age groups. An increasing trend was observed in the use of illegal drugs, especially cannabis, XTC and amphetamines up to 1999, since then stabilization or a little decrease has appeared.

Among 18-49 years aged adults of the French Community, 21% (1998-99; to be compared to 10% in 1996-97) stated to have experienced cannabis at least once. New results are expected with the National Health Interview Survey 2001 (general health survey for people aged 15-64 years). Two questions on cannabis and XTC-amphetamines are included.

It is quite difficult to estimate (and even to define) the problematic drug use at the moment. A study based on 1997 data estimated the number of intravenous users as 23,200-28,400 among the 15-64 years aged (corresponding to a prevalence rate of 0.35%-0.42%).

Among users treated in centres of the French Community, a decreasing trend of intravenous administration is observed : from 30 and 34% in 1993-94 to 20% in 1999. The decrease does not seem to be due to a change in behaviour of heroin users but seems related to a relative decrease of heroin users among all demanders for treatment (and a proportional increase of patients treated for another substance).

The proportion of IDU-HIV cases remain relatively stable since 1995. In 1999, EUROTOX and VAD data show a proportion of HIV-seropositive among IVDUs demanding for treatment around 2%. HBV infections seems stable but at higher level : 20-25%. Around 40% of tested IDU's patients have antibodies against hepatitis C.

Regarding **demand reduction**, a lot of interventions were set up but still often without any planned evaluation. In Belgium, the culture of evaluation is not developed in this field. A collaborative project was initiated at European level : EDDRA (Exchange on Drug Demand Reduction Actions) is a project of the EMCDDA/REITOX aiming to develop a data base presenting an inventory of prevention and harm reduction projects conducted in Europe and focusing on their evaluative component. Belgian partners are involved.

An **early warning system on new synthetic drugs** is being developed in Belgium. A network of toxicological laboratories for substance analyses was set up. Work on establishing a second network for the collection of socio-cultural information, and a third network of clinical laboratories, which carry out analyses on blood and urine, is in progress. The aim is to provide timely and regular results not only on new drugs but also on all kinds of illegal substances circulating and on the various trends in consumption. The Belgian system is integrated in the European Joint Action.

PRIORITIES FOR THE FUTURE

In recent years, collaboration between the treatment demand network and the judicial system increased. Specifically for young first time offenders, a practice of 'therapeutical advice' was further installed and developed in a number of judicial districts.

An important effort is urgent in order to obtain harmonised reliable epidemiological data. The development of an high quality information system (collection, analysis, interpretation, dissemination) is essential in order to enlarge the knowledge on the nature, the extent and the change in drug use in term of prevalence, incidence, mortality, morbidity, social consequences, but also about attitudes and behaviours. Qualitative and quantitative information is necessary.

As most initiatives are originated by the field in order to respond to urgent problems and as their funding is often temporary, the collection of the epidemiological data is often an additional task perceived as extremely time consuming. Incentives should be found : feed-back is the minimal requirement but other benefits will help (access to documentation, trainings, automated production of reports...).

From a public health point of view, reliable epidemiological information on the prevalence of drug use in the different groups of the population, on the patterns of use, on the demand reduction initiatives, on their specific targets and on their outcomes will permit better determining the objectives, priority interventions and target groups and to correctly assess their impact. Moreover, standardized information will provide the possibility to compare the situation in different areas, to compare the outcomes of different types of intervention and to identify the most-efficient programmes.

As there are many interventions as well in prevention as in care activities, there are numerous sources of information for the data collection. Also at data collection level, any counter-productive competition should be prevented : a strategy for the data collection should be defined. Co-ordination should be implemented and a minimal harmonised data set should be collected.

In summary, the priorities seem :

- ◆ to develop consultation and co-ordination between the different authorities, between the different levels and between the various actors
- ◆ to clearly define the aims of the proposed actions, and particularly to develop a strategy in a long run perspective
- ◆ to set up a drug epidemiological surveillance and a strategy for the data collection
- ◆ to reinforce the existing structure (Focal and Sub-Focal Points) and to support the development of collaborations
- ◆ to better support quantitative and qualitative research and particularly to evaluate the impact of preventive and assistance measures as well as repressive measures
- ◆ to improve the epidemiological information and especially to estimate the prevalence of problematic drug use
- ◆ to monitor and evaluate the demand reduction interventions and the various treatments.



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BELGIAN NATIONAL REPORT ON DRUGS 2001

PART I National Strategies : Institutional & Legal Frameworks

Part I of the National Report 2001 was coordinated and written by Patrick LEURQUIN
in close collaboration with the responsables of the Sub-Focal Points,
with the participation of his colleagues of the Belgian Focal Point
and with the help of a large number of people that are specially thank for their contribution.

We would like to especially thank for their very active contributions (by alphabetical order):

DERUYVER B. (Universiteit Gent)
GILLARD C. (Ministry of Justice)
HARIGA F. (EUROTOX)
KÖTTGEN S. (ASL)
LAUDENS F. (VAD)
LEUS E. (REITOX Focal Point)
TECCO J. (Université Libre de Bruxelles)
VANDERVEKEN M. (CTB-ODB)
VANDENBOSCH B. (General Pharmaceutical Inspectorate/Ministry of Public Health)
WILLEKENS M. (Federal Police)

CHAPTER 1. Developments in Drug Policy and Responses

INTRODUCTION

In **2000**, an inter-ministerial working group was set up in order to re-design the drug policy in Belgium. The group was coordinated by the federal minister of Public Health and involved the federal ministers of Justice and of Internal Affairs : this group worked in close collaboration with Community and Region authorities.

In January **2001** the Council of ministers of the Belgian government approved a policy note for a new drug policy, based upon the recommendations of the parliamentary working group report (1997), a university situation report (De Ruyver et al. 2000b) and the European Union Action Plan to Combat Drugs 2000-2004 (Communication from the Commission to the Council and the European Parliament on a European Union Action Plan to Combat Drugs 2000-2004, 1999). This drug note sets the strategy for the future drug policy in Belgium as a whole.

In the future a distinction will be made between cannabis and other illegal drugs. Limited possession of cannabis for personal use will no longer be prosecuted, except in cases of problematic use or of social nuisance. Regarding the limited possession of other illegal drugs for personal use, the public prosecutor can decide to prosecute or offer other modalities for settling the drug offence.

When there is an indication of problematic drug use of cannabis or other illegal drugs, the problematic user will be oriented towards treatment, on condition that the problematic drug user accepts the treatment offer. If not, the public prosecutor can always decide to prosecute or offer another modality of settling the drug offence. Problematic drug use, social nuisance and the severity of the offences will be three major criteria for determining priorities on the level of the investigation and prosecution of drug offences.

The federal note is detailed in section 1.1.b.2. The modalities concerning the distinction between cannabis and other illicit drugs, and the investigation and prosecution policy still have to be outlined in Royal Decree(s) and directive(s).

Current and expected (according to the federal drug policy note) prosecution policies are described in 1.2.b.

Other initiatives were taken recently. In the framework of the Year of the Mental Health, a political note has been elaborated in this area (see 1.1.b.3). A ministerial circular letter concerning a global approach of the drug issue in prison was issued in December 2001. (see 1.2.a.3). A Royal Decree concerning the use of the cannabis for medical purposes (July 2001) authorizes the use of the cannabis to carry out clinic trials for some therapeutical indications such that nausea and uneasiness linked to chemotherapy and radiotherapy, glaucoma, multiple sclerosis, syndromes linked to AIDS and chronic pains (see 1.2.a.4).

Developments in public attitudes have been investigated by an interview survey in 2000 (see 1.3). Section 1.4. deals with budgets related to drug-related interventions at federal and federate levels.

1.1. POLITICAL FRAMEWORK IN THE DRUG FIELD

1.1.a Objective and priorities of the national drug policy

On Friday 19 January 2001 the Belgian Federal Government decided to modify the law of 1921 prohibiting all kinds of drugs. In the near future, i.e. once the Belgian Parliament has voted the amendments to the present law, the person in possession of a small amount of cannabis for his/her personal use will no longer be prosecuted.

A project of directive on cannabis is part of a Federal Government Policy Paper that sets out a global strategy for tackling the drug misuse in our society. The strategy has four main aims :

- To prevent young people from using drugs (including tobacco and alcohol);
- To help people with a problematic drug use to overcome the problem and live a normal and crime-free life. Treatment comes before punishment;
- To avoid drug-related anti-social and criminal behaviour;
- To intensify the struggle against organized drug traffic.

The federal drug policy note wants a reply to most urgent problems concerning consumption and dependence of drugs. The note covers illegal and legal drugs (alcohol, tobacco, some medicines). In addition, the objective of this note is to put into practice some of the recommendations of the drug policy working group.

BASIC ASUMPTIONS

- Drugs = alcohol, tobacco, cannabis, cocaine, heroin, XTC...
- It is necessary to discourage the consumption of drugs
- A large number of persons consume drugs. A society without drugs is an illusion
- All consumption of drugs presents risks for the health. Even when one consumes drugs , it is necessary to know and limit health risks

OBJECTIVES

- Less drug addicts
- Less physical and psycho - social damages
- Less social nuisance

APPROACH

- Prevention: it is better to prevent than to heal costs? To heal than to punish
- In case of problematical drug use, it is necessary in the first place to limit risks for the health. Care should be given before a possible sanction. It is necessary to avoid that the drug users who have not committed crime go in prison.
- The limited consumption of alcohol, tobacco and cannabis is socially increasingly accepted. There exists no objective reason to envisage the alcohol and tobacco otherwise than cannabis.
- A distinction should be made between hard drugs and other drugs : this is new. Hard drugs (cocaine, heroin, XTC...) continue to be forbidden: during an infringement, a police report is always established.
- The note anticipates a repressive policy strengthened regarding the traffic of drugs and the criminal organizations having bonds with this traffic.

ACTIONS

- Global and integrated approach where the different sectors of competence collaborate closely.
- Evaluation, epidemiology and research
- Prevention
- Care, harm reduction and reintegration
- Repression

The federal note is presented in a more detailed way in section 1.1.b.2. The modalities concerning the distinction between cannabis and other illicit drugs, and the investigation and prosecution policy still have to be outlined in Royal Decrees.

1.1.b Basic elements of drug policy at national and regional levels

1.1.b.1 Background and milestones

Up to the coming implementation of the new policy, the Belgian **legislation** did not distinguish the applied penalties neither according to the types of drugs (“hard” or so-called “soft” drugs), nor to the quantities of the seized drugs. Only the concepts of possession, group use and trafficking were considered and were applied by the judicial authorities according to criteria applicable to each individual case.

In **1992** an inter-ministerial conference (around 15 different cabinets) was set up in order to co-ordinate the different departments involved in the drug issue. In order to develop a clear and timely view on the drug problem, the Belgian government decided in **1996** to establish a *parliamentary working group* (Report of the parliamentary working group on the study of the drug problem 1997). On 5 June 1997, the parliamentary working group reported its conclusions and recommendations to the Chamber of Representatives (Parl. St., Kamer 1996-1997).

The parliamentary working group opted for a policy of normalisation. (Report of the parliamentary working group on the study of the drug problem, 1997 p. 992-993) One has to accept that repression has its limitations for the vast majority of drug users and therefore a criminal approach towards drug users should always be the last resort. This is the so-called “ultimum remedium” philosophy. (Report of the parliamentary working group on the study of the drug problem 1997, p. 1001) The working group opted for an adaptation of criminal policy towards drug users. Except in specific risk situations, like driving under the influence and the disturbance of the public order, drug use as such should not be a reason for a criminal intervention. (Report of the parliamentary working group on the study of the drug problem 1997 p. 992, p. 1003) Criminal intervention should take into account the individual situation of the drug user and when problematic drug users come into contact with police or justice, they should be directed towards the treatment services. (Colla 1998) The incarceration of drug users, whose only criminal offence is the possession of illicit drugs, should be avoided. (Report of the parliamentary working group on the study of the drug problem 1997, p. 993-994 and De Clerck 1998) It was determined that supply-side control requires a reinforced repressive policy towards the organised drug trade and criminal organisations related to the drug trade. (Report of the parliamentary working group on the study of the drug problem 1997, p.992, p. 1010).

The conclusions of this working group have been adopted by the Parliament in June **1997**. The Council of Ministers approved the conclusions of the working group. The law enforcement on drugs was consequently adapted specifying a.o. that the **penal justice** must be an ‘ultima ratio’ in case of serious public nuisance.

Then some changes were initiated. Between an approach strictly repressive and at the opposite a full tolerance policy, a third way should exist called ‘normalisation’ policy. The policy priorities were redefined: prevention and reduction of drug use, decrease of the number of new drug users, protection of the community and its members who are facing the drug phenomenon and its consequences, provision of care to drug users and readiness to guarantee them a better life despite their drug use.

Without changing the law, a directive/circular of May 8, **1998** modified the action of the judicial authorities (adaptation of the common directive/circular harmonizing the crime policy for drug addicts signed by the attorneys general and the Justice Minister on 26 May 1993). For the first time, *a distinction was established between possession of cannabis for personal use and other illegal drugs with non-acceptable risk for health*. The possession of cannabis for personal use remains an offence but to which the lowest prosecution priority should be given.

At the investigation and prosecution levels, several options for settling drug offences are available (De Ruyver et al., 2000a, p. 35-36). Moreover, on each level of the judicial framework an orientation towards drug assistance is possible.

Nevertheless, this wide range of modalities available to cope with the drug problem on the one hand, and their vague criteria of application on the other, result in endlessly varying approaches towards drug offences by the different public prosecutor’s departments and courts. This means that the directive/ circular of May 8, **1998** has had little impact on creating a uniform drug policy and thus has not met the recommendations formulated by the parliamentary working group.

In general, further clarification is needed regarding both the role of the many different actors involved in coping with the drug problem and the terminology used in the circular of May 8, 1998 is concerned.

In the framework of the future prosecution policy, a new directive on the prosecution policy will be issued by the Minister of Justice and the Board of Prosecutors General for the police and the public prosecutions office, in accordance with the planned amendment of the Belgian Narcotic Drug Act of 24 February 1921 and the Royal Decree outlining the investigation and prosecution policy. This directive will clearly delineate boundaries of judgement in investigation and prosecution policy. It should exclude differences due to interpretation as much as possible in order to reach a uniform application.

Several other important measures have been decided. The access to needle exchange was made possible. The supply, the sale and the delivery of materials with the aim to prevent infectious diseases (it means a.o. *the implementation of 'needle exchange' programmes*) were made possible by a new law (1998). The obligations proceeding from the UN 1971 convention on *psychotropic substances* (regarding Table III and IV, including a.o. *benzodiazepines, meprobamate, MDMA, MBDB, barbiturates*) were completely integrated in the national legislation in 1998.

The policy of Internal Affairs is embedded in a **crime prevention** philosophy. A financial framework to support the municipalities with a high criminality rate was created. Those municipalities have to set up projects aiming at drug treatment and prevention.

In the Communities and Regions a growing effort is made to get a **global prevention**: the focus is mainly health and welfare oriented. Several evolutions are clear: development of a policy plan, increasing education and expertise of prevention workers, improved co-ordination of prevention activities from a health perspective, further development of local crime prevention initiatives with focus on drug prevention, enlarged provision in training, community approach. Many organisations and municipalities have developed prevention and/or care and cure activities in different fields: social services, workplaces, youth organisations, schools, peer groups, harm reduction, leisure time.

Three types of services offer treatment : inpatient centres (e.g. psychiatric centres, therapeutic communities, crisis intervention centres), outpatient centres (centres for mental health, day care centres, medico-social care centres, low threshold services) and primary care (general practitioners, welfare organisations, etc.). There is a tendency to lower the admittance level of the treatment centres. In 1996, medico-social relief centres for illicit drug users (MASS/MSOC) were initiated by the federal ministry of Internal Affairs. These active centres are low threshold services. They are located in Antwerp, Brussels, Charleroi, Genk, Ghent, Liege, Mons and Ostend. Existing therapeutic communities and crisis intervention centres received 'expansion of their capacity'.

The focus of treatment has been broadened: not only abstinence but also harm-reduction and methadone maintenance. In 2000, there are 8 'MASS-MSOC' centres offering low threshold facilities located in the large cities of the country (an evaluation of their activities is in progress). A case management approach is considered in order to improve the coordination of these various treatment facilities and to make easier the provision of a follow-up assistance to the patients.

Specialised residential treatment centres (therapeutic communities and crisis intervention centres) offer inpatient treatment for a limited number of persons. Residential treatment centres have also developed outpatient aftercare treatment provision. Other residential treatment centres (psychiatric hospitals) traditionally focused on alcohol problems. Some of them have expanded their focus towards illicit drugs. In outpatient treatment centres (centres for mental health care), people can get help for problems of dependence. The day-care centres are relatively recent in the treatment scene (since 92 - 93). Mostly they work with illicit drug users.

The breakdown between these three types varies from one region to another.

In Flanders, treatment of people with illicit drug problems is offered by a variety of services. Since the beginning of the nineties (92 - 93) a growing number of services have been established. In addition, those services already working towards illicit drug users expanded (are expanding) their offer. General practitioners seem to engage more often than in the past in treatment of illicit drug users. It is unclear to what extent people rely on this offer of treatment.

In the French Community, in addition to a large number of specialised services for treatment of addiction, the role devoted to general practitioners in the care of problematic drug users is

particularly striking. Their role is one of the components of the global intervention programme called ALTO.

Most of Brussels treatment facilities are non-residential (specialised centres, GPs, specialised emergency units, mental health care centres).

In the German-speaking Community, the centre of mental health is the main institution in charge of non-residential treatments of drug users (including methadone substitution treatment) : several psychiatrists also offer ambulatory treatment. Residential treatments are offered in the psychiatric unit of the general hospital, but most patients are treated outside of the geographical area of the German-speaking Community. Due to linguistic reasons, most of in-patient treatments are given in residential centres located in Germany.

In **1994**, a consensus conference was set up with the medical world to reach a consensus about methadone maintenance : according to conditions included in the Consensus document, substitution treatments have been made 'judicially' possible. Legislation to define substitution treatment is in preparation at the Federal Parliament. The issue of assisted medical deliverance of heroine in Belgium still remains under discussion.

1.1.b.2 Policy note of the federal government on the drug problems (19/01/2001, electronic copy : <http://www.minsoc.fgov.be>)

On Friday 19 January 2001 the Belgian Federal Government decided to modify the law of 1921 controlling the production, trade and use of drugs. In the near future, **i.e. once the Belgian Parliament will have voted the amendments to the present law**, the person in possession of a small amount of cannabis for his/her personal use will no longer be prosecuted. However, cannabis will still remain an illegal drug.

When there are indications of problematic use (the drug user is for instance no longer controlling his/her drug consumption) or when the drug consumption causes social nuisance (consuming drugs in the presence of minors, smoking near schools or in situations where it may disturb other people), the police will serve a summons. The judicial authority will receive clear instructions on how to react in such a case. The main objective is that treatment should come before punishment.

The Belgian government has not defined the maximum quantity of cannabis that can be possessed for non medical uses, and this for two reasons. First, in order not to give the message that cannabis is harmless and second, because someone who possesses a small amount of cannabis can be a problematic user.

Other illegal drugs (cocaine, heroine, ecstasy, etc) remain forbidden. Police will keep serving a summons.

As most European countries, Belgium was so far adopting a kind of tolerance policy towards cannabis, but this has created great insecurity and has led to differences in judicial treatment. The federal drug policy note respects all the international treaties adhered to by Belgium. Because of these treaties the selling of cannabis remains prohibited.

By transposing this policy of prosecutions in a royal decree and in a directive, the policy becomes "more visible" that in some neighbour countries that apply de facto the same strategy.

In order to prevent people from taking drugs and to ensure that people with drug problems or likely to develop serious drug problems receive appropriate help and advice, the federal Government has decided to provide an additional federal budget of 500 Million BEF (12.4 Million EURO).

ACTION PLAN

This action plan aims to control the illicit market/consumption of drugs.

1. A GLOBAL AND INTEGRATED APPROACH

- Drug Cell / Inter-ministerial Conference on Drug Policy : the ' Drug Cell' is composed of representatives of the different levels of power (federal State, Communities and Regions) and is chaired by a drug coordinator, competent for the coordination of the drug policy in all its aspects (prevention, care, repression). The Drug Cell supports and counsels authorities as well as the inter-ministerial Conference on Drug Policy. It will act also as a national coordinator at the European level. The set up of this Drug Cell (anticipated for 2002) is prepared by the Political Cell Health Drug (creation in 2001) that will elaborate an integrated health policy concerning drugs.
- Justice - Assistance : clear agreements
 - Agreements related to the professional secret, to the respect of treatment programmes and to the status of assistants in the framework of security contracts, prevention contracts and other drug-related contracts and alternative judicial measures;
 - Agreements related to crisis centers;
 - Designation of judicial 'case-managers' in each 'house of justice';
 - Better delimitation of prevention tasks between police services and the sector psycho-medico-social in the framework of security contracts.

2. EVALUATION, EPIDEMIOLOGY AND RESEARCH

The national Focal Point has been transformed into a Belgian monitoring centre on drug and drug addictions. Its mission consists among others in gathering and analysing best data on the consumption of drugs in Belgium, to examine and compare the effects of the different measures. The Monitoring centre will also continue the development of an 'Early Warning System' in order to detect rapidly the introduction of new substances on the drug market.

Evaluation of treatment methods, health care institutions, cares circuits and prevention techniques will be carried out.

3. PREVENTION

The federal government asks the Communities to continue their efforts concerning prevention and recognizes the competence autonomy of Communities in this area. If necessary, agreements will be established between the different levels of competence.

The federal note includes a number of relative concrete actions regarding psychoactive medicines, driving under drug influence and the policy concerning tobacco and alcohol.

A particular attention will be granted to youths in order to avoid they come into contact with illegal and legal drugs at an increasingly younger age and to learn them to face these substances in a responsible manner.

4. HEALTH CARE, HARM REDUCTION AND REINTEGRATION

The ministers of Social Affairs and of Public Health will develop a more integrated legal framework, by taking into account local needs. This framework will have to make possible the organization of health care to drug addicts at the level of local care networks.

Mental health care centres will be an integral component of these health care circuits, if Communities wish it. Youths, psychiatric patients with drug problems (double diagnosis), the foreigner population as well as the crisis care centres will receive a particular attention.

The various sources of funding (INAMI, legislation on hospital funding, etc.) will be better coordinated. Substitution treatments will be organized legally. An evaluation will be conducted on basis of clinical trials on medical prescription of heroine.

5. REPRESSION

The struggle against the trade of drugs has to go together with measures aiming to reduce the demand of drugs and consequently, a policy oriented to a maximal limitation of the personal consumption. Authorities will give a particular attention to the derived criminality and to the social nuisance. Prosecutions in case of simple consumption have to constitute an ultimate stage in the

framework of the intervention by judicial authorities. If a drug user is put in detention, he has to have access to the therapeutic and medical assistance.

- Penal policy and trade of drugs

The Minister of Justice will establish a directive on the trade of drugs. Priorities are among others the struggle against the illegal production and the trade of raw materials, against synthetic drugs and against the cocaine and heroin trade. Seizure and confiscation possibilities will be improved. The benefit of these seizures will be used to finance the offer of health cares and prevention interventions.

- Penal reaction to the consumption of drugs

The law of 1921 on drugs will be adapted : it will establish a distinction between the cannabis and the other illegal drugs. Furthermore, the qualification "use of illicit drugs in a group" will be eliminated from the Narcotic Drug Act. A Royal Decree will rule modes.

1. The possession of cannabis for personal use or in a quantity such that one can suppose that it is not destined to the sale, is no longer continued.

Exceptions :

- Indices of a problematical consumption

- Social nuisance (ex. consumption in the presence of minors and in situations of breach to the public order such that described in the local law)

- Priorities to situations to risk : a.o. driving under influence of cannabis, resale around schools or places with strong concentrations of youths...

2. The introduction, the production, the transportation, the possession of a quantity of drugs that exceeds the qualification of 'possession for personal consumption' or when these crimes of drugs are committed in the framework of aggravating circumstances anticipated by the drug law (for example presence of minor) remain liable prosecutions.

3. 'Hard' drugs remain forbidden.

- Fixing of the sanction

The measure of 'probation' will be applied more largely. The 'therapeutic notice' will be recognized legally (the 'therapeutic notice' has for objective to put consumers of illegal drugs questioned by the police under the supervision of the public ministry in contact with the assistance in order to determine if an accompaniment is indicated).

- Penitentiary policy on drug (see 1.2.a.3)

Measures will be established to struggle against the introduction of drugs in prison. The approach will be oriented to the accompaniment of the drug user. Substitution treatments will be organized. The consumer will be able during its detention to call an assistance of quality, possibly through external services.

The modalities concerning the distinction between cannabis and other illicit drugs, and the investigation and prosecution policy still have to be outlined in **Royal Decrees**.

1.1.b.3 Federal political note related to mental health care (2001, Source : <http://www.minsoc.fgov.be/>)

Mental health is to the centre of the attention of the minister of the Public Health in 2001. It concerns the annual theme of WHO. A certain number of Belgian coordination organisms also have proclaimed the year 2001 'Year of the mental health'.

The minister of the Public Health proposes a vision of the organization of mental health cares oriented to the future where the patient occupies a central place. The psychic invalid condemnation can be avoided by respecting the apparent "difference" of these persons and by adopting a constructive approach of the problem. A new more integrated organization of health care is required.

Points of action are : the patient as starting point (demand of care and participation, reorganization in function of target groups: care and dialogue offer, platforms of dialogue for mental health cares, plug in by first line health cares and by general hospital, reform of cares), specificities of target groups (youths, adults, elderly, drug addicts, handicapped presenting serious behaviour problems) and health quality care (research and recording of data, training).

1.1.b.4 Main actors

There are a lot of key actors. On the one hand, at the **federal level**, there are the ministry of Justice, the ministry of Foreign Affairs, the ministry of Internal Affairs and the ministry of Social Affairs and Public Health, and on the other hand, at the **federated level**, there are the communities and regional governments (Flemish, French and German-speaking Communities, Brussels-Capital Region).

An **inter-ministerial conference** (different departmental staffs) was set up in order to co-ordinate the different departments involved in the drug issue.

The federal drug policy note of January 2001 anticipates the creation of a coordination structure '**Cellule Drogue / Drug cell**' (see Action 1 of the federal note). This Drug Cell will be composed of representatives of the different levels of power (federal State, Communities and Regions) and will be competent for the coordination of the drug policy in all its aspects (prevention, care, repression).

In January 2000, the Belgian government and the Minister of Justice circulated a **federal plan for security and for penitentiary policy** (the extended version of the text is available on the ministry of Justice's web site : <http://www.just.fgov.be/>). The plan will be supported by scientific contributions and aims at two general objectives: an actual decrease of all forms of criminality and a considerable increase of the low rate of elucidation of offences. Some issues of the plan are dedicated to drug related matters. The specific objective is defined as 'to limit the public nuisances and the criminality related to the drug market and traffic'. There is an obvious willingness to develop diversion to treatment and alternative measures and to make the links between the judicial system and the health care system easier.

Belgium is an observer at the United Nations Narcotics Commission and has ratified **international conventions** on narcotics, psychotropic substances and illegal trafficking. Belgium is among the UNDCP contributors (United Nations Drug Control Programme). The aspects of repression and supply reduction are an exclusive federal competence. Community and Regional governments also have **international relationships and collaborations**: EMCDDA, WHO (as national counterparts of European alcohol action plan / WHO-Europe), Pompidou working groups, European Union projects (Intereg-, Euregio-, Multicity- projects), European Drug Prevention Week ...

The **Belgian Focal Point**, located at the Scientific Institute of Public Health, is the Belgian representative in the REITOX^b European network settled down by the EMCDDA. The **BIRN** (Belgian Information Reitox Network) was created in 1995 and links the National Focal Point with the 4 Sub-Focal Points : **ASL** (Arbeitsgemeinschaft für Suchtvorbeugung und Lebensbewältigung) for the German-speaking Community, **CCAD** (Comité de Concertation sur l'Alcool et les autres Drogues) up to August 2000 and **EUROTOX** from September 2000 for the French Community, **CTB-ODB** (Concertation Toxicomanies Bruxelles - Overleg Druggebruik Brussel) for the Brussels-Capital Region, **VAD** (Vereniging voor Alcohol -en andere Drugproblemen) for the Flemish Community (see Annex B).

The Focal and Sub-Focal Points are getting in touch with a lot of partners from different fields (justice, police, toxicological laboratories, universities and other research centres, prevention and harm reduction organisations, therapeutic communities and other treatment actors...) exchanging information, collecting and analysing data and disseminating results, research reports, guidelines...

In 1999 and 2000, a feasibility study on the transformation of the Belgian Focal Point in a **Belgian monitoring centre** for drugs was performed (Sartor *et al*, 2000). According to the federal note of January 2001 (see Action 2 the federal note), the national Focal Point will be transformed into a Belgian monitoring centre for drug and drug addictions. Its mission will consist among others in gathering and analysing best data on the consumption of drugs in Belgium and to examine and compare the effects of the different measures. The monitoring centre will also continue the elaboration of an 'Early Warning System' in order to detect rapidly the introduction of new substances on the drug market.

b REITOX : Réseau Européen d'Information sur les drogues et TOXicomanies / European network linking EMCDDA and National Focal Points for the exchange of information on drugs and drug addictions.

1.1.b.5 Drug Policy in the Flemish Community

As an answer to the federal drug policy paper, the **Flemish government** agreed upon a brief 'Point of View of the Flemish Government concerning drug problems'. This Point of View was prepared by an inter-cabinet working group and accepted by the council of ministers of the Flemish Government on November 24th 2000. The Point of View gives a general and philosophical framework for the approach towards drug problems, mainly in the field of prevention and treatment. It includes the promotion of health and wellbeing, the prevention of drug problems, harm reduction and treatment facilities for different target groups. It favours co-operation between federal and community governments to develop a global approach to the problem.

Structures

The Flemish government is funding the *Vereniging voor Alcohol- en andere Drugproblemen (VAD)* as a co-ordinating agency for demand reduction at a Flemish level. It is responsible for information, training, data collection, consultancy and networking at the level of the Flemish community.

At provincial level, there is a network in every of the 5 Flemish provinces and in Brussels for the co-ordination of prevention (*Provinciale Preventieplatforms - PPP*). The Flemish ministry of Health is financing a co-ordinator. For treatment, there are networks in the field of mental health (*Overlegplatforms Geestelijke Gezondheid*) in every province, financed by the federal ministry of Health.

At a regional level, there is a structure of 10 prevention workers, based in centres for mental health. They are working since 1988 and have created networks and contacts with different sectors in society (education, youth work, workplace, adult education, welfare sector, leisure sector, ...), to empower them to develop a prevention policy in their setting.

The centres for mental health all provide outpatient treatment for drug users (some are more specialised and offer more substantial treatment than others). In 2000 their number was reduced to 24 centres as a result of a fusion process. The centres for mental health are financed by the Flemish ministry of Health.

Psychiatric hospitals and psychiatric wards of general hospitals offer inpatient treatment. Some of them have a drug specific unit. The hospitals are financed by the federal government but recognised by the Flemish Community. The federal government finances all therapeutic Communities, Crisis Intervention Centres and Medical Social Centres

At a local level, there are various projects that operate rather independently. They deal mainly with prevention and outreach, some deal with treatment. These different local projects vary a lot. The Ministry of Internal Affairs finances some, others are financed by the local authorities, others are funded through welfare budgets (SIF), some projects are privately sponsored. These various local projects are co-ordinated through the provincial networks.

In the Flemish Community, there is a global approach for prevention and to a much lesser extend for treatment (as treatment is mainly financed by the federal government). The Flemish government has organised its policy through a 'covenant' that is signed between the government and the co-ordinating agency VAD. A policy plan was developed in which 8 areas of work were defined to implement a Flemish drug policy 1999-2001. The plan contains different actions in each area of work, with indicators for measuring its realisation (evaluation).

The main areas of work are: information and sensibilisation, consultancy, training and support, development of new concepts and data collection and research.

The provincial networks also have a 'covenant' with the Flemish government in which their areas of work are defined to strengthen the Flemish drug policy (the areas are in the field of co-ordination, implementation of concepts, data collection).

Sectors: the global prevention policy is implemented through the different sectors in society (education, youth work, workplace, adult education, health and welfare sector, leisure sector, ...). Key

persons in these sectors are identified and training and consultancy is set up to empower them to develop a prevention policy in their setting.

At a local level, drug networks are set up to develop a local drug policy with representatives of the different sectors.

In some regions, the treatment sector has organised itself in the area of crisis intervention by setting up 'crisis network'. These voluntary networks are in an experimental phase in some regions in Flanders.

1.1.b.6 Drug Policy in the French Community

The Ministry of health of the French community is competent for health promotion including prevention projects. The Ministry of health defines health promotion according to the Ottawa convention. In its five-year Health Promotion Programme (1998-2003), the French Community has identified six priority health problems: infectious diseases (HIV, immunisation and tuberculosis), cardio-vascular diseases, cancers, addictions, mental health problems and accidents.

In terms of target population, priority is given to socially excluded population, and school children.

At the French-speaking Community level, the following strategies to deal specifically with addiction are proposed:

- a) To fight the anxiety and activism often associated with the issue of drugs, to promote sensitisation and training programmes for adults (teachers, parents and responsible for young people).
- b) To promote reflections and debates between young people and adults around drug issues in the scope of general education prospect. The issue of drug use should be placed within a larger context of questioning the meaning of life and our choices in life, at a critical period in the psychosocial development of adolescents.
- c) Instead of focusing on drugs themselves, prevention should focus on attitudes and behaviour and perceptions of young people.
- d) To tend toward a global perception of addiction, not restricted to illegal drugs.
- e) To choose also strategies aiming at reducing the risks of using legal or illegal drug, by intravenous or otherwise.
- f) Finally, in order to avoid getting off course, it is absolutely essential that prevention issues be addressed in a manner that respects human rights, democracy and a law-based society.

Under the AIDS prevention programme, intravenous drug users are identified as one of the target population.

1.1.b.7 Drug Policy in the German-speaking Community

In the coalition agreement of the government of the German Speaking Community (DG) in Belgium, the prevention has been set as the primary step in the drugsphere. According to the government of the DG, the nearness to the border of Germany, the Netherlands and Luxembourg demands collaborations across borderlines. A forum to permit international exchange is the „Mondorfgroup“. Representatives from the Saarland, Rheinland-Pfalz, Luxembourg, the German Speaking Community of Belgium and the department Moselle in France cooperate in this team. Like in the international field, the German Speaking Community puts emphasis on a more active communication between local working people in the drugsphere. On Minister Niessen's wish, people being responsible for prevention and therapy/aftercare should be in permanent dialogue. The main actors are :

- the ASL Arbeitsgemeinschaft für Suchtvorbeugung und Lebensbewältigung (Team for drug addict prevention and life-mastering) which acts as the sub-focal-point for the EMCDDA. The main concern is however the primary prevention within the german speaking area.
- the SPZ Sozial-Psychologisches-Zentrum (social-psychological centre) in St. Vith and Eupen which is the primary responsible for the therapy/aftercare.

For the year 2000 the German community supported with a total budget of 10,237,750 Bef the following activities and institutions in the drugsphere:

- SPZ-international meeting October 2000
- Anti-drug-disco in Kelmis,
- SPZ with ¼ drug-interests, and
- ASL drug prevention and life-mastering "life skills"

1.1.b.8 Drug Policy in the Brussels-Capital Region

The CTB-ODB (the Brussels Drugs Programme) is a co-ordinating agency, set up in 1994. It covers the Brussels-Capital Region (19 urban municipalities), representing a population of almost one million inhabitants.

Two main partners operate in the same area : Brussels French Authority (funding for drugs programmes) and Brussels Flemish Authority (funding co-ordination for prevention).

Objectives

The Brussels Drugs Programme, with an emphasis on reducing demand, brings together those involved in helping drug addicts in prison, treatment centres, crisis centres and short stay centres, hospital centres, 24-hour hot-line services, prevention, mental health care centres, assistance, rehabilitation, day centres and ambulatory care. It should be noted that funding for Brussels-based drug-related health programmes can originate from six different sources.

It co-ordinates regional health actors' projects or initiatives with other sectors (lawyers, Justice Department, Public Prosecutor's office, federal and local Police forces).

Among the eleven issues dealt with by the programme, two focus on external collaborations (with the various authorities in Belgium and with international collaborators).

Structure and organisation

The office moved at the beginning of the year 2001.

From April 1st, 2001, a new structure has been set up. The 11-issues programme as well as the overall aims are kept unchanged. Five working groups (for five target populations) are going to report regularly for providing policymakers with up-to-date information.

Main responsibility deals with information, networking, data collection, expertise and reporting.

It also favours co-operation between governments to improve a comprehensive approach to the drugs problem.

The staff consists of a co-ordinator, an assistant and a secretary, all part-time.

1.1.b.9 International co-operation

FEDERAL LEVEL

The aspects of repression and supply reduction are an exclusive federal competence. The ministry of Foreign Affairs is the main responsible. Regarding specifically relationships with the UN (e.g. UNDCP), they are co-ordinated by the ministry of Justice that passes the specific demands through to the different administrations or organisations concerned.

- Belgium is an observer at the United Nations Narcotics Commission and has ratified the International Convention on Narcotics (New York, 1961) and its Protocol (Geneva, 1972), the Convention on psychotropic substances of 1971 and the Convention against illegal trafficking of 1988.
- Belgium is among the UNDCP contributors. In particular, it participates in agriculture re-conversion projects in Colombia and Vietnam.
- Belgium has set up a network of liaison officers in order to increase law enforcement, in particular in the area of narcotics.

The Focal Point (see 1.1.b.4) is the Belgian representative in the REITOX European network settled down by the EMCDDA.

Reporting to and from the Group Pompidou passes along the Permanent Correspondent who sends the international information demands to the relevant persons or departments.

FEDERATE LEVELS

Community and Regional governments have international relationships: EMCDDA, WHO (as national counterparts of European alcohol action plan / WHO-Europe), Pompidou working groups, European Union projects ('Intereg Projects', 'Euregio projects', 'Multicity project-Liège'), European Drug Prevention Week...

- Flemish Community

- Sub-Focal Point EMCDDA (via VAD)
- National counterparts of European alcohol action plan (WHO-Europe) (VAD)
- EU Intereg projects: province of east Flanders and South Holland, and province of west Flanders and north of France, EU Euregio projects: provinces of Limburg and Liege, Germany and The Netherlands.
- Pompidou group (via national representative at federal level)

- French Community

- Sub-Focal Point EMCDDA (via CCAD/EUROTOX)
- Pompidou working groups: Epidemiology Group (CCAD), First Treatment demand (CCAD), "Multicity report -Liege" (CCAD-cellule Drogues ULg)
- Programmes of the European Union (DG V), EU "Intereg Projects" : Province. Hainaut and France, Rhin-Moselle-Meuse, European network for AIDS prevention in prison, EU Snowball project, ITACA.

- Brussels Region

- Sub-Focal Point EMCDDA (via CTB-ODB)
UNDCP
- Council of Europe (Pompidou group)
- European Commission (DG V)
- Specific agreements with European Cities or regions
- Several projects within European Community action and prevention of drug dependence (DG V/F2).

- German-speaking Community

- Sub-Focal Point EMCDDA (via ASL)
- Pompidou working groups
- Specific agreements with European cities or regions : the ASL collaborates on a regular basis with prevention institutions of various countries of the European Union and of oriental Europe. The EU awarded a European project to the ASL, notably in order to implement primary prevention at the local level of the participating countries.

1.2. POLICY IMPLEMENTATION, LEGAL FRAMEWORK AND PROSECUTION (LEGISLATION AND ENFORCEMENT)

1.2.a Law and regulations (drug-related issues about health, social affairs, youth, justice, drug control, etc.) : legal frame stipulating the current prosecution policy

Royal decrees and directives should implement the federal drug policy note of January 2001. In the meantime, the Belgian legislation does not distinguish the applied penalties neither according to the types of drugs (“hard” or so-called “soft” drugs), nor to the quantities of the seized drugs. Only the concepts of possession, group use and trafficking are considered and are applied by the judicial authorities according to criteria applicable to each individual case. Although the law was not changed, a directive (1998) modified the action of judicial authorities : **a distinction was established between possession of cannabis for personal use and other illegal drugs with non-acceptable risk for health** (see 1.2.a.2).

1.2.a.1 Drug laws and infringements (*De Ruyver et al. 2000a, p. 23*)

Currently, the Belgian Narcotic Drug Act of 24 February 1921^c, nor the Royal Decree of 31 December 1930, nor the Royal Decree of 2 December 1988, distinguishes between offences on the basis of the nature of the substance (e.g. no distinction is made between cannabis and other illegal substances). Belgium has not penalised **the use of drugs** as such. However, the courts proceed from the assumption that possession is the prerequisite for use, and possession of narcotic drugs – irrespective of type and quantity – is in it an offence constituting valid grounds for prosecuting the user. In Belgium only *group use* is punishable, by imprisonment for three months up to five years and/or a fine of 200,000 to 20,000,000 BEF (5,000 to 500,000 Euro). (Sections 2bis and 3 of the Act of 24 February 1921 on poisons, soporific and narcotic drugs, disinfectants and antiseptics, as amended by the Acts of 9 July 1975 and 14 July 1994)

Belgium law punishes **drug possession** with imprisonment for three months up to five years, and/or a fine of 200,000 to 20,000,000 BEF (5,000 to 500,000 Euro). This term of imprisonment may be increased to fifteen or even twenty years of confinement in the event of specified aggravating circumstances i.e. drug offences relating to minors aged less than sixteen / twelve, or committed in the course of occupational activities such as the management of a firm, or if the use of the drug causes death. (Section 2bis of the Act of 24 February 1921 on poisons, soporific and narcotic drugs, disinfectants and antiseptics, as amended by the Acts of 9 July 1975 and 14 July 1994)

More precisely the infringements are as follows :

- The production, import, export, manufacture, keeping (i.e. store under the required conditions, labelling), transport, possession, sale and offer for sale, acquisition either free of charge or against payment, of toxic, hypnotic, disinfectant or antiseptic substances (as well as the cultivation of plants from which these substances can be extracted), without authorisation, excluding the purchase and possession justified by a medical prescription. The same rule applies to all psychotropic substances liable to produce drug dependence, and not only to narcotics and hypnotics
- The use of substances in a group
- Aiding and abetting the use of substances, for money or otherwise, either by providing premises, or by any other means
- Instigation to use (pushing)
- The act of procuring or attempting to obtain narcotics or psychotropic substances by using a forged prescription, a false claim, a forged signature or any other fraudulent means the act

^c Act of 24 February 1921 on poisons, soporific and narcotic drugs, disinfectants and antiseptics (Belgian Narcotic Drug Act), B.S. 6 March 1921; as amended by the Acts of 9 July 1975, B.S. 26 September 1975 and 14 July 1994, B.S. 21 October 1994.

Royal Decree of 31 December 1930 on trade in soporific and narcotic drugs., B.S. 10 January 1931.

Royal Decree of 2 December 1988 regulating the trade in certain psychotropic substances, B.S. 3 February 1989.

Act of 8 April 1965 on the youth protection, B.S. 15 April 1965, as amended by the Acts of 24 December 1992, B.S. 31 December 1992 and 2 February 1994, B.S. 17 September 1994.

committed by a medical or veterinary professional, or by someone in a paramedical profession, of over-prescribing, or administering medication containing controlled substances likely to lead to, maintain or aggravate a condition of dependence the act of refusing or obstructing site visits, inspections or sample taking.

1.2.a.2 The directives of 1993 en 1998 (De Ruyver et al. 2000a, p. 24-25)

While prosecution was the rule in the past, it became the exception in a criminal justice system that was confronted with the explosion of criminal law provisions. Therefore public prosecutors had to make more use of their discretionary powers to dismiss cases or to find solutions to divert the cases out of the ordinary sentencing process. The Belgian public prosecutor plays a central role in the filtering process of offences in the criminal justice system, (Parmentier and Peters, 1998). Until 1998, this expediency principle was not established in law. Article 28quater Code of Criminal Procedure now stipulates that the public prosecutor decides about the expediency of the prosecution. To ensure a uniform and coordinated prosecution policy, the public prosecutors have to take into account the guidelines of criminal policy of the Minister of Justice and the Board of Prosecutors General (Article 143ter Code of Criminal Procedure).

In relation to the prosecution for possession and the retail sale of illicit substances, two specific circulars of the Board of Prosecutors General have been enacted. These circulars are aimed at a further elaboration and implementation of the Belgian Narcotic Drug Legislation. The prosecutors are bound by the circulars, but may depart from it when required by practical circumstances. The circulars do not give enforceable rights to private persons.

A directive dated 26 May 1993 (Circular of May 26, 1993 for the elaboration of a common drug policy) set out a number of general principles to establish a uniform policy on the handling of drug offences by public prosecution departments. Because the circular called for a judicial response to any form of drug abuse, be it no more than a warning or an order to attend a treatment centre, it is obvious that this policy was inoperable, especially for the major cities. As a consequence of the differences in application of the circular, a non-uniform drug prosecution policy remained in practice.

Therefore, on May 8, 1998 a new directive of the Board of Prosecutors General was enacted (Board of Prosecutors General, 1998). The contents of this circular are based upon the recommendations of the 1997 parliamentary working group.

The law was not changed and the directive only modifies the action of judicial authorities : **a distinction was established between possession of cannabis for personal use and other illegal drugs with non-acceptable risk for health. The possession of cannabis for personal use remains an offence but the lowest prosecution priority should be given.**

It means that in case of single or occasional use of cannabis, a simplified policeman's report is to be filled in and (as in all other cases of drug offence) the drug has to be seized.

Regarding the **retail sale**, the judicial prosecution to be taken will be differentiated according to the intents: either sale to provide for funding its own use or on the contrary with the intention to make profit.

Evaluative comments on the heterogeneous enforcement of the directive can be found in section 1.1.b.1.

1.2.a.3 Ministerial Circular-letter on 'Drugs and prison' (December, 18 th, 2000)^d

The Minister of justice issued this circular concerning a global approach of the issue of drug within penitentiary system. This directive has three main components. The first one, and priority one, concerns the control of deal, the second one the medical and psychosocial assistance to drug

^d Circulaire relative à l'approche intégrale de la problématique de la drogue dans les établissements pénitentiaires.

Omzendbrief met betrekking tot de integrale aanpak van de drugproblematiek in de penitentiaire instellingen.

addicted persons including the role of external services and the third one the implementation of new penitentiary policy. The objectives enounced within the preamble are to avoid drugs from entering prisons, to provide assistance and treatment to detained persons, equivalent to what is available within the community, to train and inform staff and prisoners on prevention and harm reduction measures.

- The circular-letter makes a clear distinction between dealers and consumers. Sanctions to detained persons must be applied only in case of implication within a deal. In case of consumption, measures must be taken to avoid health damages and repetition of drug use. If a visitor or a staff member is implicated in a deal, magistrate must be informed, and access to prison immediately forbidden or limited for the visitors.
- The medical doctor of the prison is sole responsible for the treatment of detained persons, even if an external medical doctor prescribes a treatment. All drug users entering a prison must be informed on the drug policy applied in the prison as well as on health risks linked to drug use. If a drug user was under treatment outside the prison, his/her treatment centre can be contacted. The main policy in terms of treatment to drug users is detoxification, possibly with the assistance of medications. ***Continuation*** of maintenance treatment is recommended in the cases of pregnant women, short-term detention and persons positive for HIV or hepatitis. When a person is transferred to another prison for a short time, maintenance treatment must continued. Before release, maintenance treatment can be initiated, in close collaboration with external services for drug users. Prisons must collaborate as much as possible with external services for drug users to implement within the penitentiary establishment prevention and therapeutic activities both collective and individual.
- Three instruments must facilitate the implementation of the new penitentiary policy: the local and central steering committees and the drug coordinators.

This penitentiary drug policy constitutes a clear improvement compare to the previous situation characterised by a cloudy and often arbitrary management of the problematic. But it mainly enounces the policy already applied in many prisons. It must be noticed that, even if it does not prevent from starting substitution treatment in prison, this drug policy will not facilitate these initiations. In addition to the possible damage for the health of the concerned persons, this situation is in complete contradiction with health policy within the community where a wide access to methadone is one of the main priorities.

1.2.a.4 Royal Decree on the medical use of cannabis (published on 19 July 2001; Source : <http://www.just.fgov.be>)

This Royal Decree authorizes the use of cannabis to carry out clinic trials for some therapeutic indications such as nausea and uneasiness linked to chemotherapy and radiotherapy, glaucoma, multiple sclerosis, syndromes linked to AIDS and chronic pains. Treatments using cannabis can only be prescribed by physicians engaged in an university hospital or an hospital legally recognized for the treatment of the above-mentioned therapeutic conditions.

Clinic trials are submitted to some conditions such as the notification to the General Inspection of the Pharmacy, the writing and the transmission to the same authority of a report on the results of these trials. They also must be reviewed and accepted by an *ad-hoc* ethical committee.

The prescription should be made by a physician attached to a university hospital or to a recognized hospital for the treatment of aimed therapeutic conditions or by a reference centre for the pain control.

1.2.a.5 Driving and drug consumption

Since March 1999, Belgium has adopted a law that allows Police Officers to test drivers under the influence of illegal drugs (Royal Decree of March 16th, 1999; published in the Official Journal on March 30th, 1999). Several Belgian and European studies served as base for this law (BTTS study, Rosita

study, ...). Up till then, there were two articles in the traffic code referring to driving under influence of drugs (DUID), but there was no mention of testing methods.

Now, the testing consists in three following steps:

- 1) Determination of the physical signs of influence, by means of a standardised testbattery, including four psychomotoric tests (Romberg, one leg stand, walk and turn, finger to nose),
- 2) If positive (at least one case among the physical signs, and one case among the psychomotoric part), a urine sample is taken and tested. For this purpose, the police officer disposes of an immunoassay provided by the Ministry of Justice. The test detects signs of the products included in the law (amphetamines, methamphetamines, cocaine, heroin and THC) above a specific cut-off value (see table below). If any of these substances is detected, there is an immediate interdiction to drive for 12 hours. After that, the person has to pass testing again before being allowed to drive again.
- 3) If the urine test is positive, a doctor is required to take a blood sample. This sample will be analysed and used as proof in Court if the specific concentration for blood concentration is passed.

Substance	Concentration below which the result is not taken into consideration	
	Urine (ng/ml)	Blood (ng/ml)
THC	50	2
Amphetamine, MDMA, MDEA, MBDB	1000 *	50 **
Morphine	300	20
Cocaine or benzoylecgonine	300	50

* qualitative immunoassay testing globally amphetamine, MDMA, MDEA and MBDB in urine;

** for each molecule, separately determined by GC-MS method in blood sample.

1.2.a.6 Harm reduction and access to injection material

The supply, the sale and the delivery, even free of charge, of syringe and needle with the aim to prevent infectious diseases (a.o. the implementation of 'needle/syringe exchange' programmes) was made possible outside of the pharmacies by a new law dated 17/11/1998 and published in the *Moniteur belge/Belgisch Staatsblad* on 23/12/1998 (full text of the law http://www.just.fgov.be/html/fd2_w3.htm; box:1998022758). This law modifies the places where syringes can be obtained. The law specifies also that the distribution or exchange of syringes can no longer be considered as supporting or facilitating illicit use of drug and cannot be prosecuted as such. The Royal Decree published on 6th of July 2000, allows health and social workers from specialised treatment facilities to exchange needles and syringes. This service must be accompanied by the distribution of information on HIV, hepatitis, on access to tests and to treatment facilities (full text of the Royal Decree : <http://www.just.fgov.be/cgi/t>).

Before this law, only medical doctors and pharmacists were allowed to exchange or to sell needles and syringes. If this law is an improvement and legalises a practice that was already generalised in the French Community of Belgium for more than five years, it has its limitations. On one hand, it is too restrictive as only workers from a specialised treatment facility are concerned. Secondly, there is no provision made for processing of used material.

1.2.a.7 New substances under control

The Royal Decree dated 22 January 1998 on the regulation of some psychotropic substances (published on 14/01/99) updates the list of substances covered. The obligations proceeding from the

UN 1971 convention on psychotropic substances (regarding Tables III and IV) were integrated in the national legislation. The Decree lists the psychotropic substances controlled by law in Belgium, among others: MDMA, DMT, psilocybine, methamphetamine, ketamine, MBDB and PMA. (The full text of the Royal Decree can be found on the website of the Ministry of Justice, Moniteur belge/Belgisch Staatsblad, at: <http://www.just.fgov.be/>).

The substance 4-MTA was submitted formally to risk assessment by the EMCDDA in 1998. A recommendation was subsequently made that it should become a scheduled drug in all EU Member States. In Belgium, a Royal Decree enacted on 16/11/1999 (published in the Belgian Official Journal on 08/02/2000) added the substance 4-MTA to the list of controlled substances.

1.2.a.8 Precursors

Precursors are used for the chemical synthesis of various drugs. European legislation on precursors has been integrated into the Belgian legislative texts by virtue of the Royal Decree of 26 October 1993, published in the Moniteur Belge/Belgische Staatsblad (Official Journal) of 22 December 1993, and the offences covered by the penalties provided by the law of 24 February 1921 and the article 231 of the law on customs.

This Decree also designates the authorities in charge of enforcement: a Co-operation agreement was signed by Customs Authorities and the Department of Narcotic Drug of the General Pharmaceutical Inspectorate^e of the ministry of Public Health.

The "Precursors" cell, set up as a result of this agreement, is made up of members of both departments and is responsible for:

- Delivering general authorisations
- Delivering export certificates
- Monitoring intra-community transactions (notification must be given five days prior to all shipments) in the case of art.1 substances.

Customised software has been developed for this purpose.

1.2.a.9 Legal basis for substitution treatments

The federal drug policy note of January 2001 mentions that substitution treatments will be organized legally. An evaluation will be conducted on basis of experiences of medical prescription of heroine (see Action 4 of the federal note).

A follow-up of the 'Consensus Conference on methadone substitution treatment' (Committee on Addiction of the Hygiene High Council (Health Council - ministry of Social Affairs, Public Health and Environment and published in 1994) has been organised. **Between 1997 and 1999**, about one hundred experts discussed the state of Art of methadone substitution treatment in the light of recent developments in Belgium. Therapeutic efficiency of methadone has been reassessed.

The limited and minor changes in the 'Conference de Consensus' document underline its very high acceptance/adoption by all actors in the field of the drug addiction therapy. Reductions of heroin use, of IV use, of the spread of the HIV virus and of the mortality related to opiates use, are the major results generally attested by all Belgian practitioners through their professional experience. Some minor changes only have been brought to the original text of the "Consensus Conference" and recommendations have been issued to strengthen the development of this therapeutic orientation in the interest of the patient, his/her surroundings and the Community in general. These recommendations focus on therapeutic practice and relationships between practitioners and evaluation.

e Ministère de la Santé Publique, Service des stupéfiants de l'Inspection générale de la pharmacie/Ministerie voor Volksgezondheid, Dienst verdoovende middelen van de Algemene farmaceutische inspectie.

Medical delivery of heroin is not used for treatment of addiction in Belgium. The most advanced initiative is a written project protocol approved by the local academic (University of Liege) and medical (Commission médicale provinciale / 'Provincial Council of Doctors' and Medical Association of the Province of Liege) authorities in Liege. The Pharmacists Inspection's Office of Liege and the Royal Prosecutor and Court of Appeal offices of Liege informally approved the project. Before its implementation the protocol still has to be approved by the governments of federal and federate entities. No progress had been made in the recent months. When approved it is intended to extend similar projects in Antwerp and Brussels.

1.2.a.10 Confidentiality of the data

The 'Privacy Act' of 8 December 1992 and the Royal Decrees pertaining to this law guarantee individual privacy rights. An adaptation of the Belgian law to the 1995 European Directive was made in 1998. A Decree of execution of the adapted law has been adopted on the 13th of February 2001. The adapted Law and its Decree provide amongst other rules, a regulation for scientific research in general and research with medical / sensitive data. The current legislation includes the possibility to use personal data for another purpose than initially foreseen, such as for scientific research purposes. The Decree of execution distinguishes procedures to follow when using anonymous data –encoded personal or non-encoded personal data.

1.2.b Prosecution policy, priorities and objectives in relation to drug addicts, occasional users, drug related crime

As in many other countries, appreciation that adjudication and punishment are not always the best responses to crime has grown over the past few years in Belgium. In the relevant policy notes of the last two Ministers of Justice (De Clerck 1996; Verwilghen 2000) it is recognised that criminal law, in itself, cannot wholly control a social phenomenon and that the courts may not be the only site of social regulation. Furthermore, the logistical limits of both the capacity of adjudication and traditional criminal sanctioning through imprisonment have become very clear. Considerable backlog for the courts, and the overpopulation of the prisons (see e.g. Beyens et al. 1993; Snacken 1997), illustrate that the traditional criminal sanctioning system has reached its limits. (Vander Beken and Kilchling 2000)

1.2.b.1 The current practices in the prosecution policy

(Report of the parliamentary working group on the study of the drug problem 1997; Board of prosecutors –general, 1998; De Ruyver et al. 2000a, p. 37-39)

On the **investigation and prosecution** level, several options are available for settling drug offences. Moreover, on each level of the judicial framework a direction towards drug treatment facilities is possible. These options will be elaborated in the Part III Demand Reduction / Chapter 9.6.(Alternative measures).

I. POSSESSION FOR PERSONAL USE

a. Cannabis

Normally, the lowest priority is given towards the possession for personal use of cannabis. (Report of the parliamentary working group on the study of the drug problem 1997, p. 1004). Conforming article 29 of the Belgian Code of Criminal Procedure and Article 40 of the Act of August 5, 1992 on the Police, *police* officers are allowed to make shortened and simplified reports, nevertheless (as in all other cases of drug offence) the drug has to be seized. As far as the possession of cannabis products in small quantities for single and incidental personal use is concerned, the public *prosecutor's* departments usually drop the case.

However, in the case of problematic use or (risk of) disturbance of public order, the public prosecutor's departments opt for a transaction, a conditional dismissal or a mediation. However, taking the seriousness of the offences into account, if the public prosecutor is convinced that no diversion is possible, s/he can always demand the application of the Probation Act of June 29, 1964 before the court.

b. Other illegal drugs

The *police* normally have to report. Dependent on circumstances, particularly in the case of problematic use or (risk of) disturbance of the public order, the public *prosecutor's* departments opt as a rule for a transaction or a mediation. However, as with cannabis possession, if the public prosecutor is convinced that the seriousness of the offence means no diversion is possible, he can always demand the application of the Probation Act of June 29, 1964 before the court. At the *sentencing* level, the courts normally divert the case, thereby falling back on those possibilities provided under the Probation Act of June 29, 1964. In exceptional circumstances an unconditional sentence is imposed.

II. RETAIL SALE

In the settlement of this type of crime, no substantial distinctions are made in the law between retail sale to existing users who immediately use together, retail sale to existing users who buy and depart and retail sale in open/street market.

The police normally make an official report and as far as the *prosecution* and *sentencing* levels are concerned, a clear distinction has to be made between retail sale, and dealing in drugs. As a rule, dealing in drugs will lead to a (un) conditional conviction of the dealer. As far as the retail sale is concerned, a further distinction is made depending on whether the retail sale is committed for purely *commercial* reasons, or to support the *personal drug use*.

In the first case the retail sale will usually be put on the same level as the drug wholesaler and the reaction will be a repressive one, identical to the approach of organised crime.

In the second situation the quantity of drugs found is a guiding but not decisive factor in determining the character of the retail sale. In the settlement of this kind of criminality, as far as the *prosecution level* is concerned, priority is given towards the mediation procedure. On the *sentencing level* in this second situation, most of the time the courts make use of the possibilities provided by the Probation Act. Nevertheless, often unconditional sentences are pronounced.

In more serious cases of retail sale (e.g. dangerous drugs, quantity, in public,) the public prosecutors normally summon. In cases where drugs are used in groups, the public prosecutor does not necessarily summon because this is primarily considered to be a problem of individual possession.

In cases of repeated use, or when another modality of settlement (mainly a therapeutic treatment) failed, the drug users will usually be brought before court. Also when the drug user commits serious crime he will normally be brought before court. As far as this is concerned, most public prosecutors consider the use of drugs as an aggravating circumstance when other crimes have been committed. In short, the most important criteria that lead to prosecution are health risk, public order disturbances, and the level of dependency.

III. DRUG RELATED CRIMES

Suffering from a drug addiction is not an acceptable justification or excuse for drug related crime (Report of the parliamentary working group on the study of the drug problem 1997, p. 1001).

The nature of the criminal reaction is, generally speaking, determined by the *seriousness* of the acts committed on the one hand, and the *individual situation* of the drug user on the other hand.

The police will always record the reported offence. In the settlement of this kind of criminality, as far as the *prosecution level* is concerned, priority is given towards the mediation procedure. In more serious cases of drug related crime the public prosecutors normally summon. On the *sentencing level*, most of the time the courts make use of the possibilities provided under the Probation Act. Nevertheless, on rare occasions an unconditional sentence is pronounced.

1.2.b.2 The future prosecution policy in Belgium (Policy note of the federal Government on the drug issue 2001)

THE LEGAL FRAME STIPULATING THE FUTURE PROSECUTION POLICY

Prosecution policy is an integral part of the federal drug policy note of January 2001.

Drug policy of the federal government on the drug problems, Annex 2, The criminal reaction towards drug use, 19/01/2001, policy note. (electronic copy, URL: <http://www.minsoc.fgov.be>)

The federal drug policy note plans to **amend the Belgian Narcotic Drug Act** of 24 February 1921 on two accounts. First, a distinction will be made between cannabis and other illicit drugs and second, the qualification "use of illicit drugs in a group" will be eliminated from the Narcotic Drug Act. The modalities concerning the distinction between cannabis and other illicit drugs, and the investigation and prosecution policy will be outlined in **Royal Decrees**.

The Minister of Justice and the Board of Prosecutors General will issue a new directive on the prosecution policy for the police and the public prosecutions office, in accordance with the amendment of the Narcotic Drug Act and the Royal Decrees. This directive will be based upon the recommendations of the parliamentary working group of 1997. It will take into account the results of an evaluation study (Ministry of Justice, 1999) on the application of the directive of May 8, 1998 as well. This evaluation study demonstrated that the directive of 1998 resulted in a lack of uniformity in the prosecution of drug users due to the wide range of measures offered by the directive, and the vagueness of criteria and definitions.

