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Unit of Epidemiology

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BELGIAN NATIONAL REPORT ON DRUGS 2000

Extended version

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BELGIAN NATIONAL REPORT ON DRUGS 2000

SUMMARY

The Belgian National Report 2000 is divided in 4 Parts. The Part I deals with policy and legislation (Chapter 1) ; the Part II give an overview of the epidemiological situation (Ch. 2 to 7); the Part III is related to demand reduction interventions (Ch. 8 to 11) and the Part IV presents more in depth information on national policy and strategy (Chapter 12), cocaine (Ch. 13) and infectious diseases (Ch. 14). Various annexes, list of abbreviations and bibliography are listed at the end of the report.

In 2000, an inter-ministerial working group has been set up in order to define a new drug policy. The group is co-ordinated by the Minister of Public Health and involves directly the Ministers of Justice and of Internal Affairs, closely collaborating with Ministers of Community and Region governments involved in the drug issue. The new drug will be soon presented to the parliament.

GLOBAL APPROACH, LEGISLATION AND POLICIES

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.

Without changing the law, a directive/circular (1998) modifies the action of the judicial authorities. For the first time, a distinction is 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.

The supply, the sale and the delivery of materials with the aim to prevent infectious diseases (it means e.a. the implementation of 'needle exchange' programmes) was made possible by a new law (1998).

The obligations proceeding from the UN 1971 convention on psychotropic substances (regarding Table III and IV, including e.a. benzodiazepins, meprobamate, MDMA, MBDB, barbiturics) were completely integrated in the national legislation in 1998.

In 1999 the law related to road traffic was modified extending the list of substances concerned from alcohol to other psychoactive substances that could influence driving skills (THC, amphetamines, MDMA, MDEA, MDBD, cocaine…).

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.

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 and the Ministry of Social Affairs and Public Health, 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), 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[a] 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) 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,….

Since drugs are high on the agenda in the media and political arena, the general public requests more information about various issues.

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.

In general the data quality of the school surveys is good. Most of them 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 team 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

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.

1998 [9]. In the French Community, the trends of the behaviour of youngsters from 1986 to 1994 (and 1998) have been analysed and published [10]. A very large survey aiming to evaluate drug policy at school was conducted in 1999 in the Flemish Community [11].

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.

Information on the situation of drug use in the general adult population is partial but developing : since 1996, a CATI health monitoring survey [7] has been started in the French Community (including questions on cannabis and cocaine) whereas a CATI survey was conducted in Flanders in 1995 [6]. The 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 (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, … No cohort research has been carried out.

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 (hospital data, mortality data, pharmacological data, judicial data,..). The data on deaths related to drug use from the National Institute of Statistics are still olddated 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 demand [33,34,35]. One observes a progressive harmonisation [32] 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 us 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. At Belgian level, several ad hoc working groups based on the experience and skills of the different partners were set up.

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

It can be globally observed that, in 1998-99 around 25% of 15-16 years aged students has tried an illegal substance at least once; the frequency of use increases with age reaching its maximum figure (around 40%) among 17-18 year old boys having used drug at least once; around 20% of 17-18 aged boys are 'regular' users (use at least one drug during the last month). Cannabis derivatives are the products used most by young people. XTC is the second product used with a slight increasing trend : 1998-99 surveys reported 4-6% of 15-16 year-old students stating at least one use.

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. Among Flemish adults aged 18-65 years (1995 data), 6% stated to have at least once used an illicit drug.

It is quite difficult to estimate (and even to define) the problematic drug use at the moment. A study conducted in 1999 but based on 1995 data estimated the number of intravenous users as 20,200 among the 15-54 years aged (corresponding to a prevalence rate of 3.6/1000).

Anonymous data on 7,958 patients treated in centres participating in the VAD, CCAD and CTB-ODB registration systems were collected : these data were aggregated at national level. In 1996, more than 14,000 stays in general or psychiatric hospitals were connected to problematic drug use.

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 is actually related to a relative decrease of heroin users among all demanders for treatment (and a proportional increase of patients treated for another substance among which cannabis). A street snowball survey conducted in 1998 reports a current injecting rate (at least once during the last 6 months) of 43% of drug users (comparable to 1996). Other studies report global lower figures : of course, the extent of IV route varies largely between groups and subgroups of users and patients.

Intravenous drug use (IVDU) represents 3% of the HIV transmission causes for the period 1998-99 (decreasing trend mainly from 1985 to 1995 and then stable). Some information on prevalence of infectious diseases among drug users are available but should be improved. They could show a decreasing trend of HIV infection among drug users (low prevalence compared to some other European countries as Spain, Italy). In 1998, CCAD and VAD data show a proportion of HIV-seropositive among IVDUs demanding for treatment around 2%. HBC and HCV infections seems stable but at higher levels : respectively 24% (HBC) and 38-52% (HCV) of tested IVDUs (having injected at least once) were infected respectively by hepatitis B or C. However, these studies investigate sometimes different types of users and using different definitions of IVDU making comparisons quite uneasy. Harmonisation is required. Cohorts of drug users should be set up and followed up.

The data on deaths related to drugs from the National Institute of Statistics are delayed and the numbers of overdoses provided by police services are not fully reliable. The police data on arrests and seizures are depending from the resources engaged : nevertheless one observes a three-fold increase (particularly evident for years 1991-1992) of the number of persons taken in for questioning about drug-related affairs : from 3,917 in 1985 to 19,482 in 1993 and then relatively stable). The figures indicates that cannabis is involved in 2/3 of cases (stable for 1995-99). Almost ¾ of cases are related to possession for personal use. Judicial statistics about sentences are not available on a regular basis.

The prices of cannabis and cocaine are stable over the last years. One observed a diminution of the price of heroin and XTC pills between the years 1993-1995. The youngsters state that cannabis is easily available anywhere ; even adults reported a high accessibility to cannabis (65%) and cocaine (40%).

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, etc. Nevertheless reliability of most data remain relatively poor and should be improved in order to take decisions on solid basis.

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 substances circulating and on the various trends in consumption. The Belgian system is integrated in a larger European Joint Action. The issue of pill testing is in discussion but controversed.

CURRENT CONSTRAINTS AND 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.
In general the widening of the treatment network with more attention to low-threshold services and differentiated treatment goals (abstinence, reduction, substitution, maintenance) continued.

On a political level ambiguous signals are launched towards the general public : on the one hand the 1998 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.

Globally, the following constraints were identified :

- Lack of long term strategy and of consultation at political, intermediary and field workers levels

At a political level, Belgium has known many policy papers on drugs in the last few years. Different ministers have made action plans. The federal government has launched a 10-point plan on drugs and the Communities have their own policy statements. However there is no agreement between the different policy papers, nor between the different government levels. The interministerial conference on drugs, which is needed in this complex political structure, has only met once in the last three years.
At the intermediary co-ordination level, there is one co-ordinating agency at the Flemish Community level, one at the French Community, another one in the Brussels Region and a fourth organisation coordinating actions in the German-speaking Community.

Each Flemish province has a provincial prevention forum and at the local level, there are prevention boards in major cities, from a crime prevention perspective. New health promoting structures (LOGO's) are set up at an intermediary level (250.000 - 400.000 inhabitants) to implement the health targets of the Flemish Government. Neither alcohol nor drug abuse are one of the five targets at this moment.

However, there is no structural link in the different regions of the country between the various levels (Community, provinces and local). Communication and co-ordination are based on personal preferences and good will.

One should hope that the works conducted by the Minister of public health will lead to an improved coordination and integration of the various policies.

At the level of field workers, due to the diverse initiatives and the short term contracts in which they take place, there is lack of continuity and as a result, co-ordination between the field workers is too often scattered or absent.

- Over-demand of prevention activities and its consequences

Drug problems are high on the political agenda and as a result, many sectors request prevention activities. Different initiatives are being set up, yet they lack clear aims and there is no structure to continue the project in the long run.

Activities with high visibility are often preferred in order to get funding. Many activities are one-shot activities and there is no co-ordination between them.

The high demands result in huge pressure for prevention workers and field workers. Little by little there is a growing group of well-trained prevention workers although the pressure on their output often prevents them from spending required time in training and improving quality.

Despite the growth of the number of prevention workers over the last couple of years, there is no guarantee for a better outcome, as long as there is a lack of general framework which outlines the long term aims of prevention.

- Limited means dedicated to prevention and demand reduction

The expectations towards prevention are very high, considering the limited outcome of treatment programmes. However, compared to the budgets for treatment, those dedicated to prevention are very small. In addition, most budgets are on a one-year project basis, which, in absence of a long-term strategy, does not provide an efficient prevention.

- ***Lack of harmonisation of the information and need of epidemiological surveillance***

An important effort is urgent in order to obtain harmonised reliable 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 : as access to documentation, trainings, automated production of reports… The various expertises of the field actors are absolutely necessary in the interpretation of the data.

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.

Regarding demand reduction and treatment centres, a lot of interventions and actions were set up but often without any evaluation. Specifically, there is a very important need to evaluate and monitor the practice of (methadone) maintenance and substitution treatment.

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. Harmonised indicators for the evaluation of demand reduction interventions and co-ordination should be implemented and a minimal harmonised data set should be collected.

- ***Lack of evaluation and lack of resources for research***

There is a growing demand of decision makers and also professionals them-selves for evaluation and for evidence-based approach towards prevention and treatment. At present, most attention is given to certain quantitative indicators mainly those indicating the number of activities (process evaluation). Qualitive indicators are also being identified and tools developed to evaluate mainly in the field of prevention.

Several researches and evaluations of policies, treatment facilities, treatment or prevention programmes, research on specific at risk groups (prisoners, youngsters out of school) are currently running. More research is needed into trends in drug use, characteristics of groups of users, 'soft use' and 'hard use', informal control mechanisms, causal factors, effectiveness of repressive measures, direct and indirect costs of drug use,…

In all cases dissemination of results and of experience is crucial as unfortunately there are often not easy access because not officially published or not disseminated (grey literature).

In summary, the PRIORITIES FOR THE FUTURE 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, and particularly the methadone substitution maintenance treatment**
- **to open perspective on alcohol, medicines and illicit drug use as a global problem.**

This report was coordinated and written by Dr Patrick LEURQUIN

in close collaboration with the responsibles 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.

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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.