In view of these findings the future directive will *clearly* delineate boundaries of judgement in the investigation and prosecution policy. It will exclude differences in the interpretation as much as possible in order to reach a uniform application. This directive will be binding to all members of the public prosecutors office. (Policy note of the federal Government on the drug issue, Annex 2, The criminal reaction towards drug use, p. 4)

It is important to note that the criminal law and, as a consequence, the prosecution policy, **does not apply to minors**, these are persons under the age of eighteen. The prosecution of minors is organised according to the Youth Protection Law of 8 April 1965 (see also: Smets 1996; Verhellen 1996). Thus, on a judicial basis the future prosecution policy will not change towards persons under the age of eighteen. And, as the criminal law does not change, the judicial position of minors does not change either.

THE BASIC PRINCIPLES OF THE FUTURE PROSECUTION POLICY

It is important to emphasize that the present section reflects the political proposals of the current government concerning the drug problem. One should keep in mind that these proposals are not yet enforced.

Future prosecution policy will be based upon a policy of **normalisation** that constitutes a third way, between the classic prohibitionist thesis on the one hand (general prohibition and repression), and the anti-prohibitionist thesis on the other hand (general legalisation and decriminalisation).

The outlined drug prosecution policy focuses on the following **priorities**:

The criminal intervention towards drug users will always be the "*ultimum remedium*". Drug use should never be a reason for a criminal approach, except in cases of specific risk situations, such as driving under the influence of drugs, and social nuisance.

The criminal intervention will take into account the *individual situation* of the drug user.

When problematic drug users come into contact with the criminal justice system public prosecutor's will endeavour to direct them towards *treatment* facilities. The problematic drug user can refuse to accept the offer of a referral to a treatment facility, however, doing so means that the public prosecutor can always decide to prosecute or offer an other modality of settling the drug offence.

Drug addiction is not accepted as justification for criminal offences.

To further enhance a uniform investigation and prosecution policy, one or more **specialised magistrates** will be appointed to handle drug files. One magistrate from the public prosecutors office, the so-called “referention magistrate drugs” will have the final responsibility for the handling of the drug problem files within each legal district. This magistrate will follow up the other magistrates when drug cases are involved to ensure a uniform drug policy within the legal district. The referention magistrates of the different legal districts will gather a few times a year to exchange problems and best practices. (Policy note of the federal Government on the drug issue, p. 64)

In the future directive **a distinction will be made between three categories of drug offences** (Policy note of the federal Government on the drug issue, Annex 2, The criminal reaction towards drug use, p.5):

Category 1: the import, production, transport, possession of a small amount of illicit drugs for personal use.

Category 2: the import, production, transport, possession of an amount of illicit drugs that surmounts the qualification of “possession for personal use” (category 1) and / or that is committed in the framework of aggravating circumstances that are stipulated under the Belgian Narcotic Drug Act of 24 February 1921 (e.g. use in the presence of minors).

Category 3: drug related crimes, other than those outlined in category 1 and category 2.

I. CATEGORY 1

(Policy note of the federal Government on the drug issue, Annex 2, The criminal reaction towards drug use, p. 6-7)

Within category 1 a distinction is made between **cannabis** and **other illicit drugs**.

a. Cannabis

In the case of **limited possession** of cannabis for personal use without indication or suspicion of problematic use, an official report by the *police* will no longer be made up (only an anonymous registration) and the user will no longer be *prosecuted*, unless there is an indication of problematic drug use or the use of drugs is accompanied by social nuisance.

The federal government has, after careful reflection, decided not to indicate a maximum quantity of cannabis to decide whether or not there is limited possession, in order to avoid giving the message that cannabis use would be commonplace.

In the case of **problematic use** of cannabis an official report by the *police* will be made up. The use of therapeutic advice will be decided upon by the *magistrate* and direction to a treatment facility will be aimed at. However, should the problematic drug user choose not to accept the treatment offer, the public prosecutor can always decide to prosecute or offer an other modality of settling the drug offence.

In the case of drug use combined with **social nuisance** and in risk situations the public prosecutor will decide upon the criminal response. This can be a warning, a transaction, a praetorian probation, a mediation or prosecution.

In conclusion, the investigation and prosecution policy will primarily aim at social nuisance and risk situations, such as the concentration of users and / or dealers in the neighbourhood of schools, play grounds, etc.

b. Other illegal drugs

In the case of the **limited possession** of other illegal drugs for personal use, an official report by the *police* will be made up. At the investigation level, as a rule, the use of illicit drugs, other than cannabis, is seen as problematic use. Again, investigation and prosecution policy will focus on social nuisance and risk situations.

In the case of limited possession of other illegal drugs for personal use or incidental use without an indication or suspicion of problematic drug use, the public *prosecutor* will decide upon the criminal response. This can be another modality of settling drug offences or a prosecution.

When there is an indication of **problematic drug use**, the use of therapeutic advice will be decided by the magistrate and the direction towards a treatment facility will be favoured, on condition that the problematic drug user accepts the treatment offer. If not, the public prosecutor can always decide to prosecute or offer another modality of settling the drug offence.

In the case of drug use combined with **social nuisance** and in other risk situations the public prosecutor will decide upon the criminal response. This can be a warning, a transaction, a praetorian probation, a mediation or prosecution.

II. CATEGORY 2

(Policy note of the federal Government on the drug issue, Annex 2, The criminal reaction towards drug use, p. 8)

The *police* normally makes an official report. The investigation policy is primarily aimed at nuisance situations, risk situations and large-scale dealers.

At the *prosecution* level a distinction is made between drug related crime **to sustain personal use** and drug related crime committed solely for the purpose of **profit seeking**. In the first case, the reaction of the public prosecutor depends upon the presence of problematic drug use or the severity of the offences. In the case of **problematic use**, the direction into a treatment facility is aimed for. However, should the problematic drug user choose not to accept the treatment offer, the public prosecutor can always decide to prosecute or offer an other modality of settling the drug offence. In the case of **serious drug related** offences, the users will be *prosecuted*.

In the second case, or in the case of aggravating circumstances under the Belgian Narcotic Drug Act of 24 February 1921, the user will be *prosecuted*.

III. CATEGORY 3

(Policy note of the federal Government on the drug issue, Annex 2, The criminal reaction towards drug use, p. 9-10)

The drug related crimes in category three are acquisitive crimes of a severe nature (armed robbery, street robbery); expressive crimes of a severe nature (violence, heavy threats, hostage); and consensual crimes of a severe nature (membership of criminal organisations involved in drug production, drug trade, dealing on a large scale).

The investigation policy will give priority to this category of offences. The police will mention the problematic use of the involved person in the official report.

At the prosecution level, the severity of the offences and the presence of problematic drug use will be taken into account. As far as possible the premises of the protection of the society (the severity of the offence) and an individualised and early therapeutic intervention (problematic use) are to be reconciled.

In the case of serious drug related crimes, combined with problematic drug use, a referral to the treatment services is possible, although only if the public prosecutor determines that the severity of the offence does not impede with an individualised response. If the public prosecutor judges that the severity of the offence does hamper an individualised response, the offender will be prosecuted.

When no indications of problematic drug use are found, the offender will be prosecuted and the prosecution will be based upon the severity of the offences.

1.2.c Any other important project of law or other initiative with political relevance to drug related issues

1.2.c.1 Law proposals about drug

24/02/2000 : proposal (of members of parliament – not the federal government) modifying the law on drug of 24/02/1921 in order to partially decriminalize the possession of cannabis and its derivatives

The authors proposed that the positive right should be clarified. The prohibition policy against cannabis should be given up because a.o. its ineffectiveness. Nevertheless, the prosecutions against dealers should be continued and the drug use prevention efforts emphasized.

1.3. DEVELOPMENTS IN PUBLIC ATTITUDES AND DEBATES

1.3.a Public perception of the drug issues and public debates carried out by civil society, national Parliament, organisations, NGO's

On a political level, ambiguous signals are launched towards the general public : on the one hand a new directive/circular 'softening' the prosecution policy for cannabis users and on the other hand an official political statement of 'just say no'. This leads to a great deal of confusion among youngsters and parents. Most of the youngsters think now that cannabis has been legalised.

A recent development in Flanders is the public admission via T.V. and press by well-known personalities of their usage of soft drugs. More and more items appear in newspapers on drug issues and debates on drug use are not infrequent on television.

1.3.b Media presentation and imaging drug use

LAUNCH OF THE INFORMATION CAMPAIGN "BETTER UNDERSTAND THE NEW POLICY OF THE FEDERAL GOVERNEMENT" (May 2001, http://www.minsoc.fgov.be/press_releases/fr/aelvoet/2001/2001_05_29_brochure_campagne_drogues.pdf).

The minister of Public Health observes that a too important number of youths use drugs and does it too often. In the context of changes brought by the federal policy note on drugs, it will be henceforth easier to discuss about drug use and to approach real risks.

Following erroneous interpretations concerning the cannabis issue in the federal note, the government has specified first by notice in the press what it was the future penal policy in regard with the cannabis.



A brochure (600.000 issues) was circulated through secondary schools, police offices, 'justice houses' and courts, assistance services, post offices, town halls, libraries and through the website of the ministry of Public Health.

The 24-page brochure presents in the form of questions - replies : the basis of the policy of the federal Government concerning drugs, proposals in prevention and assistance, aspects linked to the penal right as for the usage (new regulation for the cannabis, problematical consumption, social nuisances) and the struggle of the Government against the trade of drugs.



The objective of the leaflet is to make clear the content of the federal political note the most largely possible. A large part of the brochure concerns obviously the cannabis, because it is the subject where persist the most numerous bad comprehensions and about which a majority of questions have been posed. One notes that it does not concern neither a brochure of information or prevention of drug use.

LAUNCH OF THE CONSCIOUSNESS-RAISING BROCHURE ON MENTAL HEALTH (2001)

The brochure “La psyche : le cadet de mes soucis? – De psyche : mij een zorg?” presents an overview from points of action that have to be carried out in 2001. These points of action constitute a concrete process aiming to improve the quality of mental health cares.

CAMPAGNES VAD

VAD prepared a state of the art concerning cannabis on the basis of the literature and the experiences of the prevention and treatment sector. This document is distributed in the sector and is available on the website.

In co-operation with the Flemish ministers of education and health, a circular letter was composed to be sent to all secondary schools in Flanders, in which the proposed changes in the legislation are explained and in which schools are given suggestions to stick to their drug policy on the one hand, but to use the public debate about cannabis on the other hand, to discuss with students about drugs in general and cannabis in particular.

VAD adapted the tv-spot that was developed for the European drug prevention week of 1998. The main message remained: ‘talking is the first step’. The tv-spot was programmed on prime time television during the month of December 2000 and repeated in January 2001 once the federal Drug Note was made public.

VAD developed some new information materials (posters, brochures) on cannabis and adapted existing materials. All available information and sensibilisation materials were brought together in a leaflet that was distributed largely to a variety of key persons in the different sectors (education, youth work, local prevention workers, ...) and through the waiting rooms of general practitioners.

1.4. BUDGETS AND FUNDING ARRANGEMENTS

The figures mentioned in the present section are extracted from a report by J. Tecco which is presented in Appendix.

1.4.a Federal Government

1.4.a.1 Law enforcement (criminal system, police forces, etc.)

The ministry for Foreign Affairs funds matters related to international relationships. Meanwhile relationships to some organisations (UNDCP for example) were delegated to the ministry of Justice (the ministry of Justice presides a co-operation between the competent departments of federal and federate levels (Communities) and among the police departments, regarding the reduction of supply and repression in the framework of international relations).

Additionally to its charge directly related to general justice affairs (a.o. the '*Police Judiciaire/Gerechtelijke Politie, the Courts,...*'), the ministry of Justice funds training projects for prison personnel. Health service in prison (prevention and treatment activities including their funding) is the competence of the prison/justice administration (health policies of the ministry of Health are not in force).

In so far as keeping law and order, and crime prevention are concerned, the '*Gendarmerie/Rijkswacht*' acts under the supervision of the Minister of Internal Affairs. With regards to repression, the '*Gendarmerie/Rijkswacht*' reports to the judicial authorities and the Minister of Justice. The '*Gendarmerie/Rijkswacht*' set up a specific Drug Programme in the framework of its Bureau Central de Recherches / Centraal Bureau voor Opsporing (Central Office for Investigation). This programme covers the following domains: prevention, drug and road traffic, local traffic and drug tourism, international traffic organisations, drug production (laboratories), international co-operation (Europol, Pompidou groups).

The ministry of Finance through the custom services is charged to control all imports including illicit ones (actually a large part of seizures are performed by customs).

The 589 Belgian municipalities all have and support their own police force under the authority of the municipality mayor, and under the orders of a chief of police (a new legal framework (police law) is under preparation that should lead to a uniform police).

A complete reform of the police structure is in progress, organizing an integrated police service (law of 7/12/1998).

1.4.a.2 Epidemiology, research, evaluation, quality

The ministry of Health funded in 1999 and 2000 a feasibility study for the transformation of the National Focal Point in a multidisciplinary monitoring centre. The Prime Minister, through the SSTC/DWTC, funds various investigations : treatment facilities (an evaluation of low threshold centres –MSOC/MASS- is in progress), criminological, and epidemiological researches.

In addition the FRS/FWO funds several research projects (as example a study on consumption of cannabis among youngsters).

1.4.a.3 Prevention, treatments, trainings

The ministry of Social Affairs, through the INAMI/RIZIV, funds treatment charges and treatment centres.

The ministry of Health supports the administration charged with the control of licit trade through the Department of Narcotic Drug of the General Pharmaceutical Inspectorate ^f (ministry of Public Health). The Belgian Focal Point of the EMCDDA is located at the IPH (the scientific research institute of the ministry of Public Health) and is funded and managed in collaboration with the Communities and the federal ministries.

The ministry of Internal Affairs co-ordinates and funds (via the VSP) projects in the framework of crime prevention. The VSP funds the employment of local prevention workers in the field of crime prevention. A transit centre and the MASS/MSOC (low threshold centres) were created thanks to funds from the ministry and from the INAMI/RIZIV.

The ministry of Justice funds training projects for prison personnel. Health services in prison (prevention and treatment activities including their funding) are the competence of the prison/justice administration (health policies of the ministry of Health are not in force).

The great diversity of financing sources does therefore not favour transparency in estimating the budget allocated in Belgium for demand reduction, treatment, prevention, harm reduction, and reinsertion. Most budgets are inclusive (i.e. general and psychiatric hospitals, general practitioners and for prevention: teachers, welfare workers, ...) This makes it difficult to precisely describe the budget. A part of the costs of treatment and prevention programs listed in the State budget specifically for the drug users and the cost of hospitalisations and substitution treatments targeting people having a drug abuse as main diagnosis can however be estimated.

Relying on the information available for the public and on those that the care providers and the administrations agreed to transmit, it is estimated that :

- the treatment of drug addicts represents a budget of 2,945 millions Belgian Francs per year,
- the functional rehabilitation centres for drug addicts (INAMI 1999 figures; multidisciplinary care: medical, psychological and social) represents a budget of 908,9 millions of Belgian Francs (2)
- the ambulatory consultations with methadone prescription represents a budget of 360 millions Belgian Francs per year,

The Ministry of the Internal Affairs has a budget of 314,7 millions Belgian Francs for the global plan, criminality prevention, and of the reception of addicts. The budget of the SPP (secretariat for prevention policies) has a global budget of 104,8 millions Belgian Francs but the specific amount allocated to drugs problems is unknown.

Besides, the given costs are based on the budgets allocated by the various administrations, but non-profit-making organisations hire regularly staff on the basis of precarious contracts in order to fulfil their team work. For some organisations the cost of this staff does not take place in the financial reports that these organisations transmit to the administrations subsidising them. It is interesting to underline that for instance in the Walloon Region in 1995, for 156 full-time contracts, there were 35.5 full-time precarious contracts (A.L.E. (local agencies for employment) subsidised contracts, voluntary helpers, self-employed workers, etc.). As the budgets do not take the precarious contracts into account, the costs are automatically underestimated

f Ministère de la Santé publique, Service des stupéfiants de l'Inspection générale de la pharmacie / Ministerie voor Volksgezondheid, Dienst verdoovende middelen van de Algemene farmaceutische inspectie.

1.4.b Community and Regional governments

LAW ENFORCEMENT (CRIMINAL SYSTEM, POLICE FORCES, ETC.)

Nothing specific for these levels.

1.4.b.1 Flemish Community

Funding (figures) at the level of the Flemish Community in the field of epidemiology, research, co-ordination of prevention and treatment, evaluation, quality and training :

- At a Flemish level : subsidy of VAD for 8 areas of work (78.6 million BEF)
- At provincial level : subsidy of 6 provincial coordinators (15 million BEF)
- At a regional level (12 regional networking projects for centres of mental health :20 million BEF)
- Syringe exchange project (2001)

EPIDEMIOLOGY, RESEARCH

The Flemish ministry of Public Health funds :

- Registration
 - Project to develop uniform registration programme in treatment sector
 - Registration project for prevention activities
 - Flemish participation in Sub-Focal Point of European Monitoring Centre for Drugs and Drug Addiction (VAD).

The other Flemish Ministers have no specific budget for drug problems, except the Flemish ministry of Scientific Research, in which budgets are available for drug research. Private funding is also available.

PREVENTION AND TREATMENTS

The Flemish ministry of Health funds :

- Prevention
 - 10 prevention workers in centres for mental health
The funding is integrated in the global budget of the centres
 - Local prevention workers, funded by local governments and ministry of Interiors
- Treatment
 - Centres for mental health funded by the Flemish government for dealing with mental health problems, among which alcohol and drug problems
 - Psychiatric hospitals, and psychiatric wards of general hospitals
Funded by the federal government in a global funding of hospitals
 - Therapeutic communities, crisis centres, day centres, medico-social care centres (MSOC-MASS)
Funded by the federal government (RIZIV) on an individual basis
 - Within the welfare sector, different projects and organizations also offer care (and sometimes treatment) for people with drug problems.
 - Within the health sector, treatment is also done by general practitioners and non-drug specific health organizations (f.i. school health service).

1.4.b.2 French Community and Walloon Region

The Ministry of Health of the French Community has competence over the framework of the fight against addiction, essentially over the primary prevention. The budget allocated to drug addiction amounts to 50 millions of Belgian Francs. It is used to fund :

EPIDEMIOLOGY, RESEARCH

- Registration
 - Since 1992, permanent registration system on "treatment demand" indicator by the Sub-Focal Point among out-patient- and inpatient centres as well as among general services in the

French Community (in co-operation with the ministries of Health and Social Affairs of the French Community and the Walloon Region)

- Data collection and publication of results by the Sub-Focal Point.
- Through its Sub-Focal Point the French Community participates in the Belgian information Reitox Network of EMCDDA.
- Research
 - Both the Walloon region and French Community fund or co-fund several research projects on vulnerability and drug consumption such as on new synthetic drugs, on cannabis or on social vulnerability.

PREVENTION AND TREATMENTS

Within the framework of the 1997 – 2001 Health promotion decree, the ministry of Health of the French Community funds:

- Prevention on a basic and specific level
 - Field projects : focusing on children - adolescents or adults
 - Training and education programmes for key persons
 - Prevention material: folders, videos, theatre plays, pedagogic suitcase for teachers, etc.
 - Harm reduction projects: needles exchange programmes, peer AIDS and hepatitis prevention programmes, harm reduction material.
- Prevention on an unspecific level
 - Positive discrimination projects in schools: a network of +/- 45 mediators and operators are working in the schools in the Brussels and Walloon Regions to promote "school catching up" actions
 - An agreement between the Minister of Internal Affairs and the Minister-President of the French Community helped to develop and to integrate specific primary drug prevention programmes in urban secondary schools in co-operation with agreed prevention services. A federal budget is attributed to these prevention activities.

EVALUATION, QUALITY, TRAINING

The Ministry of Health of the Walloon Region supports projects within the scope of care in a broad sense. The budget allocated to this aspects amounts to 50 millions Belgian Francs. Since October 2000, this Ministry funds a harm reduction training programme for specialised professionals.

1.4.b.3 Brussels Region

Three Commissions are involved in the funding of activities in the field of addictions :

- Mixed Community Commission of the Region of Brussels-Capital which finances mainly data collection and analyses, co-ordination activities, local annual reports and participation in Belgian and international networks. Budget : 6,5 millions Belgian Francs.
- French-speaking Community Commission of the Region of Brussels-Capital which funds activities in the field of prevention, accompaniment, liaison, care and training. Budget : 105millions of Belgian Francs.
- Flemish-speaking Community of the Region of Brussels-Capital which finance co-ordination activities, prevention and other actions. Budget (1997) : 4,7 millions Belgian Francs.

The Brussels Region funds :

EPIDEMIOLOGY, RESEARCH

- Registration
 - Project to develop uniform registration programme in treatment sector
 - Collection of available data from various registration systems

- Flemish participation in Sub-Focal Point of European Monitoring Centre for Drugs and Drug Addiction (VAD)
- Publication of results by the CTB-ODB.

PREVENTION AND TREATMENTS

- Prevention - co-ordination
 - Harm reduction programmes and other projects
 - Training programmes for prevention workers and key persons.
- Treatment

Centres for mental health care and most of specialised treatment centres are funded within the global subsidies of health care provision.

The financing of the programmes is set by agreement.

In addition to this source of finance, the agents in the field of course obtain financial support notably from federal (social security health funds).

EVALUATION, QUALITY, TRAINING

Training tasks are also included in regional agreements with specialised centres.

1.4.b.4 German-speaking Community

EPIDEMIOLOGY, RESEARCH, PREVENTION AND TREATMENTS, EVALUATION, QUALITY, TRAINING

The government of the German-speaking Community subsidises the Centre for mental health as much as the ASL. The Centre for mental health is co financed by the CPAS of the 9 municipalities.

A budget of 10.2 millions of Belgian Francs is allocated by the German speaking community to the prevention of substances dependencies and also to dependencies in a broader sense not linked to the substances.

1.4.c Funding of REITOX

The National Focal Point REITOX is funded by the Federal Government, the French and Flemish Communities. The cost of activities of the National Focal Point within the EMCDDA framework amounts to 10,8 millions Belgian Francs (note that the funding of the National Focal Point is included in the budgets cited in points 1.4.a.3 and 1.4.b.1-1.4.b.4). In addition to this budget, EMCDDA contributes for 2,1 millions Belgian Francs.

APPENDIX

THE ECONOMIC BURDEN RELATED TO ADDICTION IN BELGIUM

Juan Tecco and Fabienne Hariga

1. INTRODUCTION

The purpose of this summary is to describe the budget allocated in Belgium for demand reduction, treatment, prevention, harm reduction, reinsertion in the present context where, although the resources have to be curbed, an investment in a field considered as strategic, such as the drug addiction, is required.

There is in Belgium a great diversity of financing sources. This diversity does not favour transparency. Consequent to the fact that many financial sources have to be re-evaluated annually, long term vision and job offers are unattractive.

This summary is rudimentary and incomplete, as some of its figures are uncertain. Most budgets are inclusive (i.e. general and psychiatric hospitals, general practitioners and for prevention: teachers, welfare workers, ...) This makes it difficult to precisely describe the budget. This uncertainty of information is worrying, considering the amounts allocated every year to health care.

2. METHODOLOGY

As for all the surveys on the operating costs of public organisations in the execution of a particular mission, we have been confronted to several technical difficulties. The present inventory of the costs of drug addiction care deals only with a part of the costs of treatment and prevention programs listed in the State budget specifically for the drug users and the cost of hospitalisations and substitution treatments targeting people having a drug abuse as main diagnosis.

The drug addiction is sometimes not precisely defined. The initiatives of care concern especially the heroin abuse but many centres broaden their therapeutic frame to other addictions, including sometimes alcohol.

Besides, the given costs are based on the budgets allocated by the various administrations, but non-profit-making organisations hire regularly staff on the basis of precarious contracts in order to fulfil their team work. For some organisations the cost of this staff does not take place in the financial reports that these organisations transmit to the administrations subsidising them. It is interesting to underline that for instance in the Walloon Region in 1995, for 156 full-time contracts, there were 35.5 full-time precarious contracts (A.L.E. (local agencies for employment) subsidised contracts, voluntary helpers, self-employed workers, etc.). As the budgets do not take the precarious contracts into account, the costs are automatically underestimated.

3. SOURCES

We have been relying on the information available for the public and on those that the care providers and the administrations agreed to transmit. In general, these various actors have given data without almost any hesitation. All figures come from two sources: an inventory published in 2000 (1) and the web site of the Belgian Federal Ministry of Social Affairs, Public Health and the Environment.

4. BUDGETS AND FUNDING ARRANGEMENTS

A. Treatment of drug addicts

We found that the treatment of drug addicts represents a budget of 2,945 million Belgian Francs per year. (2)

- Psychiatric departments of general hospitals
Budget; 665.805.945 BF (=12.814 treatments*10 days*5511 BF) (average cost for one day)
- Medicine and surgery departments
Budget; 210.648.801 BF (= 26.587 days*7923 BF)
(In 1993, 26,587 hospitalisations occurred in medico-surgical wards for problems related to abuses and dependencies to substances, as main diagnosis. In 1996, the median cost for a day in those departments was 7923 BF).
- Psychiatric hospitals
Budget; 1.866.225.586 BF (=15.552 treatments*27 days*4453 BF) (average cost for one day)
- Houses of psychiatric care
Budget; 1.222.355.896 BF (=152 treatments*247 days*3259 BF) (average cost for one day)
- Protected housing
Budget; 80.613.000 BF (=568 treatments*175 days*811 BF) (average cost for one day)

B. Functional rehabilitation centres for drug addicts (INAMI 1999 figures) (multidisciplinary care: medical, psychological and social)

Budget: 908.892.600 BF (2)

- 659.250.102 BF for residential programs.(8 crisis intervention centres and 14 therapeutic communities)
- 249.642.498 BF for ambulatory centres (6 day centres and 8 socio-health open houses for marginalized drug users)

1134 patients were treated in residential centres, 3248 in ambulatory centres (2672 in socio-health open houses) and 447 both residential and ambulatory centres.

C. The ambulatory consultations with methadone prescription.

Budget: 360 millions BEF per year (1)

In Belgium, the substitution without methadone is so marginal that it cannot be taken into account in terms of expenditure. The global volume of prescribed methadone reached 104 Kg. in 1996. Considering that the average prescribed dose is 50 mg per day, we can evaluate that the number of methadone doses reached 2.8 millions in 1996. As a prescription of 50 mg of methadone costs 145 BEF, the total is evaluated to 301.6 million BEF. If we suppose that a drug user under substitution consults his physician every two weeks for prescriptions, we evaluate a total of 148,165 consultations per year. As the cost of a consultation in general medicine amounts to 394 BEF, we can calculate an overall cost of 58.4 million BEF. This very basic calculation is of course poorly satisfactory and needs to be sharpened.

D. Ministry of the Internal Affairs (The global plan. Criminality prevention and of the reception of addicts)

Budget: 314.669.400 BF (2)

- 67.500.000BF Prevention contracts (16 in Flanders, 12 in the Walloon region and 1 in Brussels)
- 247.169.400 BF Security and society contracts (11 in Flanders, 5 in the Walloon region and 6 in Brussels)

E. SPP (Secretariat for prevention policies) (1999)

Budget: Unknown

104.800.000 BF (2) is the global SSP budget; the specific amount allocated to drugs is unknown.

F. The Flemish speaking community (2000)

Budget; 113.600.000 BF (2) (78.6000.000 VAD + 15.000.000 provincial co-ordination + 20.000.000 regional coordination of alcohol and other drug related problems by Centres for Mental Health)
It finances prevention activities, the creation of data banks, to activities of co-ordination, dialogue, collaboration, accompaniments, training and educational events + provincial co-ordination.

G. The French-speaking Community. (2000)

Budget: 50.000.000 BF (2)

Has competence over the framework of the fight against addiction, essentially over the primary prevention)

H. The Walloon region (2000)

Budget: 50.000.000 BF (2)

Supports projects coming within the scope of care in a broad sense

I. Mixed Community Commission of the Region of Brussels-Capital (2000)

Budget 6.475.000 BF (2)

It finances mainly data collection and analyses, co-ordination activities, local annual reports and participation in Belgian and international networks

J. French-speaking Community Commission of the Region of Brussels-Capital

Budget 105.500.000 BF in 2000 (2)

Prevention, accompaniment, liaison, care and training

K. Flemish-speaking Community Commission of the Region of Brussels-Capital

Budget 4.700.000 BF in 1997 (2)

Co-ordination, prevention and other actions

L. The German speaking community (2000)

Budget: 10.200.000 BF (2)

Prevention of substance dependencies and also to dependencies in a broader sense not linked to the substances.

M. REITOX

	Cost of activities within EMCDDA framework	Budget from EMCDDA
Focal Point	10.782.012 BF	2.120.551 BF
VAD	3.628.453 BF	516.211 BF
EUROTOX	3.500.000 BF	531.066 BF
CTB	3.045.662 BF	393.658 BF
ASL	217.000 BF	152.264 BF
BIRN	320.240 BF	320.240 BF

CONCLUSION

Not forgetting the limited scope of the cost concerning more specifically the care market for the drug users and without confining the public policy to its budgetary dimension, it is interesting to try to outline the financial aspects. The results have to be considered as size orders depending on calculation hypotheses that we wanted to detail as clearly as possible. It may constitute a basis for discussions notably as regards the allocation of resources between the care, the prevention and the substitution.

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*Scientific Institute of Public Health
Unit of Epidemiology*



ASL



Deutschsprachige
Gemeinschaft

CTB-ODB



Région
Bruxelles-Capitale
Brussels Hoofdstedelijk
Gewest

EUROTOX



Communauté
française

VAD



Vlaamse
Gemeenschap

BELGIAN NATIONAL REPORT ON DRUGS 2001

PART II Epidemiological Situation

Part II of the National Report 2001 was written by :

HARIGA F. (EUROTOX)
LEURQUIN P. (REITOX Focal Point)
LEUS E. (REITOX Focal Point)
ROBERT E. (REITOX Focal Point)
SARTOR F. (REITOX Focal Point)
WALCKIERS D. (REITOX Focal Point)
VAN DENBUSCHE H (VAD)
VANDERVEKEN M. (CTB-ODB)

With the active contribution of :

DE WINTER Ch., LEBRUN V. and VANHYFTE C. (Federal Police Drug programme)
KOHN L. (Promes)
RAES V. (De Sleutel)
SASSE A. (IPH - AIDS surveillance)
VANDENBOSCH B. (General Pharmaceutical Inspectorate/Ministry of Public Health)
VERECKEN C. (UG Vakgroep Maatschappelijke Gezondheidskunde)
WANLIN M. and DE SAINT HUBERT B. (FARES/VRGT)

CHAPTER 2. Prevalence, Patterns and Developments in Drug Use

2.1. MAIN DEVELOPMENTS AND EMERGING TRENDS

The trends observed in the last year have been the same trends for several years : growing popularity of cannabis and XTC use among youngsters. Focusing on the recent evolution by comparing 1998-99 with 1994-96 data, the life-time prevalence and the last-month prevalence increase, both for boys and for girls in all age groups. This is the case for cannabis/hashish and speed/XTC use. The most commonly used product is cannabis. The use of LSD which was popular in the mid 80's but decreased gradually after, regaining some popularity these last years (since 93). For half of youngsters, the use of illicit drugs is limited to experimenting, which then goes no further.

As studies in general adult population were conducted in different part of the country (French Community from 1996 to 1999 and Flemish Community in 1994), it is difficult to generalise their results to the whole country and to perform a trend analysis from 1994 to 1999. Meanwhile regarding cannabis use one observes that the Flemish prevalence of 1994 (6%) does not conflict from a trends point of view with the prevalence of the further periods observed in the French Community in 1996-97 and 1998-99, possibly indicating a global increasing trend during the nineties (as observed in other EC countries). Information on use of other drugs by adults is still lacking.

Illicit drugs problematic users are typically younger than 25. Boys use drugs more frequently than girls and use increases with age. The most common reasons for the request of treatment are problems related to the use of heroin and cocaine. The 'typical user' starts at a young age (younger than 18, even younger than 15 years old). Poly-addiction has become very common.

Corresponding to the increase of the use of cannabis by youngsters, one observes an increase of demands for treatment of problematic cannabis use. This trend is particularly striking from the data of the VAD monitoring systems because it is covering a.o. centres of mental health care. Indeed, most cannabis problematic users have easier access to advice and treatment in these centres than in 'specialised' addiction centres classically more oriented to opiates users. Nevertheless, in some of the latter centres, the situation is moving making more accessible the support to cannabis problematic users.

Unlike to an apparent trend towards less intravenous use that could be caused by the fear of HIV and HIV-prevention campaigns, prevalence of intravenous use of heroin seems not decreasing and some sources suggest an increase of cocaine intravenous use. The apparent decrease is in fact due to the relative increasing proportion of 'non-injected' drug among drug whose the use is problematic enough to involve in a treatment demand.

In 1999, HIV-seroprevalence among drug users remains low in Belgium. In contrast, studies show high prevalences of hepatitis B and C, which are not decreasing with years. Given its evolution to chronicity and cancer, hepatitis seems to become the main public health consequence of intravenous drug use. Nevertheless, keeping watch over HIV among drug users is essential as there are a very susceptible group.

The set-up of low threshold centres offers an additional possibility to access to treatment including methadone substitution and to enlarge risk reduction interventions.

Tables 2.1, 2.2, 2.3 and 2.4 give a summary of the available data and indicate trends when possible.

Table 2.1 : Synthesis table of epidemiological indicators on drug use : prevalence of drug use in the population in Belgium for the period 1993-2000

INDICATORS	ORGANISATION	1993	1994	1996	1997	1998	1999	2000
ADULT POPULATION								
Cannabis	Vlaamse G.	-	5.8	-	-	-	-	-
Lifetime prevalence	ULB/Promes	-	-	-	12.8*	-	20.8	-
Last year preval.	Vlaamse G.	-	1.5	-	-	-	-	-
SCHOOL POPULATION								
Cannabis	UG/Publ.Hlth	-	11.7	14.6	-	18.9	-	20.7
Lifetime prevalence	VAD	-	-	-	-	-	24.1	23.9
	ULB/Promes	-	-	-	-	26.2	-	-
The last month preval.	UG/Publ.Hlth	-	6.1	8.8	-	12.0	-	11.8
	ULB/Promes	-	-	-	-	13.6	-	-
XTC	UG/Publ.Hlth	-	4.1	4.2	-	5.0	-	2.6**
Lifetime prevalence	VAD	-	-	-	-	-	4.0	3.6
	ULB/Promes	-	-	-	-	5.1	-	-
The last month preval.	UG/Publ.Hlth	-	1.4	1.3	-	2.1	-	1.3
	ULB/Promes	-	-	-	-	2.4	-	-
USE IN PRISON								
The last month preval.	Free Clinic	42.0	-	-	-	-	-	-
	Modus Vivendi	-	-	-	38.0	-	-	-
	FC / MV	-	-	-	-	-	42.0	-

* adjusted rates for age, sex (for the total figure), education and area

** The definition of XTC in 2000 is not the same as preceding years. Before 2000 the item XTC contained speed. In 2000 XTC does not contain speed.

Table 2.2 : Synthesis table of epidemiological indicators on drug use : prevalence rate of problematic drug use, Belgium, period 1993-2000

INDICATORS	ORGANISATION	1993	1994	1995	1996	1997	1998	1999	2000
Lifetime IVDU (%)	IPH	-	-	2.9	-	3.5-4.2	-	-	-
Heroin use (%)	CCAD	-	6.3	-	-	-	-	-	-
Poly-drug use (%)	Modus Vivendi	-	-	-	32.0	45.0	36.0	36.0	40.0
Injecting use (current)									
• Main drug	CCAD/Eurotox	30.2	34.3	28.7	24.0	24.0	19.9	15	-
• Heroin	CCAD/Eurotox	35.9	40.9	39.9	37.0	37.3	35.3	19	-
	Coord.Drog.Charl.	-	-	-	-	-	-	17.1	20
	VAD	-	-	-	-	-	26.6	-	-
• Cocaine	CCAD/Eurotox	22.2	25.9	34.6	22.9	34.8	29.5	33	-
	Coord.Drog.Charl.	-	-	-	-	-	-	10.8	21
	VAD	-	-	-	-	-	8.9	-	-

Table 2.3 : Synthesis table of epidemiological indicators on drug use : trends of health consequences of use, Belgium (figures are percentages except when specified)

INDICATORS	Area	1993	1994	1995	1996	1997	1998	1999	2000
MORTALITY									
Drug related deaths (n)	Belgium	346	376	346	-	-	-	-	-
DRD involving opiates	Belgium	47.0	48.0	53.0	-	-	-	-	-
MORBIDITY									
IDU / new HIV	Belgium	5.5	7.2	3.4	3.7	5.0	2.9	3.1	4.8
HIV / drug treatments	French Com. (Charleroi)	-	-	0.9	-	-	-	-	-
IDUs	French Com.	-	2.9	-	-	-	-	-	-
	French Com.	4.9	5.7	3.0	1.4	2.6	1.6	2.0	-
	Flemish Com.	-	-	-	2.2	-	-	-	-
	Flemish Com.	-	-	-	-	0.8	5.4	0.5	1.2
	Flemish Com.	-	-	-	-	-	1.9	1.9	-
HBV / drug treatments	French Com. (Charleroi)	-	-	36.0	-	-	-	-	-
IDUs	French Com.	-	-	-	-	22.4	23.6	20.1	-
	Flemish Com. (anti-HBc)	-	-	-	-	20.5	24.1	23.9	21.9
HCV / drug treatments	French Com. (Charleroi)	-	-	78.0	-	-	-	-	-
IDUs	French Com.	-	56.0	-	-	-	-	-	-
	French Com.	-	-	-	-	46.7	51.9	51.1	-
	Flemish Com.	-	-	-	-	39.5	46.4	37.9	36.0

Table 2.4 : Synthesis table of epidemiological indicators on drug use : offences, availability and drug market data, Belgium.

INDICATORS	ORGANISATION	1993	1994	1995	1996	1997	1998	1999	2000
People taken in for questioning (n)	SGAP	19,482	19,467	18,376			21,184	17,129	-
Cannabis (% involv.)				72.7		65.0	65.7	68.6	-
XTC/amphet. (%)				3.5		16.0	0.9	15.6	-
Opiates (%)				16.5		7.0	25.6	5.9	-
Cocaine (%)				5.9		5.0	4.6	4.3	-
SEIZURES (n)	SGAP								
Cannabis		6,380	8,628	13,379			13,020	7,362	14,264
XTC/amphetamines		684	978	1,002			2,672	2,163	3,578
Opiates/heroin		3,082	3,024	3,158			1,112	720	1,340
Cocaine		897	927	1,046			799	547	925
RETAIL PRICES (euro)	SGAP								
Cannabis / g					2.5-12.4	2.5-5.0	6.5-7.4	3.7-9.9	3.4-6.2
XTC/amphet. /tab.					12	6.5	8.7	4.5-10	5.7-8.9
Heroin / g					37	20-25	21	20-60	19-35
Cocaine / g					37-62	49-61	59	37-74	46-74
AVAILABILITY (% adults)	ULB-Promes								
Cannabis					59.2	70.4	62.9	64.5	
Cocaine					45.6	50.8	41.1	40.0	

2.2. DRUG USE IN THE POPULATION

2.2.a General adult population

In 1994, a telephone interview study (Quataert and Van Oyen 1995) was conducted among the Flemish general population (2,259 adults aged 18 and 65 years). The study showed a low level of drug experience among the general population. The prevalence rate of 'at least once use' of any illegal drug was 6.4% and about 5.8% experienced cannabis (Table 2.5). It was higher among younger adults (<=35 years old): 11% used an illicit drug at least once, 9% cannabis, 2% amphetamine or speed and a little bit more than 1% XTC as well as cocaine. Prevalence rate was higher among males than females. Sixteen percent of young males aged 35 years or less had tried an illegal drug at least once and 7% during last 12 months. Cannabis represented the main substance used by more than 90% of consumers.

Table 2.5 : Lifetime prevalence (%) and last 12 months prevalence (between brackets) of drug use among the adult population (18-65 years old), Flemish Community, 1994

Drug	All Adults 18-65 years (n=2,259)			Young adults 18-34 years (n=924)		Older adults 35-65 years (n=1,332)		
	Total	M	F	Total	M	F	Total	
Any illegal drugs	6.4 (1.8)	16.5 (6.9)	6.8 (1.9)	11.0	5.8 (0.4)	1.2 (0.0)	3.2	
Cannabis	5.8 (1.5)	14.8 (5.7)	6.6 (1.5)	9.2	5.1 (0.4)	1.2 (0.0)	2.9	
Amphetamine-speed *	0.9 (0.3)	-	-	2.0	-	-	0.1	
XTC	0.5 (0.1)	-	-	1.3	-	-	0.0	
Cocaine	0.5 (0.2)	-	-	1.2	-	-	0.0	
Heroin	0.04 (-)	-	-	0.1	-	-	0.0	

* Amphetamines and speed were grouped in this analysis. Unfortunately grouping varies between studies. This remark is also valid when considering other types of grouping (age group, etc.). Harmonisation in reporting of results is progressively improving, e.a. thank to the REITOX-EMCDDA guidelines.

Since 1996 a continuous health behaviour monitoring (Piette and De Smet 2000) has been conducted in four areas, representative of the French Community households. The survey is using a computer assisted telephone interview method with random dialling of the household and random selection of one adult. Every three months around 300 adults are interviewed (each person being interviewed once). During the 1996-1999 period the monitoring covered 3,311 adults of 18-69 years of age (the drug questions were asked to adults of 18 to 49 years; n = 2,112, table 2.6). The participation rate is 69%.

The access to cannabis and to cocaine as well as the consumption of cannabis (at least once and during the last 7 days) was investigated. Regarding the prevalence rates, 21% (95%CI 13.2-28.6) of adults interviewed in 1998-99 stated to have used cannabis at least once. The prevalence decreases with age from 34% in the age group 18-24 years to 13% in the age group 45-49 years. Males (29%) stated cannabis experience more than females (13%). Thirty-five percent of males aged 35 years or less experienced cannabis at least once. These differences remain significant after standardization respectively for sex, education and area, and for age, education and area. Twenty-nine persons out of 231 having experienced cannabis (12.5%) smoked cannabis during the last 7 days, representing 2.6% of interviewed people.

Table 2.6 : Lifetime prevalence rate (%) of cannabis use among the adult population, French Community, 1996-97 and 1998-99

Period	n	All adults 18-49 years		Young adults 18-34 years		Older adults 35-44 years		
		Total	M	F	Total	M	F	Total
1996-97	976	12.8 *	24.9	11.0	17.8	12.7	8.7	10.5
		(10.8-14.8) **			(14.6-21.1)			(7.3-13.8)
1998-99	1106	20.8	35.3	17.0	26.1	23.4	10.1	16.3
		(18.3-22.8)			(22.5-29.7)			(13.0-19.6)

* : adjusted rates for age, sex (for the total figure), education and area;

** : 95 % confidence interval

As these studies were conducted in different parts of the country (Flemish Community in 1994 and French Community from 1996 onwards), it is difficult to generalise their results to the whole country and to perform a trend analysis from 1994 to 1999. However the results of the continuous monitoring of the French Community adults can be compared. Figures were standardized for age, sex (except when stratified by sex), education and area : around 1,000 people were interviewed for each period 1996-97 and 1998-99 (Table 2.6). The survey shows a significant increasing trend in the lifetime prevalence from 13% in 1996-97 to 21% in 1998-99. Taking into account the remark mentioned here above, one observe that the Flemish prevalence of 1994 (6%) does not conflict from a trend point of view with the prevalence of the following periods, possibly indicating a global increasing trend during the nineties (as observed in other EC countries (EMCDDA 2000)).

For the beginning of the 90ties, the only prevalence estimates are based on conscripts (see 2.2.d) and are not comparable with the figures mentioned above.

Drug questions are included in the national Health Interview Survey (HIS) of 2001. HIS is a general health survey and the number of 'drugs' questions is consequently limited: 2 questions on cannabis prevalences and 2 on XTC-amphetamines; no opinion questions. These questions are included in the self-administered questionnaire for people aged 15-64 years.

2.2.b School and youth population

This section aims to present the various studies carried out on the consumption of drugs in school population. The international protocols will be presented first. Indeed, Belgium is taking part in one of those (HBSC). Then the studies repeated each year or every two years will be analyzed and compared and last the point studies will be presented successively. No statistic tests about the comparisons between the various studies were carried out because of the difference of methodology used in these investigations.

The Health Behavior School-aged Children (HBSC) survey is a research project that aims to gain new insight into, and increase our understanding of health behaviors, lifestyles and their context in young people in different countries and cultural settings. The study also aims at increasing the understanding of young people's health including how they perceive health itself. HBSC started in 1982, initiated by researchers from Finland, Norway and England. Shortly afterwards it was adopted by the World Health Organization (Regional Office for Europe) as a WHO collaborative study. There are currently 35 HBSC member countries and regions. The surveys are carried out in schools among 11, 13 and 15-year-old pupils. A standardized questionnaire is used. The recommended sample size is 1500 students per age group in each country. In Belgium, two studies are conducted, one in the Flemish Community leads by the University of Ghent (UG) and one in the French Community leads by the University of Brussels (ULB).

Each country can, if it wishes it, add additional questions. It is the case in Belgium where the two responsible teams add a module "drugs". The Belgian samples are representative of the various networks and types of teaching as well as sex.

Contrary to HBSC, the European School Project on Alcohol and Other Drugs (ESPAD) is a European project only based on the uses, attitudes and opinions concerning alcohol and drugs. This survey is carried out in about thirty European countries. This project is the initiative of the Swedish Council for information on alcohol and other drugs (CAN) and is supported by the Pompidou group. Belgium does not take part in this study.

2.2.b.1 Repeated community surveys

The University of Ghent is responsible for the HBSC study in the Flemish Community. The study is repeated on a regularly basis (1990, 1994, 1996, 1998, 2000). The sampling of the schools is based on stratification according to educational networks (local community schools, provincial schools, official schools and government schools). The respective samples for the study of 1994, 1996, 1998 and 2000 consisted of 10,414; 4,771; 12,088 and 7072. In 1994 and 1996 the students of the third grade of secondary school only were interviewed. As from 1998 all students of secondary school were interviewed.

The University of Brussels is responsible for the HBSC study in the French Community. 'Health Behavior in School-aged Children' studies were conducted in 1986 (n=3,593), 1988 (n=2,482), 1990 (n=4,649), 1992 (n=3,869), 1994 (n=15,347) and 1998 (n=12,987). The sampling of the schools is representative for the different provinces, educational networks (public and catholic) and type of educational cursus. Results are standardized for age, sex and type of education.

In 1999 and 2000 VAD ("Vereniging voor Alcohol en andere drug problemen", one of the four Sub Focal Points) conducted a very large study in the Flemish Community schools using a different protocol (Kinable 1999) : this study will be repeated every year and covers representatively all types of schools.

From January to June 1999, a survey was conducted in 104 secondary schools of Flanders inquiring 47,657 representative students aged 11 to 22 years (boys 55% and girls 45%). This study was repeated from September 99 to June 2000 with a sample of 82.375 pupils. The lifetime prevalence of illicit drug use increases with age from 4% in the first grade to 44% in the third grade. Some results are presented in Table 2.7.

RESULTS

1. AMONG YOUNG PEOPLE AGED 15-16 YEARS

The prevalence of drug use is higher in males than in females (Table 2.7)(Maes and Vereecken 1999; Kinable 1999). The results of the surveys carried out by the University of Ghent suggest that the lifetime prevalence of :

- cannabis use increased from 15 % in 1994 to 21 % in 2000,
- XTC use decreased from 4,1 to 2,6 % during the same period. However, this decrease may only be apparent since the definition of XTC changed in 2000 : indeed, in surveys conducted before 2000, the XTC category include both XTC and speed,
- amphetamines use shows no particular trend (2,6 and 3,3 % in 1994 and 2000, respectively), and,
- solvent use also shows no significant trend.

The lifetime prevalence rates found in the survey conducted in 2000 by the VAD are higher than those estimated by the University of Gent for the same period.

The results of the surveys carried out by the VAD suggest that the lifetime prevalence of :

- cannabis use shows no particular trend (24.0 and 23.9% in 1999 and 2000, respectively),
- XTC and solvents uses show no significant trend.
- amphetamines use decreased from 6.5% to 5.3% between 1999 and 2000.

Table 2.7 : Evolution of the lifetime prevalence (%) of drug use among the school population aged 15-16 years, Flemish Community (1994-2000)

Drugs		HBSC (UG**)				VAD	
		1994	1996	1998	2000	1999	2000
Cannabis	Boys	20	17.9	22.2	25	28.8	29.3
	Girls	10	11.6	15.4	16.3	18.6	18.8
	Total	14.9	14.6	18.9	20.7	24.1	23.9
XTC	Boys	5	5.8	6.6	3.2	4.9	4.8
	Girls	3	2.7	3.3	1.9	2.9	2.5
	Total	4.1	4.2	5	2.6*	4	3.6
Amphetamines	Boys	3	2.7	4.2	4.1	7.9	6.7
	Girls	2	1.7	2.3	2.6	5	4
	Total	2.6	2.2	3.3	3.3	6.5	5.3
Solvents	Boys	4	3.4	5	5	4.6	4.4
	Girls	2	1	2.7	2.2	3.8	3.2
	Total	3.3	2.1	3.8	3.6	4.2	3.8

Hypnotics, sedatives and benzodiazepines are not reported in the tables because of the figures are not precise enough. This question will be discuss more rigorously in the course of the year within the working group.

* The definition of XTC in 2000 is not the same as preceding years. Before 2000 the item XTC contained speed. In 2000 XTC does not contain speed.

** UG : University of Ghent

The only prevalence that increased these last two years is the prevalence of cannabis but only in the data of the University of Ghent. All other consumptions of drugs seem to have been stabilized or have decreased.

The lifetime prevalence of cannabis, XTC, amphetamines and solvent use is higher in the French Community (Piette et al. 1997) than in the Flemish Community (Maes and Vereecken 1999)(Table 2.8). With regard to the difference in consumption between the sexes, the prevalence is always higher among boys (up to 7 % for cannabis).

Table 2.8: Lifetime prevalence (%) in the HBSC survey conducted in French Community and the Flemish Community in 1998

Drugs	Sex	Fr C	Fl C
Cannabis	Boys	29.1	22.2
	Girls	23.9	15.4
	Total	26.2	18.9
XTC	Boys	5.5	6.6
	Girls	4.7	3.3
	Total	5.1	5
Amphetamines	Boys	5.4	4.2
	Girls	4.5	2.3
	Total	4.9	3.3
Solvents	Boys	5.4	5
	Girls	3.8	2.7
	Total	4.5	3.8

For each drug, a slight decrease of the last year prevalence is observed between 1999 and 2000 (Kinable 1999) (table2.9).

Table 2.9 : Evolution of the last year prevalence (%) among the school population aged 15-16 years in Flemish Community (VAD)

Drugs	1999	2000
Cannabis	19,5	19,3
Amphetamines	4,5	3,6
XTC	2,9	2,6
Solvents	2,4	2,1

The last month prevalence is the prevalence that shows better the situation of the consumption of drugs among the population (table 2.10). The only prevalence that increased these last two years is the prevalence of cannabis. All other consumptions of drugs seem to have been stabilized or have decreased (table 2.10) (Maes and Vereecken 1999).

Table 2.10 : Evolution of the last month prevalence(%) in Flemish Community (HBSC) (1994-2000)

Drugs	1994	1996	1998	2000
Cannabis	7,6	8,8	12	11,8
XTC	1,4	1,3	2,1	1,3**
Amphetamines	0,8	0,8	1,3	1,3**
Solvents	1,3	0,7	1,5	1,3

** The definition of XTC in 2000 is not the same as in the preceding years. Before 2000 the item XTC contained speed. In 2000 XTC does not contain speed.

Cannabis always remains the most used drug. We notice certain changes of consumption with regard to XTC, amphetamines and solvents. Indeed, before 1999, XTC was the second drug most used. Since then amphetamines seem to take this place. Indeed, prevalence of XTC (lifetime and during the last month) decreased as much in the survey of the University of Ghent as in the VAD survey.

2. AMONG YOUNG PEOPLE AGED 17-18 YEARS

The lifetime prevalence of drug use is higher in males than in females (Table 2.11) (Maes and Vereecken 1999; Kinable 1999). The results of the surveys carried out by the University of Ghent suggest that the lifetime prevalence of :

- cannabis use increased from 23.1 % in 1994 to 39 % in 2000,
- XTC use increased from 6.3 to 8 % during the same period,
- amphetamines use shows an increase (4.3 and 8.2 % in 1994 and 2000, respectively), and
- solvent use decreased from 5.5 to 4.6%.

The lifetime prevalence rates for cannabis and amphetamines uses found in the survey conducted in 2000 by the VAD are higher than those estimated by the University of Ghent. The prevalence rates estimated of XTC are the same. The data estimated for solvents are higher for the University of Ghent.

The results of the surveys carried out by the VAD suggest that the lifetime prevalence of :

- cannabis use shows no particular trend (39 and 40.2 % in 1999 and 2000, respectively),
- XTC uses shows no significant trend.
- amphetamines use decreased from 11.4% to 9.2% between 1999 and 2000.
- solvents use shows no significant trend

Table 2.11 : Evolution of lifetime prevalence (%) of drug use among the school population aged 17-18 years, Flemish Community (1994-2000)

Drugs		HBSC (UG)				VAD	
		1994	1996	1998	2000	1999	2000
Cannabis	Boys	32.1	37.1	42.7	44.7	48.1	49
	Girls	14.2	23	30.7	33.8	27.5	30.9
	Total	23.1	29.9	36.7	39	39	40.2
XTC	Boys	8.9	11.4	13.2	10.1**	11	11.6
	Girls	3.7	4.3	8	6.1**	4.7	4.9
	Total	6.3	7.7	10.6	8**	8.1	8.2
Amphetamines	Boys	6.5	6.1	7.2	10.2**	14.5	13.2
	Girls	2.1	2.5	4.3	6.4**	7.5	6.3
	Total	4.3	4.2	5.7	8.2**	11.4	9.8
Solvents	Boys	8.0	8.7	9.3	5.7	5	4.8
	Girls	2.1	3.1	5.4	3.6	2.7	2.3
	Total	5.5	5.8	7.3	4.6	3.9	3.6

* Hypnotics, sedatives and benzodiazepines are not reported in the tables because of the figures are not precise enough. This question will be discuss more rigorously in the course of the year within the working group.

** The definition of XTC in 2000 is not the same as preceding years'. Before 2000 the item XTC contained speed. In 2000 XTC does not contain speed.

*** UG : University of Ghent

The lifetime prevalence is higher in the French Community than in the Flemish Community except for solvents (table 2.12) (Maes and Vereecken 1999). With regard to the difference in consumption between the sexes, the prevalence is always higher among boys (up to 10 % for cannabis).

Table 2.12 : Comparison of the lifetime prevalence (%) between the HBSC survey in French Community and the Flemish Community (VAD) in 1998

Drugs	Sex	Fr C	Fl C
Cannabis	Boys	48.9	42.7
	Girls	37.7	30.7
	Total	42.4	36.7
XTC	Boys	13.6	13.2
	Girls	8.5	8
	Total	10.7	10.6
Amphetamines	Boys	11.3	7.2
	Girls	6.7	4.3
	Total	8.6	5.7
Solvents	Boys	6.2	9.3
	Girls	3.1	5.4
	Total	4.4	7.3

For the last year prevalence, there are no significant differences between the results obtained in 1998 and in 1999 by the VAD (table 2.13)(Kinable 1999).

Table 2.13 : Last year prevalence (%) among the school population aged 17-18 years in Flemish Community (VAD) (1999-2000)

Drugs	1999	2000
Cannabis	29.7	30.4
XTC	5.8	5.8
Amphetamines	7.6	6.1
Solvents	2.1	1.9

However, in the surveys conducted by the University of Ghent, the prevalence of last month use increased significantly between 1998 and 2000 for cannabis : from 12 to 20% (table 2.14) (Maes and Vereecken 1999). With regard to the difference in consumption between the sexes, the prevalence is always higher among boys (up to 10 % for cannabis).

Table 2.14 : Evolution of the last month prevalence(%) in Flemish Community(1994-2000)

Drugs	1994	1996	1998	2000
Cannabis	7.6	14.6	12	20
XTC	1.4	3.3	4.5	3.9**
Amphetamines	0.8	1.1	2.3	2.8**
Solvents	1.3	1.7	2.7	1.4

** The definition of XTC in 2000 is not the same as in the preceding year'. Before 2000 the item XTC contained speed. In 2000 XTC does not contain speed.

We observe the same phenomenon with the 17-18-year olds as with the 15-16 year olds. Cannabis remains the most consumed drug by far. Since 1999 amphetamines are more consumed than XTC. Amphetamines become in this way the second drug most used. XTC becomes third in terms of consumption. With regard to the difference in consumption between sexes, prevalence is always higher among boys (up to 10 % for cannabis).

In the age group 17-18-years, the prevalence of drug uses shows the same trends as in the age group 15-16 years. The only increases we observe are those of the consumption of cannabis and amphetamines. Thus we can say that the tendencies are the same with the 15-16-years olds as with the 17-18-year olds. The consumption of cannabis continues to increase and the other consumptions are stabilized or decreased.

Conclusions

Even if one should be careful in interpreting the quantitative elements of drug consumption by young people, based on the data obtained by means of self-administered questionnaires, the results of the above mentioned studies globally indicate that in 1998-2000 :

- around 22% of students of 15-16 years of age tried cannabis at least once;
- around 20% of students aged 15-16 years experienced at least once cannabis during the last year;
- around 12% of students aged 15-16 years experienced at least once cannabis during the last month;
- around 40% of students of 17-18 years of age has tried cannabis at least once;
- around 30% of students aged 17-18 years experienced at least once cannabis during the last year;
- around 20% of students aged 17-18 years experienced at least once cannabis during the last month;
- the proportion of users of illicit substances is higher among boys than among girls;
- from 15-16 years of age onwards, cannabis derivatives are the products most used; ecstasy before 1999 was the second product most used and became after this year (2000) the third or the fourth; on the other hand hypnotics and amphetamines are more used than XTC;
- in terms of trends, the prevalence rates seem to be stabilized in all age groups. An increasing trend was observed in the use of illegal drugs, especially cannabis, XTC and amphetamines up to 1999, since then stabilization or a little decrease has appeared.

3 ADDITIONAL RESULTS FROM THE HBSC SURVEY IN FLANDERS

Cannabis is most popular among boys : 25% of 15-16-year old boys and 45% of 17-18-year old boys had used this drug at least once, followed by XTC/speed and then volatile inhalants (table 2.15) (Maes and Vereecken 1999). Among girls cannabis is also the most popular, followed by XTC/speed, tranquillizers are third. For XTC, the tendency of consumption seems to decrease, as much among boys than girls.

Table 2.15 : Proportion (%) of students having used a drug at least once (lifetime), for girls and boys according to age, Flemish Community schools, 2000

Drug	Aged 15-16 years		Aged 17-18 years	
	Boys (n = 719)	Girls (n = 870)	Boys (n = 603)	Girls (n = 780)
Cannabis	25.0	16.3	44.7	33.8
XTC	3.2	1.9	10.1	6.1
Sniff, volatile inhalants	5.8	2.9	11.0	6.8
Amphetamines	4.1	2.6	10.2	6.1
Tripmiddelen (LSD)	4.0	2.1	7.5	4.7
Cocaine	1.3	1.1	4.3	3.1
Heroin	0.6	0.7	1.8	1.1

More boys than girls used cannabis during the last month (table 2.16). This is both the case for the age group 15-16 years as for the age group 17-18 years. In 2000, compared to 1996, the last month prevalence of cannabis use increased both among boys and girls in both age groups (Maes and Vereecken 1999).

Table 2.16 : Proportion (%) of students having used a drug during the last month according to age, Flemish Community schools, 2000

DRUG	Aged 15-16		Aged 17-18	
	Boys (n = 719)	Girls (n = 870)	Boys (n = 603)	Girls (n = 78)
Cannabis	15.1	8.5	25.4	15.0
XTC	1.5	1.1	5.0	2.9
Sniff, volatile inhalants	2.2	1.4	3.4	2.5
Amphetamines	1.8	0.9	3.3	2.3
LSD	1.7	0.5	1.3	1.2
Cocaine	0.5	0.3	1.0	1.0
Heroin	0.3	0.0	0.2	0.4

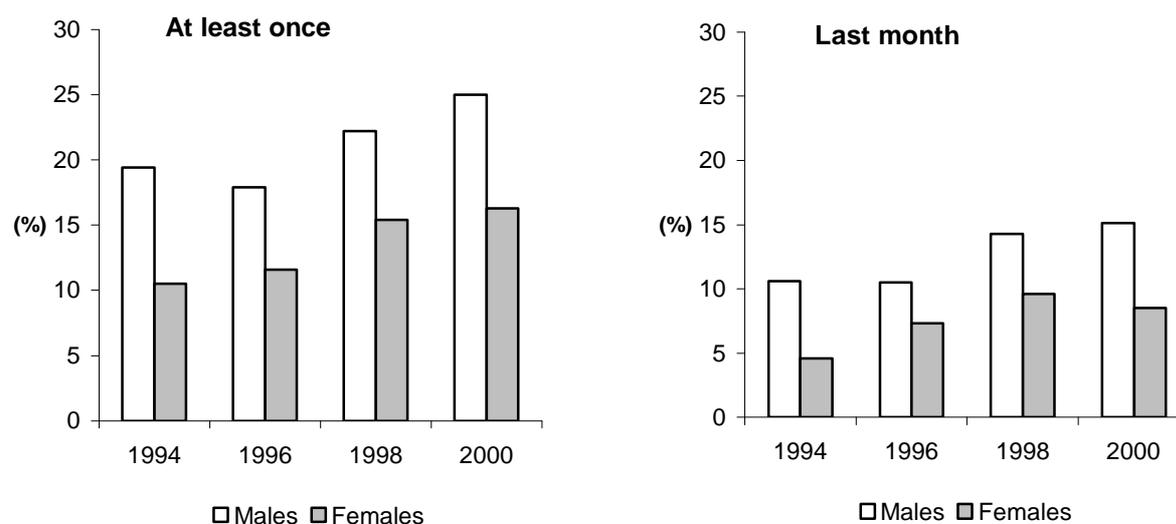


Figure 2.1 : Proportion of people (15-16 years of age) having used cannabis, Flemish Community schools, 1994-2000

The proportion of 'the last month' users of cannabis increased regularly from 1994 to 2000, only for the boys (Figure 2.1) (Maes and Vereecken 1999). Nevertheless for the girls the consumption has doubled between 1994 and 2000. More boys than girls used cannabis several times during the last month.

The frequency of last month use of cannabis among young people of 17-18 years of age increased since 1994 among boys and girls of the Flemish Community schools (table 2.17). More boys than girls used cannabis several times during the last month (Maes and Vereecken 1999).

Table 2.17 : Frequency (%) of last month use of cannabis; 1994-2000, Flemish Community schools

	1994		1996		1998		2000	
	1-2 times	More than 3 times						
Boys	7.9	7.8	9.4	11.2	11.4	14.3	11.7	13.7
Girls	3.6	2.0	5.2	3.7	6.9	7.0	7.6	7.3

4. ADDITIONAL RESULTS FROM THE HBSC FRENCH COMMUNITY

The products that young people consume most are alcohol, tobacco and medicines (especially among girls) as well as derivatives of cannabis. In 1994, 19% of young people aged 13-17 years used a drug at least once and 10% were 'regular' users (defined as last month use; Figure 2.2). For comparison, these figures were 8%, 8%, 13% (at least once) and 1%, 3%, 7% (the last month use) respectively in 1988, 1990 and 1992. An increasing proportion is using cannabis, reaching 84% of users in 1994. Experimenting with drugs leads to 'regular' use (the last month use) in 50% of cases. This proportion is stable from 1988 to 1994.

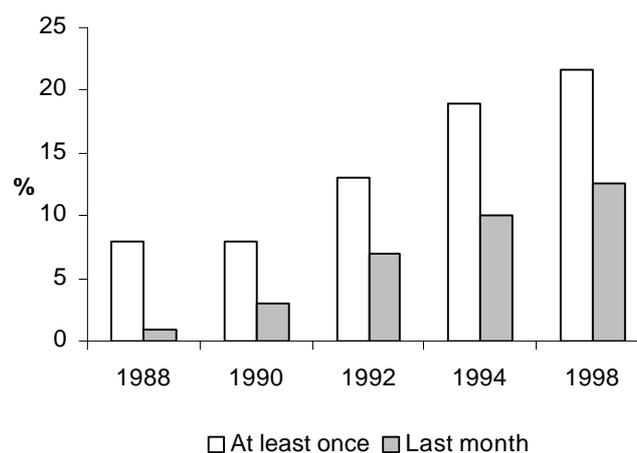


Figure 2.2 : Proportion of young people aged 13-17 years having used a drug at least once and during the last month, French Community secondary schools 1988-1998 (Piette et al. 1997).

5. OTHER RESULTS FROM THE VAD SURVEY

The lifetime prevalence of illicit drug use increases with age from 4% in the first grade to 44% in the third grade. Some results are presented in Table 2.18. (Kinable 1999).

Table 2.18 : Lifetime prevalence(%) of drug use according to the drug, secondary Flemish schools, 1999 and 2000

Drug	15-16 years old		17-18 years old	
	1999	2000	1999	2000
Cannabis	24,1	23.9	39.0	40.2
Amphetamines	6,5	5.3	11,4	9.8
XTC	4	3.6	8,1	8.2
LSD	4,2	3.6	6,9	6.1
Cocaine	1,9	1.8	3,9	4.1
Heroin	0,9	1.0	1,1	1.2

A reduction in consumption is observed for each drug between 1999 and 2000. In the age group 15-16 years, the figures also seem to decrease. In the age group 17-18 years, we observe a stabilization of consumption.

2.2.b.2 Repeated local surveys

REPEATED SCHOOL SURVEYS IN BRUGES

“De Sleutel”, an organization active in the field of drug help and in the field of prevention and research, conducted these school secondary surveys in Bruges (Lombaert and Raes 2000). This study describes the use of drugs in relation with the students’ life (example: familial relations, school situation, friendly relations, occupation of the spare time, ...). It includes only the students aged 16 years or over. It insists on risk factors. The influence of different risk factors was calculated via multivariate logistic regression.

In 1993-1994 2,492 students of 25 secondary schools participated in this study (boys: 50%; girls: 50%). The mean age is between 17 and 18 years.

In 1996-1997, 3,534 students of 18 secondary schools in Bruges participated in this study : 48% were boys and 52% were girls. Lifetime use of cannabis was reported by 36% of students, 8% used at least once LSD, 8% used at least once XTC, and 7% used at least once amphetamines.

In 2000, 4,588 students of 26 secondary schools in Bruges participated in this study : 52% were boys and 48% were girls. The mean age was 17 years. Lifetime use of cannabis was reported by 46% of the students, 10% had used at least once LSD, and 12% had used at least once XTC.

The three surveys (Raes 1995; Verhaegen and Raes 1997; Lombaert and Raes 2000) conducted in Bruges (Table 2.19) show increasing trends in the consumption of each drug. (The mean age in these three studies borders the 17 year.) The figures are higher than for those reported by the VAD and the Flemish HBSC study (UG).

Table 2.19 : Proportion of students (%) having consumed at least once, used illicit drug, Bruges

Drug	1993-1994 (n=2492)	1996-1997 (n=3534)	2000 (n=4588)
Cannabis	22.8	35.8	45.6
Amphetamine	3.6	6.8	12.8
XTC	4.6	7.5	11.6
LSD	4.2	8.3	9.6
Cocaine	2.2	3.9	7.6
Heroin	0.5	0.8	3.7

Table 2.20 shows how many times the 'at least once-users' used illicit drugs. 'Regular' users were defined as using illicit drugs at least 1 time per month during the last 6 months. Of the total group who used at least once cannabis, 15% used cannabis only once ('experimental use') and 39% used it 'regularly'; in total 50% of users (experimental, intermediate, 'regular') stopped using cannabis. Experimental use was proportionally high for cocaine and heroin. The proportion of 'regular' users is high for cannabis but also for cocaine. The absolute number of 'regular' users, defined as use at least 1x/month during the last six months, was similar for cocaine and amphetamine and close to the number of XTC 'regular' users.

Table 2.20 : Pattern of use of illicit drugs among users having consumed at least once, according to the type of drug, Bruges secondary schools, 1996-97

	Users (n)	Only once (%)	Intermediate (%)	Regular * (%)
Cannabis	1.266	14.7	46.0	39.3
LSD	292	33.3	52.3	14.4
XTC	266	27.2	45.7	27.1
Amphetamine	239	29.3	47.3	23.4
Cocaine	138	45.2	15.7	39.1
Heroin	28	50.0	28.6	21.4

* see text

REPEATED SCHOOL SURVEYS IN BRUSSELS

The Vrije Universiteit Brussel (VUB) (Lambrecht et al. 1996) carried out surveys in secondary and higher Dutch-speaking schools in 1994, 1998 and 2001 (these last figures are not yet available). In 1994, 2,103 students from 42 secondary schools and 25 higher schools were inquired. In 1998, 2,626 students were inquired. These studies provide information of drug consumption use in young people after the secondary school. We will discuss here only about students from 18 to 22 years old. These studies are also interesting because of various situations (family, friends, love) of the young people, situations of consumption (age, place of the first consumption, ...) are also investigated. Only the figures for the 18-years-old students or more are presented in the table 2.21.

Table 2.21 : Proportion of students (%) having used illicit drug at least once, VUB, Brussels

Drugs	Period	18 years		19 years		20 years		21-22 years	
		1994	1998	1994	1998	1994	1998	1994	1998
Cannabis	Lifetime	28.1	30.5	20.6	28.0	22.9	34.0	19.6	44.0
	Last month	11.8	15.8	7.4	13.0	6.8	9.9	5.8	14.7
	Last year	22.6	24.6	14.4	18.4	16.2	18.8	13.3	28.0
Amphetamines	Lifetime	7.6	6.9	4.9	6.1	4.0	5.3	4.4	8.1
	Last month	2.8	1.4	1.2	3.0	0.8	1.3	0.8	1.4
	Last year	5.3	4.6	3.5	3.7	2.0	2.7	2.4	3.6
XTC	Lifetime	-	4.1	-	6.6	-	7.3	-	9.5
	Last month	-	2.1	-	1.2	-	2.3	-	2.3
	Last year	-	4.1	-	3.2	-	4.0	-	4.5
Halucinogenes	Lifetime	6.3	6.9	4.9	7.4	4.4	6.6	4.5	10.4
	Last month	2.0	1.7	0.7	0.5	0.0	0.3	0.7	0.5
	Last year	3.5	5.2	2.1	2.7	2.8	2.0	3.2	2.7
Solvents	Lifetime	6.3	5.7	3.2	7.3	3.9	5.3	3.3	8.2
	Last month	1.3	1.2	0.4	1.7	0.8	1.0	0.6	0.9
	Last year	2.6	2.9	2.5	2.9	1.2	2.3	1.3	2.3
Cocaine	Lifetime	6.3	3.4	4.9	3.7	4.4	3.0	4.5	4.1
	Last month	0.6	0.3	0.0	0.0	0.0	0.0	0.0	0.5
	Last year	20.	2.3	1.0	1.7	22.9	1.0	0.8	1.8

In 1994, the highest prevalence rates of drug consumption were observed among the students aged 18 years, whereas in 1998 the highest prevalence rates of drug consumption occurred in the age group 21-22 years. The prevalence of each drug use increased between 1994 and 1998, only the consumption of amphetamines and solvents slightly decreased for the 18 year olds. In other words, the young people aged 19 to 22 increased their consumption compared to 1994. Based on the 1998 data, the prevalence of consumption continues to increase after 18 years old.

2.2.b.3 Point surveys

SECONDARY SCHOOLS IN BEVEREN (FLANDERS)

“De Sleutel” conducted this school survey in Beveren (Verhaegen et al.1998). 1238 students of 3 secondary schools participated in this study : 59% were boys and 41% were girls. The mean age was 15.6 years of age (13-19 years). This school population filled in the same questionnaire as mentioned here under in the Bruges study.

This school population filled in a questionnaire about the following topics: school, leisure time, the use of drugs like alcohol, tobacco, illicit drugs and medication. 21% of students used at least once cannabis, 5% used at least once amphetamines, 3% used at least once LSD, and 6% used at least once XTC. This school population filled in the same questionnaire as mentioned here above in the Bruges study

SECONDARY SCHOOL SURVEY IN CHARLEROI (WALLONIA)

From March to June 1999, a survey was conducted in 12 secondary schools of Charleroi (Depaepe and De Clerck 2000) (among 23 invited schools) inquired 2,005 students aged 14 to 23 years (mean age : 16.1 years) including 49% of boys and 51% of girls. They are respectively 1,066 in the third year and 934 in the fifth year. The lifetime prevalence of the drug use increase with age (Table 2.22). Boys used more than girls. Taking into account tobacco and alcohol for which use is more frequent (respectively 61 and 88%), poly-use is stated by 41% of students.

Table 2.22 : Proportion (%) of students having used at least once a drug according to their secondary school level, Charleroi, French Community, 1999

Drug	n	All	Third grade	Fifth grade
Cannabis	1985	36.5	29.7	44.3
XTC	1976	7.5	6.2	8.9
Heroin	1971	1.9	1.9	5.6

SECONDARY SCHOOLS IN VERVIERS (WALLONIA)

In November and December 1999, a survey was conducted in three secondary schools of Verviers (Bils et al. 2000) inquiring 929 students aged 11 to 20 years (boys 54% and girls 46%). They are respectively 265 in the first grade, 388 in the third grade and 274 in the fifth grade. The lifetime prevalence rates of the use of cannabis and XTC increase with age without any significant differences of the cannabis prevalence between genders (Table 2.23)(Bils et al.2000).

Table 2.23 : Proportion (%) of students having used at least once a drug according to their secondary school years, Verviers, French Community, 1999

Drug	First grade	Third grade	Fifth grade	Total
Cannabis (n=830)	6.1	15.5	31.7	18.2
XTC (n=818)	1.8	5.4	7.1	5.0
Cocaine (n=814)	2.8	2.6	3.2	2.8
LSD (n=813)	1.9	1.4	3.9	2.5
Heroin (n=817)	1.9	1.7	1.9	1.8

MENTAL HEALTH SURVEY IN BRUSSELS, 1994

A study on the mental health of young people in secondary schools was carried out in 1994 (Vranckx et al. 1996). The purpose was to assess the mental health and the subjective feeling about the health of adolescents and the use of illegal drugs. 2,209 students (aged 14-19 and over) (boys: 57% / girls: 43%) of 20 secondary schools of Brussels (17 French-speaking and 3 Dutch-speaking schools) completed a questionnaire about their socio-demographic situation (age, sex, ...), their subjective health status, their relation to the school, their family, their behavior and consumption of illegal drugs, and their use of services helping with drug problems.

The use increased with age and boys more than girls. The differences between boys and girls are observed both in the aspect of trying and for the drug use during the month prior of the study : 34% of boys and 27% of girls aged 17-18 years stated that they had tried an illegal drug and, for the same age group, 21% of boys and 14% of girls used drugs during the month before the study.

DRUG USE IN A PRIMARY SCHOOL SURVEY : STUDY OF YOUTH BEHAVIOUR IN THE CITY OF NINOVE (FLANDERS), 1995

The specificity of this study was to involve also younger teenagers aged less than 12 years and attending primary school (D'Haeseleer 1997). 2,824 pupils of 8 schools in Ninove, aged 10 years or over, filled in a questionnaire at the end of 1995: 47% were boys and 53% girls; 838 of these children are 10 to 12 years old among which 550 pupils attend primary school.

Among the 550 pupils of the primary school, 0.8% had used at least once drugs (boys and girls comparable). The consumption of illegal drugs increases up to 18 years olds (Figure 2.3) (D'Haeseleer 1997). Meanwhile only 7% of the Ninove school population stated to having used drugs at least once (boys: 10% / girls: 4%), which seems low compared to the 'Flanders HBSC' study of 1994 (Maes and Vereecken 1999) (globally 17% of the 14-18-year olds used at least once cannabis).

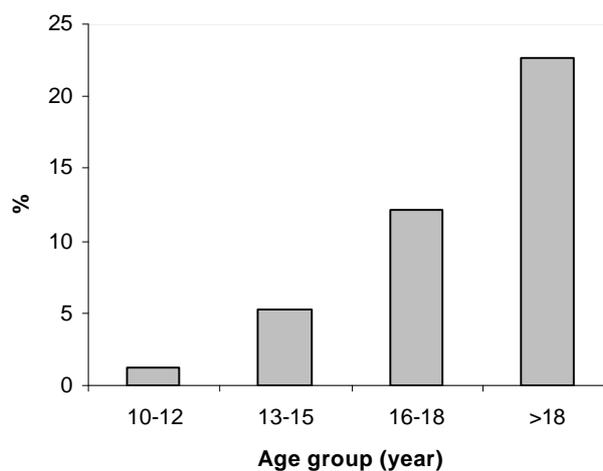


Figure 2.3 : Pupils having used at least once an illicit drug according to age, Ninove, 1995

School working group

A working group "school and drug use" was created in June 2001. Currently, this group consists in three Sub Focal Points, teams of HBSC (UG and ULB), VUB, Ulg, De Sleutel, Coordination Drogue Charleroi and the Focal Point.

Its various goals are:

- discussions about a common protocol for the realization of the various investigations carried out about school populations,
- discussions about the comparability of the various studies,
- discussions about various problems encountered at the time of the achievements of the investigations by the various members of the group,
- developments of surveys concerning young populations but less frequently investigated (university and school students, students breaking off school, ...),
- development of a specific report on this topic.

2.3. PROBLEM DRUG USE

Beside the information on treatment demands obtained from registration of demands in treatment centres and in hospitals (see 3.1), it still remains quite difficult to estimate the problematic drug use at the moment in Belgium.

Some estimates were made but with very large confidence intervals, making them unreliable. In the framework of the European Reitox project on prevalence, the feasibility of various methods was evaluated for Belgium (Sartor and Walckiers 2001). Two estimates of drug use prevalence (one national and one regional) are presented here.

Risk behaviours (injection, sharing, polydrug use) are documented from the various monitoring systems of treatment demands and from surveys of patients (GPs) or users (snowball surveys).

2.3.a National prevalence estimate of intravenous drug users

The feasibility in Belgium of different methods has been assessed in the framework of the EMCDDA project on problematic drug use prevalence (Sartor and Walckiers 2001). It has been shown that only one method could presently be used. This method is based on the use of HIV/AIDS data as well as an estimate of the prevalence of HIV among IDUs. More specifically, the number of IDUs was derived from the number of alive HIV persons, the prevalence rate of IDU among HIV patients and the prevalence rate of HIV seropositivity among IDUs. If n_{IDU} represents the number of injecting drug users, IDUs, in a given population, and $n_{HIV \cap IDU}$ the number of IDUs being HIV positive, the prevalence rate of HIV positive patients among IDUs is given by :

$$p(HIV | IDU) = \frac{n_{HIV \cap IDU}}{n_{IDU}}$$

The number of IDUs may therefore be estimated from the equation :

$$n_{IDU} = \frac{n_{HIV \cap IDU}}{p(HIV | IDU)} = \frac{n_{HIV} \cdot p(IDU | HIV)}{p(HIV | IDU)}$$

where n_{HIV} is the number of HIV positive patients in the population and $p(IDU | HIV)$ is the prevalence rate of injecting drug use among HIV patients (Sartor et al. 2001).

In Belgium, HIV and AIDS cases are registered in two integrated databases at the Scientific Institute of Public Health in Brussels (Sasse *et al*, 1998). Approximately 600,000 screening tests (ELISA) are yearly performed, excluding the tests related to blood donations. Eight reference laboratories are recognised by the Federal Ministry of Public Health to confirm the results of a positive ELISA test by a Western-Blot test or equivalent techniques. Since they are the only laboratories subsidised for Western-Blot tests, their reporting on new HIV-positive individuals is supposed to give the number of newly diagnosed seropositives in the country. A standardised form sent by these laboratories to the clinician is used to collect data on age, sex, nationality, risk factors and clinical stage at the time of diagnosis. The data allow the exclusion of multiple counting.

The AIDS cases are notified in an independent way by the clinicians on a standardised form. They are validated by a Commission of experts referring to the definition adopted by the European Centre for the Epidemiological Surveillance of AIDS. A follow-up survey is conducted each year to collect data on last consultation and possible death of reported AIDS cases.

The prevalence of HIV among lifetime IDU patients in 1995 was derived from the database of the monitoring system on drug treatment demand of the French Community (CCAD; Preumont and Bils, 1999).

The results of a survey conducted between September 1996 and March 1997 in Flanders among 225 IDUs aged 16-47 years (Driesen *et al*, 1999) provided the prevalence of HIV among lifetime IDU patients in 1997.

From the HIV/AIDS database, the prevalence rate of IDU among HIV patients 15-64 years old was estimated to be 8.73 and 8.0 % in 1995 and 1997, respectively (table 2.24).

Table 2.24 : Prevalence rate of injecting drug use among alive HIV patients aged 15-64 years registered in Belgium in 1995 and 1997 (Sasse A., 2001)

Population	Cumulated number of cases	
	1995	1997
All alive HIV registered patients	6734	7819
Alive HIVs & known IDU status	4034	4505
Cases with known IDU status (%)	59.9	57.6
Alive IDUs among HIV patients	352	360
Prevalence rate of IDU among HIVs (%)	8.73	8.00

In 1995, 7 IDUs reported to be HIV positive in a sample of 235 IDUs older than 15 years reporting to have been tested for HIV. The prevalence rate of HIV among IDUs was therefore estimated to be 3.0 %.

In the survey conducted in Flanders (1996-1997), 186 drug users reported to have been tested for HIV and 5 of them, i.e. 2.7 % of the sample, reported to be HIV seropositive. During this survey, a HIV blood test was also performed on all IDUs (n=225) but no new case was detected, giving thus a more accurate estimate of 2.2%.

The number of prevalent lifetime IDU cases and the prevalence rate of IDU in 1995 and in 1997 were computed using the number of alive HIV patients, the prevalence of IDU among HIV cases and the prevalence of HIV seropositivity among IDUs (table 2.25).

Table 2.25 : Prevalence of lifetime injecting drug use in the population aged 15-64 years, in 1995 and 1997

	1995	1997	1997
Alive HIV cases	6,734	7,819	7,819
p(IDU/HIV) (%)	8.73	8.00	8.00
p(HIV/IDU) (%)	3.0 ¹	2.7 ²	2.2 ³
Prevalent IDU cases	19,600	23,200	28,400
Prevalence rate (%)	0.29	0.35	0.42

¹ HIV+ : self-reported in 1995; ² HIV+ : self-reported in 1997; ³ HIV+ : blood test in 1997

2.3.b Regional prevalence estimate of opiate users

Local prevalence of problematic drug use in the French Community of Belgium was estimated (Ledoux et al. 1999). The capture-recapture method was applied to the data on drug treatment demand database of the French Community of Belgium (CCAD) collected in 1993 and 1994. In this analysis, a problematic drug user is defined as an opiate user demanding for treatment.

The number of opiate users was estimated for the French Community and various sub-entities (Brussels and Walloon Region). The prevalence rates were calculated for the 15-54 years group. Table 2.26 presents the estimates where the results for the French Community are the addition of the figures of Brussels and Wallonia (Ledoux et al. 1999). Analyses were also performed for provinces. The prevalence estimate is the higher in the province of Liège : 0.79 %. These results have however to be interpreted with caution because the underlying assumptions required to apply the method are obviously not met (lack of mutual independence of the two samples, and probability of selection into a sample/list for each individual probably not equal).

Table 2.26 : Number and prevalence of opiate users in the French Community of Belgium, 1993-1994

Area	Population 15-54 years (01/01/1995)	Number of opiate users	Prevalence rate / 1000
Brussels	523,664	6,769	10.9
Wallonia	1,811,515	7,841	4.3
French Community	2,335,179	14,610	6.3

2.3.c Risk behaviour and trends

The use of multiple drugs and the sharing of needles and/or syringes for intravenous administration are recognised risk behaviours. Information on these behaviours comes from treatment centres and from various studies. It should be considered as an indication of the prevalence of these behaviours among some selected groups of drug users. More than absolute figures, trends are probably more reliable.

Poly-drug use

Rock Festival (French Community), 1996-2000

A survey on drug use is repeatedly conducted during a Rock Festival in the camp where 50,000 spectators live during the festival (Hariga et al. 1999; Eurotox Personal Communication).

In 1999, 686 spectators were interviewed : 88% stated to use at least one illicit drug, 33% of respondents used exclusively one drug.

Table 2.27 : Proportion of poly-drug use, Rock festival, French Community of Belgium, 1996-2000

	1996	1997	1998	1999	2000
Number interviews	123	167	157	686	435
Only 1 drug (%)	47	40	25	33	30
3 drugs or more(%)	32	45	36	36	40
Total : at least 1 illicit drug (%)	87	93	88	88	83

In 1999, the survey was performed in the whole site of the festival and not around the stand (as for previous surveys). There is no major difference in the pattern of consumption observed in 2000 compared to the three other years : thus these figures are probably representative of the whole population of the festival.

2.3.d Early Warning System on New Synthetic Drugs

On June 16, 1997, the Council of the European Union (EU) adopted a Joint Action on New Synthetic Drugs (NSDs). This Joint Action aims at the creation of a mechanism for rapid exchange of information on new synthetic drugs, as soon as possible after their appearance on the illicit market. The information about these drugs (production, traffic and use) and the assessment of their risks permit the application of a decision-making process through which they may be placed under control in all Member States (Leus et al. 2001).

The Early Warning System in Belgium uses different ways to collect this information. These channels of information all have advantages and inconveniences and the kind of information obtained is different:

- 1) Scientific information on NSDs. Can be supplied by the Laboratory Network: toxicological laboratories (laboratories performing analyses on drugs) can provide chemical information on NSDs. Clinical laboratories (laboratories performing analyses on biological samples such as blood, urine, ... of drug users) for their part can provide information on effects of drug use, derived from results of analysed samples and from medical records.

- 2) Social, medical and cultural information on new synthetic drugs. The kind of information hereby meant, comes from the users and field workers, is not linked to specific cases and can be collected by the Focal Point and the Sub-Focal Points. It is however not easy to detect new synthetic drugs at users' level in an early stage, because drug users can seldom provide information on the chemical composition of the drugs they use. NSDs are often presented in the form of tablets bearing logos that provide no clue to the chemical contents. This obviously complicates the exchange of information on new synthetic drugs. Therefore the laboratory network and the social-cultural network should be complementary: chemical and clinical information can serve to identify NSDs more efficiently at users' level.
- 3) Monitoring of drug-related emergencies. This can serve to assess health consequences of drug use and to monitor drug use trends. Sources for this kind of information are: emergency departments and other hospital wards. Poison Control Centres telephone help lines or press also exist but most often do not offer detailed information on the substance involved in the intoxication, is more based on rumours or does not ensure that all intoxications in a certain region are covered.

Data of the Laboratory Network for 2000

For 2000, data on 1091 analysed samples were collected from nine laboratories. Some of these samples contained more than one illegal drug and were counted for each substance. Thus the amount of detected substances is higher (1174). Figure 2.4 (Leus et al.2001) shows the frequency of occurrence of different substances. The category 'other' consists of different classes of compounds, most of them are listed in the Royal Decree on Psychotropic Substances. Adulterants and diluents are not counted in this group, except when they are found alone.

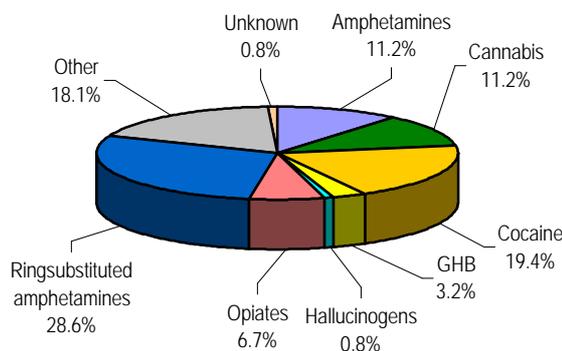


Figure 2.4 : Type of substances found in the samples analysed in 2000 (N = 1174 substances)

The ringsubstituted amphetamines and cocaine are the most represented categories of the drugs in 2000. Note that these percentages indicate in how many cases a specific drug was found and reveal nothing about the amounts of the drugs seized. As the data collection from laboratories in the framework of the Early Warning System started in 1999, the results of 2000 can be compared to those of 1999. In 1999, results of 251 samples, accounting for 259 different substances, were collected from seven laboratories. Figure 2.5 (Leus et al. 2001) shows the distribution of the detected substances in 1999.

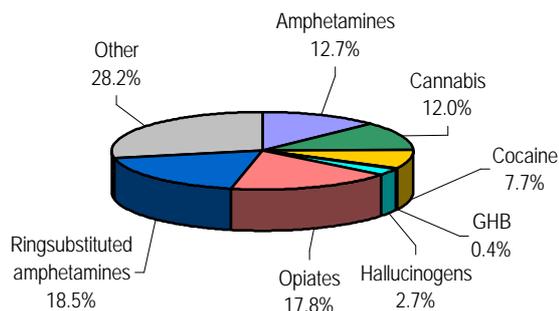


Figure 2.5 : Type of substances found in samples analysed in 1999 (N = 259).

In 1999, the ring-substituted amphetamines and opiates were the most represented categories. The percentage of ring-substituted amphetamines is however almost 10 percent lower than in 2000.

In 2000, the ring-substituted amphetamines and cocaine represent a bigger share ($P < 0.01$) in the distribution of the substances than in 1999. The percentages of amphetamines and cannabis are comparable ($P = 0.05$) between the two years. The proportions of opiates and hallucinogens were smaller ($P < 0.001$ and $P < 0.05$ respectively) in 2000. It has to be mentioned that there is a big difference in the number of substances considered for 1999 (259 substances) and for 2000 (1174 substances). Furthermore, the distribution of seized drugs does not necessarily reflect the proportions of the drugs used in Belgium.

Socio-cultural information

Some sources systematically collect data on drugs in Belgium. These include the Poison Control Centre and, to some extent, "drug telephone helplines" (Druglijn and Infor-drogues) that collect information from the phone calls they receive from people in distress or asking for information.

In 2000, the Poison Control Centre received 269 calls for intoxications related to drugs. The group 'XTC-amphetamines-speed' is the most often mentioned during the phone calls and cannabis ranks second.

The Druglijn received in 2000 11.628 calls on the subject of drugs (VAD 2000). This is less than in 1999, when 12.044 calls were registered. Most callers ask for information on drugs. Some phone calls (twenty to thirty) are in the framework of the Early Warning System and come from field workers. They give information on new synthetic drugs or new trends. This information is spread through the EWS network by means of an EWS-newsletter.

The two groups most represented are the age categories 16 – 25 years and 36 – 45 years. These correspond to the age groups of young (often starting / experimenting) drug users and the worrying parents. Youngsters call for information on the risks of drug use, on effect and on where to turn to for help. Parents ask for advice in the approach of drug using children and where to find help. There were more parents calling than users.

In February 2000, Modus Vivendi and the Belgian Focal Point conducted a survey on drug use at an exhibition on techno and house music and related aspects. The collected information aimed to provide an insight on the context of use in the group XTC-speed-amphetamines. The questions probed the frequency of using, the frequency of going out, the places where the respondents go out, the places where they use their drugs, poly drug use and their intention to have their pills tested if they had the possibility.

Results of monitoring drug-related emergencies

In July 2000, a sudden increase in media coverage on GHB (Gamma Hydroxy Butyrone) intoxications was observed and a study on GHB overdoses in Belgium was consequently initiated by the Focal Point. Thirteen cases of GHB overdose were identified between July 2000 and October 2000.

There was no system in which the emergency units automatically notified the Focal Point of the occurrence of a drug-related emergency. Information for 13 cases was collected through:

- 1) the Poison Control Centre. They receive calls from people in distress or professionals, asking for information on intoxications. They are thus well informed about the occurrence of intoxications;
- 2) Laboratories and hospitals. Labs cooperating in the EWS Laboratory Network sent information on analysed samples of blood and urine. The hospitals ordering the analysis were then contacted by the Focal Point and requested for cooperation in giving more detailed information on the symptoms;
- 3) The press. If the press was the first source of information, a request for information was sent around to the labs to see if a detailed analysis was ordered. The hospitals in the region mentioned in the article were contacted and it happened also that the press was contacted directly for more information.

From this exercise was concluded that in most cases of GHB overdose, symptoms of respiratory depression and a condition resembling coma were present. Apart from GHB, other substances were sometimes also present: amphetamines (4/13), MDMA (4/13) or cannabis (1/13).

More detailed information on the Early Warning System can be found in a report published in September 2001. This report gives an overview of the data collected in the framework of the Early Warning System, but does not interpret these. Additional data, currently not available at the Focal Point, are necessary to make this interpretation possible.

CHAPTER 3. Health Consequences

3.1. DRUG TREATMENT DEMAND

3.1.a. Characteristics of clients, patterns of use and trends

Belgian statistics on treatment demand data collected in 1998 and in 1999 are based on the experience gained through the EMCDDA Treatment Demand Indicator exercises carried out in 2000-2001 (BIRN 2000). The figures have been obtained by pooling the data from the 4 regional monitoring systems : Flemish- (VRM/VAD), French- (EUROTOX) and German-speaking Community (ASL-data 1999 only), Region of Brussels-Capital (ADDIBRU/CTB-ODB). Despite some initial differences between categories reported by these registration systems, the pooling of the data collected in 1998 and in 1999 was made possible thanks to the running harmonization process conducted in the framework of the EMCDDA.

The treatment centres are classified into five categories in the TDI protocol :

- outpatient treatment centres,
- inpatient treatment centres,
- low threshold / drop-in / street agency,
- general practitioners, and
- treatment units in prison.

A clear definition of the types of treatment centres involved is essential to increase comparability of treatment data between countries.

At the European level, the data are collected from different types of treatment centres and thus the samples of drug users covered differ accordingly. To improve the current comparability of treatment data between countries, all basic types of treatment centres should be distinguished and reported separately. Data from GPs are important, especially if these physicians play a significant role in substitution treatment. In most countries, however, coverage of this statistical field is very limited. The definition of low-threshold centres is difficult to definitely cut and thus units grouped in this category vary according to countries.

Table 3.1: Type and number of treatment unit covered by the four regional monitoring systems, Belgium, 1999

Treatment Unit	VAD	EUROTOX	CTB-ODB	ASL	TOTAL
Outpatient treatment center	92	-	10	3	105
Inpatient treatment center	48	5	3	0	56
General practitioner network		1			1

In Belgium, similar differences occur among regional monitoring systems. Even when comparing results within the 'EMCDDA' categories, differences in the coverage of different type of treatment centres can explain apparent differences between regions.

Regarding first the Outpatient category, the VRM-VAD database covers centres of mental health care where ambulatory treatments are offered to drug users : these centres represent 58% of outpatients cases. However, centers of mental health care without specific services to drug users are presently not covered in the EUROTOX and Addibru-CTB-ODB surveillance systems. Regarding the Inpatient

category, the VRM-VAD database covers therapeutic communities, crisis centres and also a large number of psychiatric hospitals (not yet covered by other systems) : hospital records represent 68% of inpatients of the VRM-VAD database. We shall show hereafter to what extent particular types of centres attract different population of drug users.

It explains why some Belgian figures (age distribution, main drug) differ compared to the previous results of CCAD (French Community) and CTB-ODB (Brussels Region) systems : for instance, in 1998, the proportion of opiate users was found to be 67 and 73% in the CCAD and CTB-ODB databases, respectively, when it was only 25% in VAD database (as a consequence, the 1998 global Belgian table reports 43%).

Considering these differences in the coverage of treatment centres, the validity of compilation of regional data into a Belgian set is questionable. Confirming that regional variations are due to a methodological difference (coverage of different types of centre) and that there are no reasons to believe that the situation should be strongly different in Brussels and in the French Community in the mental health care centres and psychiatric hospitals (that CTB-ODB and EUROTOX systems do not cover), the Belgian TDI partners agreed that the figures pooled from the regional could be used as Belgian ones without any additional weighting of the data.

According to the European standardized protocol for registration of treatment demands (reference 2001), the drugs included illicit substances (heroin, cocaine cannabis, MDMA,...) and also prescribed medicines causing psychological, social or medical problems. About substitution substances (methadone,...) information is asked in order to distinguish between licit or illicit supply. For each client a main drug is defined as 'the drug that causes the client the most problems'. Clients whose primary drug is alcohol are excluded from the European protocol.

In 1999, 10,273 patients attended ambulatory and residential centres to undergo a treatment for problematic drug use (alcohol as main drug excluded, Table 3.2). Seventy nine percent of these patients (8,098) were registered in the ambulatory and residential centres located in the Flemish Community (Vandendussche and Wydoodt 2000), 10 % (1,026) in the French Community (Preumont and Bils 2000) and 10 % (1,054) in centres of Brussels(Vanderveken and Meremans 2000). A hundred of patients were registered in the German-speaking part of the country. The regional systems cover also treatment for alcohol-related use (Table 3.2). The EMCDDA definition excludes these cases.

Table 3.2 : Number of patients registered by regional monitoring systems, Belgium, 1998-1999

MONITORING SYSTEM	YEAR	%	TOTAL*		CASES
			ALL	FIRST *	ALCOHOL
EUROTOX	1998	18	1491	518	425
CTB-ODB		22	1836	77	29
VAD		60	4855	2568	3355
BELGIUM		100	8182	3086	3809
ASL	1999	1	95	41	-
EUROTOX		10	1026	333	322
CTB-ODB		10	1054	231	104
VAD		79	8098	4235	6619
BELGIUM		100	10273	4840	7045

*: TOTAL includes Outpatients, Inpatients, patients treated by GPs and patients treated in prison

Sex and age distributions

There are almost 3 times more treatment demands from males than females (Table 3.3) : In 1999, 7,498 males (73%) vs 2,744 females (27%) were registered in the different regional monitoring systems. The sex ratio is similar for all treatment demand and first treatment demands (2.7 vs 2.8).

The mean age is 27.8 years. It is lower among outpatients than among inpatients (26.4 vs 30.6 yrs). As expected patients treated for the first time are younger. The mean age of patients registered in the VAD system is lower compared to the mean age of those registered in the EUROTOX and CTB-ODB systems (27.3 vs 28.6 years, and 27.3 vs 30.7 years respectively).

Table 3.3 : Male/female ratio and mean age of patients registered by the regional monitoring systems, Belgium, 1999

	Treatment demand	EUROTOX (n=1026)	CTB-ODB (n=1054)	VAD (n=8098)	BELGIUM (n=10,273)
Sex ratio *	All	2.4	5.3	2.6	2.7
	First	2.5	5.8	2.7	2.8
Mean age (year)	All	28.6	30.7	27.3	27.8
	First	n.a.	29.3	26.2	26.4

* : males/females

In 1998 and 1999, the proportion of males in treatment centres is much higher than that of females in the age groups 15 to 44 years (more than 4 times higher in the age group 20-24 years, Fig. 3.1). In the older age groups (above 45 years), the proportion of females in treatment is higher than that in males (however, patients older than 45 years represent only 18 % of the entire sample).

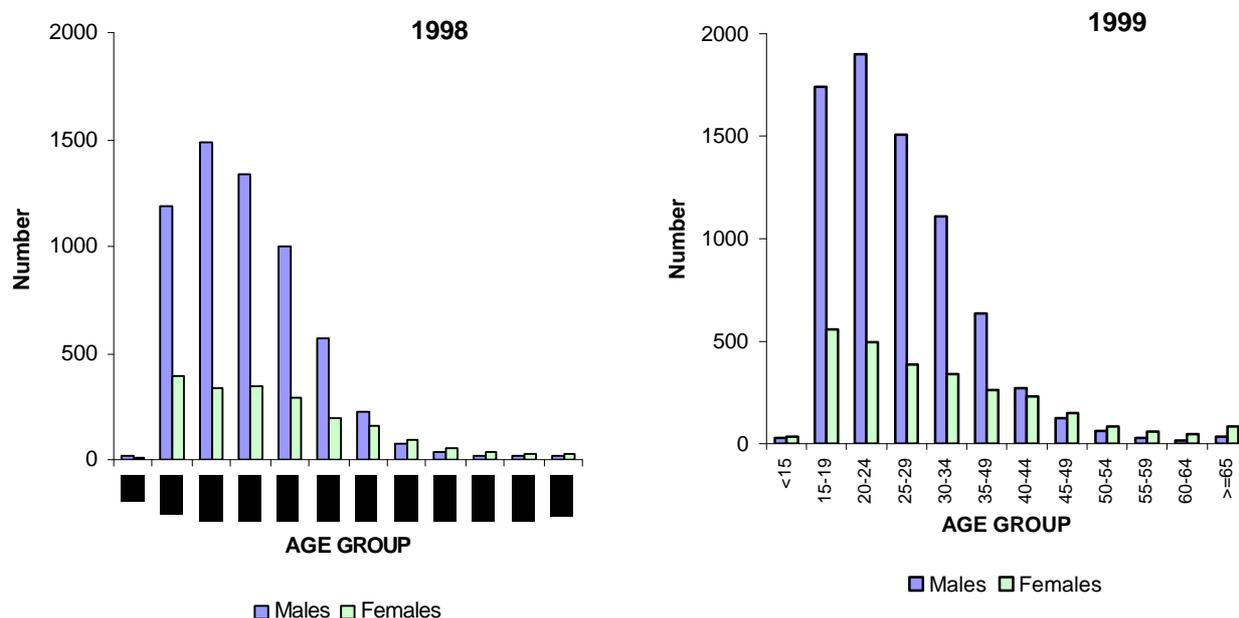


Figure 3.1 : Age distribution of patients in treatment centres, Belgium, 1998 and 1999 (all treatment demands)

Mean age is slightly increasing over time in each registration system (Table 3.4).

The age distributions of the population covered by both CCAD and CTB-ODB registration systems differ from that of the VAD registration system (figure 3.2, table 3.5). In 1998, the age group 15-24 years represent 29 and 19 % of the population covered by the CCAD and CTB/ODB, respectively, whereas 54.7 % of the population covered by the VAD falls in this same age group. On the contrary, the proportion of patients aged 25-34 years is higher in the CCAD and CTB/ODB registration systems

(48.6 and 56.2, respectively) compared to the VAD registration system (27 %). The same pattern is observed in 1999. It should also be emphasized that the proportion of patients aged 15-24 years in the CCAD registration system shows a decreasing trend during the period 1993-1999.

These differences in the age of the populations covered by the three registration systems should be taken into account when comparing the type of drug used reported by the patients in the different systems.

Table 3.4 : Number, mean age and sex ratio of people undergoing treatment (1993-1999)

	Region	1993	1994	1995	1996	1997	1998	1999
All treatment	French Community*	1,618	1,212	1,176	1,570	1,681	1,466	1,026
	Flemish Community**	-	-	-	2,374	-	4,855	8,098
	Brussels region***	-	-	-	-	1,810	1,836	1,054
Mean age	French Community	26.8	26.1	27.3	26.9	27.4	31.5	28.6
	Flemish Community	-	-	-	26.6	-	26.2	27.3
	Brussels region	-	-	-	-	30.0	30.5	30.7
Sex ratio (male/female)	French Community	3.3	3.4	3.3	2.9	2.8	3.2	2.4
	Flemish Community	-	-	-	3.0	-	3.0	2.6
	Brussels region	-	-	-	-	3.6	3.2	5.3

*(Vandenbussche and Wydoort 2000)

** (Preumont and Bils 2000)

*** (Vanderveken and Meremans 2000)

Table 3.5 : Age distribution of people undergoing treatment (1993-1999)

Age group (year)	Region	1993	1994	1995	1996	1997	1998	1999
Less than 15	French Community	0.3	0.7	0.4	1.1	1.4	1.0	0.6
	Flemish Community	-	-	-	2.0	-	2.0	0.7
	Brussels Region	-	-	-	-	-	0.0	0.0
15-24	French Community	42.5	41.9	39.6	40.0	36.0	29.3	33.2
	Flemish Community	-	-	-	50.0	-	54.7	51.2
	Brussels Region	-	-	-	-	21.0*	19.1	17.1
25-34	French Community	46.6	50.2	46.3	47.4	48.4	48.6	48.3
	Flemish Community	-	-	-	29.3	-	27.0	28.0
	Brussels Region	-	-	-	-	62.0	56.2	57.5
35-44	French Community	8.2	6.6	9.9	8.1	11.3	13.6	14.5
	Flemish Community	-	-	-	12.5	-	11.3	12.5
	Brussels Region	-	-	-	-	17.0**	21.9	23.4
45-54	French Community	2.0	0.5	2.5	2.8	1.7	2.0	2.8
	Flemish Community	-	-	-	4.5	-	3.6	4.6
	Brussels Region	-	-	-	-	-	2.4	2.0
More than 55	French Community	0.7	0.2	1.2	0.7	1.1	0.5	0.6
	Flemish Community	-	-	-	1.5	-	2.3	4.2
	Brussels Region	-	-	-	-	-	0.5	0.1

* : <25 year old; ** : > 34year old

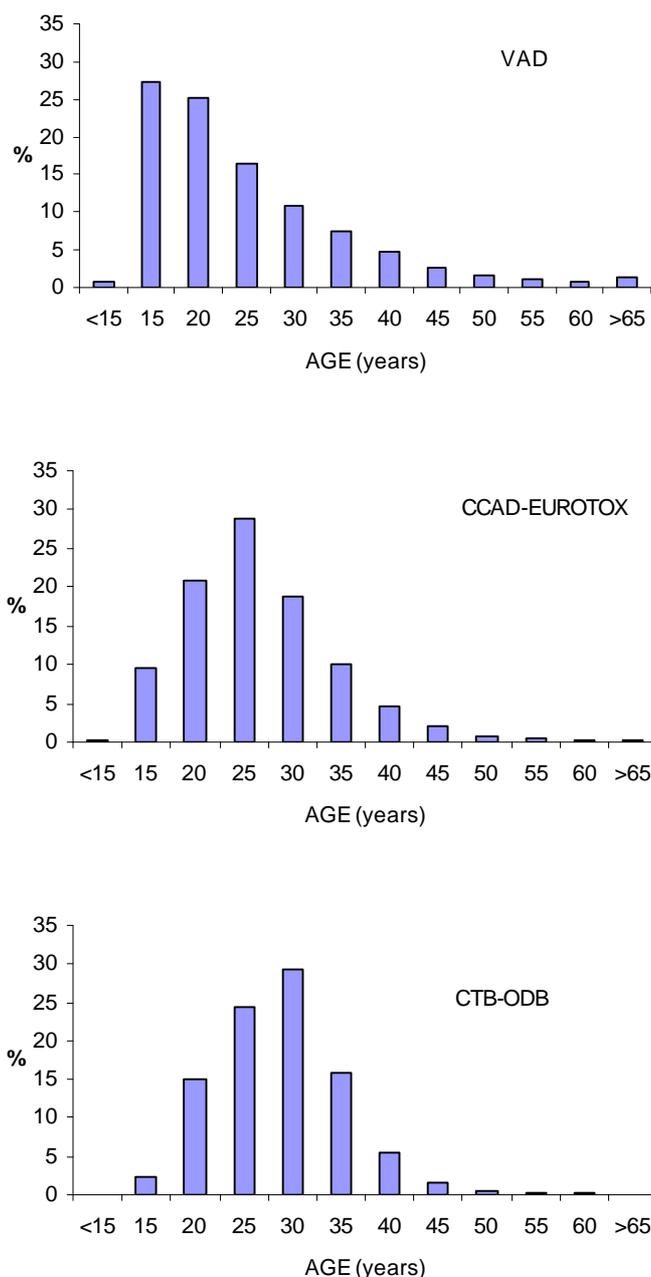


Figure 3.2 : Age distribution of patients in treatment centres, Belgium, 1998 - 1999

Age at first use

Age at first use of the main drug (at the time of starting treatment) was recorded for 6,489 patients. Most of the patients using opiates, cocaine, stimulants or cannabis as the main drug started between 15 and 19 years of age (Figure 3.3). More specifically :

- nearly one third of cannabis users and 16 % of amphetamines users started before the age of 15,
- half of heroin users started between 15 and 19 and ¼ at 20-24 years of age; in comparison and as expected the first use of methadone is delayed (47% started at or after 25 years of age),
- age at first use for cocaine is similar to heroin,
- a large majority of MDMA users (81%) started at 15-19 years, and
- age at first use is higher regarding hypnotics and sedatives : respectively 23, 19, 16 and 18 % of patients when aged 15-19, 20-24, 25-29 and 30-34 years.

Age at first use was similarly distributed among patients treated for the first time (First treatment demands).

Figures are comparable in Charleroi centres: the average age when a subject takes heroin for the first time is 19.5 years (stable from 1995 to 1999) (Goelens and De Clerck 2000). The methadone first use age (it means the start of the substitution treatment) is 24.1 years in 1999. First use of cannabis of patients undergoing treatment decreases regularly from 16.4 years in 1995 to 15.6 years in 1999.

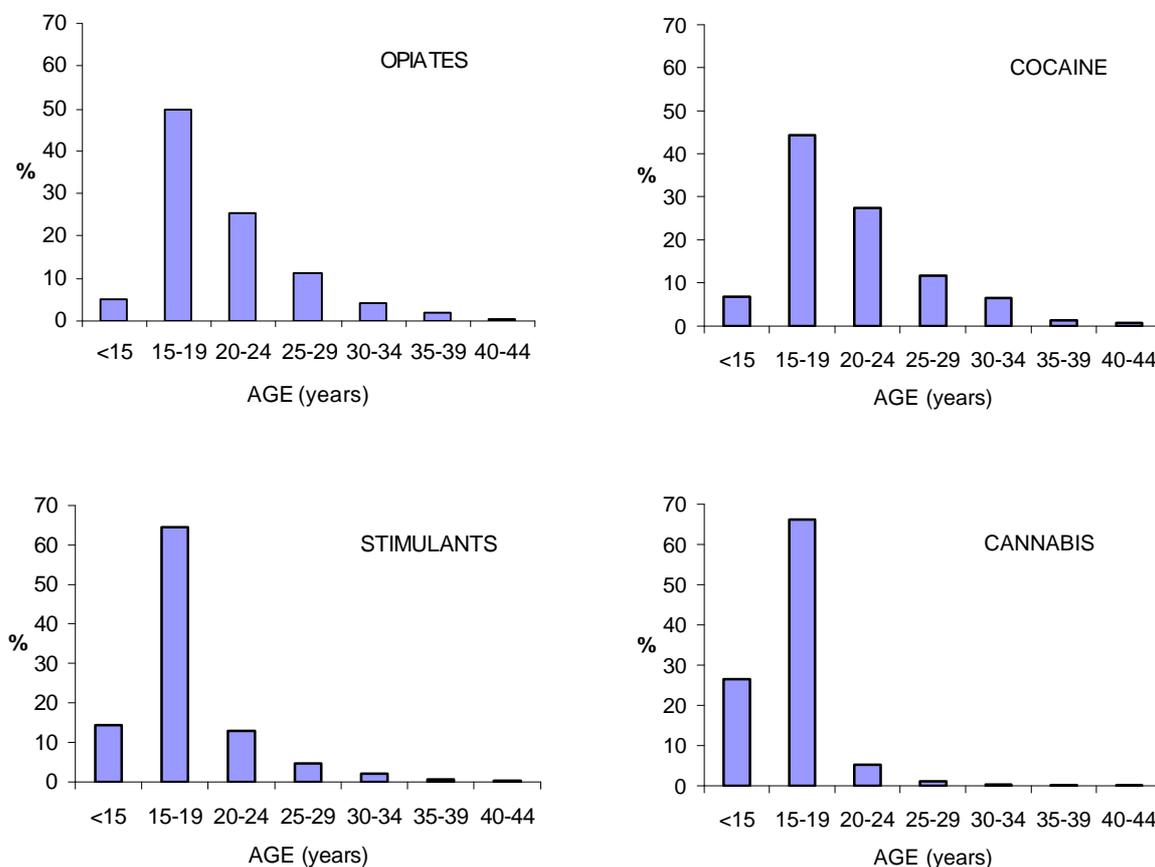


Figure 3.3 : Age at first use, Belgium, 1999

Frequency of use

One observes some differences in the frequency of use of the main drug according to the drug (Figure 3.4):

- most of opiates and of hypnotics users consume their product daily, respectively 60 and 64%,
- a third of users of cocaine are using it daily (35%), 22% 2-6 days a week and 13% once a week or less,
- stimulants and cannabis present an equal distribution between daily, 2-6 days/week and once a week or less users. One observe that 42% of MDMA users use it once a week or less,
- when stating as main drug opiates, cocaine, stimulants or hallucinogens, it should be noted that a fifth of patients use occasionally its main drug. That proportion is lower (10%) for hypnotics users and cannabis users.

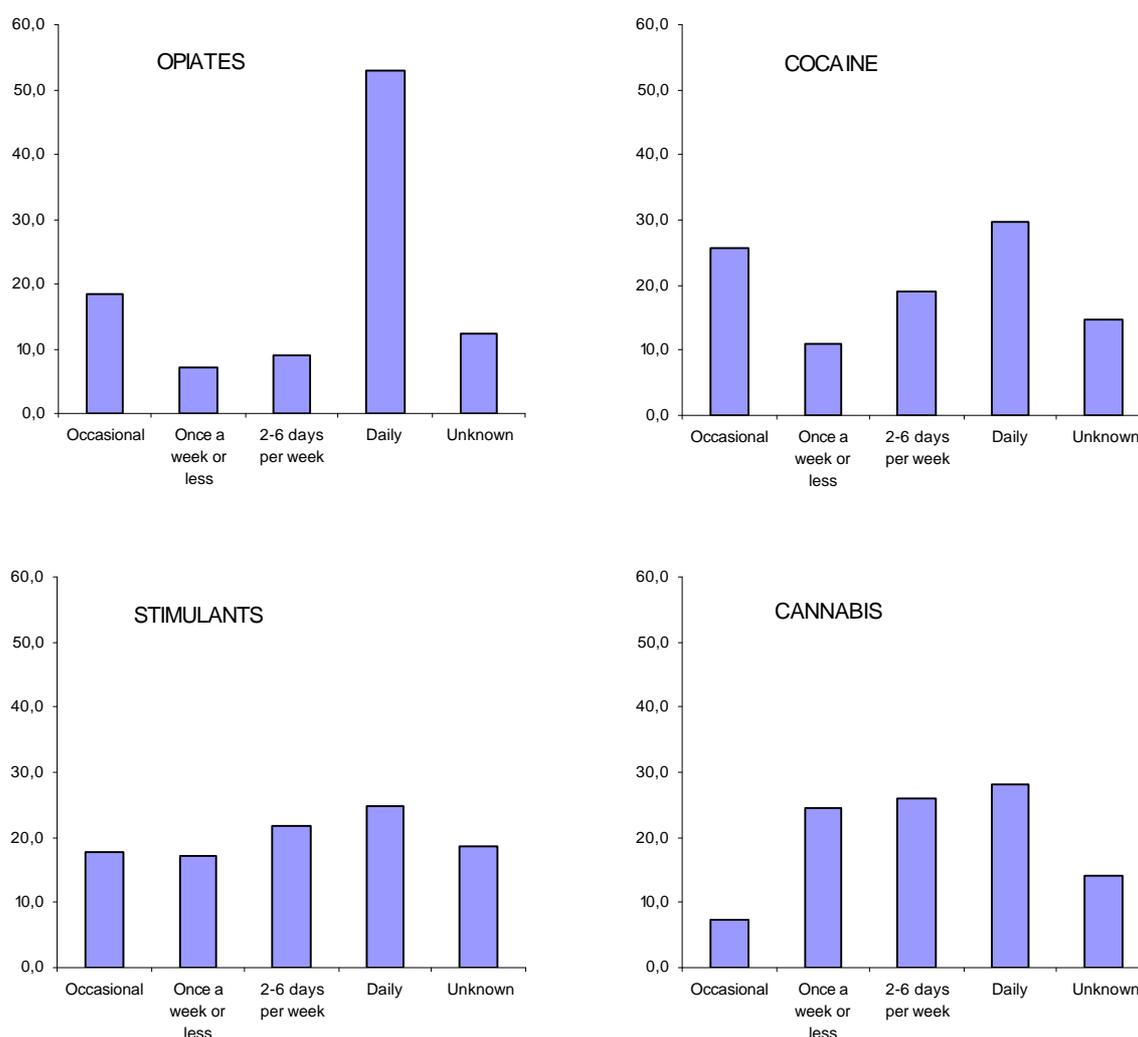


Figure 3.4 : Frequency of use, Belgium, 1999

3.1.b Client profiles in different type of treatment

More than 60 % of registered cases are treated in outpatient centres whereas 38% are in residential centers (table 3.6). The number of patients followed by physicians participating to the general practitioner network «ALTO » amounted to 95 and 172 in 1998 and 1999, respectively (EUROTOX-CCAD).

In the three systems, around one third of treatment demands are registered in specialized residential centres. Most of patients (68%) registered by VAD in 1998 and 1999 demanded for treatment in units based in general services (mental health care centres) whereas 50% and 74% of patients registered by CCAD (1998) and CTB/ODB (1997), respectively, were treated in specialized non-residential centres.

Table 3.6 : Number of patients registered by regional monitoring systems, Belgium, 1998-1999

Monitoring system	Year	%	TOTAL*		OUTPATIENTS		INPATIENTS	
			All	First *	All	First *	All	First *
EUROTOX	1998	18	1491	518	816	301	482	79
CTB-ODB		22	1836	77	1119	n.a.	717	77
VAD		60	4855	2568	3115	1800	1740	768
BELGIUM		100	8182	3086	5050	2101	2939	847
ASL	1999	1	95	41	73	35	0	0
EUROTOX		10	1026	333	570	234	284	43
CTB-ODB		10	1054	231	837	120	217	111
VAD		79	8098	4235	4700	2764	3398	1471
BELGIUM		100	10273	4840	6180	3153	3899	1625

* TOTAL includes outpatients, inpatients, patients treated by GPs, and patients treated in prison

In 1999, more than half of all registered applicants for care (53%) had already been treated on previous occasions. This figure is lower in the VRM-VAD database (48%) and much more higher in the EUROTOX database (68%). This difference is due to the definition of 'first treatment': in the EUROTOX system, 'first treatment' is defined as the first treatment for a drug problem in any centre when for VAD it means the first treatment in the same centre. Technical problems caused misregistration of the variable 'previous treatment' among outpatients in the CTB-ODB system.

Sex and age distributions

The sex ratio is similar for all treatment demands and first treatment demands: 2.7 vs 2.8 (table 3.7). Different male/female ratios are obtained when comparing outpatients (3.4) with inpatients (2.0) for all treatment demands, but these ratios mainly reflect the VRM-VAD figures. In Eurotox, the sex ratio shows an opposite trend: 2.1 and 3.4 in outpatients and inpatients, respectively. The male/female ratio of patients registered in Brussels (CTB-ODB system) is higher among outpatients (5.6) as well as among inpatients (4.4).

Table 3.7 : Male/female ratio of patients registered by the regional monitoring systems, Belgium, 1999

Monitoring system	n	TOTAL*		OUTPATIENTS		INPATIENTS	
		All	First *	All	First *	All	First *
EUROTOX	1026	2.4	2.5	2.1	2.3	3.4	3.8
CTB-ODB	1054	5.3	5.8	5.6	7.6	4.4	4.6
VAD	8098	2.6	2.7	3.4	3.2	1.8	1.9
BELGIUM	10273	2.7	2.8	3.4	3.3	2.0	2.0

* TOTAL includes outpatients, inpatients, patients treated by GPs and patients treated in prison

The mean age is 27.8 years. It is lower among outpatients (26 years) than among inpatients (30.6 years, table 3.8). As expected patients treated for the first time are younger. The mean age of patients registered in the VAD system is lower compared to the mean age of those registered in the EUROTOX and CTB-ODB systems (27.3 vs 28.6 years, and 27.3 vs 30.7 years respectively).

Table 3.8 : Mean age of patients registered by the regional monitoring systems, Belgium, 1999

Monitoring system	n	TOTAL ^a *		OUTPATIENTS		INPATIENTS	
		All	First *	All	First *	All	First *
EUROTOX	1026	28.6	n.a.	28.2	n.a.	29.5	25.8
CTB-ODB	1054	30.7	29.3	30.7	28.4	30.6	30.2
VAD	8098	27.3	26.2	24.9	24.3	30.5	29.9
BELGIUM	10273	27.8	26.4	26.0	24.5	30.6	29.8

^a : TOTAL includes Outpatients, Inpatients, patients treated by GPs and patients treated in prison

Currently, the registration of patients through a GP network is only limited to the French Community.

A first treatment was demanded by 47 % of the registered patients. The proportion of first treatment demand was slightly higher among outpatients (51 %) than among inpatients (42 %).

Self-referred treatment is reported by 21 and 32 % of outpatients and inpatients, respectively. Courts or probation or police have directed towards treatment nearly one third of the outpatients compared to only 8 % of the inpatients. A proportion of 15,5 % of outpatients have been directed to treatment by other drug treatment centres compared to about 30 % for the inpatients.

Nearly one third of the outpatients are less than 20 years old, and more than 50% of them are aged less than 25 years. The sample of registered inpatients is older : 14 and 37 % are aged less than 20 and 25 years, respectively.

Among the patients treated for the first time, 38 % of the outpatients are aged less than 20 years compared to 14 % for the inpatients.

The proportion of outpatients living with parents amounts to 49 % whereas only 17 % are living with a partner. This trend is reverse among inpatients where inpatients living with parents represent 22 % of the sample and inpatients living with partner 40 %. Stable accommodation was reported by 72 % of the outpatients and unstable accommodation by 5%. Similar proportions are observed among inpatients : 70 and 10 % respectively. However the proportion of missing values for this item is very important : 87 and 77 % among inpatients and outpatients, respectively.

Main drug used

Opiates are used as main drug by 34, 31 and 93 % of inpatients, outpatients and patients registered in the GP's network ALTO, respectively. Daily use of opiates was reported by 60 % of the inpatients considering all treatment demands, and 84 % of the inpatient treated for the first time.

Problematic use of cannabis is reported by one third of the outpatients (34%), problematic use of opiates by 32 % and problematic use of stimulants by 19 %. The use of opiates as main drug is mentioned by 33% of the inpatients, whereas the use of hypnotics and sedatives and the use of cannabis are reported by 22 and 11 %, respectively.

The use of hypnotics and sedatives as main drug is more frequent in women than in men : the ratio males/females ranging from 0.5 to 0.8 in outpatients and inpatients, respectively. On the contrary, the proportions of men to women are higher for all the other drugs with a sex ratio ranging from 2.6 to 5.3. In males, the age distribution differs with the main drug used. Cannabis and amphetamine users are younger than opiate and cocaine users who, in turn, are younger than hypnotic and sedative users.

The same pattern is observed among inpatients and outpatients, as well as among patients treated for the first time.

Among inpatients reporting hypnotics and sedatives use as main problematic drug, women aged more than 40 years represent 43 % of this group compared to 30 % in men.

Substitution treatment

Data on substitution treatment are only registered in the EUROTOX registration system. A high proportion of patients has previously received a substitution treatment : 61 % among outpatients and 85% among inpatients.

Injecting use of drugs

Three categories of substances are injected a significant proportion : opiates (42 % of inpatients and 32 % of outpatients), cocaine (28 % among inpatients and 13 % among outpatients) and stimulants (23 and 10 % among inpatients and outpatients, respectively). Similar proportions are observed for patients treated for the first time. However, only 14 % of the patients treated by GPs inject opiates.

The proportion of currently injecting users among inpatients (27%) is higher than among outpatients (22%) and among patients registered in the GP network (16%). The same pattern is observed for ever injected, but not currently, users, the proportion among inpatients (29%) being higher than among outpatients (17%) and among patients registered in the GP network (16%).

Opiates were currently injected among 40 % of the inpatients using these drugs and treated for the first time. The same proportion was observed for cocaine and stimulant users, respectively, treated as inpatients for the first time. In the sample of outpatients treated for the first time, these proportions were lower: 30, 28, and 15 %, respectively. It should also be mentioned that inpatients and outpatients using cannabis, treated for the first time, reported to currently injecting cannabis in 16 and 9 cases out of hundred, respectively.

Poly-drug use

Poly-drug use (primary drug and secondary drug used) is known for 5,248 patients. In descending order of importance, the most frequent associations are opiates-cocaine (22.8%), cannabis-stimulants (16.4%), stimulants-cocaine (8,1%), opiates-cannabis (7.2%), opiates-hypnotics (6.7%) and various forms of stimulants (5.2%). A detailed analysis of poly-drug use is provided in **Part IV, Chapter 11**

3.1.c Treatment demand for different drugs

Regional monitoring systems

Opiates are the main substances reported as primary drugs causing problem for the patient (33%). This proportion is relatively low compared to figures of other European countries. Even between the regional monitoring systems covering the different parts of Belgium there are differences : figures of ADDIBRU-CTB-ODB (Brussels) and EUROTOX (French Community) report higher proportions of patients treated for their opiate misuse. The Flemish monitoring system (VRM-VAD) is largely covering two types of treatment units generally not covered : psychiatric hospitals and mental health care centers. Table 3.9 shows that around half of the patients treated for hypno-sedative problematic use (49%) are undergoing treatment in psychiatric hospitals and more than half (53%) of cannabis problematic users are treated in a centre for mental health care. Practically it means that the coverage of both these types of unit cause a relative decrease of the number of opiate users undergoing treatment.