Belgian Information REITOX Network : Structure

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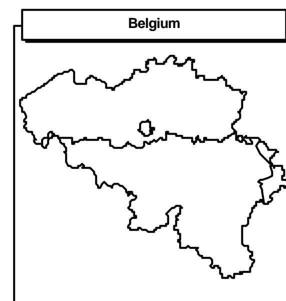

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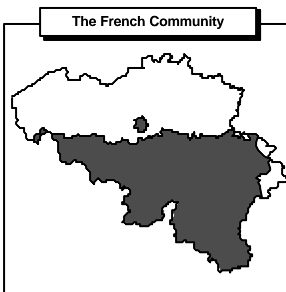

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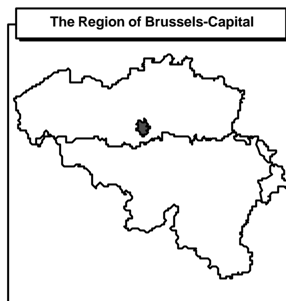

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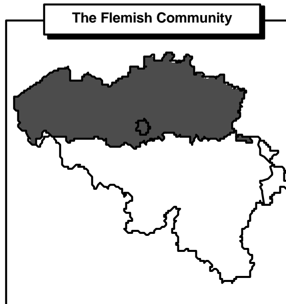

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BELGIAN NATIONAL REPORT ON DRUGS 2000

PART I :

Policies and Strategies

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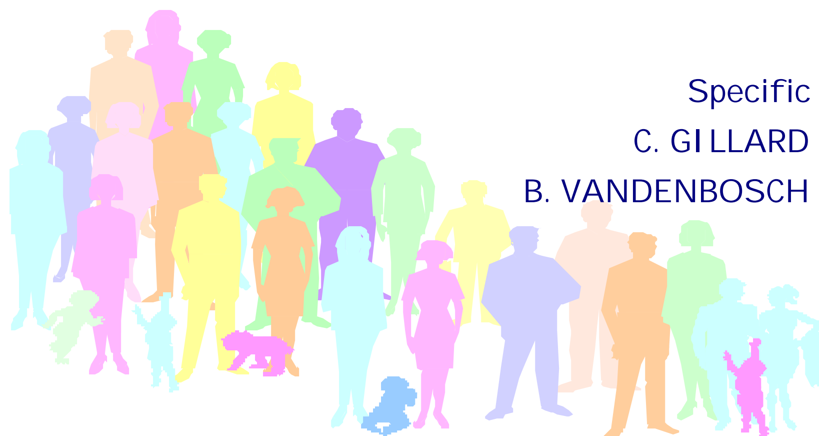

The present Report,

short versions in Dutch and French

and additional information on the activities of the BIRN

are available on demand
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REITOX Belgian Focal Point

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

PART I. **NATIONAL AND LOCAL POLICIES AND STRATEGIES :** INSTITUTIONAL & LEGAL FRAMEWORKS

Chapter 1. Developments in Drug Policy and Responses

1.1. Political framework in the drug field

1.1.1 Summary

In **2000**, an inter-ministerial working group was set up in order to re-design the drug policy in Belgium. The group is coordinated by the federal Minister of Health and involves the federal Ministers of Justice and of Internal Affairs : this group works in close collaboration with Community and Region Ministers. The proposals for a new drug plan will be submitted by the federal government at the end of the year 2000.

At the moment, 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.

Without changing the law, a directive/circular (**1998**) modifies the action of the judicial authorities. For the first time, *a distinction is 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.

The supply, the sale and the delivery of materials with the aim to prevent infectious diseases (it means e.a. *the implementation of 'needle exchange' programmes) was made possible by a new law* (**1998**). The obligations proceeding from the UN 1971 convention on *psychotropic substances (regarding Table III and IV, including e.a. benzodiazepins, meprobamate, MDMA, MBDB, barbiturics) 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.

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. In 1996, medico-social relief centres for illicit drug users were initiated by the federal ministry of Internal Affairs. The focus of treatment has been broadened: not only abstinence

but also harm-reduction and methadone maintenance. In 1999, 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.

1.1.2 Objective and priorities of the national drug policy

1.1.2.1 Brief historical background

Apart from the signing of international treaties, the drug policy was dealt with from a "health care" perspective since the seventies. Specialised therapeutic communities and outpatient centres were set up to deal with problematic drug users, and in a second phase, psychiatric hospitals established drug-specific wards, in addition to their alcohol treatment centres. Out-patient centres for mental health care also deal with illegal drug problems.

The interventions, co-ordination bodies,… were already initiated at the end of the 70ies or later depending on the regions. **Globally the call for demand reduction strategies was heard in the 80ies in a general approach of addiction prevention**.

In the **French Community**, the CCAD co-ordinated the prevention activities since 1978. From September 2000, this task has been given to another organization : EUROTOX. Currently, the drug prevention activities are focused on prevention and harm reduction in the field of "addiction" (alcohol and other drugs) which is developed by several facilities subsidised by the French Community's Health Authorities. Various global or specific programmes and initiatives were set up or supported: ALTO [b] (network of GPs working with drug addicts), a network of organisations taking care of drug addicts in Brussels and Liège, etc…

In the **Flemish Community**, there is a global approach for prevention and to a much lesser extent for treatment (as treatment is mainly financed by the federal government). The Flemish government has organised its policy through a 'covenant' which is signed between the Flemish minister of Health and the co-ordinating agency VAD. VAD is the umbrella organisation that co-ordinates prevention and treatment institutions since 1981.

Specialized umbrella organisations were set up later in the **Brussels Capital Region** and in the German-speaking Community. "Brussels Drug Addiction Concertation" (CTB/ODB) is the Brussels-Capital Region's "drugs" programme. Its object covers the entire drug use problem (demand reduction), which does not prevent concertation with those responsible for the policy for reducing the supply on the territory. The Brussels programme began in October 1992. Recently an eleventh point regarding harm reduction has been added to its programme.

In the **German-speaking Community**, the ASL is an autonomous NGO since 1997. It was part of the Centre for Mental Health since 1980 (the Centre has two sites). 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 of the population.

Since the beginning of the 90ies, drug use became more visible in certain youth cultures. Politics and media reacted firmly. Drugs became high on the political agenda from a variety of perspectives: health perspective, safety and crime prevention, repression, and welfare. Different ministers laid down a policy paper on the drug issue.
Through initiatives of the federal government (ministry of Internal Affairs), local initiatives were set up to tackle the drug problem from a crime prevention perspective. More, efforts were made to extend and broaden the treatment centres as well. Some health professionals (psychologists,..) are paid by

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b ALTO (Alternatives aux Toxicomanies) 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.

the ministry of Justice and integrated in mental health care centres staffs. All this resulted in a diversity of treatment centres with special attention to easy accessibility of new centres.

1.1.2.2 Recent background (1995-1998)

The Belgian political structures required an interministerial conference (around 15 different cabinets) in order to co-ordinate the different departments involved in the drug issue (set up in 1992).

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.

In 1996, a federal parliamentary working group was set up to study the drug problem, in particular the situation of soft drugs. Many experts from the field of prevention, treatment and repression were heard. 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. Penal justice must be an 'ultima ratio' and may only intervene in case of serious societal damage or disturbance; a distinction should be made between the prosecution for possession of cannabis for personal use on the one hand and retail drug trade to provide financial benefits on the other hand. The lowest priority should be given to the prosecution by judicial authorities to possession of cannabis for personal use.

In 1998, according to the decision of the Federal Parliament, a directive/circular modified the action of judicial authorities: a distinction was established between the possession of cannabis and other illegal drugs with non acceptable risk for health, and the access to needle exchange was made possible (the drug law it-self -even regarding cannabis- was not changed). Legislation to define substitution treatment is in preparation at the Federal Parliament.

1.1.2.3 Current objectives and principal components

The proposals of the interministerial working group are expected in November 2000.

In the mean time, the current philosophy can be summarised as follows :

The three main tools of the drug policy are prevention, treatment and repression. Between an approach strictly repressive and a tolerance policy, a third way should exist, called 'normalisation' policy. Meanwhile it doesn't mean that drug use could become normal or usual in our society.

A realistic and modern policy against drugs must fit with the following priorities:

1. The main objective is **to prevent and reduce drug use** and to decrease the number of new drug users.
2. The second priority is **to protect the community** and its members who are facing the drug phenomenon and its consequences. This concerns also the drug addicts who should be helped to guarantee them a better life despite their drug use.
3. It is not possible, nor hoped that the justice is the only way for social regulation. Before the justice works, the drug users should have the possibility **to take up solutions among a large panel of treatment methods**.
4. **It should be avoided that drug users who, apart from possessing drugs, committed no other infringement, get into prison**.
5. The judicial approach, particularly imprisonment, should be the '**ultimum remedium**' in order to deal with problematic use of drug.
6. If we want to adapt the drug policy to the context of the societal evolution, **regular evaluations** of the results of the applied measures are needed.

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.

Meanwhile the **practical enforcement of the legislation** is changing. The crime policy for drug addicts was harmonised by a common directive/circular signed by the attorneys general and the Justice Minister on 26 May 1993. From 8 May 1998 this directive was revised based on the conclusions of a report of a working group of the Federal Parliament adopted on 5 June 1997 (see 1.2). The full text is Annex X.

The law was not changed and the directive only modifies the action of judicial authorities : for the first time (**April 1998**), **a distinction is 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.

The issue of assisted medical deliverance of heroine in Belgium still remains under discussion.

1.1.3 Basic elements of drug policy at national, regional, local level

1.1.3.1 Main 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 and the ministry of Social Affairs and Public Health, and on the other hand at **federate levels** : the communities and regional governments (Flemish, French and German-speaking Communities, Brussels-Capital Region) (see Part IV Key issue).

It is the objective of the interministerial current working group initiated by the Minister of Health in 2000 to re-design the drug policy and to co-ordinate the approaches of the various governments (federal, Communities, Regions) and their ministers.

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 [c]). 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 a obvious willingness to develop diversion to treatment and alternative measures and to make easier the links between the judicial system and the health care system.

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 [d] 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

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c http://www.just.fgov.be/html/nb2.htm in Dutch or http://www.just.fgov.be/html/fb2.htm in French.

d 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.

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 Drug problemen) 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. This study includes an evaluation of the BIRN activities and gives recommendations for the transformation [1].

1.1.3.2 Main outlines of the drug policy

Given the federal structure of Belgium, there are several policies in relation to the drug problems, according to the competency of each different levels. Different departments have their own policy papers and documents. As a result, different approaches may be dealing with the drug problem in different sectors and geographical areas. On the other hand, depending on the perspective, different philosophies are being held.
As a whole, there is room for prevention, harm reduction, treatment and repression.

Globally the interventions are coming from :
- health services : treatment in in-patient and out-patient centres. 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;
- outreach work : it is being used as a methodology to reach drug users in their own setting. This group of workers fit in many different projects and sectors, although they are not yet recognised as an independent sector;
- social services : they claim a larger role in the approach of drug problems. Not only the medical or health perspective, but a holistic approach towards the drug users and their problems is getting more attention;
- prevention activities which are being set up within the context of socio-cultural organisations, local communities, etc;
- prevention programmes conducted in education. Primary and especially secondary schools are most popular. Most programmes are directed at teachers and other workers of the education community, who fulfil a role as prevention workers towards young people. There is a growing tendency for primary schools to implement drug prevention programmes.
- other sectors in which prevention programmes are being introduced: the workplace, youth work, leisure time sector, welfare sector...
- police and justice system (prisons) fulfilling their role in repression. Prevention is another function of the police force.

PREVENTION receives a growing attention in Belgium. At federal level, the policy from Internal Affairs is embedded in a crime prevention philosophy. A financial framework to subsidise the municipalities with a high(er) criminality rate was created. These municipalities have to set up projects. Among these, drug projects are set up in a context of crime prevention. These projects are both 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. A lot of organisations and municipalities have developed prevention, harm-reduction and/or care and cure activities in different fields: workplaces, youth organisations, schools, peer groups, leisure time.

In Belgium, TREATMENT of drug addiction is offered in three types of services :
- inpatient centres (psychiatric centres, therapeutic communities, crisis intervention centres)

- outpatient centres (centres for mental health care, day care centres, medico-social care centres)
- general care (GPs, welfare organisations, etc.).

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.

In 1996, medico-social relief centres for illicit drug users (MASS/MSOC) were initiated by the federal ministry of Internal Affairs. These 8 active centres are low threshold services and are located in Antwerp, Brussels, Charleroi, Genk, Ghent, Liège, Mons and Ostend. Existing therapeutic communities and crisis intervention centres received 'expansion of their capacity'.

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 has 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, 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 (for more information see issue 14.18).
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.

Drug Policy in The Flemish Community

A policy plan was developed in which 8 areas of work are 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 policy paper 2000-2004 of the Flemish minister of Health, published in December 1999 defines prevention of drug misuse as one of the priorities of the present government in the coming years. The policy paper refers to the Flemish drug policy plan and stresses a continuation of the actual approach (which was developed by a different minister).