Taking into account this coverage characteristics, opiates represent 33% of primary drugs, cannabis 25%, stimulants (including amphetamines, MDMA and other XTC-like drugs), 18% and hypno-sedatives 18% also. One observes that when restricting the analysis to patients treated for the first time, cannabis is the primary substance in 34% of patients and opiates 24%. The distribution of the primary drug among female patients indicates an increased proportion of hypno-sedatives (26%) representing the most frequent substance among female patients treated for the first time.

These figures are quite similar among outpatients (60% of patients of the database are outpatients). Nevertheless cannabis is the primary substance among as well as 'all' cases (34%) as 'first' cases (44% reaching 49% among male patients treated for the first time).

In residential centers, the distribution is different. Opiates are the main substance among as well 'all' cases (33%) as 'first' cases (27%). The second 'primary' drug is the hypno-sedatives (22%). These figures result from different patterns among males and females. In male 'inpatients', opiates are the 'primary' substance (39%) followed by stimulants (19%). Whereas among female 'inpatients', hypno-sedatives represent 43% (46% among 'first' treated female patients) followed by opiates (21%).

Considering the age of patients, cannabis is the 'primary' substance stated by 20 years of age and under. In older age groups, opiates represent the 'primary' substance : the maximum number of opiate users are 25-29 years old. One observes two different patterns of age of treated patients. The first pattern shows a maximum number in young people (aged 15-19 years) then decreasing with age (cannabis, stimulants). The second pattern is a convex curve culminating among 25-29- year aged patients (opiates, cocaine).

Among 'outpatients', the figures and the age distribution are comparable except in 20-24-year old patients, cannabis is also the main substance.

In residential centers, opiates are the 'primary' drug except in 15-19 years old where stimulants are the most frequently stated 'primary' drug.

Table 3.9 : Distribution (%) of the 'primary' drug according to type of centre, VRM-VAD, Flemish Community, Belgium, 1999

Type of center	Primary drug						
	Opiates	Cocaine	Stimulants	Hypn/sed	Halluc	Cann	Other
Psychiatric hospitals	10,6	4,0	13,9	49,3	1,0	11,3	11,2
Psychiatric unit of general hospitals	24,5	9,8	14,4	22,2	0,6	18,2	10,4
Mental health care centres	10,1	4,8	20,4	5,6	0,8	53,1	6,1
Low threshold centers	62,6	7,2	17,2	2,0	0,2	10,2	0,7
Day centers	25,9	13,8	28,1	1,9	0,5	29,1	0,9
Crisis centers	48,6	15,3	27,7	1,7	0,3	5,9	0,4
Therapeutic communities and other residential centers.	43,9	13,8	34,4	2,3	0,0	5,5	0,0

Hospital discharge data

RCM/MKG (Résumé Clinique Minimum / Minimale Klinische Gegevens) and RPM/MPG (Résumé Psychiatrique Minimum / Minimale Psychiatrische Gegevens) are registration systems operating respectively in general hospitals and in psychiatric hospital and psychiatric units of general hospitals. The aim of these systems are to provide information on the number of patients admitted in hospitals and on various characteristics related to the diagnoses and the treatment. The data of RCM/MKG of 1995 and RPM/MPG of 1996 (second mid)-1997 (first mid) were analyzed (table 3.10). We present some results extracted from the first issue of the RCM/RPM Flash (Ministry of Social Affairs 1998). Further analyses have not been performed.

The hospital stays where the diagnoses (main or associated) are related to the use of illicit drugs, amphetamines or solvents were selected. This figure represents an over-estimate of the number of patients as one patient can stay several times in hospital during one year. When several diagnoses were mentioned, a hierarchical ordering was used as follows : poly-addictions, opiates, cocaine, hallucinogens, amphetamines, cannabis, induced troubles, intoxications, non-specified. As medical use of opiates was excluded for the analysis, opiates consumption means in fact heroin consumption. All poly-addiction diagnoses included the use of heroin.

Table 3.10 : Annual number of stays related to drug use in medicine/surgery (1995) and psychiatric units (1996-97) of Belgian hospitals

Drug use	Medicine – surgery units	Psychiatric Units	Total
Opiates	1,945	1,742	3,687
Cocaine	129	246	375
Cannabis	145	779	924
Hallucinogen/amphetamine	343	483	826
Poly-addiction	46	1,707	1,753
Unclassified	1,570	1,866	3,436
Not specified	2,903	429	3,332
Total	7,081	7,252	14,333

More than 14,000 stays per year are connected to a problematic drug use: around half of the stays are hospitalisation in medical or surgery units. Opiates (heroin) is the main reason when the reason is specified : 75% of cases in medicine/surgery units and 35% in psychiatric units.

The proportion of poly-addiction is high in psychiatric units : 24% of all cases (34% when not taking into account unclassified and not specified diagnoses). From the RPM/MPG, 68% of stays are associated with a psychiatric co-morbidity and 20% a somatic co-morbidity.

Records where the drug is 'unclassified' or 'not specified' are frequent especially in medicine/surgery units (63%). Several reasons are possible. When one code of ICD9 or DSM IV cover different substances, it is consequently not possible to specify the involved drug. On the other hand, it seem that some clinicians prefer not reporting or specifying the use of illicit substance in any administrative/official report in order to ensure privacy or for medico-legal reasons (but it is clear that the information is processed in an anonymous way).

Overdoses cannot be estimated as most of them are treated in emergency units, not covered by the RCM/MKG or RPM/PMG systems.

Substitution treatment in specialized treatment centres

Up to 1998, this information could only be obtained for the French Community. Since 1999, this information is also registered in the Flemish Community system (although some institutions could already provide figures). Nevertheless this information is very partial: indeed in Belgium, most treatments are offered by general practitioners and are not yet covered by the treatment demand indicator information system. This situation is fully true for the French Community whereas a distinction should be made for the Flemish Community, where the involvement of GPs started very recently (before that, specialized centres were practically the only ones to offer methadone treatment in Flanders).

Among patients demanding treatment in the centres of the French Community (Preumont and Bils 2000), 13% (222/1,681) in 1997 as well as in 1998 (194/1,466) were undergoing a substitution treatment with methadone. Mean age was respectively 27.1 and 29.3 year old (to be compared with the mean age of all treated patients respectively 27.4 and 31.5 year in 1997 and 1998). As expected, patients substituted for the first time are younger : in 1998, their mean age was 27.8 compared to 29.3 for all substituted patients and 31.5 for all patients (table 3.11).

Table 3.11 : Number and characteristics of people undergoing methadone substitution treatment, French Community, CCAD, 1998

	All treatment			First treatment		
	Males (n=139)	Females (n=55)	Total (n=194)	Males (n=27)	Females (n=13)	Total (n=40)
Mean age	29.0	30.0	29.3	28.2	27.1	27.8
Age distribution (%)						
<25 years	38.8	23.6	34.5	33.3	30.8	32.5
25-39 years	53.9	67.3	57.7	59.3	69.1	62.5
40 years and over	7.2	9.0	7.7	7.5	0.0	5.0
IVDU when starting treatment (%)						
Currently injecting any drug	31.1	36.0	32.6	-	-	-
Ever injecting any drug	49.6	50.0	49.7	-	-	-

The mean age at starting methadone substitution in centres of the region of Charleroi (Goelens and De Clerck 2000) is stable (respectively 24.2, 23.3, 23.6, 13.9 and 24.1 year old from 1995 to 1999) and started 4 years after the first use of methadone (4.1 to 4.8). Twelve percents of substituted patients got at least once methadone which was not prescribed : this proportion was stable over years. In 1999, in the treatment centres van De Sleutel, 23% of patients among 852 for which medical data are recorded started a methadone substitution treatment (Raes 2000).

Estimate of the number of people undergoing methadone substitution

Figure 3.5 presents the quantities of methadone sold in Belgium based on data centralised by the Ministry of Public Health - General Pharmaceutical Inspectorate (Inspection Générale de la Pharmacie-Service des Stupéfiants / Dienst Verdoovende Middelen van de Algemene Farmaceutische Inspectie; Van Den Bosch personal communication).

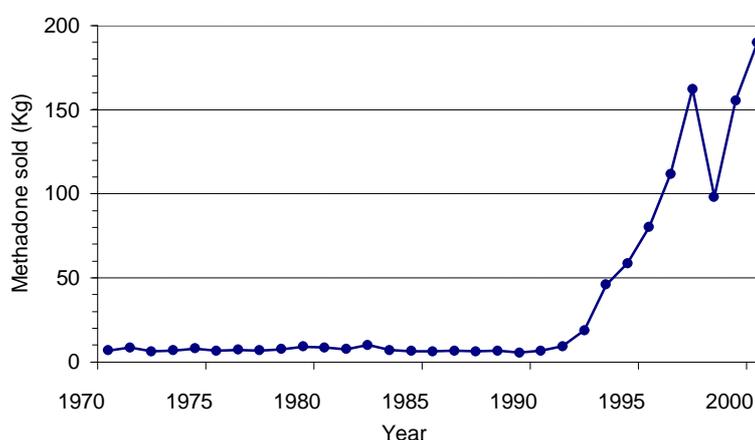


Figure 3.5 : Trend of release of methadone in Belgium from 1975 to 2000 (the 1996 figure is probably underestimated)

The increase of global quantities of methadone is striking since 1990. Before 1990, the small peak observed in 1982 corresponds to a period when the medicalization of the use of methadone was very large. The increase started before the 'Conférence de Consensus sur la méthadone / Consensusconferentie over methadon' (October 1994). Nevertheless the impact of the 'Conférence / Conferentie' made easier the prescription of methadone. The increase in methadone use since the end of 1994 is observed on Figure 3.5. The increasing trend is continuing since 1997. These data will allow to determine an estimate of the number of patients undergoing a substitution treatment with

methadone (calculation based on the quantities of methadone sold by wholesalers to pharmacies divided by a mean daily used quantity per patient) but there are some methodological problems to obtain a reliable figure of the quantities sold in Belgium as well as for the determination of the mean daily dose (differences between the regions, the cities regarding the daily dose, the compliance,...).

Patterns of use

Treatment centres : French Community, 1995 (Preumont and Bills 2000)

The average age when a subject takes heroin for the first time (978 individuals) is 19.3 years and the addiction lasts on average for 6 years. The requests from people of Belgian nationality represent 88% of the total number of requests. The courts constitute the source of referral for 8% of drug users, an individual request of subject 38%, general practitioner 10%, hospital 9%, parent or family 9%, friends 9% and another centre 8% (unknown 9%).

Treatment centres : Charleroi, 1995-1999 (Goelens and De Clerck 2000)

Figures are comparable in Charleroi centres: the average age when a subject takes heroin for the first time is 19.5 years (stable from 1995 to 1999) and the addiction lasted on average 6.6 years (1997 data).

First use of cannabis of patients undergoing treatment decreases regularly from 16.4 years in 1995 to 15.6 years in 1999 (Table 3.12). The methadone first use age (it means the start of the substitution treatment) is stable : 24.1 years in 1999.

Table 3.12 : Age at first use of substances, Charleroi, 1995-1999

Substance	Mean age (sample size)				
	1995	1996	1997	1998	1999
Cannabis	16.4 (481)	16.1 (509)	16.1 (510)	16.0 (606)	15.6 (674)
LSD	19.0 (138)	18.6 (153)	19.4 (164)	19.0 (220)	18.8 (244)
Heroin	19.8 (564)	19.3 (490)	19.5 (542)	19.4 (597)	19.5 (709)
XTC	20.7 (149)	19.8 (174)	20.2 (195)	20.6 (268)	20.0 (287)
Cocaine	20.4 (342)	19.9 (346)	20.0 (366)	20.0 (482)	20.2 (589)
Medicines	20.6 (195)	20.4 (251)	21.0 (258)	20.0 (308)	21.5 (330)
Methadone	24.2 (349)	23.3 (350)	23.6 (379)	23.8 (466)	24.1 (546)

Rapid Opiate Detoxification under General Anesthesia

The Rapid Opiate Detoxification under General Anesthesia (RODA) is proposed to opiate dependent patients to induce an Opiate Receptor Blockade (ORB) with Naltrexone, a long lasting opiate antagonist (24 h), which is thought to reduce relapse rates. Several evidences support the assumption of a better detoxification completion, a good compliance and consequently higher abstinence rates if the detoxification technique is as short as possible and not painful. This is the role of the induced detoxification under general anesthesia. Many studies support the hypothesis of a substantial benefit in inducing an ORB through a RODA in opiate dependent patients. However, prospective studies and long term evaluation of the technique are lacking. In order to evaluate long-term abstinence rates among a sub-type of opiate addicts, studies were started in several Belgian hospital units (Pinto et.al. 2001; Hanak et al. 2000).

3.2. DRUG-RELATED MORTALITY

3.2.a General population mortality register

Aiming at the identification of mortality due to drug use in the Population mortality register, the following codes of the International Classification of Diseases version 9th were selected (alcohol was excluded when possible) :

304	Drug dependence
305	Nondependent abuse of drugs
E850-E858	Accidental poisoning by drugs, medicaments and biologicals : opiates and related narcotics, barbiturates, other sedatives, hypnotics, tranquillisers, antidepressants, psycholeptics (hallucinogens), psychostimulants (amphetamine), central nervous system stimulants
E950	Suicide and self-inflicted poisoning: analgesics, antipyretics, antirheumatics, barbiturates, other sedatives, hypnotics, tranquillisers, psychotropic agents, other specified and unspecified drugs and medicaments
E980.0-E980.5	Injury undetermined whether accidentally or purposely inflicted by analgesics, antipyretics and antirheumatics, barbiturates, other sedatives and hypnotics, tranquillisers and other psychotropic agents, other specified drugs and medicament, unspecified drugs and medicaments

According the EMCDDA DRD standard^g, the definition of the groups are as follows :

- 304 : 304.0-304.9;
- 305 : 305.2-305.9;
- E850 - E858 : E850.0, E850.8, E850.9, E851, E852, E853.2, E854.1, E854.2, E855.2, E855.9, E858.8 + N codes according to DRD standard;
- E950 : E950.1 - E950.5 + N codes according to DRD standard;
- E980 : E980.1- E980.5 + N codes according to DRD standard.

Changes have been made to the selection to adapt to the specific Belgian situation (over- and under-inclusion occur because it is impossible to make combinations with more than one N code).

Only underlying causes stated on the death certificates are used. The data cover Belgium completely. The number of deaths (identified on the basis of the selected codes above described) is quite stable over years. In 1995, there were 207 male and 139 female deaths (table 3.13).

Table 3.13 : Number of drug related deaths according to the cause, Belgium, 1986-1995

Gender / Code	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Males	-	-	-	-	-	186	187	195	208	207
Females	-	-	-	-	-	128	138	151	168	139
304	-	-	-	-	-	20	23	13	12	11
305	-	-	-	-	-	12	4	21	13	13
E850-E858	-	-	-	-	-	31	24	89	94	97
E950	-	-	-	-	-	191	209	200	223	204
E980.0-E980.5	-	-	-	-	-	60	65	23	34	21
Total	350	na	365	292	296	314	325	346	376	346

The registration covers all deaths but it is possible that the notification of the cause can vary (work in progress). There could have been variations in the coding throughout time due to different institutions responsible in different Regions for coding. At the end of the eighties, the responsibility of the processing of the forms moved from the federal level to the Community levels. It could probably explain the increased number of 'accidental poisoning' (E850-E858) and the corresponding decrease

^g DRD-Standard Field Trial definitions were used : there are codes that are possibly overinclusive or over- and underinclusive because of the non-availability of specifications required by the DRD-standard.

of 'undetermined injuries' (E980.0-E980.5) due to a methodological variation in coding. For Brussels, there was another change when the Flemish Community started coding the certificates for them as well.

There might be an underreporting due to other causes of death used by physicians who fill out the death certificates. There is no clear view on this yet and no other reference available to estimate the extent of the underreporting. An assessment of the quality of these data is currently in progress.

Table 3.14 shows the relative part of opiates as toxicological cause associated to the death. Based on the most recent data (1995) where toxicological information is specified in the death certificate (60%), opiates are associated in half of cases, showing a slight increase compared to 1991 and 1992.

Table 3.14 : Proportion of drug related deaths according to the toxicological cause, Belgium, 1991-1995

Toxicological cause	1991	1992	1993	1994	1995
Cases with known toxicology (%)	40	51	58	56	60
Opiate +any other drug (%)	32	27	47	48	53
Any drug without opiates (%)	68	77	53	52	47

3.2.b Overdoses registered by police services

There is a register of overdoses that is however not held in a systematic way. The figures do not cover the total amount of fatal overdoses, but only these actually recognized as such and recorded by the police services. Although Table 3.15 (SGAP APSD personal communication) shows a decreasing trend of the annual number of recorded deaths by overdoses, it should be interpreted with caution, as it is reasonable to think that the coverage could vary for the presented period.

Table 3.15 : Number of overdoses recorded by police services, Belgium, 1991-1995

	1991	1992	1993	1994	1995
Overdoses	90	75	80	46	48
Boys	73	60	67	43	na
Girls	17	15	13	3	na
Minors	9	1	0	1	na
Mean age	28	27	28	28	na
Mean age boys	28	27	27	28	na
Mean age girls	27	27	27	28	na

3.2.c Mortality and causes of death in drug-users

As far as we know the only follow-up survey of patients was started in 1996 at the Solbosch therapeutic community (average follow-up two and a half years). It revealed a mortality rate of 9% among patients in the group studied, i.e. an annual mortality rate of 3.6% in this population of former patients (Ledoux et al. 1993; Ledoux et al.1996). However, this study involved a small sample of 80 patients among which there were 7 deaths and 18 patients were lost of follow-up. The generalization of these results is difficult.

3.3. DRUG-RELATED INFECTIOUS DISEASES

3.3.a HIV/AIDS

3.3.a.1 AIDS and HIV-seropositives register

In Belgium, diagnosed seropositive HIV persons and AIDS cases are registered in two integrated databases at the Scientific Institute of Public Health in Brussels (Sasse et al. 1998). Approximately 600,000 blood samples are yearly screened for HIV antibodies with the ELISA assay, excluding testing related to blood donations. Eight reference laboratories are recognised by the Ministry of Public Health to confirm the results of these positive ELISA tests. Since they are the only laboratories subsidised for this confirmation, their reporting on new positive HIV individuals gives the number of newly diagnosed seropositives in the country. Data on age, sex, nationality, residence, and possible route of transmission are collected through a standardised form sent by these laboratories to the physician of each new HIV patient. On the other hand, the newly diagnosed AIDS cases are notified in an independent way by clinicians on a standardised form. They are validated by a Commission of experts referring to the definition of the Centres for Diseases Control, adopted by the European Centre for the Epidemiological Surveillance of AIDS. This Commission guarantees data confidentiality. A follow-up survey is conducted each year to collect data on last consultation and possible death of reported AIDS cases. Since a common code is used to record each case, whether HIV-positive or AIDS, it is possible to avoid multiple counting and also to link the two databases.

From the beginning of the epidemic till December 2000, 12798 HIV infected patients have been registered. Among these, 2717 have reached the clinical stage of AIDS (Sasse et al.2001). Between 1987 and 2000, the average number of new HIV-cases registered were 1.9 to 2.7 per day. The number of HIV infected people is much greater among males than among females. Since 1997 an increasing trend in the number of new diagnosed cases of HIV infection is observed (table 3.16). Information on the risk factor status is globally available for 61 % of cases.

Table 3.16 : Number of new HIV-cases, number of new cases with IDU* as risk status, in Belgium, per year, from the beginning of the epidemic to 2000

Year	Incident HIV cases	HIV with IDU			
		Total	15 - 24 years	M	F
1985 and before	654	58	37	47	11
1986	739	45	27	32	13
1987	929	47	17	31	16
1988	748	65	20	50	15
1989	753	55	19	46	9
1990	810	41	9	35	6
1991	803	38	11	26	12
1992	977	37	9	29	8
1993	943	31	5	29	2
1994	802	38	7	31	7
1995	765	15	2	10	5
1996	717	14	4	10	4
1997	690	18	3	12	6
1998	750	11	1	7	4
1999	796	12	2	7	5
2000	922	20	2	16	4

* Intravenous Drug Use

The proportion of IDU-HIV cases (cases of HIV with intravenous drug use as risk factor) decreased, reaching 3.4 % in 1995, and then remain relatively stable (figure 3.5). It is striking that the proportion of drug users among seropositives and AIDS cases is very low in Belgium compared to some

European countries (reaching 60 % or more in Spain) (European Centre for the Epidemiological Monitoring of Aids 2000).

Infection via intravenous drug use is the highest among young people, but it becomes comparable in the last years (figure 3.6). Among infected people aged between 15 and 24 years, the number of new cases stating IDU is quite low, respectively 1 case in 1998 and 2 cases in 1999 and 2000. This declining trend will have to be confirmed in the long run.

Since 1995 the proportion of IDU-HIV cases is similar among males and females (figure 3.7).

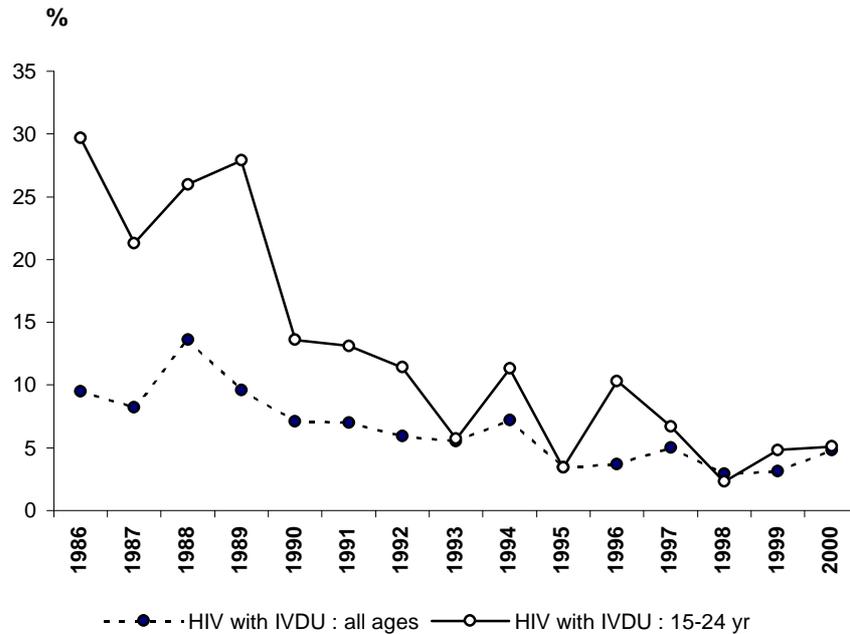


Figure 3.6 : Percentage of IDUs among new HIV-cases from 1986 to 2000 in Belgium (all ages and 15-24 years)

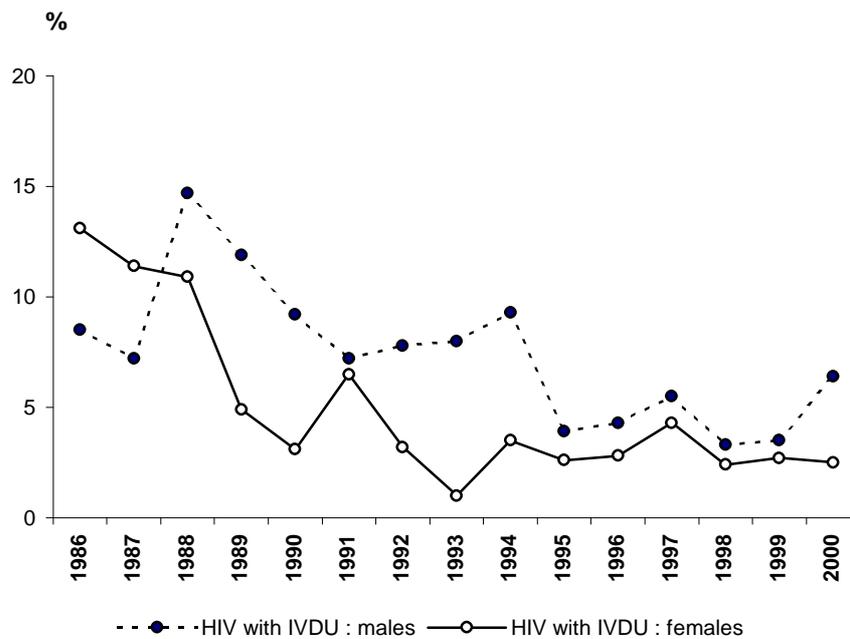


Figure 3.7 : Percentage of IDUs among new HIV-cases from 1986 to 2000 in Belgium, according to sex

3.3.a.2 HIV sero-positivity among drug users

During a snowball survey carried out in 2000, 574 drug users have been interviewed in Brussels, the provinces of Hainaut oriental (Charleroi) and Namur. The mean age of users is 29 years; female are 30 %. 61 % of users are unemployed, migrants are 54 %, without social welfare insurance 12 %, homeless 9 %. 70 % are or have been under treatment for their drug consumption. 345 users (60 %) reported to have ever injected. The mean age for first injection is 19 years and range from 10 to 32. 266 of these users reported to have been tested : the result was positive for 12 of them 4.5 %; (Hariga F., Modus Vivendi, personal communication).

3.3.a.3 HIV sero-positivity among treated patients

Most of monitoring systems register information on the infectious status of the patients. Usually the information is based on the reporting by the patient him/her-self.

GEMT (Groupe d'Etude des Maladies liées à la Toxicomanie : study group of drug-related diseases) is a group of general practitioners with family practice, having also drug user patients in charge (mostly by methadone maintenance) in Charleroi (Wallonia). Biological testing was performed in the framework of the GEMT studies (1992-93 (Denis et al. 1993) and 1995 (Denis et al. 2000); table 3.16).

In 1994, 523 questionnaires were filled in by drug users treated by general practitioners, most of them participating in the ALTO programme (ALTO is a group of general practitioners giving care to drug users in the French part of Belgium) (Tafforeau et al.1995) . Patients (males : 78 %; mean age : 26 years) were mainly heroin users (mean age at start : 20 years, mean duration of use : 6.2 years). 77 % stated that they have been tested for HIV; 348 knew the results of the test : 2.9 % stated to be HIV-positive. In this study, there was no association between HIV status and IDU, but the number of positive cases is low.

In the framework of the Flemish GIG project (Gezondheidsbevordering bij Injecterende Gebruikers : health and injecting drug users), a six-month study was conducted in 1996-97 (Driesen et al. 1997) : 248 IDUs were interviewed according to an European questionnaire developed by the workgroup "AIDS and intravenous drug use". Respondents were users having contact with ambulatory or residential centres or users recruited by the snowball method. An HIV test was offered to everybody. Among 225 people tested for HIV, 5 were seropositive (2.2 %); all five had stated before testing that they were HIV-seropositive.

"De Sleutel" (De Sleutel 1998-1999-2000) is an organisation with several ambulatory and residential treatment centres in Flanders (1997 : 862 unique and new clients; 1998 : n=1186; 1999 : n=1945; 2000 : n=1870), conducting also prevention interventions. Biological testing is performed only for the clients seeing a doctor. Criteria for seeing a doctor are not linked to the type and/or the way of product-use, but all clients getting substitution and/or other medication do see a doctor. There is an overlapping between the data of "De Sleutel" and data of VAD (Vandenbussche and Wydoodt 2000; Vandenbussche 2001), but its extent is not estimated.

Table 3.17 : Percentage of HIV-infected patients among IDUs* asking for treatment : data reported by various systems (sample size into brackets)

Source	Area	Method	IDU	1992	1993	1994	1995	1996	1997	1998	1999	2000
GEMT – Charleroi	French Com.	Biological Diagnosis**	At least once	1.6 (249)	-	-	0.9 (228)	-	-	-	-	-
ALTO	French Com.	Self-report	All users	-	-	2.9 (348)	-	-	-	-	-	-
CCAD / EUROTOX	French Com.	Self-report	At least once	-	4.9 (245)	5.7 (230)	3.0 (230)	1.4 (284)	2.6 (270)	1.6 (252)	2.0 (244)	-
GIG-project	Flemish Com.	Biological diagnosis**	At least once	-	-	-	-	2.2 (225)	-	-	-	-
De Sleutel	Flemish Com.	Biological Diagnosis**	At least once	-	-	-	-	-	0.8 (120)	5.4 (56)	0.5 (186)	1.2 (161)
VAD	Flemish Com.	Self-report	Last 12 months	-	-	-	-	-	-	1.9 (373)	1.9 (628)	-

* : except in the ALTO study; ** : serological test

As the numbers of tested IDUs are low, caution should be taken in the interpretation of table 3.17. Nevertheless although the GEMT studies reported low rates in 1992 and 1995, one observes in the CCAD/EUROTOX figures a declining trend since 1995 that is compatible with recent data of VAD and "De Sleutel", except the figure of 1998 (5.4 %) of "De Sleutel" but this is calculated on a low number of patients (n=56).

Table 3.18 presents the proportion of self-reported HIV-seropositivity among users starting treatment in centres in the French Community (Hariga F., Eurotox, personal communication) and table 3.18 presents the proportion of HIV-seropositivity based on biological testing, among users starting treatment in centres from "De Sleutel" (Raes 2000). Owing to the small number of cases no conclusions can be drawn.

Table 3.18 : Percentage of self-reported HIV-seropositivity among IDUs asking for treatment in centres of the French Community

Year	1993	1994	1995	1996	1997	1998	1999
Number of treatment demands from IDUs	570	531	503	615	602	493	391
Number of tested IDUs (self-reported)	245	230	230	284	270	252	244
Number of HIV+ (self-reported)	12	13	7	4	7	4	5
% HIV+ of tested IDUs	4.9	5.7	3.0	1.4	2.6	1.6	2.0
% in males	5.2	5.5	2.9	0.9	2.1	1.5	2.3
% in females	3.9	6.3	3.6	2.7	3.8	7.7	1.5
% in age <25	4.0	2.4	2.6	1.2	0.0	2.5	0.0
% in age 25-34	5.6	8.7	3.1	1.7	3.2	2.5	1.4
% in age >34	5.0	4.5	4.3	0.0	4.3	2.3	5.7
% in opiate using IDUs	3.8	7.3	4.5	1.8	0.8	4.4	1.0
% in IDUs not using opiates	5.5	4.2	1.7	0.9	4.3	1.4	6.9

Table 3.19 : Percentage of HIV-seropositivity among IDUs starting treatment in centres from "De Sleutel"

Year	1997	1998	1999	2000
Number of treatment demands from IDUs	236	75	352	303
Number of tested IDUs	120	56	186	161
Number of HIV+	1	3	1	2
% HIV+ of tested IDUs	0.8	5.4	0.5	1.2
% in males	0	6.0	0.6	0.7
% in females	4.3	0	0	3.4
% in age <25	0	0	0	1.5
% in age 25-34	2.6	10.3	1.2	1.5
% in age >34	0	0	0	0

A seroprevalence study was made on patients seen at an outpatient clinic in Antwerp between January 1 and June 30, 2001. In this 6-month period 477 individuals visited the clinic, 337 (71 %) of them were male and 140 (30 %) were female (Matheï C., Free Clinic - Antwerp, personal communication). The age distribution in this population varied between 25 and 58 years. The mean age was 35 years. Three hundred and thirty three (70 %) individuals reported to have used drugs by intravenous way at least once in their lives.

HIV seroprevalence data are available for 336 out of the 477 patients (70 %). Seventeen individuals (5.1 %) were anti-HIV positive. Fifteen of them were intravenous drug users; this means a seroprevalence of 5.9 % (table 3.20).

Table 3.20 : Sero-prevalence of HIV in an outpatient clinic in Antwerp in 2001 (sample size into brackets)

IDU	Anti-HIV+
Yes	5.9 % (254)
No	2.4 % (82)
Total	5.1 % (336)

3.3.a.4 HIV sero-positivity among prisoners

The health service of the penitentiary administration provides figures about the HIV status of prisoners (Service de santé de l'administration des établissements pénitentiaires personal communication). In the 'prison hospital' service acting as hospital of the prisons of the Flemish Region, systematic screening of all 'hospitalised' prisoners is performed. Drug use status, and thus IDU status, are however not known. Only the last test for each patient was taken into account. In 1999, 1 patient was HIV-positive among the 316 tested (0.3 %). In 1998, the proportion was 0.6 %.

In the prison of Lantin (Wallonia), serological testing is performed on request of either prisoners or doctors. Drug use and administration route are not known. Only the last test for each patient was taken into account. In 1999, 8 prisoners were diagnosed HIV-positive among 666 having been tested (1.2%). In 2000, 7 of the 740 tested prisoners (0.95 %) were diagnosed HIV-positive.

In 1997, a study was carried out in the prison of the city of Namur (Wallonia) (Hariga 1998c). Among 175 prisoners, 115 (66 %) participated. Fifty-one percent stated having been HIV-tested previously, of whom 5.4% (3/56) reported a positive result. HIV-testing of the saliva was performed. Results are known for 112 HIV tests: none was positive (even those related to the 3 prisoners who reported a positive result).

In 1997, the penitentiary administration estimated that the prevalence of HIV among prisoners was 2%(Van Mol 1997). In 1987, it was estimated to be 1.3 % (Harding 1987). Two studies carried out in 1992 and 1993 produced similar prevalences : 1.2 % (12/996) in Antwerp (Todts et al.1997), and 0.8

% among males and 1.7 % among females in a study among 893 detained persons (14 % of detained persons) randomly selected in 14 Belgian prisons (IDEWE 1994). Besides differences according to sex, this second study showed the highest prevalence among the 25-34 age group (2.2 %).

3.3.b Hepatitis B and C

The intravenous use of drugs and the transfusion of blood and its derivatives, are the two main risk factors associated with the transmission of hepatitis C. In Belgium, IDU seems to be the first cause of HCV contamination at this time (Delwaide et al. 1997). The other sources of transmission, such as mother-child exchanges, sexual and family contamination and medical care are less frequent.

In Belgium, current hepatitis C prevalence in the general population is estimated to be around 1 % : the most precise seroprevalence estimate to date is 0.87 % (95% CI : 0.5-1.1); it is based on a survey carried out in 1993 in the Flemish population (Beutels et al. 1997).

3.3.b.1 HBV- and HCV sero-positivity among treated patients

Since 1997 information on hepatitis status of drug users starting a treatment is registered in centres of the French Community (CCAD (Preumont and Bils 2000)/EUROTOX monitoring system; Hariga F., Eurotox, personal communication) and in the treatment centres of "De Sleutel" (Flanders). Prevalence studies were carried out by GEMT-Charleroi in 1992-93 and 1995. More details on these studies are given in 3.3.1.1.

HCV sero-positivity is more prevalent under IDUs than HBV sero-positivity (table 3.21).

The prevalence rates reported by the GEMT studies (Denis et al. 1993; Denis et al. 2000) are higher, particularly for HCV : it could be due to a selective recruitment of patients or to a true local higher level of the HCV epidemic among the IDUs of Charleroi. Although based on different methods, respectively self-reports and biological diagnosis (anti-HBc), the CCAD/EUROTOX and the "De Sleutel" figures (De Sleutel 2000) are quite similar for HBV (around 20-25 %). They don't show any particular trend over the last 3 years.

Data on prevalence of HBsAg (first virological marker of the virus detectable in serum) are available from "De Sleutel" : they show an increase from 0 % (0/116) in 1997 to 7.4 % (14/190) in 1999 but a decrease to 2.6 % in 2000 (4/154). One should be cautious in interpreting these data because biological testing is performed only for the clients seeing a doctor and there are no guidelines with criteria specifying the patients to be tested.

Between 1997 and 1999, around half of IDUs (having injected at least once) registered through the monitoring system of the French Community, having declared having been tested reported they were found positive for hepatitis C. Between 1997 and 2000, around 40 % of tested IDUs (having injected at least once) patients of "De Sleutel" have antibodies against hepatitis C.

Since 1998, data are also collected by the VAD system (Vandenbussche and Wydoodt 2000; Vandenbussche 2001) (Flemish Community) but the number of tested patients is not known. The data show that HCV is more frequent than HBV : in 1998, 7 patients stated HBV- and 19 HCV-seropositivity among 619 current injectors (whether tested or not), and in 1999, these figures were respectively 106 and 185 among 2840 patients.

In 1994, 523 questionnaires were filled in by drug users treated by general practitioners, most of them participating in the ALTO programme (Tafforeau 1995). Among the 366 IDUs (at least once), 69 % (252) stated that they have been tested for HCV : 56 % stated to be HCV-positive. The association with IDU was obvious : only 9 % of non IDUs were infected.

Table 3.21 : Percentage of HBV- and HCV- infected patients among lifetime IDU patients asking for treatment : data reported by various systems (sample size between brackets)

Source	Area	Method	1992	1993	1994	1995	1996	1997	1998	1999	2000	
HBV												
GEMT Charleroi	French Com.	Biological diagnosis markers)	16.0 (all (232)	-	-	36.0 (238)	-	-	-	-	-	
CCAD/ EUROTOX	French Com.	Self-report	-	-	-	-	-	22.4 (107)	23.6 (237)	20.1 (229)	-	
De Sleutel	Flemish Com.	Biol. diagn. anti-HBc	-	-	-	-	-	20.5 (73)	24.1 (54)	23.9 (155)	21.9 (123)	
		HbsAg						0 (116)	3.5 (57)	7.4 (190)	2.6 (154)	
HCV												
GEMT Charleroi	French Com.	Biological diagnosis	82.0 (181)	-	-	78.0 (244)	-	-	-	-	-	
ALTO	French Com.	Self-report	-	-	56.0 (252)	-	-	-	-	-	-	
CCAD/ EUROTOX	French Com.	Self-report	-	-	-	-	-	46.7 (107)	51.9 (237)	51.1 (229)	-	
De Sleutel	Flemish Com.	Biological diagnosis	-	-	-	-	-	39.5 (114)	46.4 (56)	37.9 (195)	36.0 (164)	

A seroprevalence study was made on patients seen at an outpatient clinic in Antwerp between January 1 and June 30, 2001. More details on this study are given in 3.3.1.1.

Hepatitis B and C status is known for 328 (69 %) individuals (Matheï C., Free Clinic - Antwerp, personal communication).

Hundred and twenty-three individuals (37.5 %) were positive for hepatitis B core antigen antibodies. Nineteen of them (6 %) were also positive for HbsAg. The prevalence of anti-HBc was 43 % among the intravenous drug users compared to 20 % among the non-intravenous drug users (Chi-square, $p < 0.0001$; table 3.22).

Two hundred and fourteen (65 %) tested positive for anti-HCV. The prevalence of anti-HCV within the group of intravenous drug users was 80 % compared to 17 % in the group of non-intravenous drug users (Chi-square, $p < 0.0001$).

Table 3.22 : Sero-prevalence of HBV and HCV in an outpatient clinic in Antwerp in 2001 (sample size into brackets)

IDU	Anti-HBc+	Anti-HCV+
Yes	43 (249)	80 (252)
No	20 (79)	17 (76)
Total	38 (328)	65 (328)

The prevalence of HBV infection in tested IDUs (having injected at least once) registered by the CCAD (Preumont and Bils 2000) / EUROTOX system (self-reported status; Hariga F., Eurotox, personal communication; table 3.23) increases with age; the same is registered in de "De Sleutel" data (De Sleutel 2000) (anti-HBc +; table 3.24).

Table 3.23 : Percentage of hepatitis B infected among IDUs asking for treatment, in centres of the French Community

HBV	1997	1998	1999
Number of treatment demands from IDUs	602	493	391
Number of IDUs tested (self-reported)	107	237	229
Number of hepatitis B + (self-reported)	24	56	46
% hepatitis+ of total IDUs	22	24	20
% infected in males	19	22	21
% infected in females	29	29	19
% infected in age <25	14	19	12
% infected in age 25-34	23	22	20
% infected in age >34	33	36	29
% infected in opiate using IDUs	23	27	21
% infected in IDUs not using opiates	22	21	13

Table 3.24 : Percentage of hepatitis B infected (anti-HBc+) among IDUs starting treatment, in centres of "De Sleutel"

HBV	1997	1998	1999	2000
Number of treatment demands from IDUs	236	75	352	303
Number of IDUs tested	73	54	155	123
Number of hepatitis B +	15	13	37	27
% hepatitis+ of total IDUs	21	24	24	22
% infected in males	23	23	28	22
% infected in females	8	33	7	20
% infected in age <25	11	7	12	8
% infected in age 25-34	27	21	26	26
% infected in age >34	57	50	44	42

The prevalence of HCV infection in tested IDUs (having injected at least once) registered by the CCAD/EUROTOX system (self-reported status; Hariga F., Eurotox, personal communication; table 3.25) increases also with age but to a smaller extent than for hepatitis B; the increase is more important in de "De Sleutel" data (De Sleutel 2000) (HCV Ab+; table 3.26).

Table 3.25 : Percentage of hepatitis C infected among IDU asking for treatment, in centres of the French Community

HCV	1997	1998	1999
Number of treatment demands from IDUs	602	493	391
Number of IDUs tested (self-reported)	107	237	229
Number of hepatitis C + (self-reported)	50	123	117
% hepatitis+ of total IDUs	47	52	51
% infected in males	46	49	49
% infected in females	47	61	56
% infected in age <25	43	49	34
% infected in age 25-34	48	49	54
% infected in age >34	47	58	58
% infected in opiate using IDUs	38	54	50
% infected in IDUs not using opiates	52	50	59

In 1999, in the French Community, 20/229 IDUs reporting having been tested for hepatitis (9 %) stated being both HBV- and HCV- positive.

Table 3.26 : Percentage of hepatitis C infected (anti-HCV+) among IDU asking for treatment, in centres of "De Sleutel"

HCV	1997	1998	1999	2000
Number of treatment demands from IDUs	236	75	352	303
Number of IDUs tested	114	56	195	164
Number of hepatitis C +	45	26	74	59
% hepatitis+ of total IDUs	40	46	38	36
% infected in males	40	40	39	34
% infected in females	39	100	30	47
% infected in age <25	25	21	14	16
% infected in age 25-34	53	52	51	45
% infected in age >34	77	62	63	60

3.3.b.2 HBV- and HCV sero-positivity among prisoners

The health service of the penitentiary administration provides figures about the HBV and HCV infections among prisoners (cfr 3.3.1.1) (Service de santé de l'administration des établissements pénitentiaire personal communication).

In the 'prison hospital' service acting as hospital of the prisons of the Flemish Region, systematic screening of all 'hospitalised' prisoners is performed (Todts et al. 1997). Drug use status, and consequently IDU status, are however not known. Only the last test for each patient was taken into account. In 1999, 7 patients were HBV (HBsAg)-positive among the 314 tested (2.2 %; table 3.27). In 1998, the proportion was 2.1%. The infection rate is most striking for hepatitis C. In 1999, among prisoners systematically screened (without regarding any risk factor such as drug use), 56/321 (17 %) were positive (13 % in 1998).

In the prison of Lantin (Wallonia), testing is performed on request of either prisoners or doctors. Drug use and administration route are not known. Only the last test for each patient was taken into account. In 1999, respectively 51/664 prisoners (8 %) and 191/677 (a very high proportion of 28 %) were diagnosed respectively HBV- (HBsAg) and HCV-positive. In 2000, 27/708 (4 %) were positive for HBsAg and 184/741 tested detained persons (25 %) were HCV positive (Service de santé de l'administration des établissements pénitentiaire perosnl communication).

In 1997, an anonymous and volunteered based survey was carried out in the prison of the city of Namur (Wallonia) (Hariga 1998c). Among 26 detained IDUs, 10 (38 %) were HCV-positive based on saliva test, or 9% of the total number of participants (10/115).

Table 3.27 : Percentage of HBV- and HCV- infected patients among prisoners (sample size between brackets)

Area	Method	1992- 93	1997	1998	1999	2000
HBV						
Flemish Com. (Antwerp)	HBsAg	4 (888)				
Flemish Com.	HBsAg			2	2 (314)	
French Com. (Lantin)	HBsAg				8 (664)	4 (708)
HCV						
French Com. (Namur)	Saliva test		9* (115)			
Flemish Com.	HCV Ab			13	17 (321)	
French Com. (Lantin)	HCV Ab				28 (677)	25 (741)

* 38 (26 IDUs)

3.3.c Tuberculosis

Two organisations are in charge of the epidemiological follow-up of patients with tuberculosis : FARES (Fondation contre les Affections Respiratoires et pour l'Education à la Santé) and VRGT (Vlaamse Vereniging voor Respiratoire Gezondheidszorg en Tuberculosebestrijding).

In Belgium, 1,313 new cases with tuberculosis were registered in 2000 (incidence rate : 12.8/100,000 inhabitants) (Wanlin 1998; Fares 2001). Risk factors were recorded: drug addiction was stated for 14 cases, representing 1.1% of new tuberculosis cases (table 3.28).

Table 3.28 : Number and percentage of drug addicts among new tuberculosis cases, Belgium

	1994	1995	1996	1997	1998	1999	2000
Number of new cases	1,521	1,380	1,352	1,289	1,203	1,270	1,313
Addiction stated : n	8	8	8	7	10	9	14
Addiction stated : %	0.5	0.6	0.6	0.6	0.8	0.7	1.1
No addiction stated	1,499	1,361	1,334	1,275	1,188	1,210	1,217
Not specified	14	11	10	7	5	51	82

The drug addiction risk factor is more frequent in Brussels : respectively 5 (1.5 %), 4 (1.2 %), 3 (0.9%), 6 (1.7 %), 5 cases (1.7 %), 4 cases (1.5%) and 7 (1.9 %) for years 1994 to 2000.

3.3.d Determinants : injecting and sharing

Treatment centres

In the CCAD/EUROTOX database (Preumont and Bils 2000; Hariga F., Eurotox, personal communication), the proportion of intravenous drug use in users undergoing treatment shows a decreasing trend from 30 % in 1993 to 20 % in 1998 (table 3.29).

Table 3.29 : Percentage of intravenous administration in users at the time of starting treatment, French Community

	1993	1994	1995	1996	1997	1998
Number of treatment demands	1,618	1,212	1,176	1,570	1,681	1,466
Current IV route of adm. main drug	30	34	29	24	24	20
Ever injected any drug	35	45	45	44	43	38
Opiates (total)	34	39	36	32	34	33
Heroin	36	41	40	37	37	35
Cocaine	22	27	35	23	35	30

Restricting to patients starting a drug treatment for the first time, one observes in 1999 a lower proportion of 'current injectors' (10 %) as well as 'ever injected' (17 %) : 'only' 18% of heroin users and 12% of cocaine users were currently injecting their drug (table 3.30).

Table 3.30 : Percentage of intravenous administration in users at the time of starting the first treatment, French Community

	1993	1994	1995	1996	1997	1998
Number of first treatment demands	507	381	338	483	517	446
Current IV route of adm. main drug	18	24	22	14	14	10
Ever injected any drug	23	31	32	23	22	17
Opiates (total)	21	30	29	22	25	17
Heroin	21	31	30	24	25	18
Cocaine	14	13	33	19	14	12

For 1998 and 1999, information on injecting behaviour is available for respectively 69 and 85 % of patients of the VAD (Vandenbussche and Wydoodt 2000; Vandenbussche 2001) and CCAD/EUROTOX databases. 11-12 % of patients were "currently" (last month) injecting a drug at the time of the contact for treatment (table 3.31). The percentage of injectors, current or ever, is higher in males than in females ($p < 0.01$).

Table 3.31 : Percentage of intravenous administration in users at the time of starting treatment, according to gender, CCAD/EUROTOX and VAD databases

	1998			1999		
	M	F	T	M	F	T
N with information on IDU	3,318	1,024	4,350	4,668	1,700	6,389
Currently* injecting any drug	12	9	11	13	10	12
Ever injected any drug, but not currently	26	19	24	24	18	22
Ever injected any drug	38	28	35	36	28	34

* injection during the last month

Half the heroin users in treatment in the region of Charleroi (Wallonia) in the period 1995-1999 (Goelens and De Clerck 2000) have at least once injected; for 2000 it is the case for "only" 41 % of users (De Clerck B., personal communication). Regarding cocaine users, figures of 1995-2000 do not show any trend (40 % injecting; table 3.32). For 1999 and 2000, current or past injection behaviour is recorded; for 2000, a fifth of both heroin and cocaine users are currently injecting.

Table 3.32 : Percentage of injecting users in Charleroi (sample size between brackets)

Drug	Ever injecting						Current injecting	
	1995	1996	1997	1998	1999	2000	1999	2000
Heroin	53 (554)	55 (481)	50 (531)	56 (588)	53 (660)	41 (571)	17	20
Cocaine	37 (286)	31 (320)	37 (350)	43 (465)	41 (547)	34 (533)	11	21
Medicines	1.2 (163)	1.3 (233)	1.8 (226)	5.4 (93)	2.6 (230)	1.2 (453)	-	-

General Practitioners (French Community)

In 1994, 523 questionnaires were filled in by drug users treated by general practitioners, most of them participating in the ALTO programme (ALTO SSMG 1995). Patients (males : 78 %; mean age : 26 years) were mainly heroin users (mean age at start : 20 years, mean duration of use : 6.2 years). 52 % were previously treated in a specialised centre. 50 % had already stayed in prison. 70 % had injected at least once, 39 % during the last 6 months, 23 % during the last month (possible bias could be due to the fact that the questions were asked by the GP : problem of confidentiality). 46% of the last 6 months intravenous drug users shared some material and 30 % of the last month IDUs.

Snowball survey (French Community)

Snowball surveys were carried out in 1993-94, 1994-95, and yearly since 1996 : drug use, its pattern and some knowledge and attitudes were investigated (Hariga F., Modus Vivendi, personal communication). The users have been interviewed in different regions (Brussels, Charleroi, Liège, Namur, Verviers and Wavre) but these regions are not the same each year.

Owing to large inter-annual variations, there is no clear pattern in the proportion of current (last 6 months) IDU among drug users (table 3.33). There is however a declining trend in the proportion of IDUs sharing syringes. Sharing of other parts of injection equipment, such as spoon, cotton, water, happen more frequently, it was for example reported by 66 % and 61 % of current IDUs respectively in 1999 and 2000.

Table 3.33 : Percentage of lifetime and current* IDUs and of sharing of syringes among current IDUs, French Community

	1993-94	1994-95	1996	1997	1998	1999	2000
Number of users	457	1,123	1,294	1,395	1,243	928	574
Mean age			27	28	28	28	29
% males			66	69	67	70	70
Lifetime IDUs/drug users			68	74	65	68	60
Current IDUs/drug users	69	57	53	56	43	52	40
Sharing/IDUs	48	60	60	59	53	52	43

* injection during the last 6 months

In 2000, current cocaine users are 64 % : 46 % of them are intravenous users (table 3.34). This percentage is lower than in 1999 ($p < 0.001$).

Table 3.34 : Percentage of current* IDUs according to drug used, French Community (sample size into brackets)

Drug	Current use		Current injecting	
	1999	2000	1999	2000
Heroin	81	69	54 (755)	50 (397)
Cocaine	69	64	58 (644)	46 (367)
Amphetamines	23	30	19 (211)	19 (171)
Methadone	28	36	12 (208)	16 (208)

* injection during the last 6 months

Rock festival

In 1999 and 2000, the intravenous drug users represented 4 % of users (table 3.35). The proportion of IDUs is lower than the preceding years (25 % in 1996 and 13 % in 1997 and 1998 (Hariga et al. 1999; Hariga F., Modus Vivendi, personal communication).

Table 3.35 : Percentage of IDUs, Rock festival, French Community

	1996	1997	1998	1999	2000
Number of interviews	123	167	157	686	479
Current drug use	87	96	88	88	83
IDUs / users	25	13	13	4	4

The lower percentage of IDUs observed in 1999 and 2000 compared to the previous years can be explained by two reasons. First, the population has changed as the musical programme changed from a mainly rock oriented festival to a more "house" festival. Secondly, in 1999 and 2000, the survey was carried out in the whole festival and not in the camping only.

3.4. OTHER DRUG-RELATED MORBIDITY

3.4.a Non-fatal drug emergencies

No information gathered

3.4.b Psychiatric co-morbidity

No information gathered

3.4.c Other important health consequences : Drugs and driving : the BTTS study

In 1995 and mid-1996, a prospective multi-centre study was conducted in hospital emergency departments in order to determine the prevalence of consumption of alcohol, medications and illicit drugs in victims of road traffic accidents, and to describe related characteristics and associations (BRSI 1998). All drivers, aged at least 14, of bicycles or motor vehicles involved in a traffic accident on a public road and admitted in emergency units of four university hospitals (Gent, Leuven, Brussels, Liège) and one regional hospital (Namur) were included. Toxicological analyses were performed on blood and urine samples.

Among the 2,053 cases (males: 74%, females: 26%) of whom one third aged 14-24 years, 28% presented an analytical alcohol blood concentration exceeding the Belgian tolerance limit (0.5 pro mille) and 19% were positive for one or more substances. Table 3.36 shows that the highest score was noticed for benzodiazepines (8.5%), opiates (7.5%) and cannabis (6%). Age related differences were observed: the prevalence of use of benzodiazepines, barbiturates, medical opiates increases with age and amphetamines, cannabis and cocaine were more frequently observed in younger drivers.

Table 3.36 : Prevalence of detection of alcohol, medications or illicit drugs in victims of traffic road accidents, Belgium, 1995-1996

Substance (sample)	Number of analysed samples	Number of positive samples ^h	Prevalence (%)
Alcohol (blood)	1,871	529	28.3
Benzodiazepines (blood)	1,871	160	8.5
Opiates (urine)	1,879	141	7.5
Medical use		103	
Non-medical use		38	
Cannabis (urine)	1,879	113	6.0
Amphetamines (urine)	1,879	56	3.0
Barbiturates (urine)	1,879	25	1.3
Cocaine (urine)	1,879	14	0.7
Methadone (urine)	1,879	5	0.4

Considering age groups, 17% of 45-54 years and 12% of 55-64 were positive for benzodiazepine; 8.5% of 14-17 years were positive for cannabis and 12% of 18-24 years oldⁱ.

^h Limits as follows : 5 pro mille for alcohol , presence for other substances.

ⁱ As traces of cannabis may still be detected in the urine after several weeks of abstinence, it does not mean that cannabis was used when driving.

CHAPTER 4. Social and Legal Correlates and Consequences

4.1. SOCIAL PROBLEMS

We present information based on data collected by treatment centres and the regional monitoring systems of the different parts of the country (EUROTOX/CCAD – French Community, VAD - Flemish Community, CTB-ODB - Brussels-Capital). Through the treatment demand indicator, information on social characteristics of the patients is available.

Sixty percents of outpatients are living with members of their family (parents and/or partners and/or children). Among inpatients, one out of three is living alone (Figure 4.1). In inpatients and outpatients, the proportion of women living with members of the family is higher than that of men.

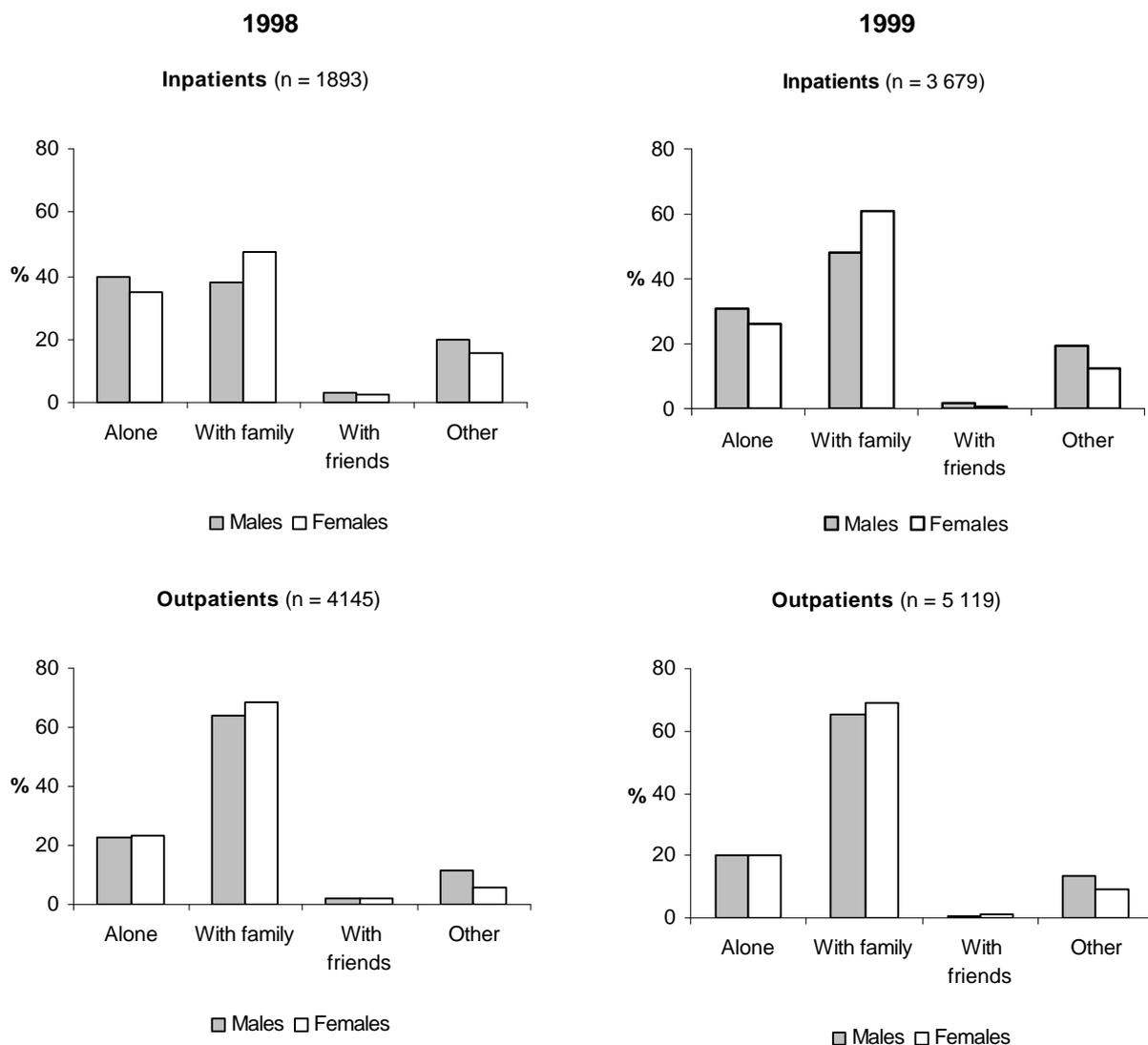


Figure 4.1 : Distribution of the living status (alone or not) of patients undergoing residential or ambulatory treatment, CCAD, VAD and CTB-ODB monitoring systems, 1998-99, Belgium

Around 22-24% of patients are living in unstable accommodations or in an institution (Figure 4.2). Women are less often living in an institution and benefit more often a stable accommodation.

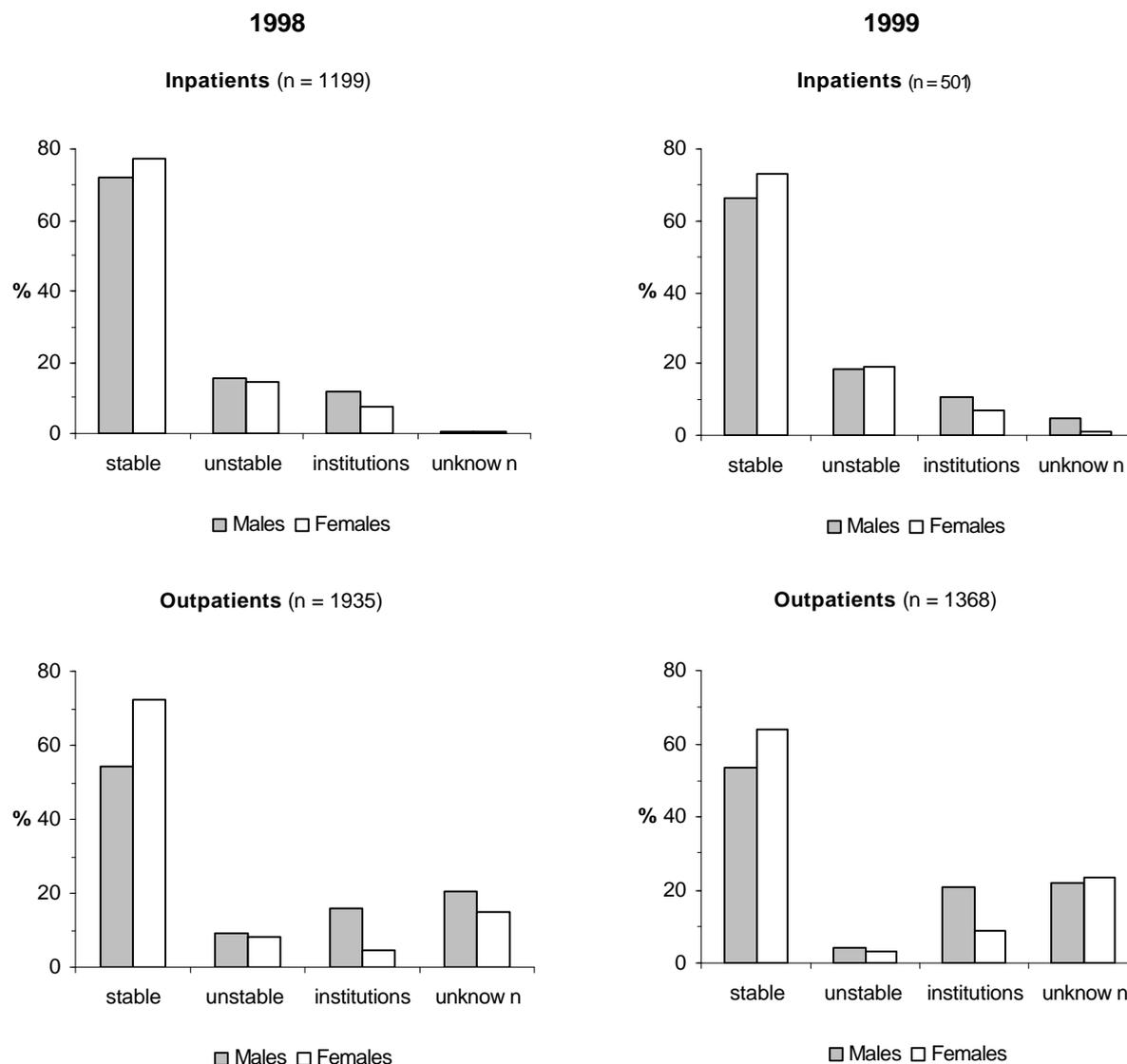


Figure 4.2 : Distribution of the living status (stable or unstable) of patients undergoing residential or ambulatory treatment, CCAD and CTB-ODB monitoring systems, 1998-1999, Belgium

As far as labour status is concerned, one observes that (Figure 4.3) :

- 60% of inpatients have a regular employment compared to only 30% among outpatients,
- 10 % of inpatients are pupils or students compared to 30% among outpatients; CTB-ODB data not available).

Around one third of patients are economically inactive or unemployed. There are no difference between males and females within each class of labour status.

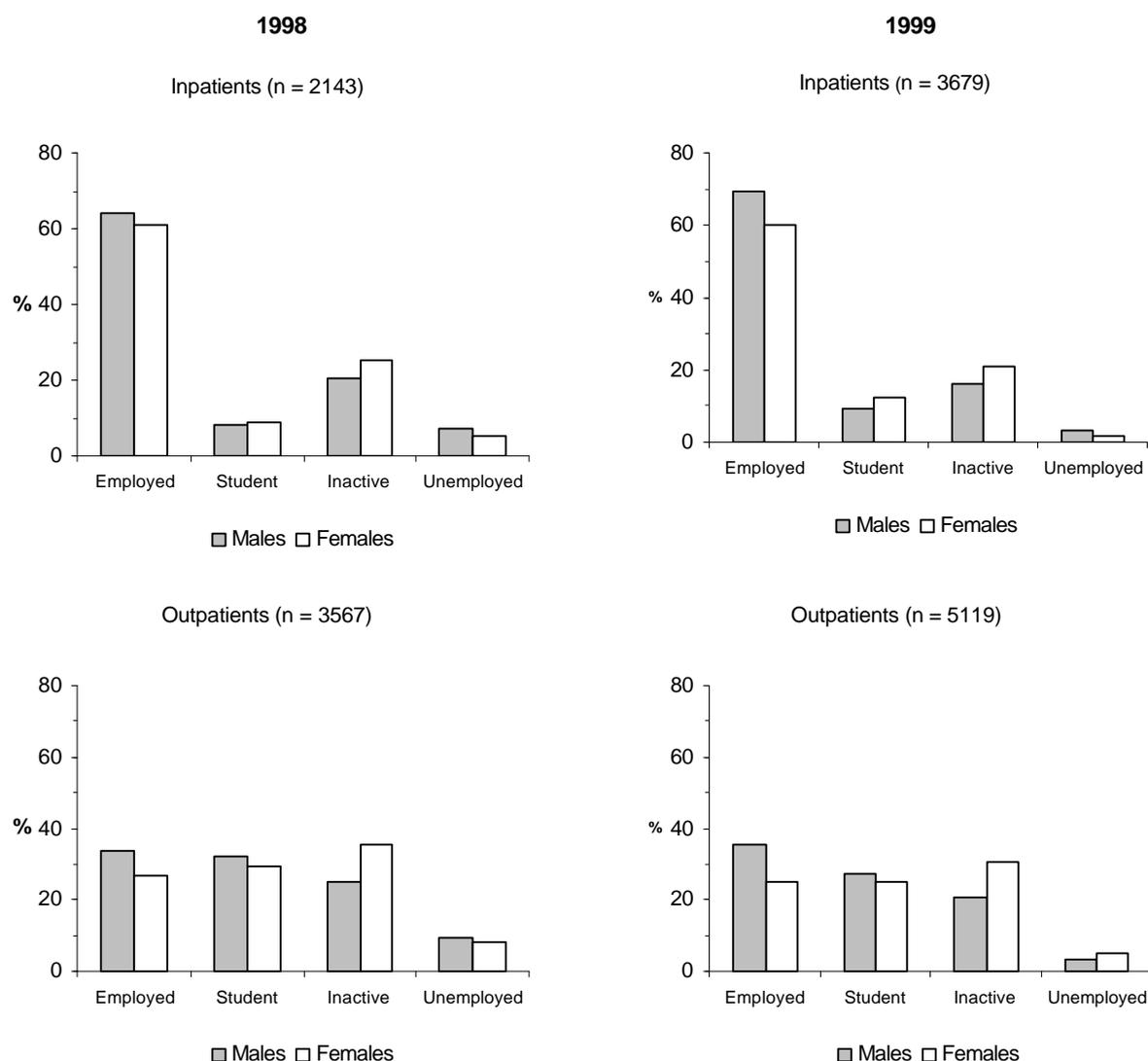


Figure 4.3 : Repartition of inpatients and outpatients according their labour status (CCAD-VAD monitoring systems, Belgium)

Depression and unemployment were associated to the use of heroin in a study carried out in 1994 on a group of drug addicts admitted to the emergency unit of Saint-Pierre university hospital in Brussels (Bechet 1994).

The average age of the patients was 27.2 year old (range: 15-41 years of age). The man/woman ratio was almost two to one ; women attended to emergency unit several times more often than men. More than 90% were unemployed; 43% were on CPAS/OCMW (public centre for social assistance) benefit; 20% had no official source of income. 75% had a fixed residence; 41% lived alone and 22% lived with their parents.

In 82% of cases, heroin was the drug causing the problem (combined with other psychotropic substances in 85% of cases). The most frequent problem among heroin addicts admitted to the emergency department was depressive behavior (in 40% of cases, this was indicated either by a suicide attempt or by a request for hospitalization). 32% came to the department requesting hospitalization for a drying-out session. These requests, which were then referred for a consultation, were seldom satisfied because of excessively long waiting lists and because more than 50% of these requests were not prompted by a well thought out desire for a drying-out session, but rather were really a request for temporary shelter from the difficulties of life.

4.2. DRUG OFFENCES AND DRUG-RELATED CRIME

These figures have been collected by the police services and grouped for the United Nations Drug Control Programme by the Belgian General Police Support Service (SGAP/APSD). This service is the Belgian contact for Interpol, Europol and the SIS of Schengen. It collects data from all police services in Belgium, specifically the municipality polices (mainly oriented to the local trafficking), the judicial police and the gendarmerie/rijkswacht (local, national and international trafficking) and the customs (national and international trafficking).

Two sources are used. Police's reports sent by units of Judicial Police, 'Gendarmerie/Rijkswacht'^j and municipality polices to the Court are the first one. From 1994 to 1997, six variables were available: identification number of the report, identification of the involved unit, type of infringement, tentative or not, location and time of the infringement. From 1998 onwards, the covered variables will be expanded (e.a. the type of drug will be available).

The second source is the 'unique form' (formulaire uniforme/eenvormig formulier) that are also transmitted by Customs and Accises (Taxes) when a seizure is performed. The aim of this form was initially to stimulate the exchange of operational information between the different police units. Although it is estimated that these forms are not systematically used (used for around 50% of infringements), interesting information is included as type and quantity of seized drugs.

A large re-organisation of the forces of police was initiated in 1998: a unique police force resulting from the merging of the Judicial Police, the 'Gendarmerie/Rijkswacht' and the municipality polices will be constituted. Simultaneously the development and improvement of a unique database used directly by all services of police for the registration of their repressive activities is in progress.

The interpretation of the national criminal statistics on the seizure of narcotics calls for some explanation. The statistical data on the seizure of narcotics is based exclusively on the positive results of searches or investigations but by no means reflects the number of infringements committed in this field. On the other hand, these figures do not provide any information on the severity of the infringement, nor on the importance of the seizure.

In the 1993 statistics, a distinction was made for the first time between the *use* and *the trafficking* of narcotics. The term *use* is applied to narcotics seized from a person who had them in his possession but only for personal consumption. The term *trafficking* is applied to all seizures of narcotics where it appears that they were not only intended for personal use. Meanwhile, it is recognized that categorizing of infringements varies largely between police units.

To distinguish between police and custom reports is not possible at the moment in Belgium.

4.2.a 'Arrests' for use/possession/traffic and trends

The evolution of the number of 'arrests' related to illicit drugs registered by police can be an indicator of the activity of the illicit drug market, although it can also be considered as the result of the effort of the police to better control it.

The definition of an arrest is varying between countries. In Belgium, the first contact with the police is reported in a police' report (several infringements can be mentioned for a person taken in for

^j The reports of the Gendarmerie/Rijkswacht units are also centralised at BCR/CBO (Bureau Central de Recherche - Programme Drogue / Centraal Bureau voor Opsporing – Programma Drugs / Central investigation office – Drug programme). Some units of the municipality police also report to this central 'Gendarmerie/Rijkswacht' office. Data are kept in a database called POLIS. Data are related to the infringements (type, location, date). Drugs classified according categories (cannabis, opiates, LSD,...) are mentioned in most of cases. For the identification of the substance, the Becton-Dickinson test as well as the experience of the policeman are used. Following information is available: involved person, vehicle used, modus operandi, tools used. There is no information on the seizure or not of substances neither on their weight.

questioning). These reports are transmitted to the prosecutor's room. The judge will then prosecute or not the person, who will be actually arrested or not. Consequently we call the figures presented here as 'number of people involved in affairs connected to narcotics' corresponding to the number of persons mentioned in police reports. The information on (definite) arrests (consequent to an order from the judge) is not available.

Figure 4.4 is based on data supplied by the police and shows the number of people involved in affairs connected to narcotics, bringing together users, as well as dealers and (international) traders.

The number of police arrests for drug law offences increased threefold over the last 10 years. Since 1992 there is a big increase in the total number of persons concerned in case of illicit drugs : in 1992 this number doubled almost involving 18,179 persons. The following years about 19,000 persons have been yearly concerned in a case of illicit drugs. In 1998 there were 23,184 persons taken in for questioning and 17,219 in 1999. Comparable data are not available for 1996 and 1997 : the figures on the numbers of persons involved is not available but well the number of infringements : 1, 2 or 3 infringements can be reported in a police's report concerning one person.

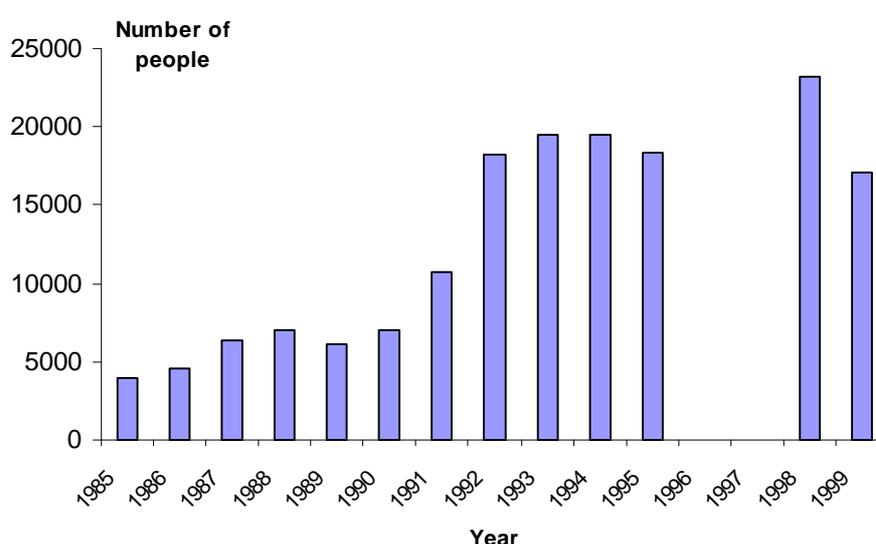


Figure 4.4 : Number of people taken in for questioning, Belgium, 1985-1999

As in most EU countries, 'arrests' for drug possession for personal use are predominant in Belgium (respectively 73, 71 and 73% in 1996, 97 and 98; Table 4.1). Cannabis is the main drug involved in the 'arrests' for drug offences : respectively 72, 65, 66 and 69% in 1995, 97, 98 and 99 (Table 4.2). When taking into account the type of infringement, the data of the year 1995 indicates that cannabis was many more involved when possession for abuse is the infringement (73%) than when trafficking is concerned (37%; Table 4.3).

Table 4.1 : Number and proportion (%) of infringements related to narcotics according to the type of infringement, Belgium, 1996-1998 (SGAP/APSD 1998)

Year	Possession/ use	Trafficking	Other	Total		
1996	27.158	73.2	8.391	22.6	1.575	37.124
1997	32.381	70.5	11.153	24.3	2.424	45.958
1998	31.586	72.6	10.158	23.3	1.778	43.522

Table 4.2 : Proportion (%) of infringements or people involved in narcotics affairs (possession for abuse or trafficking) according to the type of drug, Belgium, 1995 – 1999 (SGAP/APSD)

Statistical unit	1995	1997	1998	1999
	Infringements	Infringements	People	People
Number	28,117	-	23,184	17,604
Opiates	16.5	7.0	25.6	5.9
Cocaine, Crack	5.9	5.0	4.6	4.3
Cannabis	71.7	65.0	65.7	68.6
Speed	2.4	8.0	0.9 *	15.6
XTC	0.5	-	-	-
Amphetamines	0.6	8.0	-	-
Depressants (including methaqualone)	0.9		0.9	2.0
LSD & other hallucinogenic agents	1.5		2.2	2.4
Other	-	7.0	-	2.0
TOTAL	100	100	100	100

* : all stimulants (speed, XTYC and amphetamines); analysis based on the 'Uniform forms'.

Table 4.3 : Number and proportion of infringements related to narcotics affairs according to the type of drug and type of infringement, Belgium, 1995 (SGAP/APSD 1998)

Type of drug	Possession for abuse		Trafficking		Total	
	Number	%	Number	%	Number	%
Opiates	4,534	16.5	94	14.4	4,628	16.5
Cocaine, CRACK	1,565	5.7	95	14.5	1,660	5.9
Cannabis	19,920	72.5	239	36.6	20,159	71.7
Speed	637	2.3	51	7.8	688	2.4
XTC	0	-	129	19.8	129	0.5
Amphetamines	160	0.6	17	2.6	177	0.6
Depressants (including methaqualone)	243	0.9	0		243	0.9
LSD & other hallucinogenic agents	405	1.5	28	4.3	433	1.5
Total	26,315	100	516	100	26,831	100

4.2.b Convictions and court sentences for drug offences and imprisonment for drug law offences

Reports of sentences are centralized in the Ministry of Justice (Service de la Politique Criminelle / Dienst voor het Strafrechtelijk Beleid). The most recent available results is a specific analysis of 1994 data performed at request of the parliamentary working group on drugs. The following years data will be soon analyzed as the required computerization of this information system is nearly completed.

In 1994, 5,606 sentences were recorded with at least one qualification connected to "narcotics". Table 4.4 presents the 4,963 sentences where the information on *consumption and/or trafficking* is available.

Of the 2,016 judgments where *consumption* was the infringement, only 30% are joined with another infringement, 70% being related to *consumption* alone. Among these 2,016 judgments for *consumption*, 635 main sentences are actually custodial sentences, i.e. 32% compared with 54% suspended prison sentences and 15% fines.

For *consumption/trafficking*, we obtain the following distribution: 12% fines, 38% custodial sentences and 50% suspended prison sentences.

Finally, for *trafficking*, we found 4% fines, 36% custodial sentences and 60% suspended prison sentences.

Table 4.4 : Main sentences handed down connected with narcotics, Belgium, 1994

	Fines		Custodial sentence		Suspended prison sentence		Total	
	Number	%	Number	%	Number	%	Number	%
Consumption	299	15	635	32	1,082	54	2,016	41
Trafficking	12	4	101	36	167	60	280	6
Consumption & trafficking	335	12	1,001	38	1,331	50	2,667	54
Total	646	13	1,737	35	2,580	52	4,963	100

Although it would appear that one out of two cases ends with a suspended prison sentence (but information on the partial suspension of sentences is not available), in fact, in more than one third of cases (35%), even among the category of consumers without trafficking activity, a custodial sentence is handed down.

4.2.c Drug-related crime

Specific information on theft, violence and other drug related criminality was not gathered. Nevertheless, the treatment demand indicator provides information on the source of referral.

Own request and family/friends referral represent the major source of referral (about 40% of treatments). Court, probation or police is the second source of referral with about one fourth of patients being referred to treatment (Figure 4.5). It is also worthwhile to note that the proportion of first treatments referred by court, probation or police (25%), in 1998 and in 1999, is higher than the proportion of first treatment self-referred (20%) and the proportion of first treatment referred by other treatment centers (20%).

In 1998, the proportion of the outpatients referred by court, probation or police was higher than that of inpatients referred by the same source : 25% compared to 7%, respectively (Table 4.5).

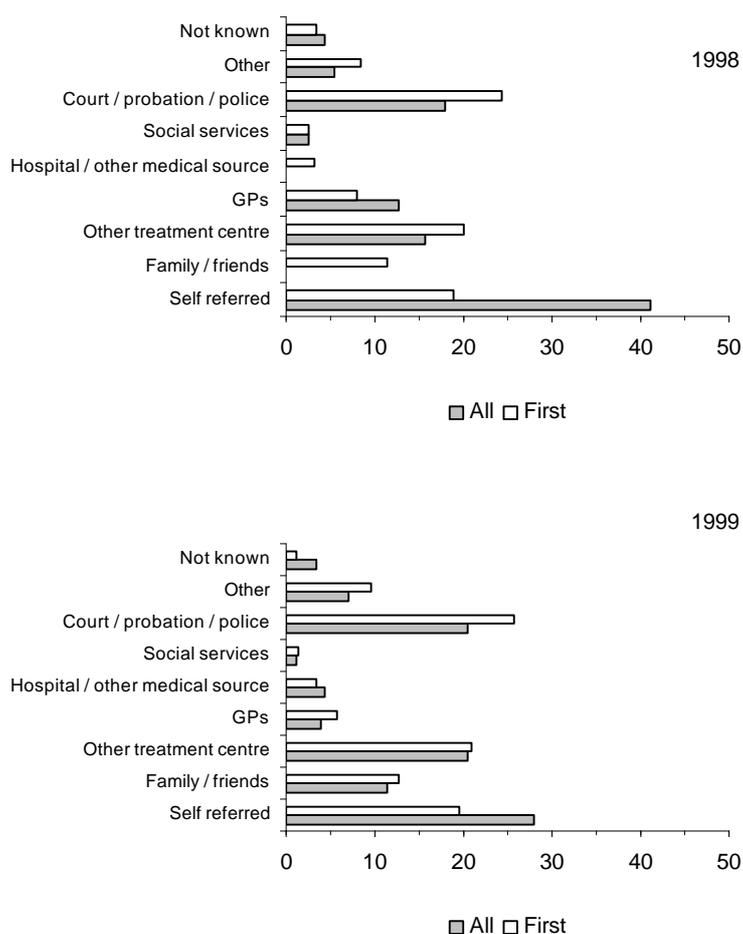


Figure 4.5 : Source of referral of patients in treatment centres, Belgium, 1998 and 1999

Table 4.5 : Source of referral (%) among outpatients and inpatients demanding treatment in 1998 (CCAD/CTB-ODB/VAD, Belgium)

	Outpatient			Inpatient		
	M	F	T	M	F	T
	(3,148)	(1,060)	(4,232)	(1,762)	(637)	(2,417)
Self referred, family, friends	38	35	37	54	49	53
Other drug treatment centre	14	13	14	20	24	21
GP, hospital, other med. sources	12	14	12	14	20	16
Social service	3	4	4	1	0	1
Court, probation, justice	25	26	25	9	4	7
Other	7	8	8	2	3	3

4.3. SOCIAL AND ECONOMIC COSTS OF DRUG CONSUMPTION

4.3.a Studies and estimates of health care costs, other social costs

See Part I

4.3.b Estimates of total consumption/demand/expenditure on drugs

No information gathered

CHAPTER 5. Drug Markets

5.1. AVAILABILITY AND SUPPLY

5.1.a Availability of different drugs, trends and possible reasons

Information on perceptions of adults about the availability of cannabis and cocaine is investigated continuously by the health behavior monitoring carried out in the French Community. Various surveys investigated pupils about the actual availability of illicit drugs :

- *Health behavior monitoring (French Community, 1996-97 and 1998-99) (Piette and De Smet 2000)* reports that two thirds of adults aged 18-49 years believe possible to get cannabis and 45% cocaine near to their house.
- In the qualitative study '*Youngsters in Brussels*' (Kohn and Piette 1997), 22 teenagers of Brussels (14 boys, 8 girls, 13-18 year old) were interviewed in July 1997. They stated that cannabis is available everywhere: from friends, in The Netherlands, during festivals, in youngster-house, at school.
- In the '*School-aged youngsters in Bruges*' (Flanders, 1996-97) (Verhaegen and Raes 1997), 3,475 pupils aged 16-18 from 18 schools of Bruges participated in 1996-1997 in a study about the relation between the use of drugs and the environment of school-aged youngsters. There was a question about how they get their drugs. More than one out of three (39%) of the users stated that he/she has asked himself/herself for the first product; 28% got it from friends, 4% got it from his boy or her girl friend and 2% got it from another person.
- *Mental health of youngsters in Brussels, 1994* (Vranckx et al. 1996). Among 2,209 pupils of secondary schools in Brussels (17 French and 3 Flemish schools), 23% have tried illegal drugs at least once: they stated that they can get hold of illegal drugs without too many problems. About 40% of boys said that they could get cannabis derivatives, 21% said the same for ecstasy and 16% could get opiates "without problems". Comparative percentages for girls are lower (23%, 12% and 9% respectively).

5.1.b Sources of supply and trafficking patterns

Information on supply and trafficking patterns is largely developed in the Belgian Questionnaire sent for the UNDCP annual report.

Based on several investigations and seizures, a new trend was observed in 1999 : the drug traffickers are mingling various type of narcotics in a same transportation. The final destination of a large part of these 'mixed' seizures, involving residents in Belgium, should be UK. It is not yet obvious to know to what extent the most famous criminal organization used this kind of operating way.

- *Heroin* : 80% of the total traffic of heroin comes from the golden croissant (Southeast-Asia) and the other 20% comes from the golden triangle (Laos, Cambodia and Vietnam).
- *Cocaine* comes mostly from Latin-American Andes-countries. The drugs come mostly via Colombia, Brazil, and Venezuela or from Trinidad and Tobago to Belgium using boats and planes. The airport of Brussels (Zaventem), the harbors of Antwerp and Zeebrugge are known for this. Most of the cocaine is in transit and is meant for other countries like The Netherlands, France, Germany and United Kingdom. Seizures of cocaine have constantly increased for the last ten years, with a record of about 3 tons in 1993.
- *Cannabis* is a popular drug in Belgium. It comes mostly from Morocco, Colombia, Nigeria and Cambodia by ship or transported via the road. The most important destination is The Netherlands, United Kingdom and Eastern Europe. Sixty two percent of the total hash traffic comes from Morocco, 28% from Pakistan and 8% from Kenya. The Netherlands and Eastern Europe are quite often the destination for this traffic.

- XTC is imported especially from The Netherlands and Eastern Europe, but also Belgium is a producing country.

5.2. SEIZURES

The numbers of drug seizures are not available for 1996 and 1997 but now 1998 and 1999 being available, it is possible to observe and discuss some trends. Of course, all preliminary remarks regarding the interpretation of these data remain valid and should be taken into account (see 4.2). These figures have been collected by the police services. The statistical data on the seizure of narcotics is based exclusively on the positive results of searches or investigations but could not reflect the number of infringements committed in this field. We can only suspect some trends and have of tentative discussion.

Globally the number of drug seizures has increased in the nineties, reaching a maximum in 1995 for heroin (as far as we know because data of 1996 and 1997 are missing). The highest number of seizure of cannabis and XTC/ Ecstasy was recorded in 2000 (Table 5.1). The number of cocaine and LSD seizures has increased up to 1994, than leveled off to decrease in 1998 and 1999. In 2000, the number of seizures of this two last drugs has slightly increased compared to that observed in 1998 and in 1999.

Over the past 10 years, the quantities of seized cannabis have increased up to 1996, but then decreased by half to 48,705 kg in 1997 and then to 9,609 kg in 1998 and 5,847 kg in 1999 (Table 5.2). The quantities of cannabis seized in 2000 had increased again compared to those seized the two preceding years. The quantities of other seized drugs have fluctuated from one year to another, particularly in the case of heroin, cocaine and LSD. In 1999, 83 kg of heroin and 1,761 kg of cocaine were seized in Belgium. The quantities of heroin seized in 2000 double compared to those seized in 1998 and in 1999. After a peak in 1995 (320,441 pills), the quantities of amphetamines/XTC seized decreased in 1996-1997, and then increased again to 271,080 and 489,566 pills respectively in 1998 and 1999. The quantities of amphetamines and XTC seized in 2000 almost double in comparison to the quantities seized in 1999.

Additionally to elements for discussion of the trends in term of number of seizures, one should mention that the large variations between years in the quantities seized in Belgium could be the result of the collaboration between countries in the fight against traffickers : the current policy/strategy when a traffic is discovered, is to postpone the intervention (arrest of the traffickers and seizure of the drugs) and to follow the travel in order to be more efficient by discovering the organization of the distribution, the partners in crime... So such data on quantities will be better interpreted at larger (European) level.

At the moment in Belgium it is not possible to distinguish police and customs seizures and this limits again strongly the relevancy of the discussion on the quantities seized.

Coming back to the numbers of seizures, the following hypothesis could explain the trends :

- actual decrease in the availability of some narcotics on the Belgian market,
- global reduction of police resources dedicated to drug control, and
- reduction of police resources dedicated to the fight against cannabis consequently to the directive of 1998.

Table 5.1 : Number of seizures : 1985-2000, Belgium

DRUG	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Cannabis	1,705	1,949	2,359	2,758	2,527	3,127	4,432	6,166	6,380	8,628	13,379	NA	NA	13,020	7,362	14,264
Heroin	321	423	507	869	887	1,045	1,732	3,316	3,082	3,024	3,158	NA	NA	1,112	720	1,340
Cocaine	132	226	254	380	422	375	513	933	897	927	1,046	NA	NA	799	547	925
XTC/Ecstasy						18	196	267	560	872	1002	NA	NA	2,672	2,163	3,578
LSD	38	7	32	22	22	36	88	233	254	301	281	NA	NA	75	73	107

NA : not available / see XTC : Amphetamines and XTC have been pooled from 1996 onwards

Table 5.2 : Quantity of products seized : 1985-2000, Belgium

DRUG	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Cannabis	10,429	3,791	6,562	13,008	9,844	7,918	6,021	9,504	35,217	59,903	70,686	106,690	48,705	9,609	5,847	15,805
Heroin	92	78	141	116	89	291	186	107	76	137	129	133	55	75	83	185,5
Cocaine	62	116	270	404	89	537	756	1,222	2,892	479	576	838	3,321	2,028	1,761	1,652
Amphetamines	3.5	2.4	9.0	47	4.2	15	77	96	19	23	68	-	-	-	-	-
XTC/Ecstasy	-	-	-	-	-	1,654	75,742	15,240	98,215	55,637	320,441	184,413	126,211	271,080	489,566	818,515
LSD	1,346	639	6,497	877	2,186	16,841	2,417	13,603	5,659	5,237	5,458	13,704	621	2,050	1,047	1,090

NA : not available / see XTC : Amphetamines and XTC have been pooled from 1996 onwards

5.3. PRICE – PURITY OF DRUGS

Table 5.3 : Mean price in Euros at street level of some illegal substances : 1996-2000; Belgium

DRUG	1996	1997	1998	1999	2000
Cannabis resin (per gram)	8,1 (3,7-12,4)*	3,1 (2,5-3,7)	7,4	8,1 (6,2-9,9)	5,6 (5,0-6,2)
Cannabis leaves (per gram)	5,0 (2,5-7,4)	3,7 (2,5-5,0)	6,5	5,6 (3,7-7,4)	4,2 (3,4-5,0)
Heroin brown (per gram)	37,2	22,3 (19,8-24,5)	21,1	39,7 (19,8-59,5)	26,8 (18,8-34,7)
Cocaine powder (per gram)	49,6 (37,2-62,0)	55,8 (49,6-61,2)	58,9	55,8 (37,2-74,4)	60,1 (45,9-74,4)
Amphetamines powder (per tablet)	-	-	-	7,9 (6,0-9,9)	5,0 (3,7-6,2)
'Ecstasy' (per tablet)	12,4	6,5	8,7	7,2 (4,5-9,9)	7,3 (5,7-8,9)
LSD (per dose)	6,2 (5,0-7,4)	6,8 (5,0-8,7)	6,9	-	3,1 (2,5-3,7)

* Minimum and maximum price are given in parenthesis.

No figures on crack trafficking are available (very minimal consumption)

Table 5.4 : Mean purity at street level of some illegal substances, Belgium, 1999-2000

DRUG	1999 ⁽¹⁾		2000 ⁽¹⁾	
	Number of analyses	Mean (Minimum-maximum)	Number of analyses	Mean (Minimum-maximum)
Cannabis resin ⁽²⁾	-	-	11	10,9 (0,9-49)
Cannabis leaves : 'nederwiet'	-	-	36	16,9 (0,8-97,6)
Heroin brown	31 ⁽³⁾	22 (3-49)	22	21,9 (2-65)
Heroin white			10	64,7 (15,9-95)
Cocaine	22	70,7 (30-100)	199	68,6 (8-99,3)
Amphetamines	15	25,9 (0,15-42,7)	65	9,8 (0,2-49,6)

⁽¹⁾ : the percentages are not weighted because the exact amount of sample on which the analysis was done is not known,

⁽²⁾ : % HTC content,

⁽³⁾ : heroin brown + heroin white in 1999

CHAPTER 6. Trends per Drug

This sixth Chapter includes information mostly mentioned above but here presenting simultaneously different indicators for each drug. The methods of the mentioned studies as well as their limitations are not described again in this section : we invite the reader to go back to Part II Epidemiology.

6.1. CANNABIS

Table 6.1 : Synthesis table of epidemiological indicators on CANNABIS : use in adult and schoolaged population, offences, seizures, price and accessibility, Belgium, 1993-2000 (Figures are percentages except when specified)

INDICATORS	ORGANISATION	1993	1994	1995	1996	1997	1998	1999	2000
ADULT POPULATION									
Lifetime prevalence	Vlaamse G	-	5.8	-	-	-	-	-	-
	ULB/Promes	-	-	-	-	12.8	-	20.8	-
Last year preval.	Vlaamse G.	-	1.5	-	-	-	-	-	-
SCHOOL POPULATION (15-16 years)									
Lifetime prevalence	RUG/Publ.Hlth	-	14.9	-	14.6	-	18.9	-	20.7
	VAD	-	-	-	-	-	-	24.1	23.9
	ULB/Promes	-	-	-	-	-	26.2	-	-
Last month preval.	RUG/Publ.Hlth	-	7.6	-	10.8	-	12.0	-	11.8
	ULB/Promes	-	-	-	-	-	13.6	-	-
PROBLEMATIC USE									
Treatment demands	CCAD/EUROTOX	3.8	5.7	6.2	11.9	13.2	14.0	12.4	-
(% cannabis= main drug)	VAD	-	-	-	22.0	-	30.3	27.9	-
	CTB-ODB	-	-	-	-	6.6	7.6	7.2	-
PEOPLE TAKEN IN for questioning (% cannabis / all offence)									
	SGAP	-	-	72.7	-	65.0	65.7	68.6	-
SEIZURES (N)									
	SGAP	6,380	8,628	13,379	-	-	13,020	7,362	14,264
RETAIL PRICES (euro)									
	SGAP	-	-	-	2.5- 12.4	2.5-5.0	-	3.7- 9.9	3.4-6.2
ACCESSIBILITY (adults)									
	ULB/Promes	-	-	-	59.2	70.4	62.9	64.5	-

It is uneasy to generalise these figures to the whole country, to compare between data and to find out trends. Nevertheless one observes that :

- the use of cannabis in adult and secondary school population is increasing over the 1990's;
- one adult of five (French Community) experienced cannabis at least once (corresponding to the European mean figure);
- the lifetime prevalences of use of cannabis among young people aged 15-16 years are regularly increasing from 1994 to 2000 from 15 to 21 %; respectively 20-22-25 % in boys and 10-12-15-16 % in girls experienced cannabis at least once;
- the proportion of patients (starting treatment) stating cannabis is their main problematic drug is increasing;
- cannabis is the cause of 70% of the cases in which people are taken in for questioning (stable);
- the number of seizures considerably fluctuates from year to year;
- the retail price is relatively stable;
- most of adults stated that they could get cannabis quite easily near to their home.

- HBSC survey : Youngsters and health in Flanders, 1990-2000

Cannabis is the most used illicit drug : 21% of 1516 year old boys and 39% of 1718 year old boys had ever used. The proportion of 'the last month' users of cannabis increased regularly from 1994 to 2000, only for the boys (Figure 6.1). More boys than girls used cannabis several times during the last month.

The last month use of cannabis among young people of 1718 years of age, by sex and frequency of use increased since 1994 in the Flemish Community schools (Maes and Vereecken, Personal Communication).

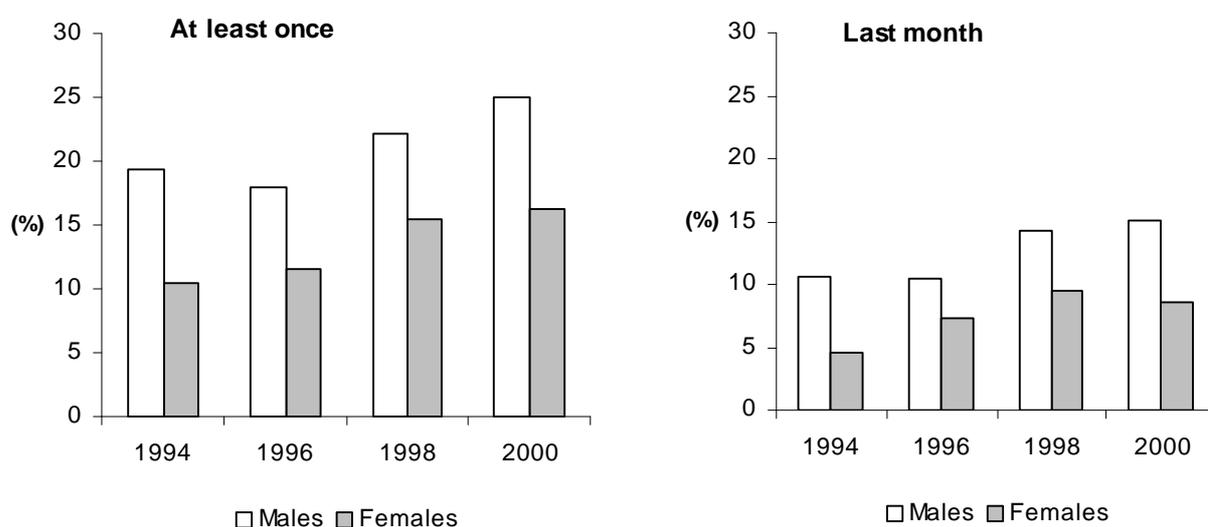


Figure 6.1 : Proportion of people (15-16 years of age) having used cannabis, Flemish Community schools, 1994-2000 (Cf: Table 2)

- HBSC survey : Health behaviour and lifestyles of youngsters in the French Community, 1988-1998

In 1998, 22% of young people aged 12-18 used a drug at least one and 13% are 'regular' users (defined as last month use ; Figure 6.2) (Piette et al. 1997). For comparison, these figures were 8%, 8%, 13%, 19% (at least once) and 1%, 3%, 7%, 10% (the last month use) respectively in 1988, 90, 92 and 1994.

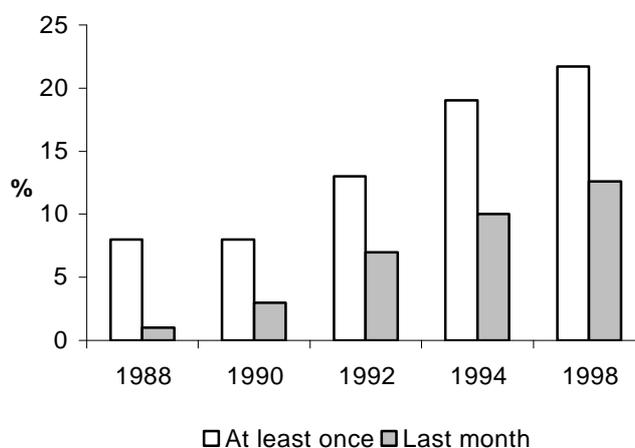


Figure 6.2 : Proportion of young people aged 13-17 years having used a drug at least once and during the last month, French Community secondary schools 1988-1998

- Qualitative research on cannabis, 1998

A qualitative exploratory survey was conducted in Brussels in July 1997. Twentytwo youngsters (8 girls and 14 boys aged 13 to 18 years) participated using semi-structured interviews. This preliminary study revealed interesting results on the multiple information sources, the 'friendly way of starting, the decisive role of parents and peers, the role of the school, the reason of the use, the consequences of the legalisation, etc...(Kohn and Piette 1998).

- Survey in Flemish Schools, 2000

In 2000, the lifetime prevalence of cannabis use is 42% of 15 to 16 year-olds (boys : 29%- girls : 19%) experienced cannabis. The use increases with age : from 1% among 12 years and 6% among 13-14 years reaching 40% in 17-18 years (boys : 49%- girls : 31%) (Kinable, Personal Communication).

- Social diagnosis in 3 secondary school in Verviers (Wallonia), 1999

The lifetime prevalences of the use of cannabis and XTC increase with age without any significant difference of the cannabis prevalence between gender. Lifetime prevalence rates are 6% in first year of secondary school (corresponding to 12 years of age), 16% in third year (around 14 years) and 32% in fifth year (16 years) (Bils et al. 2000).

- School survey on drugs in Charleroi (Wallonia), 1999

The lifetime prevalences of the drug use increase with age. Boys used more than girls. Lifetime prevalence rates are 30% in third year of secondary school (corresponding to 14 years of age) and 44% in fifth year (16 years) (Depaepe and De Clerck 2000) .

- School-aged youngsters in Bruges (Flanders), 1996-97

The most consumed products by young people are alcohol, tobacco and medicines (especially among girls) as well as derivatives of cannabis. Among the population who ever used illicit drugs, 98% used cannabis : 15% used cannabis only once ('experimental use') and 39% used it 'regularly'. The proportion of 'regular' user is the highest for cannabis. In total 50% of users (experimental, intermediate, 'regular') stopped using cannabis (Verhaegen and Raes 1997).

- Mental health of youngsters in Brussels, 1994

Out of 2209 pupils of the Brussels secondary schools, cannabis is the product most mentioned by young people: 19% have experienced using these products and 11% had used them during the month preceding the study (Vranckx et al. 1996).

- Rock Festival, 1998

The surveys repeatedly conducted during "the Rock Festival" showed extensive use of cannabis among spectators (lifetime prevalence 88% in 1998) and among drug users (98% in 1998) (Hariga et al. 1999).

- Treatment centres, 1993-1999

The most recent data from the treatment demand registration systems of the French Community (CCAD/Eurotox, 1993 to 1999), the Flemish Community (VAD, 1996, 1998 and 1999) and Brussels (CTB-ODB, 1997-1998) are compared (Table 6.1). Of course, differences in the type of centres and in the age of the patient population covered should be taken into account.

Cannabis as main drug shows an increasing trends and is reported in 1999 by 28% of clients in the Flemish Community, by 12% of the French Community (4% in 1993) and by about 7% in Brussels (but cannabis is more and more often stated as 'secondary' substance). Among first treatment demands (French Community), cannabis represented 28% in 1999.

- Drug use among prisoners, 1993, 1997 and 1999

In 1999, 41% of 246 prisoners stated to have used cannabis during the last month before their imprisonment and 37% used it 'regularly' during the current or a previous imprisonment. In 1997, nearly half of the prisoners (45%) reported cannabis use during the year before the imprisonment and 38% during their current or a previous imprisonment.

In a 1993 study conducted in the Antwerp prison, the main drugs (42% of prisoners were drug user) was cannabis (37% of users) (Todts et al.1997; De Maere et al. 2000).

- Drug telephone line (French Community), 1997

In 1997, the French-speaking drug help line was contacted 4,945 times. Most of the callers stated they were not drug users and thus the reported substances are to be considered as substance of concern and not as used substances. Among 3,085 calls involving a substance, cannabis represents the most frequently mentioned (40%) (Bastin 1997).

6.2. SYNTHETIC DRUGS (AMPHETAMINE, ECSTASY, LSD)

Table 6.2 : Synthesis table of epidemiological indicators on XTC : use in adult and schoolaged population, offences, seizures, price and accessibility, Belgium, 1993-2000 (Figures are percentages except when specified)

INDICATORS	ORGANISATION	1993	1994	1995	1996	1997	1998	1999	2000
ADULT POPULATION									
Lifetime prevalence	Vlaamse G.	-	0.5	-	-	-	-	-	-
Last year preval.	Vlaamse G.	-	0.1	-	-	-	-	-	-
SCHOOL POPULATION (15-16 years)									
Lifetime prevalence	RUG/Publ.Hlth	-	4.1	-	4.2	-	5.0	-	2.6
	VAD	-	-	-	-	-	-	4.0	3.6
	ULB/Promes	-	-	-	-	-	5.1	-	-
Last month preval.	RUG/Publ.Hlth	-	1.4	-	1.3	-	2.1	-	1.3
PROBLEMATIC USE									
Treatment demands (% XTC-stim. = main drug)	CCAD/EUROTOX	0.6	2.0	2.7	2.8	3.2	1.5	2.7	-
	VAD	-	-	-	20.1	-	22.0	20.2	-
	CTB-ODB	-	-	-	-	7.2	10.3	14.8	-
PEOPLE TAKEN IN for questioning (% XTC amph./all offence)									
	SGAP	-	-	3.5	-	16.0	0.9	15.6	-
SEIZURES (N)	SGAP	684	978	1,002	-	-	2,672	2,163	3,578
RETAIL PRICES (euro)	SGAP	-	-	-	12.4	6.5	8.7	7.2	7.3
AVAILABILITY (adults)	-	-	-	-	-	-	-	-	-

** The definition of XTC in 2000 is not the same as preceding years. Before 2000 the item XTC contained speed. In 2000 XTC does not contain speed

More difficult than regarding cannabis use, it is uneasy to generalise these figures to the whole country, to compare between data and to find out trends. Nevertheless one observes that :

- the information on use of XTC use in adult is outdated : it showed a very low (less than 1%) lifetime prevalence in 1994 (Flemish Community);
- from 15-16 years of age onwards, XTC (and other club drugs) are the second product most used (after cannabis);
- at the age of 1516 years, a slightly increasing proportion of students (reaching 4% in VAD 2000 surveys- respectively 3.6 % in boys and 6.7 % in girls) experienced XTC;
- among XTC users less than half used XTC during the last month, however, the proportion of XTC 'regular' users among users increases : respectively 33-45 % in 1994, 96 and 98;
- the proportion of patients starting treatment and stating XTC as their main problematic drug does not seem to increase; in centres participating to the Flemish VAD monitoring system, XTC and stimulants users (not including cocaine) represent 20.2% of clients in 1999 but only 15% in Brussels CTB-ODB (including cocaine) and around 3% in CCAD/EUROTOX system (these differences seems to be explained by a coverage of different type of treatment centres);
- XTC is the cause of a varying proportion the cases in which people are taken in for questioning;
- the number of seizures increased during recent years;
- the retail price is declining reaching 7 Euro for a tablet in 2000;
- no information on accessibility in adults is available.

- HBSC survey :Youngsters and health in Flanders, 1994-2000

Globally more boys than girls used illegal drugs. Data show an increasing trend for XTC in boys during the period 1994-1996 whereas among girls the increase is delayed during the period 1996-1998. Interviewed in 1998, 6% of 15 to 16-year-olds (boys : 8% - girls : 5%) and 12% of 17 to 18-year-olds (boys : 15% - girls : 10%) had experienced XTC (at least once) (Maes and Veecken, Personal Communication).

- HBSC survey :Health behaviour of youngsters in the French Community, 1988-98

In 1998, 5% of 15-16 years (boys : 5% - girls : 5%) experienced XTC. The use increases with age : from 2% among 11-12 years and 4% among 13-14 years reaching 11% in 17-18 years (boys : 13% - girls : 8%). The proportions are similar for amphetamines (6% among 17 to 18-year-olds) (Piette et al. 1997)..

- Survey in Flemish Schools, 2000

In 2000, the lifetime prevalence of XTC use is 4% of 15 to 16-year-olds (boys : 5% - girls : 3%). Use increases with age : from 0.3% among 11-12 years and 1% among 13-14 years reaching 8% in 17-18 years (boys : 12% - girls : 5%).

The lifetime prevalence of amphetamines is slightly higher : 5% of 15 to 16-year-olds (boys : 7% - girls : 4%). Use increases with age : from 0.6% among 11-12 years and 2% among 13-14 years reaching 10% in 17-18 years (boys : 13% - girls : 6%) (Kinable, Personal Communication).

- School-aged youngsters in Bruges (Flanders), 1996-97

Among the participating students who ever used illicit drugs, 20% ever used XTC, 18% amphetamines and (more surprising) 22% LSD (98% ever used cannabis). 'Regular' users were defined as using illicit drugs at least 1 time/month during the last 6 months. Of the total group who ever used, respectively 27, 29 and 33% used XTC, amphetamine and LSD only once ('experimental use') and respectively 27, 23 and 15% used it 'regularly' (Verhaegen and Raes 1997).

- Mental health of youngsters in Brussels, 1994

Out of 2209 pupils of the Brussels secondary schools, XTC has become the second most used substance by young people after cannabis (6% had tried XTC and 2% had used it within the last 30 days). For the 17-18 age group, 8% of boys had tried ecstasy, compared with 6% of girls. Medicines follows: 5% and 2% respectively. Included among medications, are amphetamines : 3% had tried amphetamines-excluding ecstasy and 1% had used them within the last 30 days. The respective frequencies of use of LSD are 4% and 1%.

The percentages of youngsters trying and using the various drugs are higher for boys than for girls, regardless of the age group : 8% of boys had tried ecstasy compared with 6% of girls; and 7% of boys had had experience with LSD compared with 4% of girls in the same age group. There is however an exception which should be noted: the percentage of girls in the 11-13 age group who have tried barbiturates is higher than for boys in the same age group (Vranckx et al. 1996).

- Rock Festival (French Community), 1998

In 1998, 88% of the 157 interviewed people stated to have used an illicit drug at least once (lifetime prevalence). Beside cannabis reported by 98% of respondents, LSD was used by 62%, amphetamines and XTC by nearly half of respondents. XTC, amphetamine and LSD use increased compared to 1996 and 1997. The main increase regards LSD use from 22% in 1996 to 62% in 1998. One possible explanation of the increasing use of stimulants and hallucinogens could be the more and more "techno music" orientation of the festival (Hariga et al. 1999).

- Treatment centres

In 1999, stimulants including amphetamines and XTC are considered the main drug by 20% of treatment patients of the VAD Flemish Community monitoring system, by 15% in CTBDB Brussels centres (including cocaine) but only by a tiny fraction of the CCAD/EUROTOX French Community system (2%) (Table 6.2). Differences in the type of centres and in the age of the patient population covered should explain these variations. Among first treatment demands (French Community), stimulants represent 5% in 1999 (males 5%, females 5%).

Among patients undergoing treatment in a centre of the Charleroi³⁷, the mean age at first use of LSD and XTC was respectively 19 and 20 years. XTC and LSD are less frequently used among patients undergoing treatment in these centres.

- Street snowball survey, 1998

In the framework of a European snowball survey conducted in 1998, 1,243 drug users were interviewed in Brussels (n= 370), Charleroi (n=501), Liège (n=254) and Namur (n=118). The snowball methodology reaches different groups of drug users aiming particularly users who do not have any contact with prevention and treatment facilities. The main used substances were heroin (75%) and cocaine (65%) when XTC was used by 2% (Hariga 1999).

- Drug consumption in prison, 1993

In 1999, respectively 8 and 9% of 246 prisoners stated to have used amphetamines and XTC during the last month before the imprisonment and respectively 8 and 5% used 'regularly' during the current or a previous imprisonment.

In 1997, respectively 17% and 21% reported amphetamines and XTC use during the year before the imprisonment and respectively 4 and 8% during their current or a previous imprisonment.

In the study conducted in the Antwerp prison in 1993, 42% of prisoners were drug users. Amphetamine was used by 10% of users (Todts et al. 1999).

- Drug telephone line (French Community), 1997

In 1997, among 3,085 calls involving a substance, cannabis represents the most frequently mentioned (40%); heroin is the second one (14%). XTC, alcohol and cocaine represent each around 7% (Bastin 1997).

- Survey on Drug Use at mega house exhibition

In February 2000 a survey on drug use was conducted at an exhibition on techno and house music, clothing, beverages and related aspects. This exhibition took place in Mechelen (Flanders).

People walking by the booth of a prevention organization were asked to fill out a questionnaire. This organization distributed leaflets with information on different types of drugs and condoms promoting safe sex to reduce the risk of infectious diseases among injecting drug users.

The respondents were mainly male (54.5 %), 27.3 % was female and 18.2 % did not mention his/her gender. 56 % stated not to have used any illicit drug in the 6 months, whereas 44 % stated to have used something. 104 respondents (21%) stated to have used XTC or amphetamines in the last 6 months. Of these 104, 64 % mentioned to use XTC, amphetamines or speed from time to time, whereas 36 % reported to use one of those 'regularly' (this is respectively 13 % and 7 % of the total number of respondents).

Among XTC users, 27 % has mentioned using XTC when being in a group on another occasion than going out. 20 % mentioned taking XTC at school, 9 % has mentioned using XTC when being at home alone and 6 % mentioned using XTC at work. The fact that there is only 6 % of the people using XTC at work whereas there is 20 % using it at school, could be related to the age distribution of this group. On the basis of these data, we could group the users in users in recreative places and people that also use XTC in other places. There are however no significant differences between the people on frequency of partying ($\chi^2(1) = .98, p = ns$) or frequency of using amphetamines ($\chi^2(1) = .01, p = ns$).

XTC users go out more frequently than users of other substances or than nonusers and they state to go out more often to a dancing than users of other substances do. Of the XTC users there is only one who does not consume any other products (also includes legal products as alcohol and tobacco). XTC users are most often also consumers of alcohol, tobacco, cannabis and magic mushrooms (in that order of preference). There are some differences between users who consume a wide range of substances and the ones that consume a limited group of products. The group that consumes more different types of products, also consumes these products at a higher frequency than the other group (except for tobacco, where there was no difference).

All XTC users have a rather positive attitude towards having their drugs tested (mean value of 3.0 which corresponds to 'I probably would have my drugs tested'). XTC users have a significantly more positive attitude than nonusers towards having the possibility to have drugs tested (mean difference = -.50, $p < .01$). There is no significant difference with other users towards having drugs tested.

6.3. HEROIN/OPIATES

Table 6.3 : Synthesis table of epidemiological indicators on HEROIN/OPIATES: use in adult and school-aged population, offences, seizures, price and accessibility, Belgium, 1993-2000 (Figures are percentages except when specified)

INDICATORS	ORGANISATION	1993	1994	1995	1996	1997	1998	1999	2000
ADULT POPULATION									
Lifetime prevalence	Vlaamse G.	-	0.04	-	-	-	-	-	-
Last year prevalence.	Vlaamse G.	-	0.00	-	-	-	-	-	-
SCHOOL POPULATION (15-16 years)									
Lifetime prevalence	RUG/Publ.Hlth	-	0.7	-	0.2	-	0.7	-	0.6
	VAD	-	-	-	-	-	-	0.8	1.0
	ULB/Promes	-	-	-	-	-	1.5	-	-
Last month preval.	RUG/Publ.Hlth	-	0.1	-	0.0	-	0.2	-	0.1
PROBLEMATIC USE									
Heroin use prevalence(‰)	CCAD/EUROTOX	-	6.3	-	-	-	-	-	-
Treatment demands	CCAD/EUROTOX	86.0	85.1	77.3	74.3	67.7	67.1	68.7	-
(% opiates = main drug)	VAD	-	-	-	39.5	-	22.1	25.7	-
	CTB-ODB	-	-	-	-	77.1	72.7	67.6	-
Injecting use (current)	CCAD/EUROTOX	35.9	40.9	39.9	37.0	37.3	32.9	28.3	-
	Coor.Drog.Charl	-	-	-	-	-	-	17.1	-
	VAD	-	-	-	-	-	26.6	40.4	-
MORTALITY									
Drug related deaths (n)	NIS-IPH	346	376	346	-	-	-	-	-
DRD involving opiates		47.0	48.0	53.0	-	-	-	-	-
PEOPLE TAKEN IN for questioning (% opiates/all offence)									
	SGAP	-	-	16.5	-	7.0	25.6	5.9	-
SEIZURES (N)									
	SGAP	3,082	3,024	3,158	-	-	1,112	720	1,340
RETAIL PRICES /g (euro)									
	SGAP	-	-	-	37.2	22.3	21.1	39.7	26.8
ACCESSIBILITY (adults)									
	-	-	-	-	-	-	-	-	-

More difficult than regarding cannabis use, it is uneasy to generalise these figures to the whole country, to compare between data and to find out trends. Nevertheless one observes that :

- the information on use of opiates and heroin in adult general population is outdated : it showed a very low (less than 0.1%) lifetime prevalence in 1994 (Flemish Community);
- at the age of 15-16 years, a very limited proportion of students (less than 1% (stable) in Flemish surveys but 1.5% in the French Community HBSC survey) experienced heroin;
- the proportion of patients starting treatment of heroin/opiates addiction as their main problematic drug seems decreasing; in 1999, heroin/opiates users represent around 69% of clients in centres participating to French Community CCAD and Brussels CTB-ODB systems but only 26% in the Flemish VAD monitoring system (these differences seem to be explained by a coverage of different type of treatment centres);
- injection behaviour among heroin users starting treatment is quite stable (in contrast to the global trend in treatment centres due to the relative increase of people treated for non injectable drug) and varies between monitoring systems;
- heroin and opiates are the main cause of drug-related deaths (stable for 1993 to 1995);
- heroin/opiates are the cause of a varying proportion the cases in which people are taken in for questioning;
- the number of seizures decreased during recent years;
- the retail price has been stable since 1995;
- no information on accessibility in adults is available.

- HBSC survey :Youngsters and health in Flanders, 1994-2000

As regarding other illicit drugs more boys than girls use opiates : respectively 0.6 and 1.8 % of boys aged 15-16 and 17-18 years used heroin at least once for respectively 0.7 and 1.1 in girls of the same age groups. Respectively 0.3 and 0.2% of boys aged 15 and 17-18 years used during the last month when nearly none girls did it (Maes and Vereecken Personal Communication).

- HBSC survey :Health behaviour of youngsters in the French Community, 1988-98

In 1998, 1.5% of 15-16 years (boys : 1.5%- girls : 1.4%) experienced heroin. The use increases with age : from 0.2% among 11-12 years and 0.8% among 13-14 years reaching 2% in 17-18 years (boys : 2.5% - girls : 1.6%). The proportions are similar for amphetamines (9% among 17 to 18 year-olds) (Piette et al. 1997).

- Survey in Flemish Schools, 2000

In 2000, the lifetime prevalence of heroin use is 1.0% of 15 to 16 year-olds (boys : 1.2% - girls : 0.9%). Use increases with age : from 0.3% among 11-12 years and 0.5% among 13-14 years reaching 1.2% in 17-18 years (boys : 1.5% - girls : 1.0%) (Kinable Personal Communication).

- School-aged youngsters in Bruges (Flanders), 1996-97

The most consumed products by young people are alcohol, tobacco, medicines and cannabis. Among the population who ever used illicit drugs, only 2% ever used heroin. Use limited to a unique experience was proportionally high for cocaine and heroin (50%) when 21% used 'regularly' (defined as 1x/month for 6 months) (Verhaegen and Raes 1997).

- Treatment centres

In 1999, opiates are reported as main drug by most people entering treatment in Brussels (67.6%) and in the French Community (69%), and by 26% in the Flemish Community. The proportion of opiate shows a decreasing trend in the French Community centres. Restricted to first treatment demands, opiates represent 50.3% among the first demands registered in centres of the French Community in 1999. Opiates are the only category where the proportion of opiates as main drug is lower in 'first treatment demand' data than in 'all treatment demands' suggesting either that opiates users restart more often a treatment or representing an actual continuous decreasing trend of the proportion of opiate users starting treatment (previous first treatment data should be considered).

Among 1026 subjects (males : 75.4%, mean age : 27.2 years) having contacted the French Community treatment centres in 1999, heroin constitutes the drug mainly taken by 598 individuals out of 996, i.e. 60% of them. The average age when a subject takes heroin for the first time (978 individuals) is 19.3 years and the addiction lasts on average for 6 years.

Figures are comparable in Charleroi centres³⁷ the average age when a subject takes heroin for the first time is 19.5 years and the addiction lasts on average for 6.6 years (1997). The proportion of daily users among users for the years 1995-96-97 were respectively 77, 78 and 67% : other types of use were probably residual use of heroin accompanying a substitution treatment.

The substitution treatments explain that the higher daily used drug is methadone, for which the average first use age (it means the start of the substitution treatment) is 23.7 years.

- Rock Festival (French Community), 1998

In 1998, 88% of the 157 interviewed people stated to have used an illicit drug at least once (lifetime prevalence) among which 16% heroin (Hariga et al. 1999).

- Street snowball survey, 1998

In the framework of a European snowball survey conducted in 1998, 1,243 drug users were interviewed in Brussels (n= 370), Charleroi (n=501), Liège (n=254) and Namur (n=118). The snowball methodology reaches different groups of drug users aiming particularly users who do not have any contact with prevention and treatment facilities. The mean age was 28 years (1455). The main used substances were heroin (75%) and cocaine (65%) (Hariga 1999).

- Drug consumption in prison, 1993, 1999

In 1999, 15% of 246 prisoners stated to have used heroin/opiates during the last month before their imprisonment and 13% used it 'regularly' during the current or a previous imprisonment.

In a study conducted in the Antwerp prison in 1993, 42% of prisoners are drug users. The second main drug was heroin (28% of users) (cannabis was used by 37% of users) (Tods et al. 1999).

- Drug telephone line (French Community), 1997

In 1997, among 3,085 calls involving a substance, cannabis represents the most frequently mentioned (40%); heroin is the second one (14%) (Bstin 1997).

6.4. COCAINE/CRACK

Table 6.4 : Synthesis table of epidemiological indicators on COCAINE/CRACK: use in adult and schoolaged population, offences, seizures, price and accessibility, Belgium, 1993-2000 (Figures are percentages except when specified)

INDICATORS	ORGANISATION	1993	1994	1995	1996	1997	1998	1999	2000
ADULT POPULATION									
Lifetime prevalence	Vlaamse G.	-	0.5	-	-	-	-	-	-
Last year prevalence.	Vlaamse G.	-	0.2	-	-	-	-	-	-
SCHOOL POPULATION									
(15-16 years)									
Lifetime prevalence	RUG/Publ.Hlth	-	0.9	-	0.4	-	1.0	-	1.2
	VAD	-	-	-	-	-	-	1.9	1.8
	ULB*/Promes	-	-	-	-	-	1.4	-	-
Last month preval.	RUG/Publ.Hlth	-	0.1	-	0.2	-	0.3	-	0.4
PROBLEMATIC USE									
Cocaine/Crack use prevalence(‰)	CCAD/EUROTOX	-	-	-	-	-	-	-	-
Treatment demands (% Cocaine/Crack = main drug)	CCAD/EUROTOX	2.3	2.5	2.7	2.9	3.8	5.9	6.6	-
	VAD	-	-	-	7.1	-	9.0	8.2	-
	CTB-ODB	-	-	-	-	-	-	-	-
Injecting use (current)	CCAD/EUROTOX	22.2	25.9	34.6	22.9	34.8	29.5	12	-
	Coor.Drog.Charl	-	-	-	-	-	-	10.8	-
	VAD	-	-	-	-	-	8.9	37.2	-
PEOPLE TAKEN IN for questioning									
(% cocaine/crack/all offence)	SGAP	-	-	5.9	-	5.0	4.6	4.3	-
SEIZURES (N)									
	SGAP	897	927	1.046	-	-	799	547	925
RETAIL PRICES /g (euro)									
	SGAP	-	-	-	37.2-62	49.6-61.2	58.9	37.2-74.4	45.9-74.4
ACCESSIBILITY (adults)									
	-	-	-	-	-	-	-	-	-

*Not including crack.

It is uneasy to generalise these figures to the whole country, to compare between data and to find out trends, nevertheless one observes that :

- the information on use of cocaine in adult general population is outdated : it showed a very low (0.5%) lifetime prevalence in 1994 (Flemish Community);
- at the age of 15/16 years, a very limited proportion of students (less than 2% in Flemish surveys and 1.4 in the French Community HBSC survey) experienced cocaine;
- the proportion of patients starting treatment when cocaine is the main problematic drug seems increasing ; in 1998, cocaine users represent around 6% of clients in centres participating to French Community CCAD and 9% in the Flemish VAD monitoring system;
- injection behaviour among cocaine users starting treatment seems slightly increasing (in contrast to the global decreasing trend in treatment centres due to the relative increase of people treated for noninjectable drug) and varies between monitoring systems (remaining

lower to heroin injecting behaviour though almost equal in French Community reporting systems).

- the number of seizures seems decreasing during recent years;

- HBSC survey :Youngsters and health in Flanders, 2000

Respectively 1.2% and 3.6% of students aged 15-16 and 17-18 years used cocaine at least once (respectively 1.3% and 4.3% in boys and 1.1% and 3.1% in girls) ; only 0.4% and 1% of students aged 15-16 and 17-18 years used cocaine during the last month (Maes and Vereecken, Personal Communication).

- HBSC survey :Health behaviour of youngsters in the French Community, 1988-98

In 1998, 1.4% of 15-16 years (boys : 1.4%- girls : 1.5%) experienced cocaine. The use increases with age : from 1.2% among 14-12 years and 1.6% among 13-14 years reaching 3% in 17-18 years (boys : 3.9%- girls : 2.4%) (Piette et al. 1997).

- Survey in Flemish Schools, 2000

In 2000, the lifetime prevalence of cocaine use is 1.9% of 15 to 16 year-olds (boys : 2.3%- girls : 1.4%). Use increases with age : from 1.1% among 14-12 years and 1.1 % among 13-14 years reaching 3.9% in 17-18 years (boys : 5.3%- girls : 2.4%) (Kinable, Personal Communication).