The prevention activities focus on the development of local drug policies (in communes and local communities and in different sectors and organisations) and on the training of key persons in various sectors of society (schools, workplace, leisure time, youth work, adult education) to empower them to develop a prevention policy in their setting. Local networks are set up to develop a coherent approach at the local level.

The 8 areas of work that are defined in the Flemish drug policy plan 1999-2001 are:

- ✧ Information
- ✧ Sensibilisation
- ✧ Co-ordination of prevention and treatment
- ✧ Representation
- ✧ Consultancy and support

- ✧ Training and education
- ✧ Development of concepts and methods
- ✧ Data collection and research

At provincial level, the areas of work are defined in order to strengthen the Flemish drug policy (the areas are in the field of co-ordination, implementation of concepts, data collection), but they leave room for additional local and regional needs and priorities.

1.1.3.3 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 reconversion 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 3.1.1) 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 (see 3.1.1) 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)
- Programmes of the EU DG V, European Drug Prevention Week (VAD) , EU Interegio projects: province of east Flanders and South Holland, and province of west Flanders and north of France, EU Eurregio projects: provinces of Limburg and Liège, Germany and The Netherlands.
- Pompidou group (via national representative at federal level)

- French Community

- Sub-Focal Point EMCDDA (via CCAD/EUROTOX)
- National counterparts of European alcohol action plan (WHO-Europe) (CCAD)
- Pompidou working groups: Epidemiology Group (CCAD), First Treatment demand (CCAD), "Multicity report –Liège" (CCAD-cellule Drogues ULg)

- Programmes of the European Union (DG V), EU “Interegio Projects” : Prove. Heinous and France, European network for AIDS prevention in prison.

- Brussels Region

- Sub-Focal Point EMCDDA (via CTB-ODB)
- Pompidou working groups
- European Drug Prevention Week
- Specific agreements with European cities or regions.

- German-speaking Community

- Sub-Focal Point EMCDDA (via ASL)
- Pompidou working groups
- European Drug Prevention Week
- 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)

1.2.1 Law and regulations (drug-related issues about health, social affairs, youth, justice, drug control, etc.)

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 (April) modifies the action of judicial authorities : 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** (see 1.2.1.2). The directive and its enforcement are currently being evaluated.

1.2.1.1 Drug laws

The first international convention on opium has been signed at The Hague the 23/01/**1912**. The basic Belgian law relating to the traffic in toxic substances, hypnotics, narcotics, disinfecting and antiseptics dates back to 24 January **1921**. This law was completely revised regarding narcotics, by the Law of 9 July **1975.** This law mainly deals with repressive issues and has to be completed by health issues.

The Law of 14 July **1994**, modifying this basic law, introduced a distinction in penalties covering toxic substances, disinfectants and antiseptics on the one hand, and narcotics and psychotropic substances likely to cause dependence, on the other hand.

A Royal Decree dated 31 December **1930**, continually revised in order to be updated, defines the substances covered by the aforementioned law. The Royal Decree currently in force dates 22 **January 1998**.

The Royal Decree dated 22 January **1998** (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 existing measures were extended to various groups a.o. : benzodiazepins, meprobamate, MDMA, MBDB, barbiturics, amfepramone, …
(The full text of the Royal Decree can be found on the website of the ministry of Justice at: http://www.just.fgov.be/cgi/t).

1.2.1.2 Driving and drug consumption

The law of March 16, 1999 (published on March 30, 1999) modifies the law of 16th of march 1968 related to road traffic, extending the list of substances concerned from alcohol to other psychoactive substances that could influence driving skills. These new substances are the following: THC, amphetamines, MDMA, MDEA, MDBD, morphine, cocaine or benzoyllecgonine.
(The full text of the law can be found on the website of the ministry of Justice at: http://www.just.fgov.be/cgi/t).

Based on a physical examination positive, a urine analysis can be performed. The maximum admitted concentrations fixed by this law are as follows :
THCCOOH : 50 ng/ml
Amphetamine, MDMA, MDEA, MBDB : 1000 ng /ml
Morphine : 300 ng /ml
Benzoylecgonine : 300 ng /ml

1.2.1.3 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 (e.a. the implementation of 'needle/syringe exchange' programmes) was made possible outside of the pharmacies by an new law dated 17/11/1998 and published in the Moniteur belge/Belgisch Staatsblad on 23/12/1998 (the full text of the law can be found on the website of the ministry of Justice (Moniteur belge/Belgisch Staatsblad) at: 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 can not 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 (The full text of the Royal Decree can be found on the website of the ministry of Justice at: 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 are no provision made for processing of used material.

1.2.1.4 The directive of April 1998

Although the law was not changed, the **practical enforcement of the legislation** is moving. The crime policy for drug addicts was harmonised by a common directive/circular signed by the attorneys general and the Justice Minister on 26 May 1993. From 8 May 1998 this directive was revised based on the conclusions of a report of a working group of the Federal Parliament adopted on 5 June 1997 (see 1.2). The full text is Annex X.
The law was not changed and the directive only modifies the action of judicial authorities : for the first time (**April 1998**), **a distinction is 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.

1.2.1.5 Infringements

Taking into account the practical enforcement of the legislation described above, the main infringements remain:

- 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 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.

1.2.1.6 New substances under control

The Royal Decree dated 22 January **1998** (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 existing measures were extended to various groups e.a. : benzodiazepins, meprobamate, MDMA, MBDB, barbiturics, amfepramone, …
(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/html/fd2_w3.htm (box:1998022699)*.

1.2.1.7 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.

1.2.1.8 Legal basis for substitution treatments

An official reference document related to the methadone substitution treatment was prepared by the experts of the Sub-Committee on Addiction of the Hygiene High Council (Health Council - ministry of Social Affairs, Public Health and Environment) and published in 1994 [2]. The four-page document 'Consensus Conference sur la Méthadone/Consensusconferentie over Methadon' (Consensus Conference on methadone substitution treatment) presents the benefits and limits of the methadone treatment and the indications and rules to be followed.

A follow-up of the 'Consensus Conference on methadone substitution treatment' 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 [3]. Therapeutic efficiency of methadone has been reassessed.

The limited and minor changes in the 'Conférence 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.

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 (Université de liège) and medical (Commission médicale provinciale / 'Provincial Council of Doctors') authorities in Liège. Before its implementation the protocol still has to be approved by the 'National Council of Doctors'. No progress had been made in the recent months. When approved it is intended to extend similar projects in Antwerp and Brussels.

1.2.1.9 Confidentiality of the data

Individual privacy rights are guaranteed by the 'Privacy Act' of 8 December 1992 and the Royal Decrees pertaining to this law. An adaptation of the Belgian law to the 1995 European Directive was made in 1998. Several aspects regarding scientific research are improved, but at the moment, the Decrees of execution of the new law are not yet completed.

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

1.2.2 Prosecution policy, priorities and objectives in relation to drug addicts, occasional users, drug related crime

Criminality linked with drugs increases at all levels of the judicial system : preliminary investigation, prosecution, sentence and enforcement of the penalty. The increasing number of people being imprisoned for drug offence demonstrates this reality well. The strictly repressive approach has been completed : at the various levels of the judicial process, practical possibilities to direct a drug addict to a care centre were developed as well as measures making possible to avoid the imprisonment.

This Section presents also a synthesis of judicial alternative measures, available at the moment in Belgium, related to the drug problem.

1.2.2.1 Prosecutions

PENALTIES

Basic penalties

For all of the above infringements, penalties include imprisonment for a period of three months to five years and/or a fine of 200,000 to 20,000,000 BEF (5,000 to 500,000 EURO).

- AGGRAVATING CIRCUMSTANCES

A number of aggravating circumstances are foreseen which turn the infringements into crimes. The severity of the penalties varies:

a) *according to the age of the victim:*

- minor aged 16 : imprisonment;
- minor over 12, but under 16 : 10 to 15 years imprisonment;
- minor under 12 : 15 to 20 years imprisonment.

b) *in relation to the consequences of the infringement*: if the use of the drug, as a consequence of the offence, causes the victim:

- a disease which appears incurable, a permanent disability, the total loss of an organ or serious mutilation : imprisonment (maximal duration not specified);
- death : from 10 to 15 years imprisonment.

c) *in relation to the traffic implication*: if the offence is committed as part of the main or accessory activities of a partnership: 10 to 20 year imprisonment.

- ACCESSORY PENALTIES

A broad range of accessory sentences are also foreseen:

a) prohibition and closure: the judge may:

- temporarily or permanently prohibit the offender from practising medicine, veterinary medicine, or working in one of the paramedical professions;
- order the closure and/or forbid the running of a business where the offences were committed.

A new law (17/11/**1998**) extends the possibility to close bars and other places where infringements (use, traffick) where committed. Previously the sentence was restricted to a person: consequently, after the simple change of the name of the manager of the bar, actually its activities could restart. Indeed it was opposite to the spirit of the law that aimed the place (bar,…) and not the person.

b) seizure: notwithstanding the common law provisions, the judge may:

seize property which was used or was destined to be used in committing the offence, even if such property does not belong to the guilty person.

- REPEAT OFFENDERS

In case of an offence being repeated within five years, sentences for minor offences may be doubled and those for major offences increased according to article 54 of the Penal Code.
Sentences delivered abroad for these offences are also taken into account when establishing if it is a repeated offence.

CAUSES FOR LENIENCY

Article 6 of the law of 24 February 1921, as modified by the law of 9 July 1975, allows for leniency in two conditions:
a) Disclosure prior to any investigation:
If the perpetrator reveals to the authorities the identities of the offenders or, if the names are not known, the existence of an offence, he/she may benefit exemption from or reduction in sentence, depending on whether it is a minor offence or an offence which has to be judged in the criminal court.
b) A reduction of imprisonment sentences may be granted for the guilty party who reveals the names of associates whose names were not known.

A new law (17/11/**1998**) extends the possibility to close bars and other places where infringements (use, traffic) where committed. Previously the sentence was restricted to a person: consequently, after the simple change of the name of the manager of the bar, actually its activities could restart. Indeed it was opposite to the spirit of the law that aimed the place (bar,…) and not the person.
The law was published in the Moniteur belge/Belgisch Staatsblad on 23/12/1998 (the full text of the law can be found on the website of the ministry of Justice (Moniteur belge/Belgisch Staatsblad) at: *http://www.just.fgov.be/html/fd2_w3.htm (box:1998022758)*.

MONEY LAUNDERING

By virtue of the law of 17 January 1990, the following may be seized, regardless of the nature or the seriousness of the offence:
- assets derived directly from committing an offence (whatever the nature of the assets);
- any goods or valuables substituting these assets;
- any income derived from investing these assets;
- equivalent assets when the judge determines that the assets were obtained by committing an offence, even though there is no longer any trace of them in the assets belonging to the perpetrator of the offence.

Participation in money laundering is punishable by imprisonment for 15 days to 5 years and by a fine of 5,200 to 200,000,000 BEF (130 to 5,000,000 EURO), or one of these sentences alone.

1.2.2.2 Alternative measures : diversion to treatment and alternatives to prison

Aims of alternative judicial measures

The objectives of judicial alternative measures are as follows [4] :

- To improve the offenders' awareness of the direct and indirect damages to the quality of life caused by their behaviour and to fight against the way in which these behaviours have become a feature of everyday life;
- To reduce the number and the duration of imprisonment in the framework of the law over detention on suspicion;
- To avoid the feeling of impunity caused by a measure of filing and disposing definitely of a case (although unsolved) when the case actually requires an organised social reaction, but without having to go to the sentence and the enforcement of a short term imprisonment;
- To provide to these people education and training possibilities by means of practicing an activity in an occupational context;
- To make the rehabilitation of delinquents having committed offences of a lesser seriousness easier;

- To associate local administrative authorities to credible initiatives aiming at reducing criminality;
- To repair in a significant way the material and moral damage, at individual as well as at community levels, and to ensure the victim' rights;
- To reduce repetition of an offence.