- School-aged youngsters in Bruges (Flanders), 1996-97

Among the students who ever used illicit drugs, 11% used cocaine : of course this is lower than cannabis (98%) and XTC or amphetamines (20%) but higher than 'ever users' of heroin (2%). Although experimental use was proportionally high for cocaine (45% used only once), the proportion of regular users is the higher for cannabis but also for cocaine : 39% of cocaine users used it regularly (1x/month during the last 6 months)- what is two times more than heroin (Verhaegen and Raes 1997) (Verhaegen and Maes 1997).

- Mental health of youngsters in Brussels, 1994

Out of 2209 pupils of the Brussels secondary schools, trying and using cocaine (as well as crack and heroin) is limited (Vranckx et al. 1996).

- Rock Festival (French Community), 1996-98

During the 1998 festival, 88% of the 157 interviewed people stated to have used an illicit drug at least once (lifetime prevalence) among which cocaine was used by nearly half of respondents (45%) and crack by 3% (it should be specified that Belgian crack users do frequently call crack 'cocaine free base'). Cocaine use increased compared to 1996 (26%) and 1997 (31%) (Hariga et al. 1999)

- Street snowball survey, 1998

In the framework of a European snowball survey conducted in 1998, 1,243 drug users were interviewed in Brussels (n= 370), Charleroi (n=501), Liège (n=254) and Namur (n=118). The snowball methodology reaches different groups of drug users aiming particularly users who do not have any contact with prevention and treatment facilities. The mean age was 28 years (45). The main used substances were heroin (75%) and cocaine (65%) when crack was used by 5% (Hariga 1999).

- Drug consumption in prison, 1993 , 1997-99

In 1999, 22% of 246 prisoners stated to have used cannabis during the last month before their imprisonment and 9% used it regularly during the current or a previous imprisonment.

In 1997, 23% reported cocaine use during the year before the imprisonment and 15% during their current or a previous imprisonment.

In the study conducted in the Antwerp prison in 1993, 42% of prisoners were drug users. The main drugs were cannabis (37% of users), heroin (28%) and cocaine (16% of users) (Todts et al. 1999).

6.5. MULTIPLE USE (INCLUDING ALCOHOL, PHARMACEUTICAL PRODUCTS, SOLVENTS)

For specific information see Part IV Chapter 11.

CHAPTER 7. Conclusions

7.1. CONSISTENCY BETWEEN INDICATORS

Progressively an overview of the epidemiological situation on drugs and related guidelines is being developed. The framework of the EMCDDA, the identification of priorities and related guidelines are a real support. Several surveys were conducted among pupils of secondary schools and their results are comparable. There are very few surveys involving adults and other subgroups, as prisoners, and ethnic minorities. There is consistency between trends of some indicators : for example, increasing cannabis use among youngsters and also in adults, consistency between the various school surveys, high level of HCV among IVDUs reported by all studies. Nevertheless reliability of most data remains relatively poor and should be improved in order to take decisions on solid basis.

7.2. IMPLICATIONS FOR POLICY AND INTERVENTIONS

7.2.a Possible hypotheses and reasons for main trends and new developments in drug use

The trends observed in Belgium are very similar to those noticed in other countries of the European Union (EMCDDA 2000) So it seems that hypotheses should be related to the European culture. For one reason or another different sorts of drugs seem to fit in the youth culture and give an answer to specific needs of (young) people.

Factors typical for a certain age, like the need to experiment, to provoke the establishment, the need for kicks, fun, distraction are important elements, although their specific impact is difficult to assess.

In all cases the opinion of young people progressively evolves they don't think that using drugs automatically leads to the old stepping-stone-theory and most of them think that people who use drugs are not specifically different from anyone else.

Also the fact that some synthetic drugs are so easy to produce leads production (and use) of these products in Belgium and in some of the neighbouring countries.

7.2.b Relevance to policy issues or interventions for policy makers and professionals

Several researches and evaluations of policies, treatment facilities, etc are currently running. Several researches and evaluation of treatment or prevention programmes, on effectiveness of repressive measures, studies of specific riskgroups (prisoners, youngsters out of school), ethnographic research, research into the aetiology of drug use, cost of drug use, trend analysis have been conducted or are currently running. Unfortunately there are often not easily accessible because not officially published or not disseminated (grey literature).

Recommendations for policy issues are generated from surveys : for example, the proposal of Decorte(1999) to abandon the classical distinction between 'soft drugs' and 'hard drugs, and to introduce a new distinction between 'soft use' and 'hard use' of any drug. This approach allows to assess the overall impact of any substance, without overreacting to the dangers it poses. Every possible effort should be made-legally, medically, and socially to distinguish between the two basic types of drug use: the experimental, recreational, and circumstantial, with minimal social costs; and the dysfunctional, intensified, and compulsive, with high social costs. In order to distinguish 'soft use' from 'hard use', greater attention will have to be paid to how drugs are used.

Some recommendations are directly to the current Belgian concern over legalisation. Again from Decorte (1999) "the drug policy should encourage the development and dissemination of information control mechanisms among those who are already using drugs. Any abrupt shift in the present policy would probably be inappropriate. Informal social controls cannot be provided to users readily, nor can formal policy create them"...." The sudden legalisation of cocaine, for instance, would leave in limbo those who have not yet had the time to internalise information social controls".

There is a growing demand of decision makers and also professionals themselves for evaluation of prevention and treatment. At present, most attention is given to quantitative indicators, which are very limited for evaluation (it mainly gives an indication of the number of activities; it concerns more monitoring than evaluation) although qualitative indicators are also being identified and tools are being developed to evaluate mainly in the field of prevention.

There is a growing demand for an evidence-based approach towards prevention and treatment. More research is needed into causal factors, trends in drug use, characteristics of groups of users, ...

7.3. METHODOLOGICAL LIMITATIONS, DATA QUALITY AND INFORMATION NEEDS

Although some monitoring systems and epidemiological research have been carried out, the global description of the situation and the alterations in drug consumption and drug related problems remain incomplete. The school population is the group where drug use is the best documented. Regarding adults, treated patients, judicial and police activities, reliable data are necessary in order to assess the actual prevalence of drug use and particularly the problematic use.

In general the data quality of the school surveys is good. Little by little we get comparable research for specific age groups. Most of them are conducted by or in close cooperation with experienced research institutions or universities, repeating regularly the survey using the same methodology and the same tools. In some cases the data have been validated by other research. Both school surveys in the Flemish and French Communities are conducted in the framework of the WHO HBSC cross national survey. So at present comparisons can be made on the level of the Flemish Community between 1994 and 1998. In the French Community, the trends of the behaviour of youngsters from 1986 to 1994 have been analysed and published (Piette et al. 1997).

Meanwhile more harmonisation between the other studies conducted in the different areas of the country is necessary. For example, the concept of 'regular' use is defined very differently in the various studies.

On the other hand, we should stress on the competition of multiple geographically limited surveys making uneasy to carry out the large standardised HBSC surveys : indeed more and more schools do not agree to participate in the HBSC survey because of recent participation in a local school survey.

In the field of epidemiological research the majority of studies conducted in schools are self-report surveys, using a paper-based questionnaire to be filled in during school time. Other methodologies (Computer Assisted Telephone Interview, postal inquiry) have been applied in other surveys. No cohort research has been carried out.

Further efforts should be made to realise local and national estimates on the number of hard drug (ab)users (or hard users). Also insight and detection of new trends in drug (ab)use is important. In general more research is needed aimed at the social context of drug use, mechanisms of drug (ab)use, ...

Some results of official statistics become available (for example, RCM/MKG and RPM/MPG), but analysis of most official statistics is not regularly carried out or not published (mortality data, pharmacological data, judicial data,..). The data on deaths related to drug use from the National Institute of Statistics are old dated and the number of overdoses provided by police services is not fully reliable. Some information on infectious diseases (HIV, hepatitis B and C) is available but should be improved and more specific and detailed.

Regarding demand reduction and treatment centres, a lot of interventions and actions were set up but often without any evaluation. There is a very important need to evaluate and monitor the practice of (methadone) maintenance and substitution treatment. Harmonised indicators for the evaluation of demand reduction interventions should be implemented and a minimal harmonised data set should be

collected. One observes a progressive harmonisation and at least an increasing compatibility between registration systems for drug users used within traditional and even less traditional services e.g. low threshold services for methadone distribution or street ~~work~~ work. Epidemiological data on the treatment demands are progressively harmonised but the coverage of the registration systems is not enough documented : this prevents us from obtaining reliable figures at national level. Efforts should be continued in order to make possible general utilisation studies.

An important effort is urgent in order to obtain reliable data. Comparable data will permit comparison between the different parts of the country and can also be pooled. Such data will provide ~~large~~ necessary information in order to better define the priority interventions and to make the evaluation of the numerous initiatives conducted all over the country possible.

There are many interventions as well in prevention as in care activities. ~~Regard~~ Regarding information and data, the sources are also increasing. ~~Coordination~~ Coordination is necessary for both issues : ~~coordination~~ coordination of interventions and coordination of data collection and surveys in order to prevent any counter productive competition. A strategy ~~for~~ for the data collection should be defined.

New developments such as Ecodrugs, alco-pops, smart drinks should be surveyed and investigated.



Scientific Institute of Public Health
Unit of Epidemiology



ASL



Deutschsprachige
Gemeinschaft

CTB-ODB



Région
Bruxelles-Capitale
Brussels Hoofdstedelijk
Gewest

EUROTOX



Communauté
française

VAD



Vlaamse
Gemeenschap

BELGIAN NATIONAL REPORT ON DRUGS 2001

PART III Demand Reduction Interventions

Part III of the National Report 2001 was written by:

LAUDENS F. (VAD)

HARIGA F. (EUROTOX)

KÖTTGEN S. (ASL)

VANDERVEKEN M. (CTB-ODB)

CHAPTER 8. Strategies in Demand Reduction at National Level

The federal government decided in January 2000 to set up an evaluation of the current drug policy. Two universities were involved and studied the current penal policy, the recommendations of the parliamentary working group on drugs and the experiences in other countries. In the meantime, an inter-cabinet working group was set up (co-ordinated by the federal minister of health) to prepare a global drug policy paper (co-ordination, research, prevention, treatment, justice). During the summer of 2000 the governments of the Communities were involved and invited to give feedback on a draft policy paper, mainly in the areas of co-ordination, prevention and treatment. Feedback was also collected from fieldworkers in the field of prevention and treatment. In January 2001 the Drug Policy Paper was discussed and accepted in parliament.

8.1. MAJOR STRATEGIES AND ACTIVITIES

National framework

At the federal level, there are a number of demand reduction projects from a crime prevention perspective (Ministry of Internal Affairs). The projects are given to local communes with higher than average crime statistics. After a recent evaluation of these projects, criteria for funding were revised taking into account socio-economic data such as number of inhabitants, resources of the commune in addition to criminality. The projects cover prevention, outreach and treatment objectives. Some projects have set up their own structure at the local level and try to fill a gap in prevention or treatment facilities. Other projects are integrated in existing health centres. Up to now, the projects operated with annual contracts, which hinder them to develop a long-term perspective^k. In 2001, the government decided to provide funding for two years, until 2003. Funding to the 29 security and society contracts have been maintained in the different main cities, but have experienced important changes in the prevention contracts of 48 communes^l.

In seven out of the 10 provinces of Belgium, a medical social low threshold centre (MSOC-MASS) is set up to deal with problematic drug users. The centres are located in the major city of the province and provide methadone, counseling, outreach... The centres are financed partly by the federal ministry of Social Affairs and partly by the ministry of Internal Affairs.

^k At present numerous contracts exist with different cities and municipalities to fight against drug abuse.

In Flanders :

<i>Volets toxicomanie:</i>	11 contracts with cities/municipalities
<i>Plans drogues</i> (prevention-contracts):	10 agreements with cities/municipalities
<i>Plans drogues</i> (outside prevention-contracts):	6 agreements with cities/municipalities

In Wallonia :

<i>Volets toxicomanie:</i>	5 contracts with cities/municipalities
<i>Plans drogues</i> (in form of prevention-contracts):	9 agreements with cities/municipalities
<i>Plans drogues</i> (outside prevention-contracts):	3 agreements with cities/municipalities

In Brussels :

<i>Volets toxicomanie:</i>	6 contracts with cities/municipalities
<i>Plans drogues</i> (in form of prevention-contracts):	1 agreement

^l In Wallonia the following regions lost their prevention contract with the Federal government: Ans, Arlon, Comblain au Pont, Estinnes, Flémalle, Fleurus, Mouscron, Sambreville, Spa, Tubize, Visé, Waremme. The new beneficiaries are: Anderlues, Boussu, Dinant, Dour, Farciennes, Frameries, Morlanwelz, Nivelles, Ottignies, Péruwelz, Auderghem et Uccle

The federal ministry of Social Affairs provides the financing for a number of Therapeutic Communities, Crisis Centres and Day Centres, which were set up in the seventies and have expanded their capacities substantially in recent years. They are recognized on an individual basis.

In the federal drug policy paper, the concept of 'treatment networks' is proposed as organizational frame for the treatment of people with drug problems at a regional and/or provincial level. The policy paper provides in the set up of LCD (Local Co-ordination groups Drugs) in which case management, and the development of circuits of care are promoted. The 'Overlegplatforms Geestelijke Gezondheidszorg' are the initiators of these LCD.

The demand reduction structures at the level of the Communities are presented on the next page.

Flemish Community	French Community
<p>As an answer to the federal drug policy paper, the Flemish government agreed upon a brief 'Point of View of the Flemish Government concerning drug problems'. This Point of View was prepared by an inter-cabinet working group and accepted by the council of ministers of the Flemish Government on November 24th 2000. The Point of View gives a general and philosophical framework for the approach towards drug problems, mainly in the field of prevention and treatment. It includes the promotion of health and well being, the prevention of drug problems, harm reduction and treatment facilities for different target groups. It favors co-operation between federal and community governments to develop a global approach to the problem.</p> <p>Structures:</p> <p>In the Flemish Community, there is a global approach for prevention (see 9.1 for description) and to a much lesser extend for treatment (as treatment is mainly financed by the federal government).</p> <ul style="list-style-type: none"> • The <u>Flemish government</u> has organized its policy through a 'covenant' that is signed between the government and the coordinating agency <i>Vereniging voor Alcohol- en andere Drugproblemen (VAD)</i>. A policy plan was developed in which 8 areas of work were defined to implement a Flemish drug policy 1999-2001. The plan contains different actions in each area of work, with indicators for measuring its realization (evaluation). VAD is responsible for information and sensibilisation, training and support, data collection, consultancy, development of new concepts and networking at the level of the Flemish community. • <u>At provincial level</u>, there is a network in every of the 5 Flemish provinces and in Brussels for the co-ordination of prevention (<i>Provinciale Preventieplatforms- PPP</i>). The provincial networks also have a 'covenant' with the Flemish government in which their area's of work are defined to strengthen the Flemish drug policy (the area's are in the field of coordinating, implementation of concepts, data collection). For treatment, there are networks in the field of mental health (<i>Overlegplatforms Geestelijke Gezondheid</i>) in every province, financed by the federal ministry of Health. • <u>At a regional level</u>, there is a structure of 10 prevention workers, based in centres for mental health. They are working since 1988 and have created networks and contacts with different sectors in society (education, youth work, workplace, adult education, welfare sector, leisure sector, ...), to empower them to develop a prevention policy in their setting. <p>The centres for mental health all provide outpatient treatment for drug users (some are more specialized and offer more substantial treatment than others). In 2000 their number was reduced to 24 centres as a result of a fusion process. The Flemish ministry of Health finances the centres for mental health.</p> <p>Psychiatric hospitals and psychiatric wards of general hospitals offer inpatient treatment. Some of them have a drug specific unit. The hospitals are financed by the federal government but recognized by the Flemish Community.</p> <p>In some regions, the treatment sector has organized itself in the area of crisis intervention by setting up 'crisis network'. These voluntary networks are in an experimental phase in some regions in Flanders.</p> <p><u>At a local level</u>, there are various projects that operate rather independently. They deal mainly with prevention and outreach, some deal with treatment. These different local projects vary a lot. The Ministry of Internal Affairs finances some, the local authorities finance others, others are funded through welfare budgets (SIF), and some projects are privately sponsored. These various local projects are coordinated through the provincial networks.</p>	<p>The Federal Ministry of Public Health funds only treatment facilities, while the Community and the Regions are also competent for harm reduction and prevention. The Ministry of Interior, through the "security and society contracts", "Drug Plans" and prevention contracts funds outreach work projects, prevention, coordination and even therapeutic activities at the level of the communes or cities. In addition some provinces also fund demand reduction activities. The Federal Ministry of Public Health funds hospitals.</p> <p>The French Community is competent for prevention of drug use within the French Community i.e. Brussels and Walloon Region. It is funding information to the public, drug prevention projects, researches and epidemiological data collection. It is also competent for AIDS prevention. There is no coordination at the level of the French Community.</p> <p>Structures:</p> <ul style="list-style-type: none"> • <u>The Regions (Walloon Region and Brussels Region)</u> are competent for demand reduction policy. It is funding harm reduction, outpatients' treatment, training, rehabilitation and related research activities. There is no coordination structure at this level. The regions fund also the mental health sector. • <u>Provinces</u> are competent for preventive health care. Under this umbrella, some provinces have developed «drug cells » with prevention and or therapeutic activities and a role of coordination. The mental health sector has established in each province a mental health platform. • <u>At local level (communes, cities)</u>, demand reduction projects are implemented by various actors such as NGOs, security and society contracts, and the sector of assistance to the youth. Projects are funded by various sources. In localities where there is a prevention contract there is often a coordination of the activities.

Brussels Region	German-speaking Community
<p>The Brussels Region is an area where the different initiatives to cut in demand follow three main lines :</p> <p>The 'Concertation Toxicomanies Bruxelles – Overleg Druggebruik Brussel' is an organization that stems from a decision to give priority in regional drug policies to cutting demand for drugs. It coordinates all the sectors involved in the fight against drug-addiction (healthcare, social welfare, policing, justice). In the framework of its 11-point programme, it is responsible for collecting information in order to provide an overview of the regional dimension of the drug issue. It is also a sub-Focal Point for the EMCDDA.</p> <p>The 'Commission Communautaire Française' grants subsidies to organisations in Brussels for them to provide the following services: reception, support, healthcare, prevention, reinsertion, liaison and training. These services or missions are described as follows:</p> <p>Support: the organisation provides for the reception of drug users, their families or close friends. According to their needs and requests, they can get psychosocial and administrative guidance by means of individual follow-up provided inside the service and based on a permanent dialogue with all the relevant individuals and institutions, particularly in the healthcare, social, academic and sociocultural networks.</p> <p>Then the organisation can also redirect them towards more appropriate individuals or institutions according to their needs.</p> <p>Healthcare: the organisation makes a diagnosis and provides for the treatment of patients who have problems linked to drug use. Solving these problems implies dealing with medical, psychiatric and psychological aspects. The goal is to improve the well-being of the patients in their normal life environment, which does not necessarily involve their weaning. If the patient agrees, the general practitioner chosen by him/her is associated to the treatment together with, as far as possible, all the professionals from outside the organisation who are likely to bring a valuable contribution to the treatment.</p> <p>Prevention: the organisation undertakes prevention activities or takes part in the undertaking of such activities, for instance in order to preclude the damage caused in drug users.</p> <p>Prevention activities may among other things consist of :</p> <ul style="list-style-type: none"> - information, awareness raising and education of the population and of the workers in the healthcare, psychosocial, academic and sociocultural networks about drug-addiction and prevention of the damage caused in drug users. - prevention actions directed at specific target groups, for instance people who are dealing with or who are more likely to have to deal with drug-addiction problems. <p>Reinsertion: the organisation provides the support needed to secure the social rehabilitation and reinsertion into family life, school or the workplace of the patients. It operates in collaboration with the relevant individuals and institutions, such as the administrative, psychosocial, academic, professional and sociocultural networks.</p> <p>Liaison: the organisation fulfils a liaison mission in order to facilitate the networking or liaison between the different actors or bodies who deal with drug users. It sets up the most appropriate partnerships to make sure that the needs of the patients are met.</p> <p>Training: the organisation provides awareness-raising, training, ongoing training or the supervision of the interventions of actors who are dealing with or likely to have to deal with the problems faced by drug users.</p> <p>The subsidized Brussels organisations are the following: Addictions, Interstices, Ambulatoire du Solbosch, Capiti, Enaden, Projet Lama, Babel, Infor-Drogues, Modus Vivendi, Prospective Jeunesse, Réseau d'aide aux Toxicomanes, Trace, Case, Alliage and Le Pélican.</p> <p>The 'Vlaamse GemeenschapsCommissie', in addition to its coordination work of Dutch-speaking services in Brussels, follows the general line of action of the Flemish Community.</p>	<p>The German-speaking Community funds a primary prevention agency as well as a mental health centre which is responsible for prevention and therapy.. For linguistic reasons, (70,000 inhabitants live in the German-speaking part of Belgium) some people have to be sent to neighboring foreign countries, that's to say to Germany and Luxembourg to be treated in their mother tongue. This is possible thanks to international treaties with these neighboring countries.</p>

8.2. Approaches and new developments

8.2.a New and innovative approaches

Flemish Community

Introduction of a prevention model for the **sport sector** within a general concept of a 'local drug policy' in which different sectors of society (education, workplace, youth work, health and welfare sector, police,...) are involved in the development and co-ordination of a drug policy. This sector involves adults as well as young people and role modeling and alternatives to drug use have a strong appeal in this sector.

8.2.b Socio-cultural developments relevant to demand reduction

Drug use among young people is still on the rise. Drug use has become part of the youth culture of different groups of young people. They experiment with various (legal and illegal) drugs (poly drug use). Many sectors in society have come to realize that drug use among young people exists and there is a growing motivation to deal with it.

Common key elements are more and more taken into account for prevention interventions. First, young people experience real life problems during the critical adolescent period: relational and psychological problems, such as the difficulty of getting along with their parents. The quality of relationships and the importance of dialogue between young people and adults are advocated by the majority as an essential preventive measure. It is crucial that young people get greater autonomy and individual responsibility, which would allow them to deal with the very considerable role of peer pressure in experience, learning and therefore in dealing with the risk factors due to exposure. No moral approach is being used, yet each individual should be equipped to make responsible choices.

The co-ordinated initiatives use a broad framework of prevention in which person-focused and structural interventions are combined. Long term approaches in which a policy is developed with the participation of all involved, forms the basis of prevention work. In recent years, drug prevention is often integrated as part of a local health policy. As a matter of fact, the drug topic is often the starting point to broaden a policy from a local drug policy to a global health policy. The theoretical frameworks are derived from international research literature.

With the emergence of HIV infection, AIDS and hepatitis, risk reduction new strategies have been developed: needles exchange, treatment with substitution substances, distribution of condoms... The activities are a.o. undertaken within the security contracts of the Ministry of the Internal Affairs with local authorities.

8.2.c Developments in public opinion

The survey on "Belgians and drugs" (Patesson and Steinberg, 2000) (see also 1.3.a.) gives some indications on the public opinion regarding prevention.^m The results of this survey showed that according to public the main actors of prevention should be the school (60%), followed by parents (50%), media (36%) and medical doctors (19%).

84% respondents regard the responsibility of the young people as the most efficient method for prevention. Are also considered effective police interventions against dealers (79%), information on risks in schools, control and repression in schools in leisure locations.

Free access to cannabis is regarded as an effective prevention by 47% of Flemish speaking respondents and by 30% of the French speaking ones. Finally forced treatment is perceived as efficient for prevention by 56% of the Flemish-speaking participants and by 44% of the French-speaking ones.

^m a sample of 1013 persons between 18 and 55 years randomly selected according to quotas

8.2.d New research findings

French community

“Drogues de rue”, Pascale Jamouille (2000): Life stories of young women and men who experimented or are experimenting different ways of an existence linked with drugs. This research brings information in nuances on the trajectories of these drug dependant persons, on their life styles, their point on view on themselves, the society, the professionals, their values system. The following items are covered: the entry in life styles linked to drugs, their socio-economic practices, their notion of time, their consumption and ways out of this lifestyle.

Misunderstandings, mistrust, are frequent between professionals and drug users. The objective of this research is to provide professionals with a better understanding of the social world of drug users. The results of this work should improve the dialogue between drug users, and professionals from the different sectors of intervention (health, social, justice, ...).

8.2.e Specific events during the reporting year

- In January 2000, the federal government decided to evaluate the existing drug policy. The evaluation was carried out by 2 universities (Ghent and Leuven)
- The set up of a federal working group (spring 2000) with representatives of different federal cabinets (Health, Social Affairs, Interior, Justice) to prepare a federal drug policy paper. Feedback was given at different levels (Regional governments of the communities, field workers). In January 2001 the Drug Policy Paper was discussed and accepted by Parliament.
- The Flemish Government produced a ‘Point of View of the Flemish Government concerning Drug Problems’ as an answer to the federal drug policy. Attention is given to the philosophy of an overall approach in which prevention and treatment are central. Co-operation with the federal government is supported. This Point of View is the start of a Flemish Drug Policy Paper that will be prepared and discussed in 2001.
- Conference : Drug Policy 2000 (Drugbeleid 2000/ Gestion des Drogues en 2000) Brussels, 22-23 November 2000 : Annual national conference in which a topic (culture and performance) was discussed and presented from different perspectives (policy, prevention, treatment, repression, international perspective,...).
- Brussels: “Festival Drogues Pur kultur” (Projet LAMA, Centre Local de Promotion de la Santé de Bruxelles). This cultural festival was held between from 20 – 26 November 2000, in Brussels. The objectives of this event were to invite the general public to have a global reflection around drugs, illegal or legal, not only in terms of health or justice but also in terms of meaning for the society. The 30 partners of this project were issued from both health and cultural associations. Each has developed a specific project according to their specificity.
The event has benefited of a large both TV and paper press cover in Brussels.
- Conference “Co-operation between the drug treatment sector and the justice sector”. Organised by VAD (November 28th 2000). The aim of the study day was to exchange constraints and discuss ways of co-operation between the two sectors. Communication and value clarification are major aims for the future.
- In December 2000, a syringe exchange programme started in the Flemish Community. The 4 Medico-Social Centers (MSOC) are the co-ordinating agencies for syringe exchange in each Flemish province. Three strategies are developed: the optimisation of the syringe sale and recuperation of used syringes through pharmacies, the distribution of syringes through low threshold health services and the setting up of exchange points in some hot points of major cities. The project has a Flemish co-ordination that is carried out by Free Clinic.

8.2.f Dissemination of information on demand reduction among professionals (networks, Internet,..)

- In the Flemish Community an EWS-network is operational with very different partners, to collect information, rumours about all kinds of illegal drug use (more than designer drugs) and to disseminate information about new drugs or new ways to use them to the partners of this network. The 'DrugLijn' (helpline) is the turning point of the information collection.
- Today's multimedia world with many technical possibilities leads to an approach of Europe also to the sector of fighting against drugs. For the exchange of information inside and outside national borders in the sphere of demand reduction, on the European level and under the management of the EMCCDA, the EDDRA data bank had been developed. All the projects are saved in a data pool, so they help to run an efficient information policy and to develop coordinated measures beyond national borders.
- Within the French Community, Modus Vivendi a.s.b.l. publishes a newsletter, "Brèves de Comptoirs etc." disseminating information relevant to harm reduction activities and early warning. This newsletter is distributed electronically and by fax to a network of specialised or not actors of demand reduction. Early warning information are also disseminate through this network by Eurotox.

CHAPTER 9. Intervention areas

Prevention: the problematic nature of alcohol and drug abuse is comprehensive and complicated. Prevention efforts should work their way through all layers and sectors of society.

The finale goal of a co-ordinated prevention policy is a responsible coping behaviour towards different products. This asks for not only actions towards persons but also asks for structural measurements.

Prevention work is based on a global intersectoral approach, meaning that in different sectors (in youth centres, in education, in the workplace, in special child welfare,...) different actions are planned and put in action.

Participation and empowerment are key factors to a successful strategy. Therefore working with keypersons (mediators) is essential in this matter. They know the language, they speak the language and they can translate the preventive messages to there own and specific target group. This methodology is also less expensive.

Treatment: Drug problems, which are more far-reaching than mere dependency upon a product, follow a certain course. Intervention into that course can occur at different moments. Taking into account the complexity of the problem and the numerous symptoms and stages, a wide variety of treatment services and methods are needed to be able to intervene in this process at different times and in different ways:

1. *Early intervention* does not need specialised (categorised) drug treatment, but rather a broad scope of persons and services that can deal with initial signs of drug use.

2. GPs, Welfare Centres, OCMW (social security),... in other words, *primary health care* services, play an important role as well. These services are easily accessible and have relief workers to take care of a variety of problem areas.

3. *Drug-specific treatment* is necessary in cases of serious and persistent problems for which intensive and frequently lengthy counselling and treatment is required.

4. *Harm reduction* plays a specific role in all this. Harm reduction advocates a more pragmatic approach that is directed to reducing as much as possible the negative consequences of alcohol and drug misuse on the user's health, his social well-being and legal status – both for the individual and his/her environment and also for society at large.

Study and research: tackling the problematic nature of alcohol and other drugs in a consistent way fundamentally requires a very thorough basic know-how. Study and research that supports the daily practice of prevention and treatment is utmost important in a way that it maximises the information supply, it provides people with efficient and reliable assistance and evaluates and optimises the field work.

Helpline: The drugline is a telephone information service for all questions or problems relating to alcohol, drugs or medicines.

Documentation: The general public and the keypersons can order a full range of documentation materials (leaflets, brochures, educational materials,...) on different themes and products.

9.1. PREVENTION

Flemish Community

The concept of a global alcohol and drug policy for local communities was developed during the European Drug Prevention Week '98. At that time, the project 'A local alcohol and drug policy. Join in!' was launched. The concept is a synthesis of 10 years of prevention work in the Flemish community. All the concepts made thus far were gathered and were merged (given a place) into one concept. Since then the concept has been implemented in the Flemish community. New brochures for various sectors have been made. In 2000 we realized a brochure for the police. 2000 was an election year, to guarantee the continuity of the efforts made in the communities concerning alcohol and drugs we have given in 2000 several incentives (mailings and new materials) and informed the local politicians to continue working on this matter.

A global alcohol and drug policy for local communities has 4 working principles:

- Focus on people (individual level), on their setting (structural level), and on the drugs (products)
- Inter-sectoral approach
- Long-term strategy
- Participation

With this concept we aim to call on all local key persons to join in a local alcohol and drug policy and to support them in this. Key persons are youthleaders, teachers and administrators, supervisors in the workplace, primary health care workers, proprietors in the hotel and catering business, local policy makers, civil servants, welfare workers, social-cultural workers, the facilitators of a local alcohol and drug policy, prevention workers, municipal and national police forces.

It is indeed up to everyone, from their specific angle, to make a contribution in a local alcohol and drug policy. Anybody can play a part in stimulating discussions about alcohol and drug problems, in trying to prevent them, in assisting in their treatment. Various sectors where the key persons are active, can thus be included in a local alcohol and drug policy.

Admittedly, the idea of developing a local alcohol and drug policy is nothing new. In many places in Flanders, people have been active with building networks and starting joint actions concerning alcohol and other drugs. With this concept it is our aim to further support local key persons in their efforts to develop a global alcohol and drug policy. This will not happen overnight. It demands long-term commitment as well as continuity.

French Community

The Ministry of health of the French community is competent for health promotion including prevention projects. The Ministry of health defines health promotion according to the Ottawa convention. In its five-year Health Promotion Programme (1998-2003), the French Community has identified six priority health problems: infectious diseases (HIV, immunisation and tuberculosis), cardio-vascular diseases, cancers, addictions, mental health problems and accidents. In terms of target population, priority is given to socially excluded population, and school children. At the French-speaking Community level, the following strategies to deal specifically with addiction are proposed:

- a) To fight the anxiety and activism often associated with the issue of drugs, to promote sensitisation and training programmes for adults (teachers, parents and responsible for young people).
- b) To promote reflections and debates between young people and adults around drug issues in the scope of general education prospect. The issue of drug use should be placed within a larger context of questioning the meaning of life and our choices in life, at a critical period in the psychosocial development of adolescents.
- c) Instead of focusing on drugs themselves, prevention should focus on attitudes and behaviour and perceptions of young people.
- d) To tend toward a global perception of addiction, not restricted to illegal drugs.
- e) To choose also strategies aiming at reducing the risks of using legal or illegal drug, by intravenous or otherwise.
- f) Finally, in order to avoid getting off course, it is absolutely essential that prevention issues be addressed in a manner that respects human rights, democracy and a law-based society.

Under the AIDS prevention programme, intravenous drug users are identified as one of the target population.

9.1.a Infancy and the family

Flemish Community

- Leaflets for parents
Several services provide leaflets on drug prevention and adolescents especially for parents
- Training programmes for parents :
Ouders en drugs (three evenings): trainers manual
Lindestraat 14 (one evening): trainers manual and video
Both are aimed at parents of adolescents. Many regional and local prevention workers provide these programmes. The sessions are mostly requested by schools, parent-teacher associations, various socio-cultural organisations, ... For *Lindestraat 14* there's also a train-the-trainer programme.
- The DrugLine :
It is a telephone information service for all questions or problems relating to alcohol, drugs or medicine. On working days from 12 a.m. until 9 p.m. and Saturdays from 3 p.m. until 9 p.m. on number 078/15.10.20. The DrugLine is not exclusive for parents but a great deal of parents consult the DrugLine.

French Community

- Activities mentioned in this chapter concern the public in general and not the projects aimed to parents of drug users, parents using drugs, pregnancy and motherhood of drug users, all developed at chapter 9.6.
- Leaflets for parents. Some services provide leaflets on "drug prevention and adolescents" for parents.
- The different organisations recognised and funded by the French Community of Belgium – Health Promotion Ministry are regularly working with parents, mainly in the framework of pupils parent associations.
- Information, increasing public awareness and training are aimed at professionals in contact with future parents, young parents and families with adolescent children. AVAT (Verviers), CPAS de Charleroi, INFOR-DROGUES (Bruxelles), NADJA (Liège), PROSPECTIVE-JEUNESSE (Bruxelles), SESAME (Namur), RE-SOURCES (Châtelet).
- Other organisation funded by other sources realize the same kind of activities: ALFA (Liège), LE REPIT (Marche), Centre d'études et de prévention Alcool-Drogues (Marche) : only programme for parents of adolescent centered on the control of alcohol use, Génération Assuétudes (Waremmé), LE PELICAN (Bruxelles).
- Parents and relatives represents the largest percentage of callers (38 %) of the drug helpline INFOR-DROGUES, central helpline for Brussels and the French Community. See also 9.1.e.
- **New** : UNISSON (Farciennes) : creation of a **Playstation Club** in order to contact young people (14-18 years) and parents (see also 9.1.c).

9.1.b School programmes

9.1.b.1 Primary schools

Flemish Community	French Community	German-speaking Community
<ul style="list-style-type: none"> • 'Drugpreventieproject' (municipal police): voluntary, general (drug education) for 11-12 years old children. Police guided approach (1 lesson). Teacher is involved (4 lessons). Parents are informed. Meeting with a former drug user in prison. Some statistics, no evaluation. • Schooladoptieproject 'Doe eens normaal': (= 'Schooladoptionproject behave normal') (municipal police): voluntary, general (drug education, focus on prevention of criminality), for 11-12 years old children. Police guided approach (10 lessons). Teacher can elaborate some subjects. Parents are informed. Proceevaluation. • MEGA (= 'Drug education to just say no'), inspired on DARE (federal police): voluntary, general (drug education), for 11-12 years old children. Police guided approach (3 lessons). Teacher is involved (7 lessons). Parents are informed. Some statistics, no evaluation. • 'Gezondheid, je kan er zelf iets aan doen' (= 'Health, you can do something about it') (VIG VZW Vlaams Instituut voor Gezondheidspromotie): voluntary, general (health promotion, lifeskills), kindergarden and primary school, including topics such as health risks, etc. Teacher guided and pupil guided approach. Parents are involved. • 'Contact sleutels' (De Sleutel VZW): voluntary, general (lifeskills and drug education) for 8-12 years old children. Teacher guided and pupil guided approach. Parents are involved. • Project 'Verbondenheid' (= 'Joint') (Katholieke Universiteit Leuven) voluntary, general (lifeskills, prevention of delinquent behavior). Teacher guided and pupil guided approach. Parents are involved. <p>Principes voor drugpreventie in de basisschool (Principles for drug prevention in primary schools) (VAD VZW). To co-ordinate the different programmes, which are addressing primary school teachers and their pupils, the VAD developed a series of general 'Principles for drug education in primary schools'. These principles must form a framework for schools to choose one of the programmes which are available and that fit best in their pedagogic approach of the school.</p>	<p>Here we notice that social workers in the field have begun to target primary schools for their prevention campaigns. Schools generally call upon social-minded associations working in the field to provide information as part of an overall effort to promote health.</p> <p>Schools frequently require assistance (follow-up, supervision, feedback) with their long-term projects. Work is focused on problem areas or underlying causes of problems in order to improve the living and working environment within the school.</p> <ul style="list-style-type: none"> • In some schools, the "<i>clefs pour l'adolescence</i>" (<i>keys for adolescence</i>) project set up in 1988 is still running. This is an education programme that deals with health and social relations between students, parents and teachers. Génération assuétudes (Waremmé). • In pre-school and primary school, prevention and assistance programmes (follow-up, supervision, feedback). These efforts are aimed at enabling parents and teachers to re-establish communication and assume their respective roles in raising children. Work is focused on problem areas or themes aimed at improving the living and working environment within the school. Le Répît (Couvin), Prospective Jeunesse (Brussels) "<i>Relation écoles-familles</i>" (relations between schools and families). • <i>New</i>: Video cassette entitled "Les matins ré-créatifs" (re-creational mornings) was produced in collaboration with Prospective Jeunesse and AMO "SOS-Jeunes". This video cassette is used to illustrate various aspects of the prevention effort launched by "relation écoles-familles" (relations between schools and families) project. Starting in 2001, this video cassette will be available for schools and psychosocial workers interested in an approach that combines prevention with health promotion. The video cassette is also intended for students in post-secondary teaching institutions who will later enter fields such as teaching, healthcare, prevention, etc. • Information exchange platforms (seminars, speeches) are also organised in order to encourage the exchange of information, experiences, and questions among the various social workers and associations involved in the education and healthcare fields. Prospective Jeunesse (Brussels). 	<p>'Bevor es zu spät ist' (Before it's too late) is the conceptual workbook and the thesis of this book are spread to the primary school teachers. Various materials were developed as exercise books: 'Gesünder und bewusster leberl' promotes a more healthy and self-conscious life and tackles nutrition habits, smoking, life in group, self assurance..., 'Rauchfrei' is a one-year programme specifically related to smoking.</p>

9.1.b.2 Secondary schools

Flemish Community

- 'Leefsleutelprogramma's' (Leefsleutels VZW): voluntary, general.
Different programmes (Life skills and drug education), all teacher guided and student guided:
-Leefsleutels voor jongeren: for 12-14 years old
-Leefsleutels in actie: for 15-18 years old
-Leefsleutels plus: for 12-15 years old, special education
-Leefsleutels in actie plus: for 15-18 years old, special education
-Omgaan met risico's plus interactive game for 12-15 years, special education
- 'De Uitdaging': social skills programme for 16-18 years old: training programme for teachers and manual
- Short programmes (1 day or less) performed by external organisations:
-Sleuteldagen (*key games*) (De Sleutel VZW): voluntary, general (lifeskills and drug education) project days performed by counsellors and former drug users, pupil guided approach.
-Forumtheater (De Kiem VZW) (Klap Klap VZW).
-Junkieblues (Educatief Theater Antwerpen)
-Workshops on groupdynamics (Klap Klap VZW).
- 'Bevraging van leerlingen in het kader van een Drugbeleid Op School' (=Questionnaire of students in connexion with a drug policy in school) (VAD VZW).
In 1998 a new tool was developed for secondary schools, based on the materials that were developed in the past (since 1994) in a global framework of 'a drug policy at school'. *'Bevraging van de Leerlingen in het kader van een Drugbeleid op school'* is a tool for schools to evaluate their drug policy. It consists of a questionnaire, which is addressing all the pupils of the school and focuses on attitudes towards smoking, drinking and illegal drug use, their actual drug use, the atmosphere in the school and what the pupils would like to change in the school, their knowledge and opinions of the school policy towards drugs, etc. The results are given back to the school with recommendations towards their prevention activities for pupils, towards working with parents and the adoption and optimisation of their drug policy.
- Stappenplan rookpreventiebeleid op school (stage plan to build out a smoking prevention policy at school) (VIG VZW).
This instrument gives guidelines and a framework to schools to develop a policy about smoking at school. All partners are involved in this process: students, teachers, parents, counsellors, ...

French Community

- This year has been characterised by the launch of numerous projects in secondary schools. Additional funding granted to schools within the framework of the Onkelinx and Hazette programmes made it possible for prevention projects to be launched in schools. All in all, 122 schools received funding for their "addiction prevention" programmes. Ministerial funding amounts to a total of 10 million BEF.

In terms of the aims set by the Ministry, each project should ideally consider the socio-economic environment of the school population, work towards establishing networks (between schools, with the local community, etc.), include project evaluation procedures and, more importantly, see to it that the entire education community is involved.

In most cases, assistance is given to projects that vary from one school to another, depending on the "institutional culture". Associations that assume responsibility for these projects often favour a "health promotion" approach. The themes addressed are not limited to drug use per se but rather address health in a wider sense: violence, communication, social relations, risks, etc.

- There is a general tendency among associations working in the field to focus their efforts on training adults to act as information relays. Indeed, these associations seem to feel that the adults who are closest to young people (youth leaders, teachers, etc.) have the most credibility when it comes to getting health promotion messages across.

Le Répit (Couvin), **Infor-Drogues** (Brussels), **Prospective Jeunesse** (Brussels), **Zone T** (Andenne), **CSM** (Charleroi), **Nadja** (Liège), **Alfa** (Liège).

- However, there are some associations that work directly with young people. In such cases, the aim is to get young people to discuss themes by means of an external medium: "trainspotting" play, playstation club, etc.

Exchanges with groups of young people (ideally around twelve) within the school context (CEFA ...), involving two hours of class on health promotion themes (communication, well-being, risks, consumption, etc.) At the request of the Ministry of Education, ten other associations organised debates following the performance of the "Trainspotting" play. **Zone T** (Andenne). This approach created strong debates.

German-speaking Community

Audio- and videotapes, lessons and other materials were produced for teachers covering the domain of primary prevention and self-control. These tools were produced by ASL in collaboration with a consultant office and involving contributions from some programmes of Germany.

- Europeers (=peerproject), CAD, Limburg VZW
Europeers is a project, directed at pupils in their third year of secondary school. The aims of the project are to improve the skills of young people concerning conflict resolution, problem solving, self esteem, to implement these skills in their social life and to transfer these skills to their peers. Every school selects two classes, in which the pupils elect two opinion leaders. These opinion leaders receive four training weekends about prevention, addiction and the above mentioned skills. The opinion leaders then transfer these skills to their classmates. This project was first implemented within the framework of the European Drug Prevention Week 1998.
- Groupwork with school attending young people (CAT-Preventiehuis Gent VZW).
The target group is young people who use drugs regularly in their leisure time and who do not consider this drug use as a personal problem. As a result of their drug use, they have some problems at school or in their home situation. The young people are referred by the school health service. The group meetings are not therapeutic. They aim at giving these young people some tools to empower them to change their individual behaviour.
- Lesgeven en praten over drugs in de klas: een wereld van verschil? (Teaching and talking about drugs in the classroom. A world of difference?) (VAD, preventiewerkers Centra Geestelijke Gezondheidszorg, Leefsleutels VZW). Training for teachers – 2 days.
- Various programmes relating to health and social relations were set up to bring students, parents and teachers together. Work on consumption in a wide sense. Activities aimed at encouraging young people to talk about psychotropic drugs use and understanding what young people go through when they use drugs. The aim of such activities is to promote interactive prevention and therefore improved communication between teachers and students. **Génération assuétudes** (Waremmes), **Sésame** (Namur), **Symbiose** (Chapelle-lez-Herlaimont).
- "Controlling alcohol use". Work with secondary students from various schools. Information on the transition from occasional use to full-fledged addiction as well as on psychological and mental addiction. **Centre d'études et de prévention alcool-drogues** (centre for the study and prevention of alcohol and drug abuse) (Marche-en-Famenne).
- "Diabolo Manques, une exploration à la découverte de soi" (Withdrawal, a journey of self-discovery). This is an itinerant exhibit (bus) used as a means to prevent drug addiction. It is an overall project (to re-establish dialogue between young people and adults and encourage thoughts on the issue). It is intended for secondary schools from all networks (adolescents between the ages of 12 and 15, school principals, teachers, etc.) Many partnerships have been set up with local associations, psycho-medical-social centres (PMS), public social welfare centres (CPAS)... **Maison du social** (Province de Liège).

9.1.b.3 Post-secondary schools

French Community

Several associations working in the field have decided to offer a special training module adapted to their specific public and context intended for post secondary educational institutions involved in teaching, education and social work. They were prompted to do so by individual requests for information and documentation from students, by the fact that social workers in the field discovered that they themselves lacked information, and by the fact that there was no study programme adapted to their specific needs. This special training module is intended for future primary school teachers, secondary school teachers, youth leaders, social workers and nurses. Prospective Jeunesse (Brussels), Infor-Drogues (Brussels).

9.1.c Youth programmes outside schools

Flemish Community

Types, settings of activities

Support of youth work in working towards prevention of alcohol and other drug problems by following working groups and developing workshops in youth movements (VVKSM scouting, KSA-KSJ-VKSJ and youth holidays), youth clubs, youth houses and young people's services.

Peer-to-peer approaches

Europeers (CAD) and Jeugdadviseurs (In Petto): training programmes for peer education approach.

Target groups

All the materials, interventions and activities which are developed, can be used by:

- Youth workers (youth leaders, ...) and trainers of sports clubs;
- Policymakers in the youth work and the sports;
- Intermediaries (professional prevention workers, teachers, other concerned adults) supporting the implementation with the youth.

Specific training

-The VAD, as the years before, organised different training weekends for coaches to develop a framework of coaches in Flanders. Local youth workers can depend on these coaches to support them in the implementation of a prevention policy and in the intervention phase at times when drug (ab)use is detected. Currently we are evaluating the training programme. We expect that by the end of 2001 the new training will be ready.

-The VAD is finalising a new training programme for the sports sector on two levels. The first training aims to explain the role of the trainer is the prevention strategy and prepares the trainers for the implementation in the sport club. In the second training, we reflect on the issue of implementing a drug prevention policy in the sport clubs with policymakers in the sport clubs and municipal responsables for sports. A try-out is planned for autumn 2001.

French Community

The different organisations recognised and funded by the French Community of Belgium – Health Promotion Ministry are regularly working with youth organisations, youth movements (different scouts federations, Patro's,...) youth houses, sports clubs and young people's services (centres INFOR-JEUNES for instance).

Among other organisations: AIGS (Huy-Waremme), AVAT (Verviers), CPAS de Charleroi, CANAL J and CITADELLE (Tournai), INFOR-DROGUES (Bruxelles), NADJA (Liège), PROSPECTIVE-JEUNESSE (Bruxelles), SESAME (Namur).

Other organisation funded by other sources realise the same kind of activities: ALFA (Liège), Centre d'études et de prévention Alcool Drogues (Marche): programme for parents and adolescent centred on the control of alcohol use, Génération Assuétudes (Waremme), LE REPIT (Couvin), RE-SOURCES (Châtelet), ZONE T (Andenne).

New: UNISSON (Farciennes) : creation of a "**Playstation Club**" in order to contact young people (14-18 years) and parents. Through discussions and discovery of a game, open the door to inform and exchange about other questions and make the service known.

New: DESTINATION (Dinant) : the "**meeting room**". Offering to young people an office space to meet out of the street, with the aim that this space will become a space for expression, listening and projects.

Publication: Re-edition of "Un autre regard sur les drogues" (16.000 exemplars), information brochure on drugs and the phenomenon of licit and illicit drug use, created by INFOR-DROGUES. Target : adolescent and young adults.

The French Community supported

German-speaking Community

Training of adolescents based on the peer-method (youth clubs, youth houses...), primary prevention trainings for leaders of youth movement, one day-intervention during summer sport trainings (with French and Flemish translations for participants from these communities).

'Zoff dem Stoff' is a free-alcohol intervention programme conducted in a big 'Mega-Disco' dancing involving 1500-2000 young people in a drug prevention programme. Police and 'Gendarmerie/Rijkswacht' collaborated. A three-week exhibition and workshops were organised in secondary schools before the event.

-In the series 'lokaal beleid, schakel jezelf in' a new brochure for the sport sector was published.

in 96-97 the realisation of a short film called '**No Problemo**' focus on daily life of teenagers. An educational tool to promote prevention among adolescents between the ages of 14-17 was added to this video cassette in the year 2000. This tool was created by Asbl Promethee with the help of CERES (Ulg)

9.1.d Community programmes

Flemish Community

Drug-specific/drug non-specific

'A local alcohol and drug policy. Join in!' is a drug-specific programme although a lot of drug non-specific issues such as 'cooperation', 'participation', 'empowerment',... are relevant.

Cities/rural area

Flanders is made up of large city centres as well as small rural communities. The scale of a community is – as far as the alcohol and drug theme is concerned – relative. How and in what degree a community – in its capacity of community – works on the problem depends on its location and the nature of its function. For instance, a small community can very well be a favourite social meeting ground for the youth from the region.

For some (smaller) communities, it can be an added value to cooperate in a larger network of services and workers which generally are not present in small communes. Such a network increases the effectiveness of prevention. In larger cities, we notice the tendency to concentrate more on a neighbourhood or district.

Cooperation structures

The regional prevention workers based in a Centre for Mental Health and local prevention workers are available for further support and follow-up with a municipal working group. They also make referrals to other agencies in the field of prevention and participate in informative and educational seminars.

Consultation and co-ordination

French Community

Within the framework of Community programmes, we find that the various initiatives attempt to reach out to a rather large public. Here, it is often parents, young people and social workers in the field who participate in setting up health promotion projects. Programmes focusing exclusively on drug use are becoming increasingly rare. More often than not, a general approach is used.

Coordination Sida Assuétudes (Co-ordination AIDS and Addiction), a provincial service in the province of Namur organises monthly meetings between social workers in the field. These meetings give them the chance to share experiences and improve their work methods.

Centre d'études et de prévention alcool-drogues (Centre for the study and prevention of alcohol and drug use) (Marche-en-Famenne): "Controlling alcohol use". Information awareness campaign for young people (aged 14-20) and adults (parents, teachers, etc.) on their experiences with alcohol. There are also debates, posters, booklets for young people.

Brussels

The 'Antennes du Projet Lama' develop in six different areas of Brussels, community projects with the participation of professionals and non-professionals.

German-speaking Community

Each community organises staffs of voluntaries coached by community responsables. These staffs carry out actions towards targeted-groups: the type of intervention depends on opportunities. Indeed ASL was the initiator of a European action involving eight other European countries and resulting in the set up of such voluntary groups.

between these various prevention workers is organised on the provincial level in the Provincial Prevention Platforms.

Statistics and evaluation results

In 2000 there were 148 cities with a local alcohol and drug policy. The actual nature of a local alcohol and drug policy differs from commune to commune, from neighbourhood to neighbourhood. It depends on local needs, structures, problems, availability of prevention and treatment services,... It is the task of the local partners themselves to develop a policy, tailored to the requirements of the locality. The local level, as the nearest management level, is perfectly fitted to serve this purpose. People always feel a closer bond with what is happening in their immediate neighbourhood.

An alcohol and drug policy also needs to be worked out in a structured and co-ordinated manner. A one-off campaign against alcohol abuse has little or no lasting effect. What is needed is a long-term strategy that is directed towards various aspects. One-off initiatives are barely capable of influencing the complex interaction between the causal factors of drug misuse.

A long-term strategy and a tailor-made policy require a permanent support system. In Flanders this might be a problem: the local prevention aren't engaged permanently. The contracts must be renewed every year. This leads to an insecure work climate.

Specific training

To keep the concept of a local alcohol and drug policy alive, the sector brochure '**A local alcohol and drug policy: the correct approach in every area**' for sports centres and sports clubs was added to the 9 sector brochures (Youth work, Education, Social-cultural work, Entertainment and Social Activities, Workplace, Welfare sector, Health sector, the Commune and the Municipal and national Police services). These brochures give an overview of the possibilities to work within and between sectors concerning alcohol and drugs. They also clarify the role the sector can play in a local alcohol and drug policy. An overview of the available support is given as well as the

training courses and the materials that are available in Flanders.

In each region a specific support programme is developed, taking into account the local needs for support. In concrete terms: training, workshops, coaching, meeting days,... are organised on a continuous basis.

9.1.e Telephone help lines

Flemish Community

There is one central Flemish helpline 'De Druglijn' which was set up in 1994. De Druglijn can be called for questions on alcohol, drugs, addictive over-the-counter drugs. Questions can be purely informative, but also for advice and help. People call anonymously, and will not be judged. The callers only pay local charge wherever they call from (unless using a mobile phone). From november 2000 onwards, when telephone rates in a whole changed in Belgium, callers pay a special reduced charge.

The line is open daily from 12 to 9 p.m., except on Saturday (open 15-21 pm). Outside of the opening hours, callers get to hear an informative message. In 2000 the Druglijn received 11,628 calls, which resulted in 5,818 effective communications. 27% of the callers were users (alcohol and/or (illicit) drugs), 50% relatives (mostly parents) an 17% professionals. Age categories of most callers are 16-25 years old (31%) and 36-45 years old (26%). The average duration of a call is 11 minutes. In 57% of all calls product information on drugs was mentioned (mostly effects and risks). In these calls, the most mentioned products where: cannabis (38%), alcohol (19%), amphetamines (15%), MDMA (13%) and cocaine (10%). In 39% of all calls emotional or relational problems where mentioned (mostly parent-child relations). De Druglijn refered to drug help or prevention centers in 60% of all calls.

De Druglijn works with paid staff members and a team of volunteers. Each new DrugLijn-operator gets intensive basic training of more than two months (including 3 Saturdays and 5 evenings of training sessions, a listen-programme and an exercise-program). De Druglijn attaches great interest to permanent training: every 6 weeks all operators have to attend evening seminar on new trends, products and telephone-communication.

French Community

"INFOR-DROGUES" is the French drug helpline set up in 1971. Since 1989 the line is open 24 hours a day, all the year.

The telephone call is not free of charge but since November 2000 the cost of the call is the same wherever it comes: local call cost. Infor-Drogues is member of the FESAT (European Foundation of Drug Helplines) and signed the charter : the service guarantee the anonymity of the caller and make sure any information taken remains confidential. Non judgement is a main principle.

In 2000, the service received 5.226 calls; it means an increasing of 12 % compared to 1999. Through these calls 10.427 demands were registered (1999 : 8.836, + 19 %) : information 32 %; demands of prevention activity 3 %; advice demands 29 %; demands of listening 3 %; help demands 25 %; demand of people for the counselling service 4 %; no explicit demand 4 %.

The callers : 18 % of the callers are users, 38 % are relatives (80 % are members of the family), 13 % are professionals, 8 % are students, 19 % "other" persons and 4 % unknown. The products usually mentioned by the callers are cannabis (40,8 % - 38,8 % in 1999), cocaine (take the second place : 10,4 - 10 % in 1999), XTC (10,3 % - had the fourth place in 1999 : 7,8 %), heroine (drop from two to fourth place : 9,6 % - 13,3 % in 1999), alcohol (same position, 6,5 % - 7,3 % in 1999), medication (4,6 %), methadone (4,5 %), LSD (4,2 %), amphetamine (3,2 %).

The advice demands about compulsory drug tests (essentially for cannabis) ordered by the justice and made by the police increased a few (8 % advice demands – increasing of 7 % compared to 1999); a sign that this practice didn't disappeared.

On the qualitative level, the lack of clearness and the confusion created by the last political and juridical measures concerning the cannabis explains the high rate of calls from users and relatives about this substance.

The statistical report 2000 contains a lot of other data. The operators are all paid, professionals (psychologist and social workers) with sometimes a long experience of work in the drug field. Weekly supervision and intervention are part of the permanent training of the staff.

9.1.f Mass media campaigns

Flemish Community	French Community	German-speaking Community
<p><i>Types and characteristics of mass media campaigns (TV, radio, posters...)</i></p> <ol style="list-style-type: none"> In the spring of 2000 VAD participated in an educational film project for school children by distributing information packages among the participants. De Druglijn held an awareness campaign aimed at young people and students. By means of the "Boomerang"-network, College Packs and Student Welcome Packs postcards with the slogan "There's always a reason for calling" were distributed throughout the year. De Druglijn started a new promotional campaign in September 2000 with the distribution of posters "Take drugs seriously". Following the announcement of the national governments new drug policy plan, VAD decided to broadcast an adapted version of the 1998 EDPW-clip "talking is the first step" on the official Flemish community television VRT. Throughout 2000 VAD tried to keep drugs on the agenda of the media by means of press releases and press conferences (esp. press conference on alcopops use resulted in large media attention). 	<p>"Affiches de prévention – Campagne 2000" was the title of the new mass media campaign created and launched by INFOR-DROGUES in April 2000.</p> <p>This campaign is built in continuity with the last campaign. Target group : young people. Secondary target group: adults.</p> <p>Among the objectives: breaking some taboos by presenting familiar situations well known by young people in which drugs can be present, promoting the helpline call number, contribution to suppress the distinction between licit and illicit drugs, showing difficult aspects of young people's life.</p> <p>The campaign consists of three different posters presenting three themes: independence, to have plans, to freak out.</p> <p>First edition: 30.000 posters. Second edition was necessary:</p> <p>A pack of three postcards with the same messages was part of the campaign. The 160.000 postcards were distributed in bars, restaurants, cultural and leisure places.</p> <p>Pre-test of the posters was made as well evaluations of the distribution and of the impact through different public and private organisations.</p>	<p>Different campaigns were organised: a one-week campaign in newspapers and a press and radio campaign during the European Drug Prevention Week 1998.</p>
<p><i>Cooperation with mass media (costs and cost-sharing with media)</i></p> <p>The postcardcampaign of the Druglijn was possible thanks to special fares of the "Boomerang"-network. For the broadcasting of television clip VAD could count on the general discount for social-profit messages.</p>		
<p><i>Statistics and evaluation results</i></p> <ol style="list-style-type: none"> 10.000 packages distributed among school children A total of 340.000 postcards distributed by Boomerang, College Pack and Student Welcome Pack Druglijn-posters distributed by mailing to social services, libraries, community services etc. <p>Television clips was shown 38 times on channel "TV1" and "Canvas". This resulted in a total GRP for 30-50 year olds of 258,1. The total coverage percentage of the target group was 63,3% and the OTS was 4,1.</p>		

9.1.gInternet

Flemish Community

Prevention

The website contains the catalogue of VAD publications and prevention materials (flyers, posters, post cards,...). These publications are aimed at the general public as well as at professional (prevention) workers working with different target groups (schools, youth work, labour, social cultural work, local authorities, ...). An important chapter of the website is dedicated to our library. Visitors can use several bibliographical databases, like ETOH, Medline, etcetera. The website also contains a discussion platform.

Dissemination of prevention know-how among professionals

Apart from the catalogue of publications mentioned above, the website offers an overview of the training programmes VAD offers for professional prevention workers (going from a basic training for new prevention workers, to follow up trainings and master classes). The website also mentions a page with links to other websites that can be relevant for prevention workers, as well as a page where the VAD newsletter can be downloaded.

Statistics and evaluation results

The website provides statistics on the DrugLijn, the Flemish drug helpline. Further, it contains full text reports of VAD, like results of the secondary schools survey, registration of prevention activities (Ginger) and registration of alcohol and drug treatment. University students are invited to choose from a range of subjects for their dissertation.

French community

The main innovations for 2000 relate to the following:

-Trempline (Châtelet) : <http://www.trempline.be>

-Sésame (Namur): Presentation of their activities.
<http://www.sesame.be/>

-Prospective Jeunesse (Brussels): Updating and restructuring of their internet site
<http://www.prospective-jeunesse.be> 349,749 requests registered in 2000.

Synthetic drugs: Search by means of a self-administered questionnaire that can be downloaded from the Internet at:

<http://www.prospective-jeunesse.be/actuel/index.htm>

They are primarily interested in obtaining the following data:

- "Profile" of drug users and comparison with people who match this profile but do not consume (i.e. people who go to techno dance places but do not consume: gender, age, background and lifestyle);
- Characteristics of consumption: How and why people consume (frequency, place, desired effects);
- Drug awareness (effects, risks);
- How users and non-users view drugs and drug users;
- Drug user experience and feelings.

9.2. Reduction of drug related harm

In 1995, the federal government formulated an action plan for illegal drugs, based on a health perspective and on the harm reduction philosophy. Although in 1994 the promising results of a pilot syringe exchange project were made public, it lasted till 2000 before the Flemish government took initiative to organize syringe exchange in the Flemish Community. This delay was mainly due to a lack in the legislation. In July 2000 the necessary legislative adaptations were finally made. In the French Community, needles exchange programmes are implemented since 1994.

So far, in Belgium, no legal framework for methadone substitution exists. Methadone is, however, being prescribed throughout Belgium, though consensus reached amongst partners concerned (1987 and updated in 2000). In the Flemish region, most methadone (maintenance) programmes are being provided by low threshold drug services. In smaller towns and rural areas, if existing at all, methadone is being prescribed by GPs under the supervision of drug services. In certain urban areas the demand outweighs the availability of methadone (maintenance) programmes.

In the French Community, access to methadone is wide either from low threshold services, GPs, outpatients specialised units, mental health facilities.

French Community

In the French community harm reduction projects are generally run by NGOs or by the cities under the "security contracts" funded by the Ministry of Interior. Needles exchange programmes have been available since 1994. Harm reduction activities in dance scene targeting young drug users in festivals, music events, rave and dancing have been widely developed in 2000. Other harm reduction projects target specifically drug users in prison.. Specific training for professionals on harm reduction are implemented in Brussels and the Walloon Region.

9.2.a Outreach Work

Flemish Community

Many outreach workers are actively involved in the drug scene and in working with high risk groups and neighbourhoods. Their approach is individual as well as structural. The outreach workers are based in various programmes and projects and they still lack a work specific sector of their own. *Vlastov* is the umbrella organisation which provides training programmes for outreach workers.

French Community

The *DELTA* programme (1998) aims at youth outside school environment: *DELTA* is an outreach work by trans-boarder street corner work between Liège (French Community of Belgium) and Maastricht (The Netherlands). Two social educators were half time employed in this program, realised in collaboration with Hasselt (Belgian Limburg) and Aachen (Germany) in the frame of an euregional partnership. Creation of contacts, listening, orientation and youth support in certain proceedings are part of the proposed activities.

Le Relais social. Based on the principle of the French Samu social, these are implemented in Brussels, Liège and Charleroi. In the latter two cities these programmes target specifically drug users including needles exchange in the street.

Dune, is a project of street workers based in Brussels, targeting exclusively drug users including needles exchange programmes.

Most "security and society contracts" of the Ministry of interior have an outreach component. Several specialised treatment services have a street work component (Sesame, Destination) :

The 'Opération BOULE DE NEIGE', HIV, hepatitis and other risks related to drug use peer prevention project aiming to reach, through a snowball methodology, target groups not easily reachable. (Ex) drug users in short-term contracts ('jobists'), training them on HIV, hepatitis or overdoses prevention. After training, the "jobists" go back to the "drug scene" to contact drug users, diffuse their prevention messages and material and recruit new candidates jobists.. The jobists are assisted in their work by a questionnaire that is secondary used to collect data on patterns of use, use and attitudes. Evaluation of each intervention is made with the "jobists" and is both collective and individual. About 1200 drug users, mainly IVDUs are reached every year in the French community.

Euro Boule-de-neige: with the support of EC-DGV, the project is currently transferred in Finland Greece, Italy, Portugal, Spain, and Slovenia. Within this framework a methodological handbook has been developed and translated in English and Spanish. Other languages will be available in 2001.

Harm reduction in music festivals, techno clubs and rave. These activities, are spread all over the French community and according to the specificity of the event can include the following services:

- Diffusion of information:

Targeting young people during Information stands. Teams are present in many events in the French Community. About 30 events have been covered in 2000. Most programmes are peers prevention projects. Activities during the event include diffusion of information on drugs, on prevention of sexual risks, distribution of condoms, information on local available services, prevention of dehydration. Through questionnaires, information on drug use and attitudes are collected from participants. "Peers" are trained and selected according to the musical program of the event (house, hip hop, rock etc.). About 1000 questionnaires collected in 2000.

- Pill testing:

On site pill testing has been realised during two events in the French Community. About 200 pills have been tested.

- Needles exchange programme:

In one festival, activities include syringe exchange programme for IVDUs attending the event. About 500 syringes exchanged.

- "Bad trips" management

targeting drug users experimenting bad trip, a team with psychologists and psychiatrist was present in one music festival. About 60 cases have been managed during this fourday event. The objective is to avoid "over-medicalisation" and/or hospitalisation of these cases through on-site assistance.

Development and diffusion of harm reduction material:

- Harm reduction brochures targeting young drug users have been developed in partnership with several organisations in the French Community. In 2000, were available brochures on amphetamines, hallucinogens, cannabis, XTC, cocaine and heroine. The first three brochures have had an evaluation both quantitative and qualitative. About 100.000 of each have been distributed.

- "Consommez les toutes": Posters campaign promoting harm reduction leaflets on different drugs (XTC, Amphetamines, hallucinogens mushrooms and LSD, heroine, cocaine and cannabis). Posters have been distributed in clubs, bars . Poster announced that the brochures were available by ordering through the Infor Drogues telephone line. About 1000 posters have been posted in different places. Evaluation: generally well received. Diffusion has been sometime out of control and posters have been posted in unsuitable locations.

- Overdoses prevention: credit card size small 4 folders small brochure on overdoses prevention and guideline.

- Methadone: harm reduction brochure for methadone users, prescribed and non prescribed.

9.2.b Low threshold services

Flemish Community

- Some shelter houses accept drug users in their setting.
- Transit Center asbl in Brussels (bi-community) is a low threshold crisis center that also can offer a bed for some nights
- In 1997 4 MSOCs (Medical social centres) in Ghent, Antwerp, Genk and Ostend have started their activities to reach drug users and drug addicts. They offer medical and social support and their activities are linked with the treatment facilities that are available in the province or region where they are situated. Methadone programmes are offered.
An evaluation study is going on.

French Community

The medico-social centres (MASS) started their activities in Charleroi (1997, Diapason), Liège (1998, Start), Mons (1998, Parenthèse) and Brussels (Interstices 1999). They offer low threshold medical and social assistance: their activities are linked with the treatment facilities that are available in the province or region where they are situated.

Other low threshold services are available in Couvin (Le Répit), Chapellelez -Herlaimont (Symbiose) and in Farciennes (Unisson).

9.2.c Prevention of infectious diseases

Flemish Community

Synthetic outline on organisation, strategies and actors:

Two organisations to coordinate : VAD for drug prevention and SENSOA for HIV and other STD's. SENSOA delegates the prevention of HIV and hepatitis B and C in prisons (a.o. incarcerated drug users) to Free Clinic, a low threshold drug service with a prevention and research unit.

VAD coordinates the drug prevention in the Flemish region, but board out part of the health promotion and prevention (a.o. needle exchange programs) for drug users to other services.

Prevention is also done in large cities by street corner workers and drug users organisations (especially in Antwerp).

Principal interventions:

-Needle and syringe exchange: became operational in 2001. Subsidized by the Flemish government and coordinated by the VAD and Free Clinic on the Flemish level, by low threshold drug services (the so called MSOC) on a provincial level. Already operational mid-2001 in the provinces of Antwerp and Limburg, to be operational in all Flemish provinces by the end of 2001.

-Safer sex / safer education : part of the needle exchange programs, but also done by a peer support network, street corner workers and drug users organisations.

-Testing/vaccination : testing is done in all low threshold drug services; vaccination whenever possible financially.

Specific training:

HIV, hepatitis B and C training in prisons (for personnel and detainees) by Free Clinic.

Risk behaviour, safer use, safer sex training for personnel in drug services and drug users themselves.

French Community

Until 1998, the Agency for AIDS Prevention was responsible for the coordination and funding of all aids prevention activities within the French Community. The coordination targeting specific at risks public was subcontracted to some NGOs. Modus Vivendi was responsible for the activities targeting drug users. Since, the agency was closed and AIDS prevention integrated within the health promotion programme. The Plate-form for AIDS prevention has been set-up by a consortium of NGOs to develop general population projects.

- Development and diffusion of Information material:
 - Brochure "*Shooter propre*", targets intravenous drug users and provide information on how to inject safely.
 - Brochure "*hepatitis B and C*": information brochures for drug users on hepatitis prevention.
- Needles exchange programmes:

Different types of needles exchange programmes are available in the French Community, stationary, street programme and programmes in pharmacists:

 - Street workers, in Liège (2 programmes) and Brussels (1 project) exchange syringes targeting most excluded drug users in the street.
 - In Brussels there is one stationary syringe exchange programme.
 - In Liège there are 5 stationary needles exchanges programmes and 5 pharmacists exchanging syringes.

In the city of Charleroi, two projects are currently under development, a street programme and a stationary programme.

Globally about 250.000 syringes are exchanged through these programmes. Other injecting equipment such as water for injection, alcoholic swabs, and Stericups®, and information leaflets and condoms are distributed. About 20.000 syringes have been exchanged by street workers .

- Injection kits: Stérifix

Stérifix is a kit containing 2 syringes/needles, water for injection, disinfectant swabs, Stericups® and information on the risk of transmission by syringe sharing, HIV screening centres. The package is distributed by pharmacies The price is 20 BEF (0.5 EURO).

These kits are available in Brussels, Charleroi and Namur. About 40.000 kits are distributed every year. Drug users participate actively in the promotion and evaluation of the programme. The programme is evaluated every year in Brussels, where the participation rate of the pharmacists is around 30%.

Prevention of sexual transmission: all harm reduction projects have a component on safe sex and provide condoms.

Hepatitis B immunisation is poorly available, as intravenous drugs users are not identified as a priority group in the Belgian Ministry of Health Hepatitis B immunisation policy. Therefore, the high costs of the vaccines make it access low.

9.3. TREATMENTS

9.3.a Treatments and Health care at national level

Flemish Community

Services offered and their characteristics

DETOXIFICATION

Most detox-programmes are carried out in clinics. Some are specialised. Detox is often condition to enter therapeutic programmes in specialised centres.

INPATIENT TREATMENT

Crisiscentres, therapeutic communities and drug centres in psychiatric hospitals are the main providers of specialised inpatient treatment.

There's only one specific therapeutical setting for only minors, RKJ-De Sleutel. In other settings minors are hospitalised in mixed patient groups.

OUTPATIENT TREATMENT

Centres for mental health, day-centres and MSOCs are the main specialised outpatient treatment centres. In addition, certain non-specialised centres in the health and social welfare sector are providing care and cure aspects of the treatment process.

French Community

Services offered and their characteristics

DETOXIFICATION

Detoxification programmes are available in many specialised services and clinics. UROD is available in Brussels.

INPATIENT TREATMENT

There are 2 groups of structures involved with inpatient treatment:

- Psychiatric or general hospitals which deal with drug rehabilitation (detoxification and withdrawal)

- Rehabilitation centres that are specialised in providing treatment to drug addicts. These centres offer an inpatient programme for "functional rehab".

There are two types of centres:

- Long-stay therapeutic communities (minimum of 3 months to 1 year or more). The final aim is to reintegrate drug addicts into society and the family unit.

- Short-stay crisis centres (around 1 month stays). The aim is to manage the crisis and break the physical habit before sending the patient to another rehabilitation centre.

These centres provide treatment to both adolescents and adults. In one city, Charleroi, a specific structure has been developed to admit minors. In other settings minors are hospitalised in mixed patient groups.

There is a new programme: the "Horus Group" (Trempline therapeutic community) has set up a specific support group for relapsed drug users who have already gone through the social reintegration phase. This involves a second, but shorter, stay during which the problem areas are addressed in greater detail.

New programme: A theme-based workshop entitled "Accueil de crise" (Crisis handling) was set up by the association Coordination Sida Assuétudes (Coordination AIDS and Addiction) (Namur Province). The aim of this workshop is to improve the treatment afforded to drug users in hospital emergency rooms. A multimedia tool was created for this purpose. This tool deals with problem substances and situations encountered in this particular area. There are also seminars and information meetings relating to this tool. The workshop gathers hospitals, doctors and nurses working in emergency rooms as well as various specific associations working in the field.

OUTPATIENT TREATMENT

There are 3 categories of structures involved in outpatient treatment:

- Mental Healthcare Departments (centres for mental health care, guidance centres), which offer psycho-medical-social cares.

medical-social cares.

-Day hospitals and drug rehab centres that have signed an INAMI convention. This category offers either group programmes (hospitals/day centreⁿ with daytime activities) or individual treatment (day hospital, MASS and session centres^o).

-Drug rehab centres that do not fall into either of the first two categories.

In addition, certain non-specialised centres in the health and social welfare sector are providing care and cure aspects of the treatment process.

Outpatient treatment constitutes an overall (multidisciplinary) approach that includes listening (psychosocial and administrative guidance and assistance), healthcare (diagnostics and treatment for medical, psychiatric and psychological aspects), and reintegration.

Psychological discussions take place in one of three ways: on a one-on-one basis, with family members, or as part of a group session. Medical treatment can include a maintenance or substitution programme.

New programmes: SIPS (Liege) is a Family Planning Centre for young people. This programme is part of the addiction project and offers places away from family, friends and school. Here young people can express themselves and feel that they are being heard. Le Répit (Respite) (Couvin) offers psychosocial counselling for drug users. Citadelle (Tournai) offers maintenance or methadone programme. Furthermore, Citadelle (Tournai) has launched a research-action programme aimed at networking social workers involved with drug use.

Objectives

Most of the inpatient settings require a drug-free condition starting and during the period of treatment. The objective of treatment in cure-programmes is staying clean.

Outpatient settings with therapeutical objectives (cure) have less control on using drugs during the treatment period. Some of them can work with the clients to controlled drinking or drug use.

Objectives

Most of the inpatient settings require a drug-free condition starting and during the period of treatment. The objective of treatment in cure-programmes is staying clean.

For those rehabilitations centres that have signed an INAMI convention, whether they be inpatient or outpatient, the final objective is the total eradication of addiction. However, there are other intermediate aims that are used as a means to attain the final objective and the psycho-social aspect of addiction is a fundamental part of treatment.

Outpatient settings with therapeutical objectives (cure) have less control on using drugs during the treatment period. Indeed, treatment can also focus on the well-being of patients in their ordinary surroundings, which does not necessarily mean that they will stop using drugs.

Some of the outpatient settings can work with the clients to controlled drinking or drug use.

ⁿ For day centres and hospitals, mention is made of semiresidential care.

^o Among the rehabilitation centres offering primarily one-on-one treatment, we find MASS (see item 9.3) and session centres. A session centre is an itinerant rehabilitation centre that offers primarily one-on-one treatment. It differs from a MASS in terms of origin, target population, and means of funding. A good example of a session centre is the LAMA project launched by the Frenchspeaking Community.

Criteria of admission

There are no uniform criteria of admission. They depend from the setting itself and eventually agreements with other centers forming part of a network (care-circuit).

Involvement of public health services and GPs

The GP is well placed to detect early abuse of psychoactive substances and to vigilance the continuity of care. But there are still many GPs who are reluctant to work with the target group because of feelings of incompetence or the idea that only specialised people can help them. VAD is working out training modules for this target group. The pilot presentations of 3 modules have passed. For the module 'How to deal with drug clients in the practice of a general practitioner?' a video production is being worked out. Collaboration with professionals of inpatient and outpatient services is still on many aspects problematic. This was revealed in focusgroup research (Shared care - VHI Brussels), which this year was followed by a Delphi-study. The results will serve for creating an education map to increase the competence concerning early detection of alcohol problems and good collaboration with specialists.

The role of GPs varies according to the regions: their role in treatment and especially in substitution treatment is more developed in the French Community.

Financing

Financing sources are diverse and the finance structure is complicated.

-The centers forming part of VVBV (daycenters, TG's, MSOC's) have a RIZIV-convention (revalidation), except RKJ-De Sleutel (minors) who is financed by the sector special youth care.

-The Centers for mental health (CGG) are financed by the Flemish community (departement of health)

-The psychiatric hospitals and the psychiatric wards of a general hospital (PAAZ) are financed by the federal government.

Criteria of admission

There are no uniform criteria of admission. They depend on the setting itself and eventually agreements with other centres forming part of a network (care-circuit). The therapeutic communities are therefore hard to get into as far as accessibility and requirements are concerned: the admission procedure is long and tedious, physical addiction must end before the patient is accepted, the patient must be highly-motivated, group living is a major part of the programme. On the other end of the spectrum, we find outpatient centres that take in drug addicts quickly and easily. There are no prerequisites like an end to physical addiction or strong motivation. In such centres, one-on-one treatment is the key.

Involvement of public health services and GPs

Integrating specialised healthcare centres into the general network of healthcare and assistance infrastructures is taking place more quickly than ever before. There are now an increasing number of departments or special branches within public social welfare centres (CPAS), counselling centres (CSM), medical clinics, general practitioners, etc. The increased accessibility of general medical and social services has come about as a consequence of the numerous training and re-training programmes set in motion. However, there are still sizeable differences from region to region, which is why networking efforts should be top priority.

A network of GP's involved in treatment and assistance to drug users was set up. This GP's network called *ALTO-SSMG* (Société Scientifique de Médecine Générale) is one component of a larger programme also called *ALTO* (Alternatives aux Toxicomanies) that is a global programme of the French Community aiming at the diversification and the co-ordination of resources of prevention of damages related to drug addiction. *ALTO* provides opportunities for exchanging of GP's experience in the field of drug use. The network is structured and there are groups in the different part of the French Community. An initial objective was to better define the role of GPs. *ALTO* participated to the development of the Belgian protocol about substitution methadone treatment. *ALTO* GP's also participated in a study on drug and AIDS.

Financing

Several levels of power provide funding for drug rehabilitation departments. To give an overview, mental health care centres are funded by the Walloon Region (COCOF for the Brussels Region). Hospitals and drug rehabilitation centres are funded by the Federal Government, the latter centres by way of INAMI conventions. There is also a third source of funding from the Ministry of the Interior for assistance and treatment structures (both outpatient and inpatient) that provide assistance to drug users. This funding takes the form of security and societal

Clients and patients have to be in order with their social security for getting help in private settings. For people who are not, exists a few of public hospitals (OCMW). They may also enter in Transit Brussels where they get help and are stimulated to arrange their social security.

Specific training

For workers in the field of drug care and cure is extra education provided, realised by three organisations for the Flemish part of the country. They have the choice between short courses on specific topics or a three year course to 'drug worker'.

French and Flemish Community

Statistics and evaluation results

First results of the study: "Drug rehabilitation from 1980 to 1999", INAMI, Dept. S. of S., June 2001.

Up until the month of October 2000 included, individual requests to have insurance cover the cost of the drug rehabilitation had to be filed with the Chief Medical Board for all drug addicts undergoing rehabilitation in INAMI drug rehabilitation centres.

INAMI gathered statistical data on certain aspects of individual requests during the period 1980-1999. The results are as follows:

Number of patients treated

Between 1980-1999, 15,250 different patients received rehabilitation treatment at least once in a drug rehabilitation centre linked with the INAMI. According to the conclusions drawn by this study, the figures constitute a serious challenge to the overly high estimates of the number of illicit drug users in Belgium that are sometimes waved around. It is nevertheless important to bear in mind the fact that this number also includes a large number of alcoholics.

The extension of drug rehabilitation departments, which mainly took place in 1996-1997 (including, among other things, the signing of new drug rehabilitation conventions with outpatient centres), had a very important impact on the sector since the number of patients treated per year tripled between 1995 and 1999. Indeed, outpatient centres are able to treat a higher number of patients simultaneously than inpatient centres. They can also do so at considerably lower cost per patient (in the short term). The study also states that, starting in 1998, more than two out of every three rehabilitation patients had received outpatient treatment whereas in 1996, at least two out of every three patients had received inpatient treatment. The trend has therefore turned upside down.

Out of nearly 5,000 rehab patients in 1999, less than half were new (that is, individuals who had never gone to a drug rehabilitation centre before).

The drug rehabilitation path that patients follow

Among the patients (except for those treated for the first time in 1998 or 99), nearly 70% had only gone to a single establishment, either outpatient or inpatient.

Three out of four patients spent less than 2 years in the rehab programme. One out of four patients spent more than 3 years on the programme.

Age and gender of patients

Over three out of every four drug addicts are male. This coincides almost precisely with the ratios reported by both inpatient and outpatient centres, which offer different therapeutic approaches. The conclusions of the study seem to indicate that there are three times more male drug addicts than female ones.

The average age of the rehab patient population is 27.88 (average 26).

Of all the patients treated during the period running from 1980-1999, over 5% were minors when they started on their drug rehabilitation programme. The study suggests creating separate inpatient therapy initiatives for this age group along the lines of the recommendations made in the Federal Policy Memorandum on Drugs.

Patient's domicile

Nearly 56% of all drug rehab patients live in Brussels, Antwerp, Liege, Charleroi or Ghent when they start on their rehab programmes. And yet only 33.19% of the total population live in these five cities.

All drug rehabilitation centres recruit their patients from their own region. To illustrate this point, 81% of patients going to outpatient centres generally live in the same city where the centre is located and nearly 89% live in the same province.

Session centres and MASS

The statistics also show only minor differences between the MASS and session centres. Both types offer multidisciplinary individual treatment and are both able to provide substitute medication. The authors argue that it would be better to eliminate current discrepancies between the amount of money reimbursed to patients, depending on whether they go to one or the other type of centre.

In conclusion

Drug rehabilitation centres linked with the INAMI clearly demonstrated their usefulness. They meet a clear need expressed by social workers in the field and act as an important complement to other treatment centres.

Specific training

For the last 8 years, *SSMG-ALto* has provided training to general practitioners as well as to other social workers in the field.

The NADJA centre also offers training and supervision for institutions and social workers in the field. By working with centres in the field and using them to reach out to drug addicts and potential consumers, the *NADJA* centre (Liege) seeks to make the most of the existing network by creating links between the various disciplines through the use of the same language. In 2000, basic training (module "Communication and addiction") and advanced training (module "Aid Relations") were offered.

9.3.b Substitution and maintenance programmes

In Belgium, methadone programmes are still waiting for a legal basis to broader operate. Nevertheless, scientific conclusions are presented as recommendations (Conférence consensus Méthadone - Consensus Conference on Methadone) issued by a panel of experts.

Flemish Community

Many centres and GPs provide methadone to drug users.

French Community

Two studies were carried out on the efficacy of methadone treatment within a given network of general practitioners. The first study refers to general practitioners from the ALTO Network (Brussels and Walloon regions), the second study refers only to the Province of Liege.

EvaluMet, ALto-SSMG, Jan 2001 (B. DENIS, G. VAN WOENSEL, D. LEJEUNE, J-B. LAFONTAINE) (see Chapter 10 quality insurance) and *Qualitative evaluation of the Liege model of methadone*

treatment, Dr F. Lequarré, 2000, with the support of the Liege Psychiatric platform and the Network of Social Workers involved with drug addiction .(see Chapter 10 Quality insurance)

German Community

Methadone substitution is offered to some drug users under the control of **SPZ** (psycho-social centre). Some general practitioners also prescribe methadone on an individual basis.

9.4. After-care and re-integration

Flemish Community

Therapeutic communities have their halfway houses. Aftercare is also organised in 'Beschut of begeleid wonen' projects and taken up by outpatient health care provisions.

Services offered are: special assistance for finding a job or education and/or lodging, advise to older drug users and their families,...

French Community

Organisation

After-care and/or social and professional re-integration take place in various outpatient or inpatient structures. After-care may consist in individual follow-up treatment at an outpatient centre or may come in the form of group support and mutual assistance within a department that is either actively involved in drug rehab or part of a residential programme.

Reintegration is one of the specific missions of departments that are actively involved in drug rehab. Reintegration is also a key element in drug rehabilitation centres.

Specific departments include Habitations Protégées (protected housing).

Accessibility for different target groups

After treatment: Re-integration occurs with the help of social workers who handle the administrative tasks relating to the search for jobs and accommodation. They also provide assistance with straightening out the patient's administrative situation. This is offered as a complement to the rehabilitation treatment given by the various outpatient centres.

After prison: Among these outpatient centres, a number of people prepare exconvicts for their release from prison and help them carry out the necessary administrative tasks.

Other specific public: for people who have been institutionalised for a long period of time, aftercare is offered through Habitations Protégées (protected housing): This department provides aid and psychiatric care within society. This type of after-care is provided by SIAJeF (Liege). Other institutions (Odyssée or the CHU, in Liege) also provide assistance with social reintegration, namely through protected housing.

Education and training

Among the specific training programmes, we find for example the SIAJeF programme (Liege), which makes use of professional instructors (construction, secretarial services, catering industry), the Essor programme, an on-the-job training company in Thuin or l'Espérance (Thuin), specific programme for alcoholic persons. .

Employment

Some departments have the specific mission to reintegrate people by finding stable jobs for them. In order to reach this aim, patients receive several types of aid: straightening out of the administrative situation, search for housing or training, specific job search (job offers available at the centre, help drafting a CV, etc.)

Housing

Many departments provide assistance in finding accommodation. Specific initiatives that provide accommodation exclusively to drug users are rare. There is one initiative, however, called "appartements encadrés" (Supervised apartments).

Example: the Hestia project (Projet Lama, Brussels) offers 6 apartments. Hestia is the main tenant and has the right to sublet these apartments. However, finding new housing is an arduous task. The results are encouraging: The programme is a factor that facilitates the success of social reintegration (breakaway from the drug using environment) and a first step towards greater autonomy (when the patient goes out and finds his or her own apartment later on).

9.5. Interventions in the Criminal Justice System

The Minister of Health is the only competent authority regarding health in general, and prevention and assistance of prisoners with AIDS in penitentiary system. There is neither prevention policy nor AIDS prevention programme. Essentially thanks to the initiatives of NGO's, and where there is good collaboration with prison authorities, local AIDS prevention actions exist in some prisons.

Interventions

- PREVENTION OF HIV INFECTION AMONG DRUG-USERS

In the Flemish community a training programme in prisons is carried out by Free Clinic, and they also set up networks and carry out research in this field, Prevention of HIV, AIDS and hepatitis are central. A syringe exchange pilot project is under preparation in Antwerp.

An harm reduction brochure for drug users in prison, "Et vogue la galère" has been developed and distributed in the French community. Currently it is being translated in Flemish for country wide distribution.

A project for improving the accessibility to condoms has been developed in the French community. Specific packaging have been developed (condom and lubricant attached).

- DRUG FREE DEPARTMENTS

There are some pilot projects of drug free departments in Flemish prisons. A training programme for guards and prison personnel and for prisoners is realised. It focusses on drug use and HIV, Hepatitis, etc.

- TREATMENT IN PRISONS

-In co-operation with the prison authorities of St-Gilles in Brussels a specialised prevention team has set up, during the past year, a prison section **Primary Day**. The aims of this treatment programme were to combat relapse offence behaviour among primary prisoners, drug addict or not, in fact people who are for the first time in prison for a period longer than six months. This programme works to promote a better rehabilitation in co-operation with outside specialised workers and the prison' personnel. Psycho-social counseling is provided by a specialised social worker.

-TIMC (Toxicomanies et Interventions en Milieu Carcéral, 1997) is an EC collaborative network involving participants from Belgium, France, Luxemburg and The Netherlands. It's aim is to create exchanges about drug use in prison and particularly focusing on the role of penitentiary workers and other workers outside of the prisons. Training of penitentiary workers is one main operational achievement. A drug use surveillance system started in 1997 in participating prisons. Data are monthly transmitted by fax to a co-ordination centre (Verviers/Nancy).

Release: referral to treatment, after care, probation

Some external therapeutic settings arrange treatment help in prison for prisoners. They also organize introduction sessions to know better the treatment possibilities. After care is offered too by some of them when it concern psychotherapeutic help. Social help is provided by workers of the centers for juridical welfare. Probation see 9.6 alternatives to prison.

9.6. SPECIFIC TARGETS AND SETTINGS

Specific training for following targets

<ul style="list-style-type: none"> • GENDER SPECIFIC ISSUES <p>-There is one project in Flanders in a therapeutic community (<i>De Kiem</i>) for pregnant women and women with children.</p>					
<ul style="list-style-type: none"> • CHILDREN OF DRUG USERS <p>-Early interventions among children</p> <p>-At the level of first childhood, 'Kind en Gezin' (Flemish Community) and the 'Office de la Naissance et de l'Enfance – ONE (French Community) organise assistance to parents on healthy living. A specific parental training '<i>Eltertraining</i>' was set up in the German-speaking Community.</p>					
<ul style="list-style-type: none"> • PARENTHOOD AND DRUG USE - CHILDREN OF DRUG USERS <table border="0" style="width: 100%;"> <thead> <tr> <th style="text-align: left; width: 50%;">Flemish Community</th> <th style="text-align: left; width: 50%;">French Community</th> </tr> </thead> <tbody> <tr> <td style="vertical-align: top;"> <p>-Few centres are specialised in parental drug use. There is one outpatient centre (Free Clinic) and a new project in a therapeutic community (<i>De Kiem</i>): pregnant women and women with children.</p> <p>-In two Centres of Mental Health Care a project for children of parents with psychological/psychiatric problems (<i>KOPP-project</i>) is worked out to avoid or decrease psychological/social problems with the children. It is not a drug specific initiative but even children of drug or alcohol misusing parents can be helped.</p> </td> <td style="vertical-align: top;"> <p>-Social workers are expressing increasing concern over the issue "drug addict parents". Various types of treatment programmes therefore include this specific issue as part of their programme. This is namely the case for Fly tox (located in Liege), the Alfa centre (in Liege), the CSM from the public social welfare centre (CPAS) in Charleroi and the MASS in Brussels.</p> <p>-<i>New programme</i>: The Kangaroo project is a specific programme for drug addict mothers over 18 with children under 8. This programme was set up to provide assistance to drug addict mothers participating in the inpatient rehab programme at the Trampoline therapeutic community. The centre is open from 5 p.m. onwards, including weekends, with patients receiving assistance from a specific team in a house set aside for them. The results have been encouraging in terms of better mother-child relationships as well as better living conditions for children.</p> <p>-The after-care centre Ellipse also has a research-action project in this area.</p> <p>-A permanent workshop between several services and a GP's Network (ALTO-SSMG) oriented their reflections on the methodology for tackling the consecutive problems about 'parenthood and drug consumption'. The aim is to try to keep children safe even if the parents are drug consumers.</p> </td> </tr> </tbody> </table>		Flemish Community	French Community	<p>-Few centres are specialised in parental drug use. There is one outpatient centre (Free Clinic) and a new project in a therapeutic community (<i>De Kiem</i>): pregnant women and women with children.</p> <p>-In two Centres of Mental Health Care a project for children of parents with psychological/psychiatric problems (<i>KOPP-project</i>) is worked out to avoid or decrease psychological/social problems with the children. It is not a drug specific initiative but even children of drug or alcohol misusing parents can be helped.</p>	<p>-Social workers are expressing increasing concern over the issue "drug addict parents". Various types of treatment programmes therefore include this specific issue as part of their programme. This is namely the case for Fly tox (located in Liege), the Alfa centre (in Liege), the CSM from the public social welfare centre (CPAS) in Charleroi and the MASS in Brussels.</p> <p>-<i>New programme</i>: The Kangaroo project is a specific programme for drug addict mothers over 18 with children under 8. This programme was set up to provide assistance to drug addict mothers participating in the inpatient rehab programme at the Trampoline therapeutic community. The centre is open from 5 p.m. onwards, including weekends, with patients receiving assistance from a specific team in a house set aside for them. The results have been encouraging in terms of better mother-child relationships as well as better living conditions for children.</p> <p>-The after-care centre Ellipse also has a research-action project in this area.</p> <p>-A permanent workshop between several services and a GP's Network (ALTO-SSMG) oriented their reflections on the methodology for tackling the consecutive problems about 'parenthood and drug consumption'. The aim is to try to keep children safe even if the parents are drug consumers.</p>
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<ul style="list-style-type: none"> • PARENTS OF DRUG USERS <p>-There are parents' groups for parents of addicts and parents of experimental drug users. Ouders & Drugspakket en 'Lindestraat 14' are prevention programmes for parents with adolescents (but not problematic drug users) developed by VAD (Flemish community).</p> <p>-A programme for provision of a help to parents of drug users has been initiated during the past year.</p> <p>-Several projects offer in the French Community assistance to parents and relatives of addicted drug users (Alfa, Génération Assuétudes, Centre de traitement destoxicomanes du CPAS de Grâce-Hollogne, Ellipse, Phénix, Parenthèse,...)</p>					

• DRUG USE AT THE WORKPLACE

Flemish Community

-There is a long tradition in developing prevention programmes in the workplace in Flanders. Alcohol problems form the major problems. Prevention programmes include the development of a policy and early intervention programmes. There is a growing interest in other drug problems (illicit drugs and medication). More and more public enterprises are willing to develop such policies.

-Local and regional prevention workers are more and more implied in the development of an alcohol and other drugs related policy, due to the increasing demand for consultation and guidance. VAD, the Flemish co-ordinating organisation, organises training sessions and intervention for these people. This should enable them to provide a better service to these local consultation demands.

-Training programmes (for company doctors, nurses, social workers and supervisors) are available in Flanders.

A survey on the relation between job-related factors and causes of alcohol problems is being finalised. The results will be published in autumn 2001.

French Community

-There are programmes to prevent and manage alcohol abuse at the work place. PAE (Prévention Alcool Entreprise) is a pluri-disciplinaire team (university hospital and other specialists) offering support for global and collaborative prevention and management of alcohol problems at the work place.

-Santé et Entreprise (health and companies) (Brussels): "Prevention and management of alcohol and drug addiction at the workplace." This is a general awareness campaign on drug addiction intended for employers and employees. It consists in group sessions within the company, data gathering and the creation of a programme to prevent and manage problems relating to alcohol, tobacco or other drugs.

• ETHNIC MINORITIES

Last year ethnic minorities could count on a growing interest both in drug prevention work as in treatment services. Several drug prevention and treatment services pay more and more attention for ethnic minorities.

Drug prevention materials were collected from the Netherlands and Britain. The University of Ghent researched the problems people of ethnic origin meet before and when entering treatment services. The focus was directed at the specific treatment needs of ethnically and culturally diverse substance abusing clients and the difficulties consequent to treating this target group. Possible approaches intended to overcome these difficulties were highlighted and elaborated during semi-structured interviews and focus groups. The results led to recommendations on these three levels by and towards the treatment system itself.

In Brussels the MASS include a large proportion of different ethnic origin. In Liège, an AIDS prevention snowball project was developed in Georgian, for this population.

In Brussels, INFOR-DROGUES take part since 1997 in the working group "Equal access for all Ethnic minorities and European drug helpline services" organized by FESAT (European Foundation of Drug Helplines). The fourth seminar was held in INFOR- DROGUES in June 2000. 9 drug helplines services coming from 7 countries took part on it. Opportunity and difficulties with the organization of the helplines in different languages were debated and the presentation of this subject at the 2nd European Conference of Drug Helpline was prepared.

• SELF-HELP GROUPS

Flemish Community

-There are many self help groups in Flanders. Most are dealing with alcohol and medication problems (AA-types). There are parents' groups (for parents of addicts and parents of occasional drug users), there is a junkie group (DEBED) and a Cannabis bond.

-One group of parents of drug users exists in the German-speaking community as well as groups oriented to alcohol problems and medicine addictions (AA approach).

French Community

- CCLA (Citoyens comme les autres), an drug users self help group was dismantled end of 2000.

- DRAPS (self-help group for parents of drug users)

German-speaking Community

One group of parents of drug users exists as well as groups oriented to alcohol problems and medicine addictions (AA approach).

- **GROUPS EXPERIMENTING WITH DRUGS**

Educational group sessions can be organised for young experimental drug users to increase the awareness of their drug behaviour and other choices in their life. Participants are transferred by schools, justice or mental health care centres. The trainer map **'Working with a group of young users'** including methods and exercises adapted for use in the Flemish community, VAD developed for external workers in the field (1998), is in use. An evaluation questionnaire to gain feedback from the trainers is made but results are not yet available.

- **ALTERNATIVES TO PRISON AND PROSECUTION**

Flemish Community

- Early detection/therapeutical advise:

'Therapeutical advice' is a method of early detection in which police services offer drug users, who are arrested, the possibility to present themselves in a Centre for Mental Health Care for one or more exploring conversations. In this way problems with drug use or other problematic life fields can be detected earlier and can be followed by psychotherapeutical sessions. In this way the drug user is stimulated to reflect about his drug use, and he has made acquaintance with a care service so that he knows the way for asking help if it should be needed in the future.

Because the number of Centres for Mental Health Care who offers 'Therapeutical advice' was increasing and there was growing a variation of different applications of this method, coordination was needed. In 1998 started an ad hoc work group with helpers of these Centres for Mental Health Care to create a blue print of the method in order to create more uniformisation and to offer a comprehensive manual for those Centres for Mental Health Care who like to start with the method too. This work group is still going on.

- Juridical alternative measures:

Educational programmes for drug users are offered by drug helpers to experimenting and advanced drug users who are referred from justice.

The current education programmes vary in aim, target group and duration. Increase the awareness of their drug behaviour and other choices in life is a very common goal of these programmes. These groups can be mixed with drug users referred from schools or mental health centers.

CHAPTER 10. Quality assurance

10.1. QUALITY ASSURANCE PROCEDURES

No Information available.

10.2. TREATMENT AND PREVENTION EVALUATION

10.2.a Treatment evaluation

- MASS/MSOC are being evaluated in 2000/2001, with funding from the Services of the Prime Minister for Scientific, Technical, and Cultural affairs.

French Community

- Evalumet, AltoSSMG, Jan 2001 (B. DENIS, G. VAN WOENSEL, D. LEJEUNE, JB. LAFONTAINE):
A transversal study was carried out from January to December 1999 covering 50 general practitioners from the ALTO Network, which includes 517 members. 42 doctors participated in the study, which included a total of 559 drug rehab patients undergoing treatment at the time of the study.

The purpose of this study was to determine the efficacy of substitution treatments prescribed by general practitioners in order to assess the public health impact of these practices.

- Qualitative evaluation of the Liege model of methadone treatment, Dr F. Lequarré, 2000, with the support of the Liege Psychiatric platform and the Network of Social Workers involved with drug addiction:

99 general practitioners participated in this study, which included 318 patients undergoing methadone treatment and 326 pharmacists operating out of the Province of Liege.

Semi-direct, face-to-face interviews were used for doctors and self-administered questionnaires were given to pharmacists. In both cases, there was no random sampling.

The purpose of this study was to be better informed of medical practices when it came to substitution treatment administered in private practices. The study was also intended to gather data on methadone issuance by pharmacists.

10.2.b Prevention evaluation

Flemish Community

Evaluation policy

Prevention activities are rarely evaluated (mainly process evaluation) and yet there is a growing demand for data that can prove the efficiency of prevention. For many years, prevention workers have been devoting great efforts to implement education and prevention programmes. Of course, they aim to make these as effective as possible. Evaluations that have been carried out show that in general the effects achieved by the prevention programmes appear rather insufficient and that in certain cases their effects are even counterproductive. Very often, however, the end result is a mixture of positive and negative effects.

The limited budgetary resources allocated to the activities geared towards reducing demand, the consequent lack of time of involved people, the lack of coherent long-term planning and the difficulty involved in coordinating at the different levels (local, provincial, Community or federal) are certainly not unconnected with this.

Nevertheless context evaluations, evaluations of implementation and process evaluations are sometimes carried out. Unfortunately very little reporting of the results is being done. Interviews with key persons involved in the implementation of the programmes, questionnaires, pilot sessions, check lists and group discussions are the most commonly used methods.

Initiatives should be stimulated to evaluate the functioning of various networks. In this field, scientific evaluation models often lack.

Some people stress that there is a dangerous pitfall in this general demand for evaluation results. Since the nature of drug prevention is complex, it is very difficult to prove, whether and how, single or a series of activities have affected non-use or non-problematic use of drugs. While a multisectorial approach for prevention is promoted, studies to evaluate the outcome of these strategies are hard to conduct.

Requirements for evaluation (e.g. for funding) and evaluation training

VAD has started the development of a series of instruments to evaluate the practice of training and consultancy by fieldworkers themselves. In a first phase, a limited instrument will be linked to the registration programme for prevention activities. More instruments will be developed and training will be carried out to support field workers in using the instruments (2001).

French Community

Evaluation policy

All health promotion projects funded by the French Community must have an evaluation built in the project. In addition, the French Community is funding two departments in universities (Promes in ULB and Ceres in ULG) to provide technical support and advise the promoters of the projects.

However, most evaluations are process evaluation and internal evaluations. Funding for impact evaluation is most limited.

10.3. RESEARCH

Flemish Community

Current :

Interaction mechanisms and group dynamics for amphetamine users

- Researchers involved
Luk VAN BAELEN
- Topic areas
Interpersonal dynamics in groups of amphetamine users
- Methodology
Ethnography- participant observation- interviews using snowball sampling

Drug use and disadvantaged youth

- Researchers involved
Else DE DONDER, Johan ROSIERS, Else VANDENBERGHE
- Topic areas
Drug and alcohol prevention in youth work with social disadvantaged youth
- Methodology
Case study, indepth interviews

Survey of Flemish students as Part of a Drug policy on Schools : a useful instrument ?

- Researchers involved
Wouter VANDERPLAESSCHEN, Else DE DONDER, Stéphanie LENOIR, Griet ROETS
- Topic areas
Drug policy on Schools; prevention; evaluation study
- Methodology
Semi-structured questionnaire

French Community

Current :

Ethno-epidemiological study on young people and new synthetic drugs use

- Researchers involved
Gilles HACOURT, Fabienne HARIGA, Catherine VAN HUYCK, Philippe BASTIN, Martine DAL, Patrick-Henri CEUSTERS
- Topic areas
New synthetic drugs use amongst people between 15 and 29 years old. Attitudes; social representations; perceptions
- Methodology
Qualitative (interviews and focus groups) followed by survey by questionnaires.

Study of cannabis consumption amongst adolescents for the development of a policy and a programme of prevention : analysis of existing data, preliminary qualitative approach and prospective quantitative survey

- Researchers involved
Laurence Kohn and Danielle Piette
- Topic areas
Cannabis use among adolescents
- Methodology
Qualitative and quantitative prospective surveys with follow up of 2 years.

Families and risk behaviours among the young people

- Researchers involved
Pascale JAMOULLE (Service toxicomanies du Centre de Santé Mentale du CPAS de Charleroi), Nadia PANUZI- ROGER (laboratoire de recherche CRISIS-IRTS Nord-Pas-de-Calais)
- Topic areas
- Social building of risk behaviours and addictions (difficulties of socialisation for young people living in precarious and marginalized neighbourhoods, crisis of meaning within families, crisis of the schools, amplification of judicial risks)
 - Trans-generation weaving of risk behaviours and addictions
 - The springs for resilience processes
 - Tracks for prevention and access to services
- Methodology
Field survey among families and relatives of young people who have developed itineraries of risks (addictions, violence, illegal activities, anorexia /bulimia, autemutilation, suicides attempts)

Three methodological approaches:

- observation and immersion in living places of the families and relatives
- Biographic or ethnographic interviews
- Survey within two vulnerable neighbourhoods

Constant implications of professionals and decision makers in the research process

Recent:

Evaluation of the drug addiction prevention intervention in some secondary French speaking schools

• **Researchers involved**

Promotor: Yves Van De Vloet, Secrétaire permanent, Secrétariat permanent à la politique de Prévention

Researchers: Michel ORBAN, Anne RIFFON

• **Topic areas**

Qualitative evaluation of the implementation processes of prevention projects in 56 secondary schools and first results of the action.

10.4. TRAINING FOR PROFESSIONALS

University training, non-university vocational training, in-service training

Flemish Community

- **University training:**
Postacademic course on legal drugs (Katholieke universiteit Leuven KUL)
- **In-service training:**
Purpose: development of knowledge, attitudes and skills
Purpose groups: professionals in different fields (education, care, cure, working places, youthwork, ...)

These trainings are developed as an answer to the needs of professionals. The performers are prevention workers, counsellors, doctors, etc. who are specialised in demand reduction interventions.

French Community

- **University training:**
Post-academic specific courses are available in University of Louvain (UCL) and in the University of Liège.
- **In-service training:**
Harm reduction training for professionals available in Brussels and Walloon Region.



*Scientific Institute of Public Health
Unit of Epidemiology*



ASL



Deutschsprachige
Gemeinschaft

CTB-ODB



Région
Bruxelles-Capitale
Brussels Hoofdstedelijk
Gewest

EUROTOX



Communauté
française

VAD



Vlaamse
Gemeenschap

BELGIAN NATIONAL REPORT ON DRUGS 2001

PART IV Key Issues

Part IV of the National Report 2001 was written by :

Chapter 11 : Polydrug use : VANDENBUSSCHE E. (VAD) with the active contribution of HARIGA F. (EUROTOX) and VANDERVEKEN M. (CTB-ODB) .

Chapter 12 : Successful treatment : VANDERVEKEN M. (CTB-ODB) with the active contribution of HARIGA F. (EUROTOX) and VANDENBUSSCHE E. (VAD).

Chapter 13 : Drug User in Prison : HARIGA F. (EUROTOX).

CHAPTER 11. Polydrug use : Drug Set and Setting

11.1. PATTERNS AND USERS GROUPS

This key issue on poly drug use consists of three parts :

- the first analysis is based on data registered for the Treatment Demand Indicator (TDI). This indicator throws some light on the characteristics of poly drug use patients that are admitted to treatment facilities in Belgium,
- The second analysis uses data collected during a survey conducted in treatments centres. The subject of this survey is the opinions on poly drug use of professionals working in treatment centres.
- the last analysis also uses survey data but these were not collected in a treatment context but in secondary schools.

The first two parts are based on data valid for Belgium as a whole, the last part uses Flemish data only. Because of these different contexts, limitations in the survey data and different opinions on the definition of poly drug use in literature we use in each part different definition of poly drug use.

11.1.a Poly drug use in treatment centres in Belgium

The analyses in this key issue are based on data collected for the Treatment Demand Indicator of the EMCDDA for the year 1999. The analyses cover the two main communities in Belgium (Flemish and Walloon) and the region of Brussels Capital.

The data have been obtained by pooling the data from the three regional systems:

- VRM, a VAD registration project, covers the Flemish community and collected 14.745 cases (86.3%) out of the 17.088 total cases
- EUROTOX, a EUROTOX monitoring system, covers the French community and collected 1.190 cases (7.0%) and
- ADDIBRU, CTB-ODB monitoring system, covers the region of Brussels Capital and collected 1.155 cases (6.8%).

A characteristic of the VRM system is its coverage of not only the drug specific centres but also the Centres of Mental Health Care (where ambulatory treatments are offered) and of a quite large proportion of psychiatric hospitals and psychiatric units in general hospitals. The Centres of Mental Health Care, psychiatric hospitals and psychiatric units in general hospitals attract different population of drug users (different in age, in the type of substance, ...) than drug specific units. In EUROTOX and ADDIBRU-CTB-ODB systems, such centres are not covered at the moment.

Considering that these regional variations are due to this methodological difference in the coverage (or not) of a defined type of centres, and that there are no reasons to believe that the epidemiological characteristics should be strongly different in Brussels and in the French Community, the Belgian TDI partners agreed that these pooled figures could be used as Belgian ones.

Firstly we give the differences in the profiles of poly and single drug users. Secondly we will present the most occurring combinations of drug use.

The primary drug is defined as the drug that is the main reason why the patient seeks help. The secondary drugs are other drugs used, besides the primary drug.

For the analysis of poly drug use we investigate the combination primary-secondary drug and the combination secondary-primary drug. Drugs include the categories opiates, cocaine, stimulants, hypnotics, hallucinogens, volatile inhalants, cannabis and alcohol. Thus in this article people with alcohol as main drug/primary drug are also included.

A poly drug user is defined as a patient in whom more than one drug is registered and a single user just one drug.

For the description of the profile of the single and poly drug users we used the results of the dataset of EUROTOX and VAD only. Because of agreements between CTBODB and the collecting centres we could not use the dataset of CTBODB although we were able to obtain some analyses carried out by CTB-ODB.

In 1999, 15.935 persons with problematic drug use (including alcohol) were registered in the different types of treatment settings (without CTB-ODB data). 8.954 of the 15.935 clients were registered as single product users (56.2%). 43.8% (6981 clients) of the clients indicated using more than one licit and/or illicit drug.

Gender and age

The group of single drug users counts proportionally more women than the group of poly drug users (30.2% versus 26.8%). In the data of the French community the proportion female/male is equal among single and poly drug users. In the data of the Flemish community there is a higher proportion of females in the group of single drug users than in the group of poly drug users (30.3% versus 26.6%).

Single drug users also have a higher mean age than poly drug users (36.9 years versus 30.7 years, table 11.1). In the VAD data, both single and poly drug users, have a higher mean age compared to the users in the EUROTOX data.

Table 11.1 : Mean age (years) by sex in single and poly drug users

	Gender	Single drug users	Poly drug users
EUROTOX	Male	32.5	28.2
	Female	32.9	28.7
	Unknown	-	30.0
	Total	32.8	28.6
VAD	Male	35.9	29.9
	Female	40.4	33.6
	Total	37.2	30.9
TOTAL	Male	35.6	29.8
	Female	39.8	33.2
	Unknown	-	30.0
	Total	36.9	30.7

Missing data : n=68 (0.4%)

Nationality

Most of the users registered by the participating treatment centres have the Belgian nationality : 88.0% single drug users and 91.6% poly drug users.

There is one remarkable difference between the EUROTOX data and the VAD data for non-Belgian users when the users don't have the Belgian nationality. In the VAD data more persons within the group of non-Belgian users originate from non-EU countries.

Labour status

There are no differences between single and poly drug users on this variable. 60.1 % is regular employed, 22.1% economically inactive and unemployed, and 11.6% is pupil/student.

In the VAD data there is no difference in labour status between single and poly drug users. In the EUROTOX data there is a clear difference between the single and poly drug users. 28.2% of the single drug users have regular work, for the poly drug users this is 10.4%. 50.0% of the poly drug users are economically inactive, where as 34.1% of the single drug users are.

An explanation for this difference may be the higher mean age of the registered drug users in the Flemish community.

Living status

Concerning the living status of poly drug users we observe that they live more often with their parents than single drug users : 25.0% compared to 18.9%, respectively (table 11.2). Besides this 39.2% of the single drug users have a family (partner or partner and child(ren)) compared to only 27.2% of the poly drug users. The higher mean age of the single drug users can explain these differences.

Table 11.2 : Proportion of single drug users and poly drug users by living status

LIVING STATUS	Single drug users (n = 8,901)	Poly drug users (n=6,968)	Total (n=15,869)
Alone	25.9	26.3	26.1
With parents	18.9	25.0	21.6
Alone with child	0.3	0.4	0.3
With partner	38.6	26.6	33.3
With partner and child(ren)	0.6	0.6	0.6
With friends	0.3	0.8	0.5
Other	7.3	13.9	10.2
Unknown	8.2	6.4	7.4

Missing data : n=67 (0.4%)

Previous treated^p

58.6% of the single drug users are new clients for the registered treatment centre, where as only 49.8% of the poly drug users are new.

Source of referral

The main source of referral for the single and poly drug users are the users themselves (25.2% versus 30.9%). The users are important actors in prevention actions (table 11.3). Single drug users are more

^p The definition of 'Previous treatment' differs according to the registration systems. In the EUROTOX database, 'never treated' means 'never treated before for the drug problem in any centre' while in the VAD registration system, 'never treated' means 'never treated in the same centre'.

referred by General Practitioners (7.9% versus 4.3%) and by hospitals and/of other medical sources (6.1% versus 4.1%) than poly drug users.

Table 11.3 : Proportion of single and poly drug users according to the source of referral

SOURCE OF REFERRAL	Single drug users (n= 8,896)	Poly drug users (n=6,962)	Total (n=15,858)
Self referred	25.2	30.9	27.7
Family/friend	10.9	12.2	11.5
Other drug treatment centre	21.3	23.6	22.3
General practitioner	7.9	4.3	6.3
Hospitals/other medical source	6.1	4.1	5.3
Social services	1.3	0.6	1.0
Court/probation/police	14.8	13.3	14.1
Other	9.6	7.3	8.6
Unknown	2.8	3.6	3.2

Missing data : n=1303 (8.2%)

Treatment centre type

Most clients are treated residential both within the group of single drug users as within the group of poly drug users. In the group of single drug users there are a little more outpatients than in the group of poly drug users (48.1% versus 42.2%).

Primary drug

The three most registered primary drugs are, for single drug users, alcohol (55.7%), cannabis (16.6%) and heroin (5.3%; table 11.4)). For poly drug users, these are: alcohol (28.1%), heroin (24.2%) and amphetamines (13.1%). For both the single drug users and the poly drug users, alcohol is the most frequent drug.

Table 11.4 : Repartition of primary drug (%) used by single and poly drug users

	Single drug users n=8,952	Poly drug users n=6,981	Total N=15,933
OPIATES	1.7	0.9	1.3
Heroin	5.3	24.2	13.6
Methadone	0.5	2.0	1.2
Other opiates	0.8	1.0	0.9
STIMULANTS	1.6	0.7	1.2
Cocaine	1.7	8.3	4.6
Amphetamine	3.9	13.1	7.9
MDMA and other derivatives	0.9	1.8	1.3
Other stimulants	0.2	0.3	0.2
HYPNOTICS AND SEDATIVES	2.9	1.5	2.3
Barbiturates	0.4	0.8	0.6
Benzodiazepines	3.0	2.8	2.9
Other hypnotics/sedatives	0.5	0.4	0.5
HALLUCINOGENS	0.2	0.2	0.2
LSD	0.0	0.1	0.1
Other hallucinogens	0.1	0.0	0.1
VOLATILE INHALANTS	0.1	0.2	0.1
CANNABIS	16.6	12.8	14.9
ALCOHOL	55.7	28.1	43.6
OTHER SUBSTANCES	4.0	0.7	2.6

Missing : n=3 (0.0%)

Combinations used

Opiates-stimulants user

The most registered combination of the generic categories (opiates, stimulants, ...) in EUROTOX-data, CTB-ODB-data and VAD-data is the combination of opiates and stimulants (or stimulants and opiates; the category "stimulants" includes cocaine, amphetamines, XTC and other stimulants).

We find the following characteristics for persons who combine opiates and stimulants.

- 77.3% of the opiates-stimulants users are male (n=1.136). Two fifth of the opiates-stimulants users live with their parents or family, a quarter live alone and one fifth registered 'other'.
- 72.9% of the opiates-stimulants users are between 20 year and 34 year. 29.7% of them have an age in the category 25 - 29 year.

The main source of referral among opiates-stimulants users is the person himself. Other drug treatment centres referred 25.6% of these users and court/probation/police 12.6%.

In the data of EUROTOX and VAD is it possible to look at subcategories of drugs.

The most registered combinations of drug used in the EUROTOX and VAD data are:

- Combination of heroin-cocaine (969 clients)
- Combination of amphetamines-cannabis (569 clients)
- Combination of amphetamines-cocaine (358 clients)
- Combination of alcohol-cannabis (344 clients)
- combination of alcohol-benzodiazepines (343 clients)
- The heroin-cocaine user (969 clients)

Heroin and cocaine users

Mean age of the heroin-cocaine users is 27.6 years. Only one fifth of the heroin-cocaine users is female. Most of the heroin-cocaine users have the Belgian nationality (81.5%). Within the non-Belgian group by far most of the clients originate from non-EU countries (10.9%). Regarding labour status, 59.5% of the heroin-cocaine users are employed on a regular basis although 29.5% is economically inactive or non-employed; 5.6% are students. As far as living status is concerned, 26.5% of the heroin-cocaine users live on their own, 25.4% live with their parents, 23.5% live with 'others'. This rest category consists of clients without a fixed home and trampers.

Two fifth of the heroin-cocaine users have taken the initiative to contact the treatment centre (42.9%) by themselves. 54.4% of them are treated in an inpatient centres and 44.2% in an outpatientcentres.

Users of so-called hard drugs, such as heroin and cocaine, are often associated with a more disintegrated social situation. Because of the illicit aspects and associated risks these users are generally seen as fringe group. But are these peoplesocially more disintegrated than users of legal products, which are more accepted by the society/public opinion. We cannot give a complete answer to this question because of the restriction that can be used to measure the social integration of the drug users: 'labor status' and 'living status' (which whom). The first gives us information about (socio-) economic participation, the latter about the integration in a primary social network. Based on the general assumption, we would expect that the heroin-cocaine users are socially less integrated than the alcohol-benzodiazepine users. A difference between the two groups of users was found for 'labour status' : 79.9% of the alcohol-benzodiazepine users are economically active compared to 62.9 % for heroin-cocaine users. So, we can say there is more (socio-) economic participation of the alcohol-benzodiazepine users. But almost two third of the heroin-cocaine users are still economically active and the difference in percentage between the two groups is not so high. Even if there is a statistical significant association between the use pattern and the economic activity ($\chi^2=31.624$; $df=1$; $p<=0.001$), this association is not strong ($\phi=-.160$). No significant association can be found between drug use patterns and living status : 41.9% of the heroin-cocaine users are alone whereas among alcohol-benzodiazepine users this proportion is 42.9%. Since labour status gives us only a slightly better

situation for alcohol-benzodiazepine users and living status shows no difference, we cannot say that the social integration based on these two indicators is more for heroin-cocaine users than for alcohol-benzodiazepine users. But, as already mentioned, we only included two potential indicators.

Amphetamine-cannabis users

Mean age of the amphetamine-cannabis users who sought help from treatment centres is 21.7 years. Nearly a quarter of the amphetamine-cannabis users is female (24.8%). Most of them have the Belgian nationality (97.4%).

Regarding labour status, 44.3% of the amphetamine-cannabis users have regular work, and remarkably 34.8% is student. As far as living status is concerned, 48.5% of the amphetamine-cannabis users live with their parents. Court/probation/police is the main source of referral for the amphetamine-cannabis users (28.8%) followed by other drug treatment centre (25.0%) and family or friends (15.8%).

The proportion of amphetamine-cannabis users treated in outpatient treatment centres amount to 69.4%.

Conclusions

The different subfocal points in Belgium have done a great effort in pooling the data together. In Belgium a uniform registration system does not exist although this is very important for situating Belgium in Europe.

Two fifth of persons with problematic drug use are poly drug users.

Some differences in characteristics between the single and poly drug users were found :

- women are proportionally more represented in the group of single drug users than in the group of poly drug users,
- single drug users have a higher mean age than poly drug users,
- poly drug users live more often with their parents than single drug users.

Alcohol is a very important drug both for single drug users and for poly drug users. The most used drugs for the group of single drug users are alcohol and cannabis. For the poly drug users these are alcohol, heroin and amphetamine.

In the Flemish community the two most important combinations are heroin-cocaine and amphetamine-cannabis and in the Walloon community heroin-cocaine and heroin-cannabis. The data of the Brussels region indicates that opiates-cannabis and opiates-stimulants are the most frequent found combinations. A possible explanation for these regional differences is the different coverage in the type of treatment centres according to the region.

Even if alcohol-benzodiazepine users seem to be a little more integrated in the (socio) economic context, the general assumption that hard users of illicit drugs (heroin-cocaine) are less integrated than socially more accepted users (alcohol-benzodiazepine users) cannot be verified with our data.

11.1.b A survey on poly drug use in inpatient and outpatient centres in Belgium

Research into poly drug use is no an easy matter. This text is based on the opinions, estimations, experiences and beliefs of people who work in inpatient and outpatient centres for treatment of drug addiction.

A questionnaire about poly drug use was filled by 45 treatment centres of which 23 inpatient centres and 22 outpatient centres (table 11.5).

Table 11.5 : Treatment centres participating to the survey

Inpatient	Number	Outpatient	Number
Crisis intervention centres	4	Centres for mental health	7
Therapeutic communities	4	Day care centres	11
Psychiatric hospital	14	Medico social care centres	4
'Supervised housing'	1		
Total	23	Total	22

In the context of this survey, **poly drug use** is defined as **the problematic use of at least 2 products that are used simultaneously or shortly after each other**. The meaning of problematic use is **abuse** or/and **dependency** according to the DSM IV criterions. In this definition the products are restricted to the following categories and subcategories:

- alcohol : alcohol,
- medicine : psychoactive medicines , anti – depressives, benzodiazepines and heavy analgesics,
- Illicit drugs : cannabis, heroine, cocaine, hallucinogens, amphetamines, ecstasy and other allied drugs and volatile snuff products.

The questionnaire contains the following questions:

1. The percentage of poly drug users in your organisation?
2. What are the 3 most common poly drug combinations for which poly drug users are treated in your organisation?
3. What are the new trends in poly drug use over the last 3 years?
4. In which way poly drug users distinct themselves from other clients on psychological, social and biomedical way?
5. What are extra health risks – related to poly drug use – in your organisation?
6. Is there a specific treatment program for poly drug users in your organisation?

The percentage of poly drug use fluctuates in the different psychiatric hospitals, centres for mental health and day centres. Some of these centres reports a high percentage of poly drug use, others reports a low percentage of poly drug users in their organisation.

In the crisis intervention centres, therapeutic communities and especially in the medico social care centres, almost every centre reports a percentage of poly drug use higher then 60%.

The pattern of poly drug use seems to differ according to the characteristics of the treatment centres.

a. Inpatient centres

Almost half of the inpatient centres report no new trends in poly drug use over the last 3 years. The use of alcohol combined with benzodiazepines is the most commonly found combination in psychiatric hospitals. In crisis intervention centres and therapeutic communities, the heroin-cocaine combination is the most common. Many psychiatric hospitals, crisis centres and therapeutic communities indicate an increase in the use of cocaine combined with alcohol, medicine or other illegal drugs. The use of cannabis as second or third drug is also growing. Many clients who use cannabis in combination with other drugs do not consider this cannabis use as problem behaviour. There is a slight increase in the

use of ecstasy combined with alcohol or other drugs, particularly among the youngest clients in the inpatient centres. Other remarkable observations in the inpatient centres about trends in poly drug use are: the increase of the combined use of methadone and other licit and illicit drugs, the decrease in age of poly drug users and the increase of the number of poly drug users.

b. Outpatient centres

Surveys in the outpatient facilities showed more evidence for new trends in poly drug use than in inpatient centres. They notice an increase in the use of cocaine and ecstasy or other synthetic drugs. Many outpatient centres agree on a trend towards a boost in poly drug use over the last years together with an increase in the number of drugs used, particularly among the youngest age groups. Furthermore, some outpatient centres notice that juveniles use more and more alcohol combined with illegal drugs or benzodiazepines or methadone. From the point of view of the poly drug user such a combined use of drugs is perceived as quite normal.

The evidence from the surveys is not strong enough to speak of real new trend in poly drug use. Although we see a few tendencies in the poly drug use: an increase of combinations with ecstasy, cocaine and cannabis, alcohol and medication stays the most common combination.

Additional results of the present study, concerning the biomedical, psychological and social characteristics of the poly drug users, will be presented in the section 11.2 Health and social consequences.

11.1.c Poly drug use in secondary schools in flanders

This analysis is based on data of a survey held in Flanders between September 2000 and June 2001. The data of 15,618 students from 71 secondary schools were analysed. These 15,618 pupils were selected on a random basis from a larger pool with the following prerequisites (for the sample as a whole): stratified age range from 12 to 18 years with a mean age of 15 years, an equal male/female distribution and the equal representation of the three branches of study (college, technical and professional study). Two kinds of analyses were conducted.

Co-occurrence of regular use of licit and illicit drugs

A first analysis used a broad definition of drugs including alcohol, tranquilizers, sedatives, anti-depressives, slimming products, cannabis, heroin, cocaine, hallucinogens, amphetamines, ecstasy, volatile snuff products, energy drinks and smart drugs. For all these substances we focused on the regular use, which was defined as 'more than once a week' use. The co-occurrence indicates the percentage of pupils in the sample using two specific substances on a regular base. This co-occurrence is used as a proxy of poly drug use.

Alcohol is found in three of the five most frequent used combinations. Alcohol and energy drinks are both used on a regular base by 4.1% (n=599) of the pupils. In second place comes the combination of alcohol and cannabis. 300 pupils (2.0%) consumed alcohol and cannabis on a regular basis. Cannabis and alcohol are used regular by 0.9% (n=140) of the pupils. The combinations of alcohol and anti-depressives and smart drugs and volatile snuff products are used by 0.3% of the sample on a regular base.