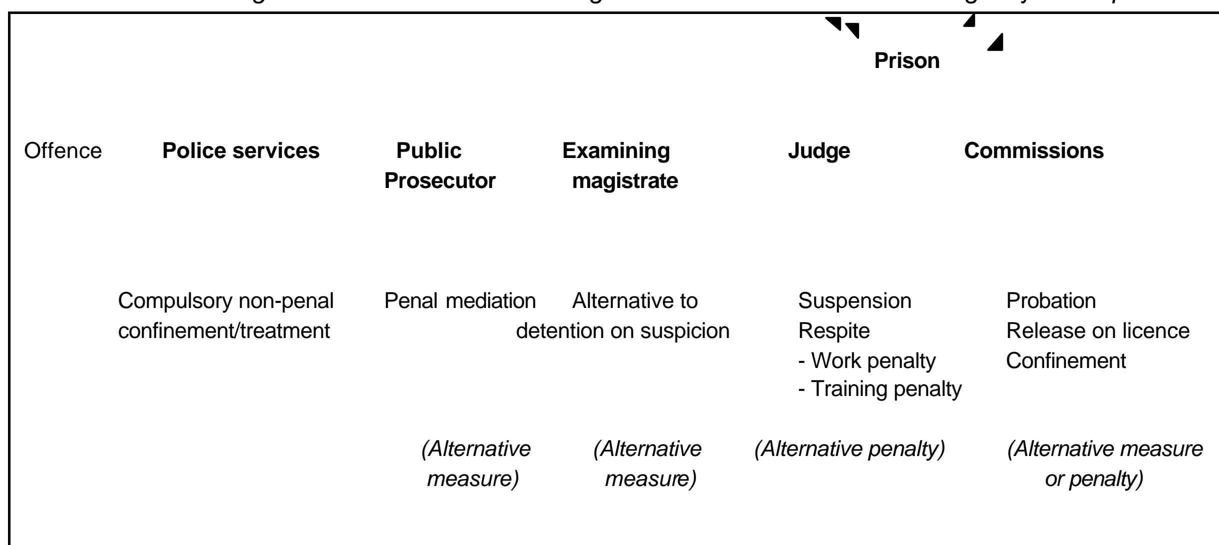
Legal framework of alternative judicial measures

The alternative measures are as follows :

- At police level : the therapeutical advice
- At public prosecutor's department level
  - Praetorian probation (probation prétorienne / pretoriaanse probatie)
  - Penal mediation (mediation pénale / strafbemiddeling)
- Alternative measures at the juvenile court level (mesures de diversion / diversiemaatregelen)
- Alternative to detention on suspicion
- At the level of the judgement (Court)
  - Suspension, reprieve and 'probation'
  - Works for the benefit of the community and trainings in the framework of the law on 'probation'
- The level of the enforcement of the penalty
  - Release on licence (libération conditionnelle/voorwaardelijke invrijheidstelling)
  - Confinement

The Figure 1 is a flow chart of the judicial process and mentions the existing alternative measures through the different levels of the judicial system. These measures are general ones and are not specific to drug related offences (however their usefulness is particularly relevant in these cases). Clear information, intended for the general public, on the alternative measures ('To Penalise without Imprisoning') is available on the web site of the ministry of Justice [f].

FIGURE 1 : *Existing alternative measures through the different levels of the Belgian judicial process*



1.2.3 Law enforcement regarding diversion to treatment and alternatives to prison

In 1998, 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. In general the widening of the treatment network with more attention to low-threshold services and differentiated treatment goals (abstinence, reduction, substitution, maintenance) continued.

f http://www.just.fgov.be/html/ni2.htm -Dutch language- or http://www.just.fgov.be/html/fi2.htm -French language.

In Flanders, the number of Centres for Mental Health Care that offer 'therapeutical advice' is increasing. One observes growing variation in applying this method in the different judicial entities. Therefore co-ordination of the method is needed. An ad hoc work group started with collaborators of these Centres for Mental Health Care to create a blue print of the method in 1998. Its aim is to create more uniformity and to offer a comprehensive manual for those Centres for Mental Health Care that intend to start with the method.

1.2.3.1 Data from treatment centres on referrals from the justice/penal system

The treatment demand indicator provides information on the source of referral [g]. Despite some initial differences between categories reported by the CCAD, CTB/ODB and VAD registration systems, the pooling of the data was made possible tanks the running harmonisation process. Table 1 shows that comparable proportions of treatment demands (respectively 18 and 19% in 1997 and 1998) were referred by Court/probation/justice services. According to the type of treatment (ambulatory/outpatient or residential/inpatient care), one observes that a fourth of patients undergoing ambulatory treatment are referred by Court/probation/justice services, what is higher than patients treated in residential centres.

TABLE 1. *Source of referral (%) of patients asking for or starting treatment in 1997 and 1998, CCAD/CTB-ODB/VAD, Belgium*

	1997*			1998			1998 Outpatient **			1998 Inpatient **		
	M	F	T	M	F	T	M	F	T	M	F	T
Number of cases	4,154	1,434	5,785	4,910	1,637	6,649	3,148	1,060	4,232	1,762	637	2,417
	%	%	%	%	%	%	%	%	%	%	%	%
Self referred, family, friends	**40**	**41**	**41**	**43**	**40**	**43**	**38**	**35**	**37**	**54**	**49**	**53**
Other drug treatment centre	13	15	13	16	17	17	14	13	14	20	24	21
GP,hospital,oth.med.sources	13	20	16	12	16	13	12	14	12	14	20	16
Social service	5	5	5	3	3	3	3	4	4	1	0	1
Court,probation,justice	21	9	18	20	17	19	**25**	**26**	**25**	9	4	7
Other	7	11	8	6	6	6	7	8	8	2	3	3

* : Data from CCAD and CTB/ODB are actually 1997 treatment demands when VAD data are 1996 demands.

** : Outpatient : data from centres offering ambulatory care / Inpatient : residential centres

1.2.3.2 Survey on collaboration between treatment services and justice/penal system

In September 1999, a questionnaire survey was conducted among 140 drug treatment services in the Flemish Community (low and high threshold services, in and out patient services, drug specialised and not drug specialised). The subject of this survey is to estimate the extent and the nature of the collaboration between the sector of drug care and the sector of justice in 1998 and 1999. VAD published an interim report at the end of 1999 [5]. 84% of centres received less than 25 referrals most of these centres are the psychiatric hospitals and psychiatric annexes of general hospitals (PZ and PAAZ) on one side and the centres for mental health (CGG) on the other side. On the other hand, more than half the day-care centres (DC), crisis intervention centres (CIC) and therapeutic communities (TC) got between 51 and 100 referrals per year. The distribution was similar in 1999 compared to 1998.

Among the institutions that refer the most, especially the police and the gendarmerie are mentioned (although the difference with the court and the public prosecutor is very slight). Probation, conditional release and provisional release, therapeutical advice and mediation are judicial measures who lead to most of the referrals.

Most centres reported that the number of referral increases or that at least is equal in 1998 compared with the referrals before 1998. The reasons most often mentioned when an increase is observed are:

g For a description of the various registration systems, see Part II : Epidemiology.

training and better knowledge, collaboration and the drugs circular. Most centres said the profile of the referred persons stayed the same : nevertheless, an increase of the number of minors and a change in the kind of drugs that are used (e.g. speed) was observed.

1.2.4 Any other important project of law or other initiative with political relevance to drug related issues

1.2.4.1 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 derivates
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

1.3.1 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.

1.4. Budgets and funding arrangements

1.4.1 Funding (figures) at national level - Federal Government

- 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).

❖ 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).

❖ 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 [h] (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 VSPP) projects in the framework of crime prevention. The VSSP also supports the education of prevention professionals and assists them in their work. It also fund 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) is the competence of the prison/justice administration (health policies of the ministry of Health are not in force).

1.4.2 Community and Regional governments

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

Nothing specific for these levels.

1.4.2.1 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 (77.6 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)

EPIDEMIOLOGY, RESEARCH

The Flemish ministry of Health Policy 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

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

The Flemish ministry of Health Policy 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, welfare budgets, 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 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).

1.4.2.2 French Community

EPIDEMIOLOGY, RESEARCH

The ministry of Health of the French Community funds:

- 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 the1997 – 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 funds since October 2000 a harm reduction training programme for specialised professionals.

1.4.2.3 Brussels Region

EPIDEMIOLOGY, RESEARCH

The Brussels Region funds :

- 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

The Brussels Region funds :

- 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.

1.4.2.4 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.

Scientific Institute of Public Health
Unit of Epidemiology

BELGIAN NATIONAL REPORT ON DRUGS 2000

PART II :

Epidemiological Situation

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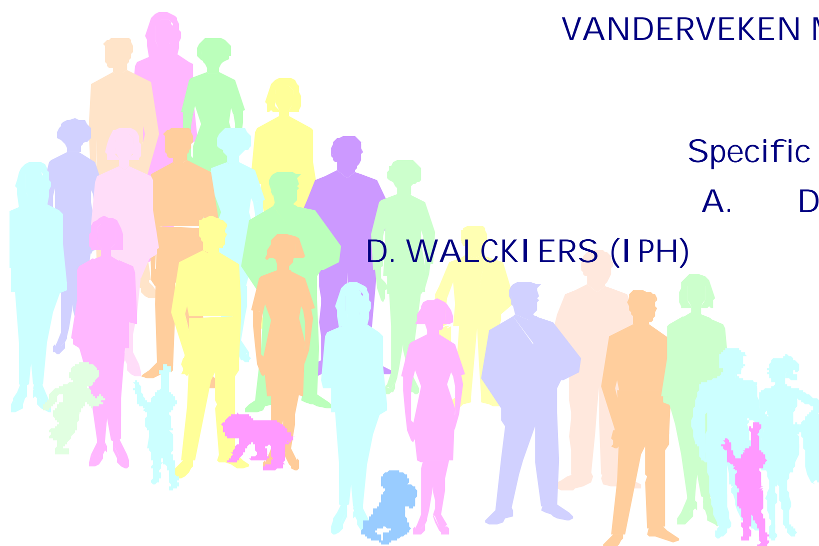
VAD

Vlaamse Gemeenschap



The present Report,

short versions in Dutch and French

and additional information on the activities of the BIRN

are available on demand
and on the Belgian Focal Point Web site

REITOX Belgian Focal Point

at

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

PART II. EPIDEMIOLOGICAL SITUATION

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). These people are confined to a psychiatric ward and/or have had previous treatments. 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, 3 ,4 and 5 give a summary of the available data and indicate trends when possible.