Regular use of illicit products and volatile snuff products

The second analysis focused on illicit drugs (cannabis, heroin, cocaine, hallucinogens, amphetamines, ecstasy) and volatile snuff products. Here we consider the conditionality of the regular use. Conditionality was defined as the chance that someone uses a certain substance given the use of another substance. Table 11.6 gives this conditionality for 7 products.

Table 11.6 : Conditionality (%) of illegal substances and volatile snuff products (number in parenthesis)

	Cannabis	Heroin	Cocaine	Hallucinogens	Amphetamines	Ecstasy	Volatile sniff products
Cannabis (n=550)	-	2.4 (13)	1.3 (7)	2.5 (14)	2.7 (15)	3.6 (18)	3.6 (20)
Heroin (n=25)	54.2 (13)	-	30.4 (7)	25.0 (6)	28.0 (7)	36.0 (9)	24.0 (6)
Cocaine (n=12)	53.8 (7)	58.3 (7)	-	33.3 (4)	33.3 (4)	25.0 (3)	16.7 (2)
Hallucinogens (n=17)	82.4 (14)	35.3 (6)	25.0 (4)	-	33.3 (5)	11.8 (2)	41.2 (7)
Amphetamines (n=28)	57.7 (15)	25.0 (7)	14.8 (4)	18.5 (5)	-	37.9 (11)	29.6 (8)
Ecstasy (n=27)	69.2 (18)	33.3 (9)	12.0 (3)	7.7 (2)	39.3 (11)	-	44.4 (12)
Volatile sniff products (n=60)	33.9 (20)	10.0 (6)	3.4 (2)	11.7 (7)	13.6 (8)	20.3 (12)	-

The table must be read from left to right. For example the chance that some one who uses cannabis regularly also uses cocaine on a regular base is 1.3%. Out of the 550 regular cannabis users 7 use cocaine regularly.

Relatively few regular cannabis users use other illicit drugs. One on thirty (3.6%) uses ecstasy or volatile sniff products on a regular base. A different picture emerge if we consider the other illegal drugs. More than half of the regular heroin users are also regular cannabis users (54.2%) and one out of three uses ecstasy regularly (36.0%). Regular cocaine use is strongest associated of all drugs with regular heroin use. 58.3% of the regular cocaine users uses heroin regularly. The regular use of hallucinogens or ecstasy is a good indicator of regular cannabis use. More than four out of five regular users of hallucinogens use cannabis regular.

Conclusions

Considering the regular use of a broad range of licit and illicit drugs, alcohol is by far the drug that is most combined with other licit and/or illicit drugs in students of the age range between 12 and 18 years. The second analysis reveals that (regular) cannabis use is not strongly associated with the regular use of other illicit drugs. The regular use of cannabis is - from a user's perspective different than the regular use of the other illicit drugs.

This analysis should be considered more indicative than conclusive because of the low number of regular users in the sample (and associated lower reliability of data).

11.2. HEALTH AND SOCIAL CONSEQUENCES

The survey on poly-drug use in inpatient and outpatients centres carried out in Belgium was presented in section 11.1.2. The results of this study has also allowed to highlight some biomedical, psychological and social characteristics of the poly drug users.

Few of the responding outpatient and inpatient centres do not see any distinction between poly drug users and single drug users. One centre reports that the issue is not the distinction between poly and single drug use in itself but has more to do with the specific products and combinations used.

The majority notice specific characteristics of the poly drug users. According to the survey there are more risks related to poly drug use at different stages than to single drug use. Poly drug users have more problems in different ways (biomedical, psychological and social). Diagnosis and treatment are more difficult and require more time. The process to abuse and addiction is shorter in comparison with single drug users. The poly drug abuser or addict is younger than the single drug abuser.

The exact characteristics depend on the specific drugs that are used and their combination. They include :

- ✓ *At the biomedical level*
 - Heavier dependency,
 - Heavier withdrawal symptoms (epileptic convulsion, delirium tremens),
 - A greater risk for HIV and Hepatitis C/B,
 - Cerebral problems,
 - Unknown effects of combined drugs, and
 - Overdoses.
- ✓ *At the psychological level*
 - More double diagnosis such as trauma, personality disorder (borderline) = More psychiatric disorders,
 - More anti social behaviour,
 - Instable personality, and
 - Aggression and irritability.
- ✓ *At the social level*
 - More and early social problems such as no home, no work,
 - More marginalisation, and
 - Social isolation
- ✓ *At the treatment level*
 - A greater demand for medication during the treatment,
 - Less good prognoses for the reason that the integration and recovery isn't so good, and
 - The poly drug user has the feeling that he must work twice as hard during the treatment (he has to quit 2 or more drugs).

As mentioned before poly drug use involves more risks and problems at different stages than single drug use. Many centres consider the health risks one of the biggest problems of poly drug use. The health risks differ according to the specific drugs used and their combination. Specific health risks by the poly drug use include :

- *Withdrawal symptoms* : during the detoxification there has to be more attention for withdrawal symptoms. Withdrawal symptoms are heavier (more danger for epileptic convulsions and delirium tremens) when the patient used alcohol with benzodiazepines or heroine with benzodiazepines or other risky combinations. Sometimes when the patient minimizes or denies the use of some medications or other drugs, the existence of different active products in the blood can camouflage withdrawal symptoms.
- *Hepatitis C/B and HIV* : some centres notice there is a higher prevalence of hepatitis C/B and HIV among poly drug users (especially when they use heroine or cocaine). The explanation could have to do more with the way of administration than with the poly drug use itself.
- *Overdoses* : the risk for overdoses is higher for poly drug users.
- *Unpredictable effects* : there are more unpredictable effects of poly drug combinations of drugs. Some combinations cause aggressive behaviour.
- *Other biomedical risks* : the survey indicates more medical complications and risks such as liver diseases (liver cirrhosis), cerebral dysfunctions, etc in the group of poly drug users.
- *Chronic* : patients, who use many drugs for a long time, are more resistant to a successful treatment. Some poly drug users are completely exhausted.
- *Other noticed healthy risks are*: Sleep disorders, anxiety problems, traffic accidents, eating problems, ...

11.3. RISK ASSESSMENT AND LOCAL MARKET

No information available.

11.4. SPECIFIC APPROACHES TO THE INTERVENTIONS

There are no specific treatment programs for poly drug users in most inpatient and outpatient centres. Most centres work with an interdisciplinary team in such a manner that the treatment of multiple drug users is possible. The treatment includes different domains as psychiatric, social, psychotherapeutic and medical therapy.

The survey indicates however, that there is a need for an individual and personalised program for poly drug users. Flexibility should be a key word of such a program.

11.5. METHODOLOGICAL ISSUES

No information available

CHAPTER 12. Successful Treatment : The Effectiveness of the Interventions

12.1. THE APPROACHES TO TREATMENTS AND THE RELATED CONCEPTS OF SUCCESS

In order to respond to the key issue «successful treatment » raised by EMCDDA for the year 2001, a letter was sent to all the Brussels institutions, to the Focal Point and to the sub-Focal Points, asking them to send back articles or references of articles from the last five years about the evaluation of the treatments. We have also questioned the institutions about the definitions, criteria and tools used for the evaluation of the treatments.

We received six answers from healthcare institutions and two from the subFocal Points. None of these answers gave information about the evaluation definitions, criteria and tools.

The three references of articles that were sent to us are listed below.

- Ledoux Y. Le devenir des patients en cure substitutive au R.A.T.– les dimensions de l'efficacité substitutive. Actes du 10 mars 2001, GEERM, RAT asbl.

Corveleyn J. Het Minnesota model: een stappenbenadering van verslavingsproblematiek. Tijdschrift voor Psychotherapie, 2001 (27) 5.

- Denis B et al. EVALUMET-Evaluation des traitements de substitution (Méthadone) menés par les médecins généralistes en Communauté française de Belgique. ALTO-SSMG, Janvier 2001.

In order to complete this collection and check whether or not the abovementioned articles have already been published as scientific papers and recorded in mainstream databases, we carried out a research on the NLM site using the following criteria (key words: illicit drugs, treatment, evaluation, years : 1995-2001, « Human »).

In total, 106 references were identified. None of these publications came from a research centre or a healthcare institution from our country.

12.2. EVALUATION OF THE TREATMENTS

No information

12.3. METHODOLOGICAL ISSUES

No information

CHAPTER 13. Drug Users in Prison

13.1. EPIDEMIOLOGICAL SITUATION

Currently, Belgium has 33 penitentiary institutions, including two social defence institutions. These institutions have each a capacity for hosting between 32 and 690 prisoners. The total capacity, including hospital beds and psychiatric aisles, was on 30th of December 1999 of 7462 places. This number is theoretical, as it does not take into account places unavailable because of works. On 30 December 1999^f Belgium's total prison population amounted to 8.135 persons and the daily average population was 8143. The theoretical occupation rate was 109% in 1999. In some prisons, the occupation rate can reach 150% or more.

The detention rate in Belgium is around 8 per 10.000 in Belgium but has been increasing regularly.

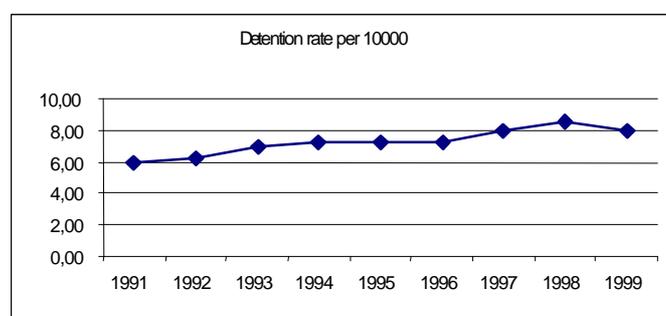


Figure 13.1 : Detention rate 1991- 1999

This increase is due to both an increase in the number of pre-trial detention and of long-term punishments.

In 1999, 62% of the prison population is Belgian, and women represent 4 % of this population.

13.1.a Drug users and drug use in prison

There is little epidemiological studies on drug use among detained persons in Belgium. It is generally accepted that 50% of the prison population are drug consumers and on third of these users are intravenous drug users.

Detained illegal drug consumers in the prison environment

It is basically impossible to determine the exact number of detained drug consumers in the prison environment. All the available figures are indicative, based either on studies or on conviction reasons.

The number of those detained for violations of anti-drug law (possession of and trafficking in illegal drugs) has been growing steadily since the 1970s (see figure 13.2)^f. This trend naturally leads to a growing number of drug consumers even within penitentiaries, and probably to a growing presence

^g Source : Direction Générale des Etablissements pénitentiaires. Rapport d'activité 1997. Ministry of Justice. 1998.

^f Van Mol. F ; Lauwers N. Drogues et Prisons. La réalité Pénitentiaire en Matière de Drogue. Actes de la journée d'étude du 22 avril 1994. Présence & Action culturelles.

and trafficking of illegal drugs in prison. On 30 December 1996 30% of imprisoned women and 14% of imprisoned men were serving a prison sentence for violating anti-drug law or drug-related offences. This percentage is higher, amounting to 70% in some penitentiary institutions.^s Excluding those "without means" and hospital inmates under social defence law from the statistics, the proportion of those detained for violating this law accounted for 50% of all prison inmates^t in 1994.

This group of prison inmates only constitutes a fraction of all drug consumers in prison, since many of them are not imprisoned for violating anti-drug law, but for larceny or other offences. The latter group's drug consumption is either a secondary offence or unknown to the prison administration.

Detained drug users account for an estimated 50% of the total prison population. The estimated number of injecting drug consumers is 30% of this figure and approximately 15% of the total prison population.

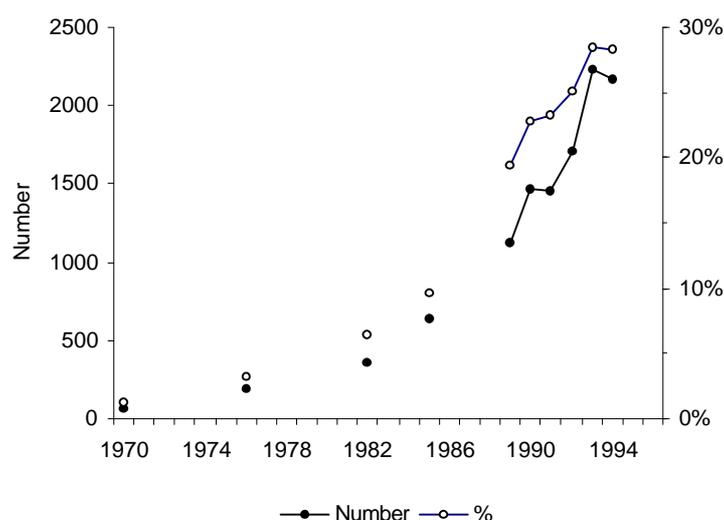


Figure 13.2 : Prisoners detained for violating antidrug law (1970-1994)⁵

The inmates with a drug addiction are comparatively young. In 1993, 51% of these prisoners were under 26 and 9% under 20.^u

In addition, there is a gender difference illustrated in table 3, which shows that one-third of female prisoners and one-sixth of male inmates (miscellaneous detention reasons) are imprisoned for violating anti-drug law. Thus, the number of drug users is higher in the female prison population than in the male population. Moreover, many female injecting drug users are either pregnant or mothers of young children (Picard 1997).

Table 13.1 : Prisoners detained for violating antidrug law on 30 December 1996

	Males	Females
Pre-trial detention.	22%	32%
Convicts	10%	28.5%

The share of detained drug consumers, particularly injecting drug users, is significantly higher in the prison population of Belgian nationality than among prisoners of foreign origin. In 1993 Todts (Todts et

^s La Prévention du Sida en Communauté Française: Plan Guide Triennal 1996-1998 Agence de Prévention du Sida. Ministère de la Santé de la Communauté française de Belgique.

^t Van Mol. F ; Lauwers N. Drogues et Prisons. op.cit.

^u Vandenbroucke M., Joosen B. La problématique des toxicomanes illégaux dans les prisons belges. Une situation au 1 December 1993. Information criminographique.

al. 1997) observed in Antwerp prison that 67% of Belgian inmates and 41% of foreign inmates among the under-25s claimed to be illegal drug consumers. And among illegal drug-using inmates of all age groups, 47% of Belgian consumers and 24% of foreign consumers claimed to be injecting the drugs. The total number of IDU accounted for 15% of all surveyed inmates

In 1989, a survey carried out in Antwerp prison on 300 inmates' urine samples detected one (26%) or several (25%) drugs (benzodiazepines, barbiturates, cannabis, opiates, cocaine, amphetamines) in 51% of examined samples. However, these figures underestimate the actual situation, given the fact that occasional consumers of heroin or cocaine, for example, may test negative three days after consumption.

In 1999, in a survey conducted in the prison of Saint-Gilles in Brussels with 246 respondents, 50% of them declared having consumed illicit drugs during the four weeks prior to their imprisonment, and about 10% by intravenous. Forty-two (42%) reported using illicit drugs during their incarceration^v.

Finally, a large proportion of drug addicts spends time in prison. Two studies, one in the Flemish-speaking (Totds; 1989) and another in the French-speaking part of Belgium (Renard et al.1994) showed that 54,1% and 49,5% of drug addicts respectively had already served at least one prison sentence. It would also seem that many drug addicts repeatedly spend time in prison.

Two prevalence survey have been carried out in the recent years: the first one, in the prison of Namur^w, in 1997 and the second one in 1999 in Brussels and Antwerp^x. We will present more detailed results from the most recent one.

Table 13.2 : Prevalence of drug use in prisons

Location	Sample size (participation rate)	Year	Prevalence (%)			
			Drug use 4 weeks prior imprisonment	Intravenous drug use 4 weeks prior to imprisonment	Lifetime drug use in prison	Lifetime intravenous drug use in prison
Prison Namur	n=115 (70%)	1997	51	16	44	1.7
Brussels – Antwerp	n=246 (33%)	1999	50	9.4	42	2.4

Please note that participation rates in these surveys are quite bad especially in the prison of St Gilles, where one can therefore suspect that the results are underestimate.

Before incarceration

About half of detained person had used an illegal drug during the month preceding their incarceration. The most common illegal drug mentioned before incarceration is cannabis. If one excludes cannabis, this proportion is one third (31%). According to the study, between 10-16% have used drug intravenously. Among them 50% had injected the day before their incarceration.

Among the IDU, 50% shared their injection equipment outside prison.

One can observe several differences according to the number of incarcerations. The proportion of drug users among persons incarcerated for the first time is significantly lower among primo-incarcerated persons than among the group of population being in prison for the second or more time.

^v De Maere W., Hariga F., Bartholeyns F. Vanderveken M. et al. Santé et usage de drogues en milieu carcéral. Développement d'un instrument de recherche épidémiologique: rapport de recherche. Publication SPO681. Bruxelles : SSTC, 2001.

^w European network on HIV and hepatitis prevention in prisons. 2d annual report. Bonn – Marseille, May 1998.

^x De Maere W., Hariga F., Bartholeyns F. Vanderveken M. Op. Cit

Table 13.3 : Prevalence (%) of illegal uses of drugs during the month before incarceration. (1999 – St Gilles)

Products	Pop Total (n = 230)	First incarceration (n=80)	Several incarcerations (n=150)	p value
Cannabis	41	30	47	<0.05
Cocaine	21	11	27	<0.05
Heroin	15	5	20	<0.05
Benzodiazepines	14	11	16	
Methadone ill.	11	3	15	<0.05
XTC	9	9	9	
Amphetamine	7	9	6	
LSD	6	9	5	
Barbiturates	4	1	6	
TOTAL:	50	31	69	<0.05
Total without cannabis	31	18	39	<0.05

First consumption in prison

One fourth of the respondents declare having used for the first time one illegal drug in prison. The most common drug mentioned is cannabis, followed by heroin. Among people being incarcerated for the first time, 10% have used an illegal drug for the first time. (Please note that in this prison a specific section has been established for people entering the prison for the first time to limit contacts with other inmates.)

Table 13.4 : Prevalence (%) of first use in prison (1999– St Gilles)

Drugs	Total population (n=226)	First incarceration (n=80)
Cannabis	19,0	9
Heroin	6,5	1
Benzodiazepines	6,5	3
Cocaine	5,0	0
Barbiturates	3,1	0
XTC	2,0	0
LSD	1,3	0
Methadone ill.	1,3	1
Amphetamines	0,4	0
Any illegal drug	26,0	10
First injection	0,4	0
Any illegal drug excluding cannabis	12	2,50

One person declared having injected for the first time in prison. In the survey in Namur, these were 15%.

Drug use in prison

The most used drugs in prison are cannabis followed by benzodiazepines, heroine and cocaine.

Table 13.5 : *Illegal drugs used in prison (Saint Gilles– 1999)*

Drugs	Total population	First incarceration	Several incarceration	p value
Cannabis	38	20	48	<0.05
Benzodiazepine	13	6	17	<0.05
Heroine	12	4	17	<0.05
Cocaine	10	5	12	
Amphetamine	7	4	9	
Methadone ill.	5	1	7	<0.05
Barbiturates	5	4	5	
XTC	4	4	5	
LSD	2	4	1	
Any illegal drug:	41	20	53	
Total IDU	2,20	0	4	
Total without 20 cannabis		5	27	<0.05

13.1.b Risk behaviours in prison

Sharing injection equipment In both surveys, 100% of persons who injected in prison reported sharing needles and equipment.

Both surveys looked also at *tattooing and piercing* in prison. Between 7% and 35% of the respondents declared having had a tattoo or piercing in prison. But this percentage is significantly higher among drug users, especially IDUs.

Sexual risks: In the 1999 survey, 9% admitted having sexual relation in prisons, 11% of the drug users and 4% of the non drug users. During most of these relations (80%) no condoms were used.

13.1.c Health status

Prevalence of HIV in prison

There are only few data on the prevalence of HIV infection in prison. In 1997 the penitentiary administration estimated that the prevalence of HIV infection was 2% (Van Mol 1997). In 1987 the estimated figure was 1,3% (Harding 1987). Two studies performed in 1992 and 1993 yielded similar results. The first was performed in Antwerp and showed a prevalence of HIV infection of 1,2% (Totds 1993^y). The other covered 14 penitentiary institutions (except patients admitted to St. Gilles CMC) showed an HIV prevalence of 0,84% among men and 1,68% among women (IDEWE 1994). Apart from the gender differences, this study showed that the most affected age group is that of 25 to 34 year-olds (HIV+ = 2,19%). The group of prisoners serving short sentences is also more affected than that of prisoners serving long sentences. In the study performed by the IDEWE, 50% of all HIV cases were detected in Brussels prisons.

^y Op. Cit.

Results from laboratory testing performed in two different prisons in 2000 showed prevalence for HIV among inmates between 0.3% in the prison of Bruges (Flemish community) and 1.2% in the prison of Lantin (French Community).

Table 13.6 : Results of studies on HIV prevalence among in prison in Belgium

Year	Sample size	Place/population	Prevalence rate (%)	Reference source
1985-1987	3,126	Inmates serving sentences for violating anti-drug law/ injecting drug users	3,1-7,7 per term	Donot 1989
1993	228	Antwerp Prison - new inmates – injecting drug users	2,6	Todts 1997
1997	100	Injecting inmates - Prison St.Gilles	8	Donot A. 1997
1997	26	Injecting inmates – Prison Namur (saliva test)	0	Hariga F;
1999	668	Prison Lantin (all detainees for whom a test was asked by the prison doctor)	1.2	Min. of Justice
1999	316	Medical center in prison of Bruges (all detainees admitted in this prison hospital)	0.3	Min. of Justice
2000		Prison Lantin (all detainees for whom a test was asked by the prison doctor)	0.95	Min. of Justice

Thus, on a daily average, Belgian prisons hold an estimated 150 inmates infected with AIDS. These inmates belong to a category of the prison population that spend a relatively shortterm in prison. The total of HIV-positive inmates that pass through the prisons every year is probably about twice as large. Hence, the prevalence of HIV infection in Belgian prisons is about fifteen times higher than in the general population.

Prevalence of hepatitis

A study performed in Belgian prisons in 1992 (IDEWE 1994) showed a 1,48 % prevalence rate of viral Hepatitis compared with a rate of 0,32 % among the general population standardised by age and sex. This study only accounted for symptomatic cases and recent blood transfusions. However, viral Hepatitis is asymptomatic in 80% (Hepatitis C) to 90% (Hepatitis B) of cases. The study gave rise to vaccinations of prison staff. Another study performed in Antwerp Prison in 1993 yielded a HepatitisB prevalence rate of 20% (Todts et al. 1997).

Table 13.7 : Studies on the prevalence of Hepatitis B and C in prison in Belgium

Year	Sample size	Population	Prevalence rate HBV (%)	Prevalence rate HCV (%)	Reference/ source
1993	996	Antwerp prison	20,5		S. Todts
1997	100	St.Gilles Prison/IDUs	32	64	J. Donot
1997	26	Prison Namur IDU		39	Hariga F.
1999	692	Prison Lantin*	7.7 (AgHBs)	28.2	Min. of Justice
1999	314/321	Medical center in prison of Bruges**	2.2 (AgHBs)	17.4	Min. of Justice
2000	708/741	Prison Lantin ¹²	4 (AgHBs)	24.8	Min. of Justice

* all detainees for whom a test was asked by the prison doctor

** all detainees admitted in this prison hospital

A survey conducted in 1997 in St.Gilles prison among injecting drug users showed an HCVsero-prevalence of 64%. The same year the salivary prevalence survey conducted in the prison of Namur through the project of the European network for HIV and hepatitis prevention in prison showed a prevalence of 39% among IDUs.

Tuberculosis

Detection rate in prison population is 5 to 10 times higher than in general population. Overcrowding, poor hygiene conditions, and higher HIV prevalence rates, participate to this higher transmission risk, for detained persons and for staff. In 1992, in the survey realised in one prison in Antwerp, Todts observed a prevalence of 436/100.000 persons. Among less than 25, the conversion rate of the tuberculin test is 23%, which is 10 times higher than the national rate for same age group.

Suicides and self-mutilations

Mortality due to suicides is eleven times higher in prison than in general population. In 1998, 29 suicides had been reported, which corresponds to a specific mortality rate of 368,9/100.000. In 1994 specific mortality rates in the general population were respectively 21,07/100.000 among women and 31,19/100.000 among men. Standardisation for age would show an even higher excess of deaths.

The beginning of the detention is of particularly high risk for suicide (see table below).

Table 13.8 : Number of suicides in prisons (Belgium)

Duration of detention at the time of suicide	1997	1998
< 1 month	5	10
1 to 6 months	5	10
6 to 12 months	4	6
1 to 5 years	6	3
> 5 years	2	0
Total	22	29

13.1.d Special regime and sanctions against drug users

In some prisons, drug users are put in a separate aisle. Due to the lack of available jobs in prison, usually drug users do not have access to these opportunities. If these jobs can bring some relief to the boredom people experienced in prison, one should note that people are only paid about 0,75 Euro per hour.

There is a whole list of possible sanctions against drug users or dealers. However, the new directive (see part one Ministerial Circular-letter on 'Drugs and prison') seems to make a clear difference between drug users and drug dealers. In case of drug use only, no sanction would be pronounced.

One can consider two types of formal sanctions: sanctions by regulation, pronounced by the director, and the consequences on the execution of the condemnation. In addition, there are informal sanctions, applied by the guards. Sanctions include to be placed in isolation cell, limitation of visits.

^z source : Institut scientifique de santé Publique – Louis Pasteur

13.2. AVAILABILITY AND SUPPLY

13.2.a Availability of drugs in prison

Illegal drugs are easily available in prison. The most common products are cannabis, heroine and benzodiazepines. However, anything can be obtained "with money.... you just have to order what you want". With the development of new uses of drugs such as cocaine, amphetamine and ecstasy these are also becoming easily available in prison. The quality of the drugs available in prison is usually comparable with what is found on the black-market in the community, with sometimes, major changes. The cost is about two to three times higher than outside prison, according to availability.

Payment is done by telephone cards, in exchange of other goods, outside by friends or relatives, and if one cannot pay anymore by participation in the traffic or prostitution.

13.2.b Smuggling

Traffic can appear in two ways in detention, individual and organised. In the houses of arrest, individual traffic is more common. In other prisons, pyramidal networks organise the traffic. As in the community the major dealers organise the traffic in prison and do not consume drugs. According to the prison, different ways are used: during visits, after penitentiary leave, through the prison staff, above walls etc.

13.3. CONTEXTUAL INFORMATION

13.3.a Environment

Most prisons are old and over-populated. In some houses of arrest one can see three detained persons in a cell for one person. Some new prisons have been built in recent years. However, according to inmates these are very inhuman as contacts are most limited.

<p>Regime: <i>Houses of arrest, closed cellular and half-open regimes</i></p> <p>In general, different types of regime can be distinguished according to your advancement in the procedure. <i>Houses of arrest</i>, where over crowding is particularly crucial. Persons are detained 22 hours a day in a closed cell, with most limited access to activities. <i>Closed cellular regime</i>, where detained are entering after their condemnation. There, conditions are usually a bit better. Cells are most of the time open and most inmates have access to work, sport, and cultural activities. There are two half-open prisons specific for drug users, one in Flanders (Merksplats) and one in the French Community (Saint Hubert). Detention conditions are usually better, in a rural environment, with a large access to many activities. It is also in these two prisons that drugs are most easily available, as the population is formed of (ex)-drug users only and smuggling very easy.</p> <p>Psychiatric sections</p> <p>In the past drug addicted were regularly placed in the psychiatric section. Recently, mainly drugs addicted in forced detoxification on entrance are admitted in these sections for one to two weeks. Inmates suffering of both psychosis and drug addiction are also placed in psychiatric sections.</p>	<p>Drug free units</p> <p>There are or have been some experiences of drug free unit or section. Most of them have aborted, due to failure (only drug dealers in the unit, drug of better quality available, traffic of urine samples, increasing consumption of heroine and decreasing consumption of cannabis, lack of human resources).</p> <p>Despite the difficulties to find volunteers, for several years one project is maintained in one semi-open drug free prison in Flanders (Dendermonde).</p> <p>Electronic surveillance</p> <p>A pilot project has been developed and is currently being evaluated.</p>
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<p>Access to work, training and other activities:</p> <p>Boredom is one of the dominant characteristics of life in prison. If access to sport and cultural activities is acceptable, access to work and training is most limited. Many criteria are therefore used to discriminate inmates. Drug users, or even sometimes persons taking prescribed psychotropic medicines have lower access to work. Persons who are HIV + or hepatitis C + have no access to work in the kitchen.</p> <p>Conjugal visiting rooms</p> <p>Since 1999, conjugal visiting rooms are allowed in prisons, and almost all prisons have established a space reserved for accommodating visits from a partner. Before, sexual relationship between inmates and visitors were common in the visitor rooms in the middle of other families. In many places, these isolated rooms are also used to meet in a more private manner, children.</p> <p>Relationship into the prison</p> <p>The main dimensions of life in prison are violence, boredom, drugs and prescribed tranquillisers.</p> <p>Between inmates</p> <p>Several criteria are the basis for alliance inside the prison, the use of a certain type of drug, the geographic origin and the ethnic origin. To be part of a group seems necessary. Many drug users know each other from outside when coming from the same area. There is no special tension between drug users and non drug users.</p>	<p>Between guards and drug users</p> <p>It seems that there are no general rules, but the attitudes of the guards depend much of their individual perception of drug consumption and drug users. There is an obvious tolerance for cannabis consumption perceived as a mean to decrease the tension in the sections.</p> <p>Violence</p> <p>Violence is the major problem met in prisons. Violence against one self, such as overdoses and suicides, violence between drug users about access to drugs, peer pressures on ex-drug users or on non drug users sharing the same cell, violence linked to traffic and debts. Violence can take different forms, robbery, physical violence, blackmailing, and pressure on outside relatives, less frequently sexual violence. Violence against staff is mainly verbal. It is more common with drug users in craving at the beginning of detention. Aggressive behaviours are also more frequently seen with the increase consumption of "uppers" such as cocaine or amphetamines.</p> <p>Sexual abuse</p> <p>It is most difficult to obtain information regarding sexual abuse.</p>
<p>Organisation of health care:</p> <p>Both preventive and curative health cares are under the responsibility of the Ministry of Justice. In theory, health care should be similar to services offer in the community. However in practice this is far from being the case, especially concerning treatment for drug users and gynaecology.</p> <p>During their detention, prisoners loose the general health insurance coverage.</p> <p>The medical doctor of the detained person is the doctor of the prison. Detained persons can ask to meet another medical doctor coming from outside the prison. However, if a detained person calls an external medical doctor, he must cover himself the costs for this intervention. As sole responsible for the treatment, the medical doctor of the prison is free to change the treatment prescribed by another MD. Medical Doctors in prison do not follow any specific training. A new plan is under development. According to the project access to external doctor will be even more limited.</p> <p>Some confusion exists concerning the exact role of the prison medical doctor as he is also requested to follow detained persons isolated in disciplinary cell etc.</p> <p>There are two general hospitals in prison, one in the Flemish Region and one in Brussels. The hospital in Brussels (CMC – Saint Gilles) is hosted in an old and in poor condition building. When the services of a specialised hospital are required, the people are transferred to an external clinic.</p> <p>Only nurses working in large and medium size prisons are civil servants. Other health staffs (medical doctors, specialists, gynaecologists) have a contract with the administration.</p>	<p>A quota of health services by speciality is established for each prison by the Central Medical service of the General Direction of the penitentiary establishments.</p> <p>Prevention activities, health promotion activities are usually undertaken by external organisations.</p> <p>In 1999, prisons have been re-equipped with new dentistry and sterilisation equipment according to current standards.</p> <p>A computerised system (EPICURE) has been developed to manage medical files of the detained persons. As a rule, prison director and non-medical staff has no access to these files.</p>

13.4. DEMAND REDUCTION POLICY IN PRISON

In December 2000, a ministerial circular letter was issued concerning the management of drug issues in prison. This directive has three main components. The first one, and priority one, concerns the control of deal, the second one the medical and psychosocial assistance to drug addicted persons including the role of external services and the third one the implementation of new penitentiary policy.

13.4.a Drug users need assessment in prison

Each detained person entering in prison is seen within 24– 48 hours by a medical doctor, for a clinical examination. If a drug user was under treatment outside the prison, his/her treatment centre can be contacted. An HIV test is only recommended for persons identified by the doctor as belonging to a risk group. This test usually does not entail pre- or post-counselling. Often, prisoners only receive the results if their test is positive. The results are passed on no later than fifteen days after the test. The test is voluntary. The prisoner does not fill in a form to give his written consent. As a rule, the test results are confidential. The procedure for Hepatitis screening is identical to that for HIV.

13.4.b Organisation of drugs services in prison

According to the new circular letter, prisons must collaborate as much as possible with external services for drug users to implement within the penitentiary establishment prevention and therapeutic activities both collective and individual. In each local steering committee there are representatives from one or two external drugs services also active in the prison. In most prison NGOs are present, however, often this presence is usually punctual.

The main policy in terms of treatment to drug users is detoxification, possibly with the assistance of medications. Continuation of maintenance treatment is recommended in the cases of pregnant women, short-term detention and persons positive for HIV or hepatitis. When a person is transferred to another prison for a short time, maintenance treatment must continued. Usually, no substitution treatments are initiated in prison. In addition to the possible damage for the health of the concerned persons, this situation is in complete contradiction with health policy within the community where a wide access to methadone through low threshold services is one of the main priorities.

Drug users have access to external specialised services. However, if the treatment entails a medical prescription, the prison medical doctor decides if this is appropriate or not. Because most medical doctors in prison have little training on treatment to drug users, because they fear overdoses and judiciary pursuits in this case, they are usually most reluctant to prescribe methadone.

HIV-positive prisoners undergo a check-up and regular follow-ups by the medical service of the penitentiary administration. Infected persons with a satisfactory CD4 count receive no treatment or particular diet. Other infected persons and/or AIDS patients have access to screening therapy. If any complications arise that go beyond the capacities of the prison's medical service, the patient may be transferred to a referral university clinic.

13.4.c Preparation for release:

There is no specific pre-release intervention implemented in prisons in Belgium.

When released, AIDS treated patients receive medications for three weeks and are refer to an external service.

Before release, maintenance treatment can be initiated, in close collaboration with external services for drug users.

13.4.d Harm reduction and prevention

- Education, information material developed for outside prison can be distributed in prisons. In some prison, when entering, the detainees receive a package including several information materials on HIV, hepatitis, tuberculosis and harm reduction linked to drug use. However, there is no strategy on informing prisoners of STDs and drug consumption. Activities of this type may exist in certain institutions under the supervision of an external NGO.. The availability of information material depends on each individual prison and its medical service and/or on the possible presence of an NGO specialised in AIDS prevention.
- Specific information material on AIDS and hepatitis prevention for drug users in prison has been developed by NGOs in co-ordination with health services of the penitentiary administration of Ministry of Justice and has been widely distributed in prisons^{aa}. A second edition has been developed, in 2000 including a specific chapter for women. This version has been translated in Flemish.
- Condoms are available in all prison canteens. In practice, the canteens do not have their own stocks but have to procure them on demand at the local pharmacy. This expensive and hardly discreet mode of distribution actually limits accessibility. In some prisons condoms may be available in the infirmary. A lubricant is rarely available. In 2000 a specific condom for prison has been developed. Each packaging is composed of one condom and one attached dose of lubricant. Different ways of distributing have been studied according to each prison. These are available in medical services, in social services and in rooms for conjugal visits.
- Bleach is available in some prisons only for cleaning the cells.
- There is no needle exchange programme in prison.
- There is a project to provide vaccination against hepatitis B to IV drug users. The Ministry of Health – Institut supérieur d'hygiène, is developing a protocol for vaccination and for treatment of hepatitis C. Currently some detainees have already been vaccinated.
- Prison nurses have been trained on HIV, and hepatitis prevention.
- In few prisons, there are also specific in-service training sessions organised for guards on harm reduction. However these activities are quite limited.

13.4.e Evaluation of drug users treatments in prison

No evaluations of treatment for drug users in prison have been published, except for drug free units. It is commonly admitted that treatment for drug users in prison is of poorer quality than outside prison. On one hand the offer for treatment is much lower in terms of different types of services available. Secondly, the prison environment is probably not a suitable environment for treatment of drug users, many of them having experienced drugs for the first time in prison.

In one prison (St Gilles) a specific section has been established for detainees entering the prison for the first time, the "section primaire". This section has recently been evaluated, through a questionnaire filled in by the inmates in this section. This evaluation showed that persons admitted in this section are most interested in having access to training activities and the lowest interest for access to "therapeutic" activities or services. The participation rate in this survey was 50% only.

13.4.f Methodological issues

Several needs in terms of monitoring and evaluations have been identified.

- A project for the implementation of a drug and risks monitoring system in prison has been developed, but has not yet been tested nor implemented.
- Treatments are not evaluated.
- There is a need to develop and evaluate pilot projects for access to chlorine or to needles.

The new directive should be evaluated. It is currently too early to see any changes in the prisons themselves.

^{aa} "Vogue la Galère" Modus Vivendi Question santé 1998.

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Arbeitsgemeinschaft für Suchtvorbeugung und Lebensbewältigung (ASL)

<http://www.asl-eupen.purespace.de/vorbeugungsmodell.htm>

Centre d'Enseignement et de Recherche en Education pour la Santé

<http://www.ste.fapse.ulg.ac.be/STE/Ceres/Pages/fceres.htm>

De Sleutel

<http://www.desleutel.org>

European Institutions

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Moniteur Belge, Belgisch Staatsblad

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Prospective Jeunesse

<http://www.prospective-jeunesse.be>

Sesame

<http://www.sesame.be/>

Université Libre de Bruxelles (ULB)

<http://www.ulb.ac.be>

Université de Liège

<http://www.ulg.ac.be>

ULB Unité de Promotion Education Santé

<http://www.ulb.ac.be/esp/promes/sommaire.html>

Vereniging voor Alcohol- en andere Drugproblemen

<http://www.vad.be>



*Scientific Institute of Public Health
Unit of Epidemiology*



ASL



Deutschsprachige
Gemeinschaft

EUROTOX



Communauté
française

CTB-ODB



Région
Bruxelles-Capitale
Brussels Hoofdstedelijk
Gewest

VAD



Vlaamse
Gemeenschap

BELGIAN NATIONAL REPORT ON DRUGS 2001

ANNEXES

ANNEX 1 : DRUG MONITORING SYSTEMS AND SOURCES OF INFORMATION

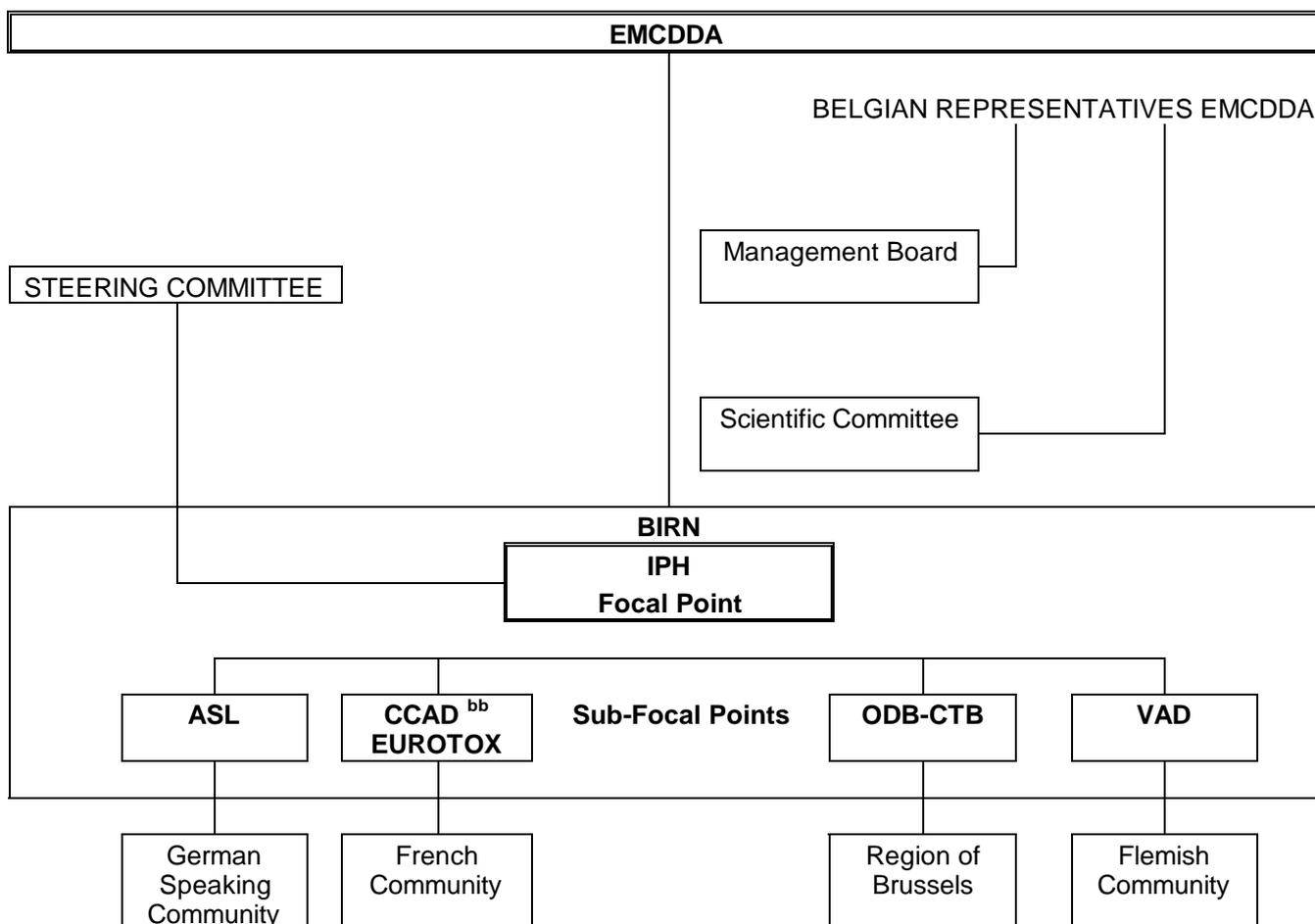
Description of the Belgian National Focal Point and partners

The Belgian Information Reitox Network (BIRN) was created in 1995 and links the **National Focal Point (FP)** with the Sub-Focal, umbrella organisations for a region or community specialised in drug matters. The Focal Point is the direct link between the EMCDDA and the BIRN.

The **Belgian Information REITOX Network (BIRN)** BIRN members meet almost every month. **Expert working groups** (reference groups) on the key indicators, on demand reduction and on the Early Warning System meet regularly.

A **Steering Committee**, meeting at least once a year, ensures the follow-up of the REITOX network activities. Representatives of the administrations and ministers from different governmental levels (federal, regional and community), as well as the Belgian representatives in the Management Board and Scientific Committee of the EMCDDA are members of this steering committee. Exchange of information between Focal Point and member of the Management Board is regular, such as for instance before and after EMCDDA meetings.

A member of the BIRN participates in the meetings of the group Epidemiology of the **Pompidou Group**.



The Focal Point : organisation, structure and budget

The Focal Point is located at the Scientific Institute of Public Health (I.P.H.), formerly Institute of Hygiene and Epidemiology. It is the scientific research institute of the ministry of Social Affairs, Public

^{bb} CCAD : up to 31/08/2000 and EUROTOX : from 01/09/2000

Health and the Environment. The Focal Point is funded and managed in collaboration with the Communities and the federal ministries.

The Focal Point's mission is to respond to queries from EMCDDA, to collect and synthesise epidemiological data on the drug problem, to participate in activities of the BIRN, and to ensure dissemination of information both between the Belgian partners, and between these partners and the EMCDDA.

In 1999, the budget of the Focal Point is 5.6 million BEF (140,000 EURO). The whole of this amount comes from the Flemish and French Communities. A financial support is also available from EMCDDA (shared between the Focal Point and the SubFocal Points for the completion of some core tasks). A feasibility on the transformation of the Belgian Focal Point in a Belgian Monitoring Centre is supported by the Federal Ministry of Public Health.

THE SUB-FOCAL POINTS

Vereniging voor Alcohol en andere Drugproblemen - **VAD**

The VAD (Association for Alcohol and other Drug Problems) was established in 1982 and is active in the Flemish Community (5,9 million inhabitants in Flanders and around 0.2 million Flemish in Brussels).

Objectives

The goals of the VAD are

- the study, the prevention and treatment of problems related to alcohol and other drug use through:
- the organisation of training
- the organisation of discussion platforms and networks
- the co-ordination and support of existing and innovative initiatives in the field of study, prevention and treatment
- the organisation of a telephone help line
- the collection of data.

Structure and organisation

The VAD is a non-profit organisation grouping 47 member organisations which have preventive and curative goals. The members constitute the General Assembly which designates a Committee of Directors. The members of this Committee of Directors designate a Management Committee and allocate the responsibilities. The daily operations of the VAD are carried out by staff under the supervision of a director.

Financing and budget

The VAD is an official institution within the Flemish Institute for the Promotion of Health. As such, for 1998, it received a fixed subsidy of 20 million BEF (500,000 EURO). In addition to this basic subsidy, the VAD receives subsidies for the preparation and implementation of specific projects, which are often short-term. For European projects, VAD receives funds from EMCDDA through the BIRN.

External relations and collaborations

As the Flemish Sub-Focal Point, together with the Focal Point and the other SubFocal Points, it is part of the Belgian Information Reitox Network (BIRN), and ensures that its engagements with the European Monitoring Centre for Drugs and Drug Addiction in Lisbon, are honoured. There is active participation with the Pompidou Group, with the European Drug Prevention Week and with WHO.

Comité de Concertation sur l'Alcool et les autres Drogues - **CCAD**

The CCAD (Consultation committee for alcohol and other drugs) was created in 1978 and was given a Community character in 1980. Its jurisdiction covers the French Community (3.3 million inhabitants in Wallonia and 0.8 million French-speaking inhabitants in Brussels). It was charged to act as Sub-Focal Point of the French Community up to August 2000.

Objectives

The goals of the CCAD regarding prevention are:

- to co-ordinate groups and/or persons involved in problems connected with the abuse of alcohol and other drugs
- to make available pedagogical modules adapted to the various target populations (in collaboration with community departments specialised in communication and methodology) and to advise them concerning the most suitable pedagogical material
- if necessary, to create or organise the creation of this material
- to collaborate with the 'Data bank Department' and the 'Documentation Department' of the French Community to gather and distribute specialised data and documents
- to collect data and to create a database about treatment demands.

Structure and organisation

The CCAD is a non-profit organisation. It is composed of three departments:

- the Community Department for Prevention provides assistance in methodology, assures the development and adaptation of material for prevention and organises Community-wide awareness and information campaigns;
- the Centre for Documentation and its Library distributes specialised information: books and collections of specialist reviews on the topic of addiction, as well as international reports (EU, Council of Europe, WHO, EMCDDA, etc.), press review on alcohol and drugs and a quarterly information letter with a bibliography of new acquisitions;
- the Permanent Unit for Sanitary and Social Observation of Alcohol and Drug Problems gathers epidemiological data in the field of drug addiction in general, and data relative to the monitoring of the "first treatment demand and treatment demand" indicators.

Financing and budget

The CCAD is funded on the basis of Decrees of the Government of the French Community (annual funding : 7.5 million BEF (187,500 EURO)). Its mission has Sub-focal Point of the French Community stopped on 31/08/2000. For European projects, CCAD receives funds from EMCDDA through the BIRN (up to 31/08/2000).

External relations and collaborations

Collaboration is pursued at all levels with specialised institutions and departments, practitioners and research teams, locally, at a Regional and Community level, as well throughout Europe and internationally. There is participation in the activities of the EU, the Pompidou Group, the WHO, etc. CCAD is the French Community's Sub-Focal Point for the Belgian Information REITOX Network (BIRN) of the EMCDDA in Lisbon.

EUROTOX -EUROTOX

EUROTOX was established in 1990 and regroups three organisations active in different fields linked to drug use:

- Infor-Drogues telephone help line, prevention, and outpatient treatment
- Modus Vivendi : AIDS prevention, harm reduction, training, liaison and research
- Prospective Jeunesse: prevention, training and assistance.

Objectives

The specific objectives of Eurotox are :

- to carry out research projects in the field of drug use
- to organise conferences, seminars
- to observe drug use phenomenon in the French Community of Belgium.

Structure and Organisation

Eurotox is a non profit organisation. Its General Assembly and Executive Board is composed of representatives of the three organisations, InforDrogues, Modus Vvendi and Prospective Jeunesse.

Financing and budget

In addition to the funds in each of the members association, current funding level of Eurotox is 5,5 million BEF (137 500 EURO) a year.

External relations and collaborations

Since September 2000, Eurotox is part of the BIRN, as SubFocal Point for the French Community of Belgium.

Concertation Toxicomanies Bruxelles- Overleg Druggebruik Brussel - CTB-ODB

The CTB-ODB (the Brussels Drug Addiction Programme) was set up by a ministerial Decree of 15 September 1994. The programme covers the Brussels-Capital Region which is made up of 19 urban municipalities, representing a population of almost one million inhabitants.

Objectives

The Brussels Drug Programme, with an emphasis on reducing demand, brings together those involved in helping drug addicts in prison, treatment centres, crisis centres and short stay centres, hospital centres, 24-hour hot-line services, prevention, mental health care centres, assistance, rehabilitation, day centres and ambulatory care.

Two objectives of CTB/ODB deal with external collaborations (with the various authorities in Belgium and with international collaborators).

Structure and organisation

A co-ordinator has been engaged by the association to implement the programme; he is assisted by a part-time secretary. The co-ordinator regularly reports to a Steering Committee made up of representatives of the associations, of the competent ministers, of the "Concertation and Co-ordination Committee" (see below) and of observers representing the Minister-President of the Region and the ministers competent for Assistance to persons. The Concertation and Co-ordination Committee is made up of experts from the field (social and medical), as well as lawyers, delegates from the Justice Department, from the Public Prosecutor's office, and the federal and local police forces.

Financing and budget

The programme's budget is established annually. The amount for the first year was 5 million BEF (125,000 EURO), and for the current year 6 million BEF (150,000 EURO). A part of this amount helps to fulfil European obligations. Additional support from EMCDDA through the BIRN is available for specific EMCDDA core-tasks.

Arbeitsgemeinschaft für Suchtvorbeugung und Lebensbewältigung - ASL
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The ASL (Association for drug use prevention and for a better quality of life) is an autonomous NGO since 1997 (it was part of the Centre for Mental Health since 1980), and officially recognised by the Government of the German-speaking Community. The care activity of the ASL extends to the 70,000 inhabitants of the nine municipalities of the German-speaking Community of Belgium.

Objectives

The ASL is responsible for drug use primary prevention in the German-speaking Community. It is also partially involved in secondary prevention. The goals of the ASL are to make the entire population aware of the dangers of addiction of all kinds and to improve the quality of life. It encourages healthy activities for the well being of the population and co-ordinates current activities. With regard to its area of responsibility, the ASL makes efforts in order to establish a dynamic relationship with the political decision makers in the German-speaking Community.

The ASL, in its role as co-ordination institution within the German-speaking Community in Belgium, is responsible for co-ordinating the registration of statistical data, including the record of the first treatment demand.

Structure and Organisation

The ASL is mainly made up of voluntary workers. At every level of society, there is a team of workers developing and co-ordinating the prevention effort. All the teams are co-ordinated by a central co-ordination team. In recent years, the ASL has concentrated its activities at the level of the municipality. It aims to create a working group in each municipality which will bring together, in the heart of the municipality, all those people who are interested in active prevention.

The prevention model developed by ASL was evaluated by a group of experts (University of Fribourg, Switzerland) in 1997: it was certified effective and consistent through its global and community approach.

Financing and budget

The ASL is subsidised by the government of the German-speaking Community. It receives the amount of 4.7 million BEF (120,000 EURO) to cover staff and operating costs. The staff consist of a full-time co-ordinator, a therapist in drug addiction, and several secretaries (70 hours per week). Additional support from EMCDDA through the BIRN is available for specific EMCDDA coretasks.

External relations and collaborations

It is part of the Belgian Information REITOX Network.

The ASL collaborates with partners in eleven West and East European countries. The objective is to adopt a long term, global community approach to preventive actions in the municipalities of these countries. This project is supported by the EU.

Belgian Information REITOX Network : Structure

FOCAL POINT

IPH - ISP – WIV

Scientific Institute of Public Health
 Institut Scientifique de la Santé Publique
 Wetenschappelijk Instituut Volksgezondheid
 Rue J. Wytsmanstraat, 14
 B - 1050 BRUSSELS

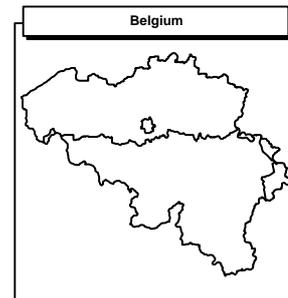
Responsible : Denise WALCKIERS

Scientific collaborators : Edith LEUS, Emmanuelle ROBERT, Francis SARTOR, Sandrine SLEIMAN/ Administrative collaborator : Sheila GOYENS

Tel : 32-2/642.50 35; Fax : 32-2/642.54.10

e-mail : BI RN@iph.fgov.be

Web site : <http://www.iph.fgov.be/reitox>



SUB-FOCAL POINTS

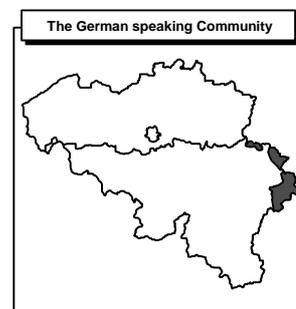
ASL :

Arbeitsgemeinschaft für Suchtvorbeugung
 und Lebensbewältigung
 Klosterstrasse, 3
 B - 4700 EUPEN

Responsible : Norbert GENSTERBLUM

Tel. : 32-87/74.36.77; Fax : 32-87/74.04.72

e-mail : ASL@skynet.be



CTB / ODB :

Concertation Toxicomanies Bruxelles
 Overleg Druggebruik Brussel
 Rue du Champ de Mars, 25/6
 Marsveldstraat
 B - 1050 BRUXELLES-BRUSSEL

Responsible : Mark VANDERVEKEN

Tel : 32-2/289.09.60; Fax : 32-2/512.38.18.

e-mail : CTB.ODB@beon.be

EUROTOX : (from 01.09.2000)

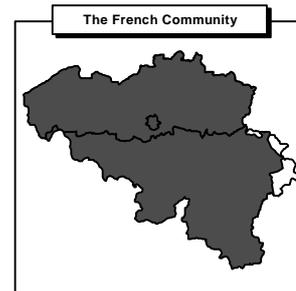
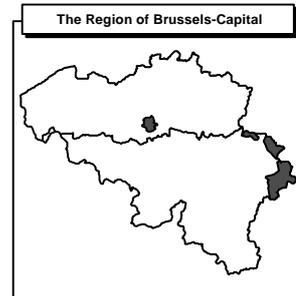
(Com.française)
 Rue de Haerne, 51
 B - 1040 BRUXELLES

Responsible : Fabienne HARIGA

Tel. : 32-2/644.22.00

Fax : 32-2/644.21.81

e-mail : Eurotox@skynet.be



VAD :

Vereniging voor Alcohol- en andere
 Drugproblemen
 Tollenaerstraat, 15
 B - 1020 BRUSSEL

Responsible : Fred LAUDENS

Tel : 32-2/423.03.54; Fax : 32-2/423.03.34

e-mail : bevraging@VAD.be



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ANNEX 4 : LIST OF ABBREVIATIONS

APSD/SGAP	Algemene Politie steundienst / Service Général d'Appui Policier
ALTO	Alternatives aux Toxicomanies
ASBL	Association Sans But Lucratif (non-profit organisation)
ASL	Arbeitsgemeinschaft für Suchtvorbeugung und Lebensbewältigung
AVAT	Aide Vervietoise aux Alcooliques et Toxicomanes
BCR/CBO	Bureau Central de Recherche- Programme Drogue / Centraal Bureau voor Opsporing – Programma Drugs / Central investigation office – Drug programme
CAD	Centrum voor Alcohol- en andere Drugproblemen (Hasselt)
CAPA	Centre d'Actions de Prévention des Assuétudes
CAT	Centrum voor studie, behandeling en preventie van Alcoholisme en andere Toxicomanieën (Ghent)
CBO/ BCR	Centraal Bureau voor Opsporing – Programma Drugs / Bureau Central de Recherche- Programme Drogue / Central investigation office – Drug programme
CCAD	Comité de Concertation sur l'Alcool et les autres Drogues
CCLA	Citoyen Comme Les Autres
CGG	Centrum voor Geestelijke Gezondheidszorg
CIC	CrisisInterventieCentrum
COCOF	Commission Communautaire Française (<i>Communauté française à Bruxelles</i>)
CPAS/OCMW	Centre Public d'Aide Sociale / Openbaar Centrum voor Maatschappelijk Welzijn
CTB/ODB	Concertation Toxicomanies Bruxelles / Overleg Druggebruik Brussel
CFWB	Communauté française Wallonie Bruxelles
DWTC/SSTC	Federal Diensten voor Wetenschappelijke, Technische en Culturele aangelegenheden / Services fédéraux des affaires Scientifiques, Techniques et Culturelles
EDDRA	Exchange On Drug Demand Reduction Action
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
FNRS	Fonds National de Recherche Scientifique
GEMT	Groupe d'Etude des Maladies liées à la Toxicomanie
GERRMM	Groupe d'Etude pour une Réforme de la Médecine Rhin-Meuse
HBSC	Health Behaviour in School-aged Children
INAMI/RIZIV	Institut National d'Assurance Maladie-Invalidité/Rijks Instituut voor Ziekte- en Invaliditeitsverzekering
IPH/ISP/WIV	Scientific Institute of Public Health/ Institut Scientifique de la Santé Publique/ Wetenschappelijk Instituut Volksgezondheid
ISP/WIV/IPH	Institut Scientifique de la Santé Publique/Wetenschappelijk Instituut Volksgezondheid/ Scientific Institute of Public Health
IVDU	Intra-Venous Drug Use
IVDUs	Intra-Venous Drug Users
LOGO	Loco-regionaal-Gezondheidsoverlegen Organisatie (Flemish Community)
MASS/MSOC	Maison d'Accueil Socio-Sanitaire / Medisch-Sociale Opvang Centra
MKG/RCM	Minimale Klinisch Gegevens / Résumé Clinique Minimal
MPG/RPM	Minimale Psychiatrische Gegevens / Résumé psychiatrique Minimal
MSOC/MASS	Medisch-Sociale Opvang Centra / Maisons d'Accueil Socio-Sanitaire
OCMW/CPAS	Openbaar Centrum voor Maatschappelijk Welzijn / Centre Public d'Aide Sociale
OCRTIS	Central Office for the Repression of Illicit Narcotics Trafficking
PZ	Psychiatrisch Ziekenhuis
PPP	Provinciale Preventieplatforms (<i>Flemish Community</i>)
PAAZ	Psychiatrische Afdeling van een Algemeen Ziekenhuis
RCM/MKG	Résumé Clinique Minimum / Minimale Klinisch Gegevens

REITOX	Réseau Européen d'Information sur les drogues et Toxicomanies / European information network on drugs and drug addictions
RIZIV/INAMI	Rijksinstituut voor Ziekte- en Invaliditeitsverzekering/Institut National d'Assurance Maladie-Invalidité
RPM/MPG	Résumé Psychiatrique Minimum / Minimale Psychiatrische Gegevens
SGAP/APSD	Service Général d'Appui Policier / Algemene Politie steundienst
SODA	Stedelijk Overleg Drugs – Antwerpen
SPZ	Sozial Psychologisches Zentrum
SSTC/DWTC	Services fédéraux des affaires scientifiques, techniques et culturelles / Federal diensten voor wetenschappelijke, technische en culturele aangelegenheden
TG	Therapeutische Gemeenschap
TIMC	Toxicomanies et Interventions en Milieu Carcéral
ULB	Université Libre de Bruxelles
UNDCP	United Nations International Drug Control Programme
UG	Universiteit Gent
ULG	Université de Liège
VAD	Vereniging voor Alcohol en andere Drugproblemen
VIG	Vlaamse Instituut voor Gezondheidspromotie
VLOR	Vlaamse Onderwijs Raad (Flemish Community)
VRM	Vlaamse Registratie Middelengebruik
VSPF	Vast Secretariaat voor het Preventiebeleid / Secrétariat Permanent à la Politique de Prévention
VAD	Vereniging voor Alcohol en andere Drug problemen
VVBV	Vlaamse Vereniging voor Behandelingscentra in de Verslaafdenzorg
VZW	Vereniging Zonder Winstoogmerk (non-profit organisation)
WIV/ISP/IPH	Wetenschappelijk Instituut Volksgezondheid/ Institut Scientifique de la Santé Publique// Scientific Institute of Public Health

B I R N P A R T N E R S

IPH

Scientific Institute of Public Health, rue J. Wytsmanstraat, 14, 1050 BRUSSELS

Responsible : Denise WALCKI ERS

Scientific collaborators : Edith LEUS, Emmanuelle ROBERT, Francis SARTOR, Sandrine SLEIMAN

Administrative collaborator : Sheila GOYENS

Tel : 32-2/642.50 35 - Fax : 32-2/642.54.10

e-mail : BI RN@iph.fgov.be

Web site : <http://www.iph.fgov.be/reitox>

ASL

Arbeitsgemeinschaft für Suchtvorbeugung und Lebensbewältigung

Klosterstrasse, 3, 4700 EUPEN

Responsible : Norbert GENSTERBLUM

Tel. : 32-87/74.36.77 - Fax : 32-87/74.04.72

e-mail : ASL@skynet.be

CTB / ODB

Concertation Toxicomanies Bruxelles / Overleg Druggebruik Brussel

Quai du Commerce, 7, Handelskaai, 1000 BRUXELLES-BRUSSEL

Responsible : Mark VANDERVEKEN

Tel : 32-2/289.09.60; Fax : 32-2/512.38.18.

e-mail : CTB.ODB@beon.be

EUROTOX

Rue de Haerne, 51, B - 1040 BRUXELLES

Responsible : Fabienne HARI GA

Tel. : 32-2/644.22.00 - Fax : 32-2/644.21.81

e-mail : Eurotox@skynet.be

VAD

Vereniging voor Alcohol- en andere Drugproblemen

Tollenaerestraat, 15, 1020 BRUSSEL

Responsible : Fred LAUDENS

Tel : 32-2/423.03.54 - Fax : 32-2/423.03.34

e-mail : onderzoek@VAD.be