TABLE 2. *Synthesis table of epidemiological indicators on drug use : trends of drug use in the population in Belgium for the period 1993-1999 (Figures are percentages except when specified)*

INDICATORS	ORGANISATION (reference nb)	1993	1994	1995	1996	1997	1998	1999	Trend
ADULT POPULATION									
Cannabis	Vlaamse G. 6		5.8						
Lifetime prevalence	ULB/Promes 7					12.8		20.8	
Last year preval.	Vlaamse G. 6		1.5						?
SCHOOL POPULATION									
Cannabis	RUG/Publ.Hlth 9		14.9		19.6		23.7		
Lifetime prevalence	VAD 11							24.1	
	ULB/Promes 10						27.9		
Last month preval.	RUG/Publ.Hlth 9		7.6		10.8		14.6		
XTC	RUG/Publ.Hlth 9		4.1		5.6		6.2		
Lifetime prevalence	VAD 11							4.0	
	ULB/Promes 10						6.3		
Last month preval.	RUG/Publ.Hlth 9		1.4		2.0		2.8		
USE IN PRISON	Free Clinic 25	42.0							
Last month preval.	Modus Vivendi 62					38.0			?
	FC / MV 23							42.0	

Legend : = : stable / : increase / : decrease / ~~ : fluctuating / : increase followed by a decrease / ? : data not available or not interpretable

TABLE 3. *Synthesis table of epidemiological indicators on drug use : trends of problematic drug use, Belgium, period 1993-1999 (Figures are percentages except when specified)*

INDICATORS	ORGANISATION (reference nb)	1993	1994	1995	1996	1997	1998	1999	Trend
PROBLEMATIC USE									
IVDU prevalence (‰)	IPH 29			3.6					?
Heroin use prevalence (‰)	CCAD 31		6.3						?
Poly-drug use	Modus Vivendi 32				32.0	45.0	36.0	36.0	
Injecting use (current) Main drug	CCAD 34	30.2	34.3	28.7	24.0	24.0	19.9		
Heroin	CCAD 34	35.9	40.9	39.9	37.0	37.3	35.3		=
	Coord.Drog.Charl. 37							17.1	=
	VAD 33						26.6		
Cocaine	CCAD 34	22.2	25.9	34.6	22.9	34.8	29.5		~~
	Coord.Drog.Charl. 37							10.8	
	VAD 33						8.9		

Legend : = : stable / : increase / : decrease / ~~ : fluctuating / : increase followed by a decrease / ? : data not available or not interpretable

TABLE 4. *Synthesis table of epidemiological indicators on drug use : trends of health consequences of use, Belgium, period 1993-1999 (Figures are percentages except when specified)*

INDICATORS	ORGANISATION (reference nb)	1993	1994	1995	1996	1997	1998	1999	Trend
MORTALITY									
Drug related deaths (n)	NIS-IPH	346	376	346					=
DRD involving opiates	NIS-IPH	47.0	48.0	53.0					=
MORBIDITY									
IVDU / new HIV	IPH 63	5.5	7.2	3.4	3.8	4.5	2.9	3.4	
HIV / drug treatments IVDUs	GEMT 66			0.9					
	ALTO 68		2.2						
	CCAD 34	4.9	5.7	3.0	1.4	2.6	1.6		
	GIG 67				2.2				
	De Sleutel 38					0.8	5.4	0.5	?
	VAD 33						1.9		
HBV / drug treatments IVDUs	GEMT 66			36.0					
	CCAD 34					22.4	23.6		=
	De Sleutel 38				20.5	24.1	23.9		=
HCV / drug treatments IVDUs	GEMT 66			78.0					
	ALTO 68		56.0						
	CCAD 34					46.7	51.9		=
	De Sleutel 38				39.5	46.4	37.9		=

Legend : = : stable / : increase / : decrease / ~~ : fluctuating / : increase followed by a decrease / ? : data not available or not interpretable

TABLE 5. *Synthesis table of epidemiological indicators on drug use :offences, availability and drug market data, Belgium, period 1993-1999*

INDICATORS	ORGANISATION (ref)	1993	1994	1995	1996	1997	1998	1999	Trend
People taken in for questioning (N)	SGAP 46	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 47								
Cannabis		6,380	8,628	13,379			13,020	7,362	
XTC/amphetamines		684	978	1,002			2,672	2,163	
Opiates/heroin		3,082	3,024	3,158			1,112	720	
Cocaine		897	927	1,046			799	547	
Retail prices (euro)	SGAP 47								
Cannabis / g		8		7		9	6	6	=
XTC/amphet. /tab.		28		12		8		9	
Heroin / g		83		38		35	35	35	
Cocaine / g		55		49		40	50	55	=
AVAILABILITY (adults)	ULB-Promes 7								
Cannabis					59.2	70.4	62.9	64.5	
Cocaine					45.6	50.8	41.1	40.0	=

Legend : = : stable / : increase / : decrease / ~~ : fluctuating / : increase followed by a decrease / ? : data not available or not interpretable

2.2. Drug use in the population

Since 1990 up to recently most population surveys carried out in Belgium have concentrated their efforts on clearly specified demographic sets, often defined as various populations of young school aged people. Although partial, investigations have been conducted (or are being conducted) in the general population.

2.2.1 Main results

2.2.2 General adult population

In 1994, a telephone interview study was conducted among the Flemish general population (2,259 adults between 18 and 65 years) [6]. The study showed a low level of drug experience among the general population : the prevalence of 'at least once use' of any illegal drug was globally 6.4% and about 5.8% experienced cannabis. (Table 6). 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 was higher among males than females.

Sixteen % 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.

Since 1996 a continuous health behaviour monitoring has been conducted in four areas, representative of the French Community households [7]. 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 people 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). The global participation rate is 69%.

TABLE 6. *Lifetime prevalence (%) of drug use and last 12 months prevalence (between brackets) among the adult population (18-65 years old), Flemish Community, 1994* [6]

Drugs	All adults 18-65 y. N=2,259	Young adults 18-34 y. N=924			Older adults 35-65 y. 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[i]	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

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 use prevalences, 21% (95%CI 13.2-28.6) of adults interviewed in 1998-99 stated to have used at least once cannabis. The prevalence decreases with age from 34% among 18-24 to 13% among 45-49 years of age. Males (29%) stated cannabis experience more than females (13%). Thirty-five % of young 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.

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

i Amphetamines and speed were grouped in this analysis. Unfortunatelly 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. thanks to the REITOX-EMCDDA guidelines.

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 7).

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 trends 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 [8]).

TABLE 7. *Lifetime prevalence (standardized % and 95%CI) of cannabis use among the adult population (18-49 years old), French Community, 1996-97 and 1998-99* [7]

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

Adjusted rates for age, sex (for the total figure), education and area.

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.

2.2.3 School and youth population

2.2.3.1 Drug use from secondary school surveys

Several regional surveys were carried out in recent years, representative for secondary school children of the Flemish [9] and French [10] Communities. Two repetitive surveys in the Flemish and French Communities used the standardized protocol validated at international level in the framework of the WHO Health Behaviour School-aged Children (HBSC). In1999 VAD conducted a very large study in the Flemish Community schools using a different protocol [11] : this study will be repeated every year and cover representatively all types of schools.
Even if one should be prudent 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 these studies globally indicate that in 1998-99 :

- around 25% of students of 15-16 years of age has tried an illegal substance at least once (Table 8);
- around 20% of students aged 15-16 years experienced at least one cannabis during the last year ;
- around 15% of students aged 15-16 years experienced at least one cannabis during the last month ;

- the frequency of use increases with age : more than 40, 30 and 20% of 17-18 years of age has tried cannabis respectively at least once, during the last year and during the last month (Table 9);

- 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 is the second product most used ; among younger students, solvents or hypnotics or sedatives are the products most used;

- an increasing trend in the use of illegal drugs, especially cannabis, XTC and amphetamines.

TABLE 8. *Prevalence of drug use among the school population aged 15-16 years, Flemish Community [9] (1994-96-98-99) and French Community[10] (1998)*

Drugs	Period	Fl C 94 N=5,247	Fl C 96 N=2,391	Fl C 98 N=9,211	Fr C 98 N=12,987	Fl C 99 N=47,657
Cannabis	Lifetime	14.9	19.6	23.7	27.9	24.1
	(Boys-girls)	(20-10)	(25-15)	(28-20)	(31-25)	(29-19)
	Last year	-	-	-	-	19.5
	Last month	7.6	10.8	14.6	-	-
XTC	Lifetime	4.1	5.6	6.2	6.3	4.0
	(Boys-girls)	(5-3)	(8-3)	(8-4)	(7-5)	(5-3)
	Last year	-	-	-	-	2.9
	Last month	1.4	2.0	2.8	-	-
Hypnotics- sedatives or Benzodiazepines	Lifetime	5.1	3.8	5.0	5.1	11.2
	(Boys-girls)	(4-6)	(3-5)	(5-6)	(5-5)	(10-13)
	Last year	-	-	-	-	5.8
	Last month	2.0	1.1	2.1	-	-
Amphetamines	Lifetime	2.6	3.2	3.8	7.0	6.5
	(Boys-girls)	(3-2)	(4-2)	(5-2)	(8-6)	(8-5)
	Last year	-	-	-	-	4.5
	Last month	0.8	0.8	1.5	-	-
Solvents	Lifetime	3.3	2.9	4.4	5.8	4.2
	(Boys-girls)	(4-2)	(4-1)	(6-3)	(7-5)	(5-4)
	Last year	-	-	-	-	2.4
	Last month	1.3	0.8	1.8	-	-

In terms of trends, the prevalences are increasing in all age groups. When we compare youngsters aged 15-16 for years for 1994, 1996 and 1998-99 (Table 8):

- the lifetime prevalences of use of **cannabis** are regularly increasing from 15 to 25 % [j];
- respectively 20-25-30 % in boys [k] and 10-15-20 % in girls experienced cannabis at least once ;
- the proportion of last month users among 'lifetime' users of cannabis increases: respectively 51-55-62 %;

- the lifetime prevalences of use of **XTC** are respectively 3-3-6 %;
- respectively 5-8-7 % in boys and 3-3-4 % in girls;
- the proportion of XTC 'regular' users among users increases : respectively 34-36-45 %.

- the lifetime prevalence of use of **hypnotics/sedatives** are respectively 5-4-5 % [l];
- respectively 4-3-5 % in boys and 6-5-6 % in girls;
- the proportion of 'regular' users of hypnotics among users are respectively 39-29-42 %.

- the lifetime prevalence of use of **amphetamines** are respectively 3-3-6 %;
- respectively 3-4-8 % in boys and 2-2-5 % in girls;
- the proportion of amphetamines 'regular' users among users are respectively 31-25-39 %.

j The 1998 French Community HBSC survey reports a higher prevalence : 28 % of youngsters stated to have used cannabis at least once : the difference is more among girls : 25% compared to 20% in Flemish Community surveys.

k 1994 : Boys : 18% (French Com.) and 22% (Brussels) / Girls : 14% (French Com.) and 13% (Brussels).

l The 1999 VAD Flemish survey reports a higher prevalence : only considering benzodiazepine use, 11 % of youngsters stated to have used at least once (10 % among boys and 13 % among girls).

TABLE 9. *Lifetime prevalence of drug use among the school population aged 17-18 years, Flemish Community[9] (1994-96-98-99) and French Community[10] (1998)*

Drugs	Gender	Fl C 94 N=5,247	Fl C 96 N=2,391	Fl C 98 N=9,211	Fr C 98 N=12,987	Fl C 99 N=47,657
Cannabis	Males	32.1	42.7	45.9	50.6	48.1
	Females	14.2	23.0	32.6	39.0	27.5
	Total	23.1	32.7	39.3	43.9	39.0
XTC	Males	8.9	13.9	14.8	14.4	11.0
	Females	3.7	4.9	10.1	8.9	4.7
	Total	6.3	9.3	12.2	11.2	8.1
Amphetamines	Males	6.5	7.0	8.5	13.1	14.5
	Females	2.1	3.1	5.6	7.3	7.5
	Total	4.3	5.0	6.8	9.8	11.4
Hypnotics- sedatives or Benzodiazepines	Males	5.9	6.1	7.0	7.0	13.3
	Females	4.9	5.5	8.7	5.6	15.9
	Total	5.4	5.8	7.8	6.2	14.4
Solvents	Males	8.0	12.4	11.0	7.4	5.0
	Females	2.1	3.7	6.8	3.6	2.7
	Total	5.5	8.0	8.9	5.3	3.9

We present here below various surveys carried out in different regions of the country and give some results as example.

- *HBSC : Youngsters and health in Flanders, 1994-1996-1998* [9]
- *HBSC : Health behaviour and life-styles of youngsters in the French Community, 1994-1998* [10]
- *Interview of youngsters of Flemish Schools, 1999* [11]
- *School survey on drugs in Charleroi (Wallonia), 1999* [12]
- *Social diagnosis in 3 secondary schools in Verviers (Wallonia), 1999* [13]
- *School-aged youngsters in Beveren (Flanders): a study in 1997-1998* [14]
- *School-aged youngsters in Bruges (Flanders): a study in 1996-1997* [15]
- *Study of youth behaviour in the city of Ninove (Flanders), 1995* [16]
- *Mental health of youngsters in Brussels, 1994* [17]

- HBSC survey : Youngsters and health in Flanders, 1990-94-96-98 [9]

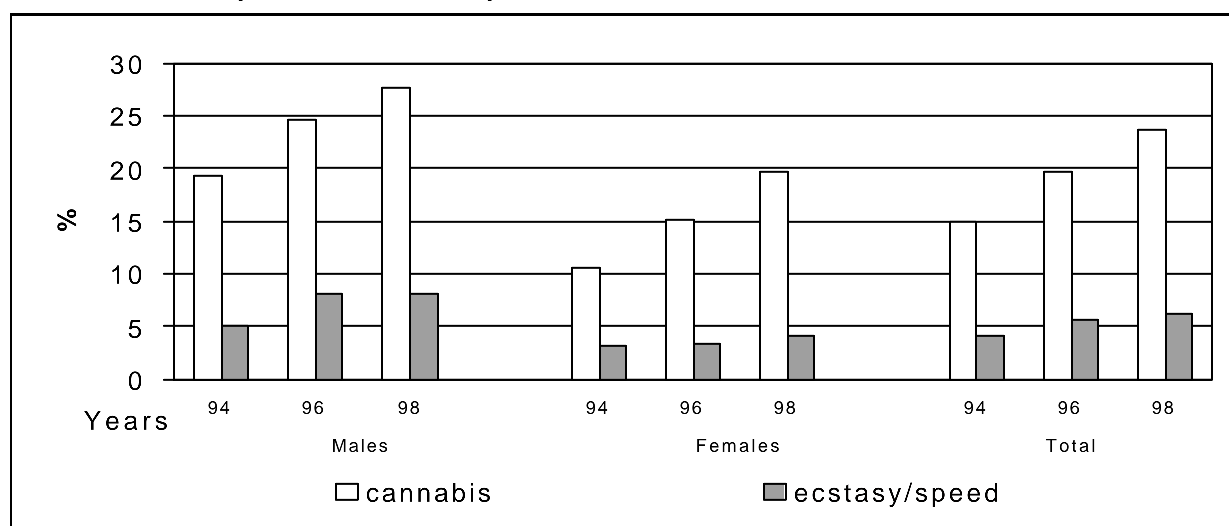
The purpose is to present an evolution about health-related attitudes and behaviours of youngsters. The study is repeated on regularly basis (1990, 1994, 1996, 1998). The sampling of the schools is based on a stratification according to educational networks (local community schools, provincial schools, official schools and government schools). The respective samples for the study of 1994, 1996 and 1998 consisted of 10,414, 4,771 and 12,088 Flemish teenagers aged 11-18. Before 1998, the question about drug use was only asked to the students aged 15-18.

The number of drug users aged 15-16 and 17-18 is presented per groups of substance (Table 10). In general more boys than girls use illegal drugs.

TABLE 10. *Students having used a drug at least once (lifetime), for girls and boys according to age, Flemish Community schools, 1998* [9]

Drug	15-16 y. Boys N = 1 432 %	Girls N = 1 355 %	Total N = 2 787 %	17-18 y. Boys N = 1 296 %	Girls N = 1 286 %	Total N = 2 582 %
Cannabis	27.7	19.6	23.7	46.0	32.7	39.3
XTC/speed	8.0	4.1	6.2	15.4	10.2	12.8
Sniff, volatile inhalants	5.8	2.9	4.4	11.0	6.8	8.9
Tranquillizers	4.6	5.5	5.0	7.1	8.7	7.9
Amphetamines, stimulants	5.0	2.5	3.8	8.5	5.1	6.8
LSD	2.6	1.7	2.1	6.8	4.1	5.4
Cocaine	1.9	0.7	1.3	4.3	4.4	4.3
Heroin	1.2	0.3	0.7	2.2	0.4	1.3

FIGURE 2 : *Proportion of youngsters (15-16 years of age) having used at least once cannabis or ecstasy, Flemish Community schools, 1994, 1996 and 1998* [9]



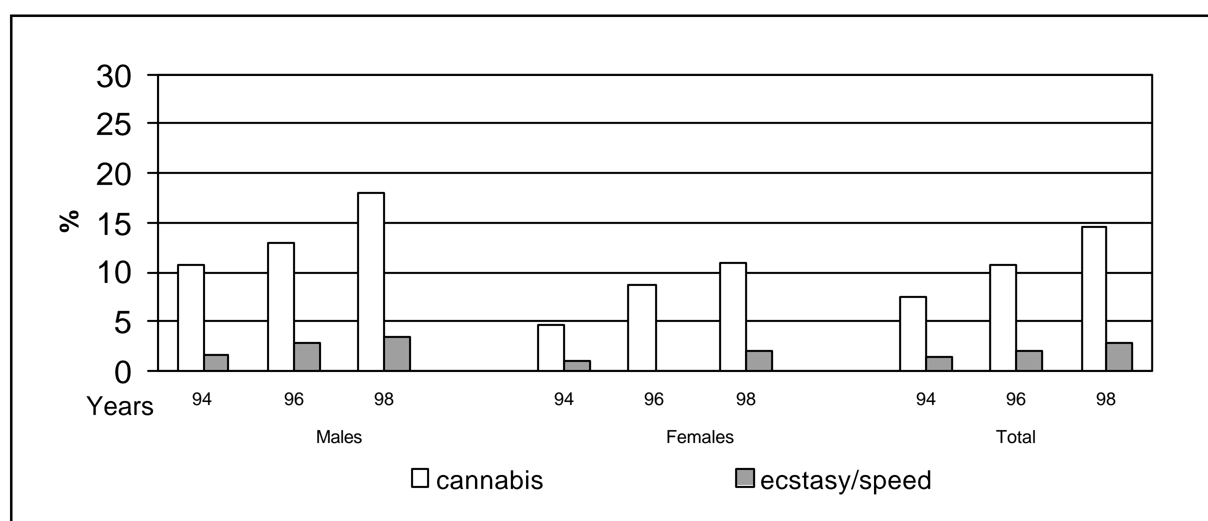
Cannabis is most popular among boys : 28% of 15-16 year old boys and 46% of 17-18 year old boys had used at least once, followed by XTC/speed and then volatile inhalants. Among girls cannabis is also the most popular, followed by XTC/speed, tranquillizers are third.
Figure 2 shows an increasing 1994-1996-1998 trends for cannabis use among 15-16 year old as well in boys as in girls. For XTC, such a trend is observed among boys during the period 1994-1996 whereas among girls the increase is delayed during the period 1996-1998.

TABLE 11. *Students having used a drug during the last month, for girls and boys according to their age, Flemish Community schools, 1998* [9]

Drug	15-16 y. Boys N = 1 286	15-16 y. Girls N = 1 355	15-16 y. Total N = 2 641	17-18 y. Boys N = 1 296	17-18 y. Girls N = 1 432	17-18 y. Total N = 2 728
	%	%	%	%	%	%
Cannabis	18.0	10.9	14.6	27.9	15.0	21.5
XTC/speed	3.5	2.1	2.8	5.8	4.3	5.0
Sniff, volatile inhalants	2.2	1.4	1.8	3.4	2.5	2.9
Tranquillizers	1.8	2.6	2.1	2.5	3.0	2.8
Amphetamines, stimulants	1.9	0.9	1.5	3.3	1.9	2.5
LSD	0.9	0.7	0.8	2.6	0.9	1.7
Cocaine	0.3	0.3	0.3	1.4	0.9	1.1
Heroin	0.3	0.0	0.2	0.5	0.1	0.3

More boys than girls have used cannabis during the last month. This is both the case for youngsters from 15-16 as those from 17-18. In 1998 compared to 1996, the last month prevalence of cannabis use has increased both among boys and girls in both age groups. The increase is the biggest amongst the oldest girls (17-18 years).

FIGURE 3 : *Proportion of youngsters (15-16 years of age) having used cannabis and ecstasy during the last month, Flemish Community secondary schools, 1994, 1996 and 1998* [9]



Comparing 1994, 1996 and 1998, an increasing proportion of cannabis users (ever used) are ‘regular’ ones (defined as last month use): 50%, 55% and 62 % respectively. It is particularly striking among youngsters of 15-16 and also among 14 year-old students (42%, 53% and 58% respectively). For XTC, a third of users were ‘regular’ in 1994 and 1996, whereas this proportion increases up to 43% in 1998.

Pattern of use

About 50% of boys who ever used cannabis, stopped. For the other products this percentage is higher. The proportion of ‘last month’ users of cannabis increased regularly from 1994 to 1998, as well for boys as for girls (Table 12). More boys than girls used several times speed or XTC during the last month. In 1998 the proportion of boys of 17-18 year of age who took it 1 to 2 times per month

TABLE 12. *Last month use of cannabis among youngsters of 17-18 year of age, by sex and frequency of use, in 1994, 96 and 98, Flemish Community schools* [9]

	Last month use of cannabis (%)					
	1994		1996		1998	
	1-2x	3x and more	1-2x	3x and more	1-2x	3x and more
Boys	9.3	8.3	9.4	11.2	11.4	14.3
Girls	3.5	2.2	5.2	3.7	6.9	7.0

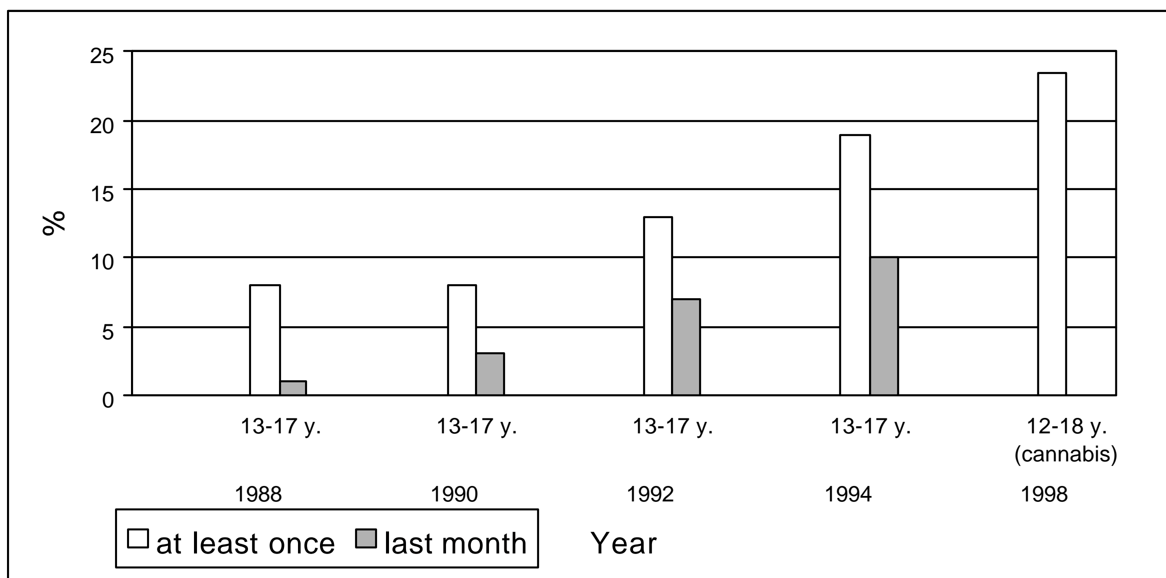
(2.7%) decreased compared with 1996 (4.2%). On the contrary for girls, the proportion who used it 1 to 2 times per month increased from about 0.8% to 2.1% in 1998.

The age of first use for the age group 15-18 was quite similar over the 3 consecutive studies : from 15.1 year old in 1994 and 1996 to 14.8 in 1998.

- HBSC Health behaviour and life-styles of youngsters in the French Community, 1994-98 [10]

'Health Behaviour 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 aim is to better know and understand the health behaviour and life style of teenagers of the French Community in order to define and evaluate the health promotion activities for youngsters. The sampling of the schools are representative for the different provinces, educational networks (public and catholic) and type of educational cursus. Results presented are standardised for age, sex and type of education.

FIGURE 4 : *Proportion of youngsters aged 13-17 years) having used a drug at least once and during the last month, French Community secondary schools, 1988, 1990, 1992 and 1994* [10]



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 youngsters aged 13-17 used a drug at least once and 10% are 'regular' users (defined as last month use ; Figure 4). For comparison, these figures were 8%, 8%, 13% (at least once) and 1%, 3%, 7% (last month use) respectively in 1988, 90 and 92. An increasing proportion is using cannabis, reaching 84% of users in 1994.

Experimenting with drugs leads to 'regular' use (last month use) in 50% of cases. This proportion is stable from 1988 to 1994.

- *Interview of Flemish students for drug policy in schools (Flanders), 1999* [11]

From January to June 1999, a very large survey was conducted in 104 secondary schools of Flanders interviewing 47,657 representative students aged 11 to 22 years (boys 55% and girls 45%) : the study covered representatively all types of schools and will be repeated every year. The students are respectively 26% in first and second year of secondary school, 36% in third and fourth year and 38% in fifth and sixth year. The lifetime prevalence of illicit drug use increase with age from 10% in the first grade to 42% in the third grade. Some results are presented in Table 13.

TABLE 13. *Lifetime prevalence and last year prevalence (between brackets) of drug use according to the drug, secondary Flemish schools, 1999* [11]

Drug	N responses	Having ever used		Last year use	
		N	%	N	%
Any illicit drug	41,256	12,430	30.1	9,333	22.6
Cannabis	43,678	10,717	24.5	8,218	18.8
Amphetamines	43,220	3,216	7.5	2,111	4.9
Hallucinogens	43,188	2,722	6.3	1,909	4.4
XTC	43,563	2,238	5.1	1,527	3.5
Cocaine	43,176	1,225	2.8	772	1.8
Heroin	43,048	388	0.9	208	0.5

- *School survey on drugs in Charleroi (Wallonia), 1999* [12]

From March to June 1999, a survey was conducted in 12 secondary schools of Charleroi (among 23 invited schools) interviewing 2,005 students aged 14 to 23 years (mean age : 16.1) including 49% of boys and 51% of girls. They are respectively 1,066 in third year and 934 in fifth year. The lifetime prevalences of the drug use increase with age (Table 14. 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 14. *Students having ever used a drug according to their secondary school year, Charleroi, French Community, 1999* [12]

Drug	N responses	Having ever used		Third year	Fifth year
		N	%	%	%
Cannabis	1985	725	36.5	29.7	44.3
XTC	1976	148	7.5	6.2	8.9
Heroin	1971	36	1.9	1.9	5.6

- *Social diagnosis in three secondary schools in Verviers (Wallonia), 1999* [13]

In November and December 1999, a survey was conducted in three secondary schools of Verviers interviewing 929 students aged 11 to 20 years (boys 54% and girls 46%). They are respectively 265 in first year class, 388 in third year and 274 in fifth year. The lifetime prevalences of the use of cannabis and XTC increase with age (Table 15) without any significant difference of the cannabis prevalence between gender.

TABLE 15. *Students having ever used a drug according to their secondary schools year, Verviers, French Community, 1999* [13]

Drug	N responses	Having ever used		First year	Third year	Fifth year
		N	%	%	%	%
Cannabis	830	151	18.2	6.1	15.5	31.7
XTC	818	41	5.0	1.8	5.4	7.1
Cocaine	814	23	2.8	2.8	2.6	3.2
LSD	813	19	2.5	1.9	1.4	3.9
Heroin	817	15	1.8	1.9	1.7	1.9

- *School-aged youngsters in Beveren (Flanders): a study in 1997-1998* [14]

"De Sleutel", an organisation active in the field of drug prevention and research, conducted this school survey in Beveren. 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 a questionnaire about the following topics: school, leisure time, the use of drugs like alcohol, tobacco, illicit drugs and medication.
Results (prevalence of use,…) are not yet available but should be probably interesting as the study was conducted in an area more rural than, for example, the study in Bruges (here below).

- *School-aged youngsters in Bruges (Flanders): a study in 1996-1997* [15]

"De Sleutel" conducted this school survey in Bruges. 3,534 students of 18 secondary schools in Bruges participated in this study : 48% were boys and 52% were girls. This study includes only the students aged 16 year or more. This school population filled in the same questionnaire as mentioned here above in the Beveren study.
36% of students ever used cannabis, 8% ever used LSD, and 7.5% having ever used XTC (Table 16).

TABLE 16. *Proportion of students aged 16 year or more, ever having used illicit drug (N= 3,534), Bruges, 1996-97* [15]

Drug	%
Cannabis	35.8
LSD	8.3
XTC	7.5
Amphetamine	6.8
Cocaine	3.9
Heroin	0.8

Patterns of use

Table 17 shows how many times the 'ever-users' used illicit drugs. '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 cannabis (N = 1,266), 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 17. *Pattern of use of illicit drugs among users having consumed at least once, according to the type of drug, Bruges secondary schools, 1996-97* [15]

	Users N	Only once (%)	Intermediate (%)	'Regular' use (see text) (%)	(N)
Cannabis	1,266	14.7	46.0	39.3	498
LSD	292	33.3	52.3	14.4	42
XTC	266	27.2	45.7	27.1	72
Amphetamine	239	29.3	47.3	23.4	56
Cocaine	138	45.2	15.7	39.1	54
Heroin	28	50.0	38.6	21.4	6

- Mental health of youngsters in Brussels, 1994 [17]

A study of the mental health of youngsters in secondary schools was carried out in 1994. 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-demografic situation (age, sex,..), their subjective health status, the relationships in school, the family, their behaviour and the consumption of illegal drugs, and the use of services which help 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 to 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 have used drugs during the month before the study.

2.2.3.2 Drug use from a primary school survey

- Study of youth behaviour in the city of Ninove (Flanders), 1995 [16]

The specificity of this study was to involve also younger teenagers aged less than 12 years and attending primary school.
2,824 pupils of 8 schools in Ninove, aged 10 year or more, filled in a questionnaire at the end of 1995: 47% were boys and 53% were 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 ever used drugs (boys and girls comparable). The consumption of illegal drugs increases up to the age of 18 and older (Table 18). Meanwhile only 7% of the Ninove school population stated to have use drugs at least once (boys: 10% / girls: 4%), which seems low compared to the 'Flanders HBSC' study of 1994 [9] (globally 17% of 14-18 years used at least once cannabis).

TABLE 18. *Pupils having used at least once an illicit drug according to age, Ninove, 1995* [16]

	10-12 [m]		13-15		16-18		>18		Total	
	N	%	N	%	N	%	N	%	N	%
Yes	11	*1.3*	54	*5.3*	94	*12.1*	37	*22.6*	196	*7.1*
No	801	*98.7*	968	*94.7*	680	*87.9*	127	*77.4*	2,576	*92.9*
Total	812		1,022		774		164		2,772	

2.2.4 Specific groups : Conscripts

In 1991, from March 1 to November 30, 2 743 military male conscripts were picked at random from the daily list at the CRS (Selection and Recruitment Centre) [18]. The objective was to get a picture of the phenomenon, even though the sample could not be considered as representative of the young male Belgian population as a whole. Medicines and/or illegal drugs were searched in urine (2 513 tests), 155 (6.2%) were positive for at least one type of drugs: 89 for cannabis (3.5%), 66 for opium based drugs (2.6%), 10 for amphetamines (0.4%), 7 for benzodiazepines (0.3%) and 3 for cocaine (0.1%). The high level of opiates should be linked to with the taking of legal medications (antitussives; n=30). On the other hand, it should be mentioned that cannabis in urine is diagnosed for several weeks after use.

2.2.5 Specific groups : Prisoners

On 31 December 1996 the total number of imprisoned people in the 33 Belgian prisons was 8,296 [19].
Available figures of drug use in prison are estimates based on specific inquiries or on judicial sentences. In 1994 the proportion of people imprisoned for breaking the drug law (possession and trafficking) was estimated as 50% [20]. As this number continuously increased since 1970, it is suspected that consequently the proportion of drug users among prisoners increased as well as drug trafficking in prison. People imprisoned for breaking the drug law are only a part of drug users in prison as many of them are imprisoned because of other offences (theft,..).
Most imprisoned drug users are relatively young. In 1993, 51% of them was 25 years or less and 9% less than 20 years of age [21].

TABLE 19. *Drug use among prisoners, 1999* [22]

Drug		Prior to imprisonment Last month use		During imprisonment (previous and current imprisonments incl.)	
	N	Use %	IV use %	Use %	IV use %
Any illicit drug	246	50.0	9.4	42.0	2.4
Cannabis	246	40.7	1.2	36.6	
Cocaine	246	21.5	5.3	8.9	N=2
Heroin	246	14.5	3.7	12.6	N=2
XTC	246	8.9	0.8	4.9	
Amphetamines	246	7.7	2.0	8.1	N=2
LSD	246	6.1	0.8	2.0	

m This figure includes pupils aged 10-12 year attending primary or secondary school .

In 1999, a self-administrated questionnaire was proposed to prisoners of 2 prisons : a men prison (Brussels) and a women section in another prison (Flanders). Participation was voluntary : 230 men participated (approx. 38% of the total population) and 16 women (61%) making a total sample of 246. The questionnaire is part of an epidemiological research tool for drug use, risk behaviour and health in prisons.

Use before and during the imprisonment were investigated based on self-reports of prisoners. Half of the prisoners stated use during the last month before the imprisonment. A nearly similar proportion (42%) reported to use during current (or having used during previous) imprisonment(s) : current and previous imprisonment were investigated together in order to minimize refusals, although of course the anonymity was guaranteed.

In 1997, a self-administrated questionnaire was proposed to prisoners of 1 prison in Wallonia. Participation was voluntary : 115 men participated. The questionnaire is part of an epidemiological research of the European Network for AIDS Prevention in Prison [23].
The period of drug use before imprisonment is different as the above presented study : last year use. Nearly half of the prisoners reported cannabis use and one out of four cocaine before the imprisonment, and respectively 38 and 15% during the current or previous imprisonment.

In 1993, a study conducted in the Antwerp prison [24] among 1,627 prisoners (17-71 years, mean : 29 years) shows that 42% used an illegal drug at least once (lifetime prevalence).
On the other hand, studies (1989 [25] and 1994 [26]) reported that respectively 54% and 50% of drug users had at least once been imprisoned. It appears that a lot of drug users are imprisoned several times.

TABLE 20. *Drug use among prisoners, 1997* [23]

Drug	N responses	Prior to imprisonment Last year use		During imprisonment (previous and current imprisonments incl.) Last year use	
		Use %	Ever IV use %	Use %	IV use %
Any illicit drug	115	n.a.	22 (n=25)	n.a.	1.7 (n=2)
Cannabis	115	45		38	
Cocaine	115	23		15	
Heroin	115	n.a.		n.a.	
XTC	115	21		8	
Amphetamines	115	17		4	
LSD	115	11		9	

2.3. Problematic 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 [27]. 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).

2.3.1 National and local estimates

2.3.1.1 National prevalence estimate of intravenous drug users

A national prevalence estimate of problem drug use in Belgium was performed in 1999 [28]. In this exercise, the studied prevalence is that of intravenous drug users (IVDUs) [n]. The estimation is based on the 1995 data from the Belgian HIV/AIDS combined with the 1995 data from the drug treatment demand database of the French Community of Belgium (CCAD).

The number of IVDUs has been inferred from the number of alive HIV persons, the prevalence rate of IVDUs among HIV patients and the prevalence rate of HIV seropositivity among IVDUs.

The Belgian HIV/AIDS registry gives information on the risk factors associated with the HIV-seropositivity of patients diagnosed in 1995 (IVDUs among all known HIV positives registered by clinical laboratories). The treatment demand database of the French Community of Belgium (CCAD) provides information of the HIV-seropositivity self-reported by patients starting treatment and having at least once used a drug intravenously.

The number of intravenous drug users aged 15-54 years in Belgium is estimated as 20,200 corresponding to a prevalence rate of 3.6 per mille among 5 602 499 people aged 15-54 years. In most European countries, the number of HIV patients being also IVDUs is not directly available and must be estimated using the back calculation methodology [29]. The prevalence rate of IVDU using this approach was 0.34% in Denmark (1195), 0.38-0.48% in France (1995) and 0.42% in Ireland (1993). In Norway, the prevalence rate of IVDU was estimated to be in the range 0.29-0.42% using the multiplier method with mortality data (1997). The Belgian estimate of the prevalence rate of IVDU (0.36%) is therefore consistent with values found in other European countries with other methods.

2.3.1.2 Regional prevalence estimate of opiate users

Local prevalence of problem drug use in French Community of Belgium was estimated [30]. The method used is capture - recapture on the basis of the 1993 and 1994 data of the drug treatment demand database of the French Community of Belgium (CCAD). 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 21 presents the estimates where the results for the French Community are the addition of the figures of Brussels and Wallonia. Analysis were also performed for provinces. The prevalence estimate is the higher in the province of Liège : 7.9 / 1 000.

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n If n_{IDU} represents the number of injecting drug users (IDU) in a given population, and $n_{HIV \cap IDU}$ the number of IDU being HIV positive, the prevalence rate of HIV positive patients among IDU is given by (1) :

$$p(HIV \mid IDU) = \frac{n_{HIV \cap IDU}}{n_{IDU}} \quad (1)$$

The number of IDU may therefore be estimated from the equation (2) :

$$n_{IDU} = \frac{n_{HIV \cap IDU}}{p(HIV \mid IDU)} = \frac{n_{HIV} \cdot p(IDU \mid HIV)}{p(HIV \mid IDU)} \quad (2)$$

where n_{HIV} is the number of HIV positive patients in the population and $p(IDU \mid HIV)$ is the prevalence rate of injecting drug use among HIV patients.

TABLE 21. *Number and prevalence of opiate users in the French Community of Belgium, 1993-1994* [30]

Area	15-54 years population (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

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).

2.3.2 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.

2.3.2.1 Poly-drug use

- *Rock Festival (French Community), 1996-1999*

A survey on drug use is repeatedly conducted during a Rock Festival in the camp where 50,000 spectators live during the festival [31].
In 1999, 686 spectators were interviewed : 88% stated to use at least one illicit drug, 33% of respondents used exclusively one drug.

TABLE 22. *Proportion of poly-drug use, Rock festival, French Community of Belgium, 1996-1999* [31]

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

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 1999 compared to the three other years : thus these figures are probably representative of the whole population of the festival.

2.3.2.2 Injecting and sharing

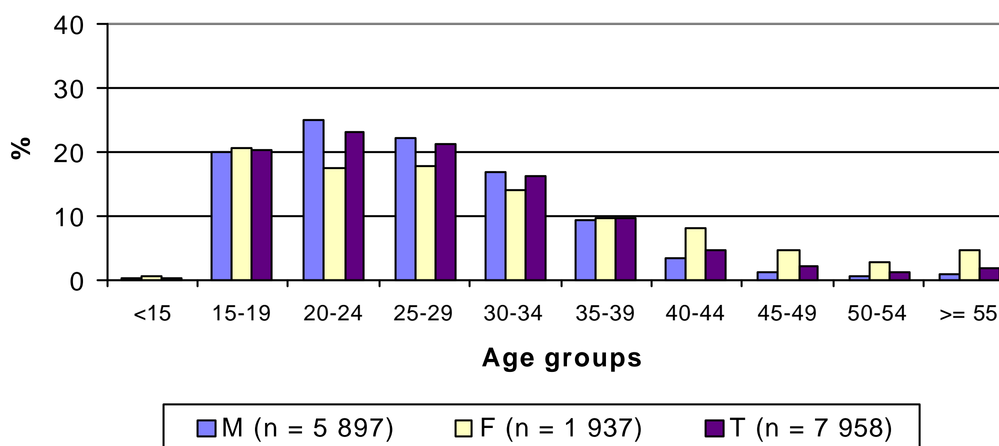
Determinants and consequences

3.1. Drug treatment demand

3.1.1 Number and characteristics of clients of treatment centres

For the first time, 'Belgian' figures are provided, based on the experience gained through the 2000 EMCDDA Treatment Demand Indicator exercise [32]. The figures have been obtained by pooling the data from the 3 regional systems. Despite some initial differences between categories reported by the CCAD, CTB/ODB and VAD registration systems, the pooling of the 1998 data was made possible thanks the running harmonisation process. The relevant institutions and regional monitoring systems in charge of data collection, processing and reporting as well as the currently harmonisation process for the development of a national information system are described in annex C.

In the three systems, around one third of treatment demands are located in specialised residential centres. Most of patients (68%) registered by VAD in 1996 demanded for treatment in units based in



general services (mental health care centres) whereas 50% and 74% of patients registered respectively by CCAD (1998) and CTB/ODB (1997) are treated in specialised non-residential centres.

The system of the Flemish Community (co-ordinated by VAD) registered 4,855 cases. One characteristic of the VAD database is its coverage of Centres of Mental Health Care where ambulatory treatments are offered and that attract a different population of drug users. In the CCAD and CTB-ODB systems, such centres are not covered at the moment. 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 example, the proportion of opiate users is respectively 67% and 73% in the CCAD and CTB-ODB databases in 1998 when it is 25% in VAD : consequently, the 1998 global Belgian table reports 43%).

Considering that these 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 that they do not cover, the Belgian TDI partners agreed that these pooled figures could be used as Belgian ones.

FIGURE 5 : *Age distribution of patients in Belgian treatment centres, CCAD, VAD, CTB-ODB, 1998*

In 1998, 7,958 patients from ambulatory and residential treatment centres undergoing treatment for problematic drug use (alcohol as first substance excluded) were recorded : 5,897 males and 1,937 females. 4,855 treatments were registered in the ambulatory and residential centres located in the Flemish Community[33], 1,466 in the French Community[34] and 1,836 treatments by centres of Brussels[35]. Table 23 shows the two-fold increase of the number of registered cases in the VAD system in 1998.

Figure 5 shows the age distribution of males and females patients for all treatments. Patients treated for the first time, as expected, are younger.

Almost 70% of applicants for care registered in 1998 CCAD database had already been taken care of on previous occasions and for 30% it was the first treatment. This figure is higher in the VAD database but the definition of first treatment is different : CCAD rules define first treatment as the first treatment for drug problem in any centre when for VAD it means the first treatment in the same centre.

TABLE 23. *Number, mean age and sex ratio of people undergoing treatment and proportion of first demands, French Community, 1993-99, Flemish Community, 1996 and 98, Brussels Region, 1997-98*

	CCAD [34]						VAD [33]		CTB / ODB[35]	
	1993	1994	1995	1996	1997	1998	1996	1998	1997	1998
Nr of ALL treatments	1,618	1,212	1,176	1,570	1,681	1,466	2,374	4,855	1,810	1,836
Mean age	26.8	26.1	27.3	26.9	27.4	31.5	26.6	26,2	30.0	30.5
Male/female sex ratio	3.3	3.4	3.3	2.9	2.8	3.2	3.0	3.0	3.6	3.2
Nr of FIRST treatment demands	513	390	352	497	547	447	-	2,568	-	-
% first demands / all demands	31.7	32.2	29.9	31.7	32.5	30.5	-	(52.9) [o]	-	-

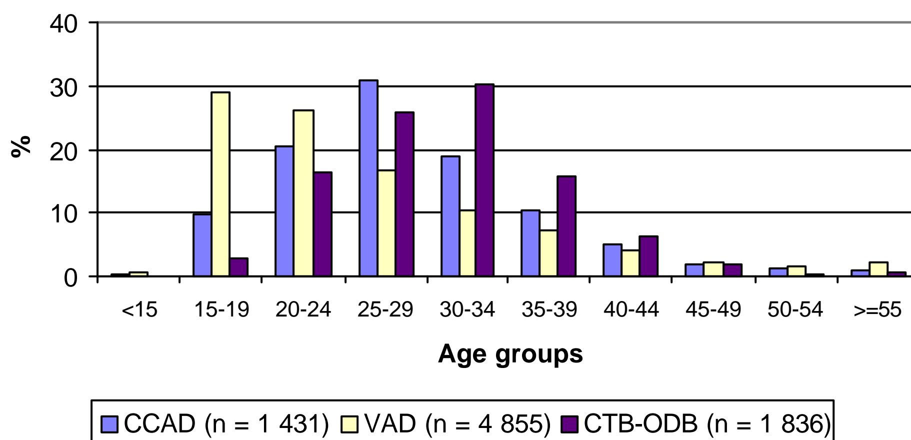
In 1998, the mean age of 'VAD' patients is younger (26.2 years) compared to CCAD (31.5 years) and CTB-ODB (30.5 years) systems. Mean age is slightly increasing over time in CCAD database. There are 3 times more demands from males than females while this ratio is stable over years and similar in the three systems. Table 23 does not show any other particular trend within each system from 1993 to 1998, but that should be investigated in relation to the coverage of the respective monitoring systems.

Figure 6 and Table 24 show the difference in the age distribution of the population covered by both CCAD and CTB-ODB (older population) and VAD (younger) registration systems.
For 1998 in the CCAD and CTB/ODB data, the 15-24 years old represent respectively 29% (decreasing from 42% in 1993) and 19 % and the 25-34 years old are respectively 49% and 56%. The proportion are at the opposite for the VAD 1998 data : 57% of the sample are aged less than 25 years (30% less than 20 years and 26% 20-24 years aged) and 27% are 25-34 years of age.

FIGURE 6 : *Age distribution of patients starting treatment: comparison between CCAD, VAD, CTB-ODB treatment databases, 1998*

o The definition of first treatment is different : CCAD : first treatment for drug problem in any centre; VAD : first treatment in the same centre.

Age distribution - All treatments - Belgium



These differences in the age of the population covered should be taken into account when comparing the stated type of drug used by the patients from the different systems.

TABLE 24. *Number and age distribution of people undergoing treatment in centres of the French Community, 1993-98, Flemish Community,1996 and 98, and Brussels Region, 1997-98*

		CCAD [34]						VAD [33]		CTB / ODB[35]	
		1993	1994	1995	1996	1997	1998	1996	1998	1997	1998
Nr of ALL treatment demands		1,618	1,212	1,176	1,570	1,681	1,466	2,374	4,855	1,810	1,836
Mean age		26.8	26.1	27.3	26.9	27.4	31.5	26.6	26.2	30.0	30.5
Age	<15	0.3	0.7	0.4	1.1	1.4	1.0	2.0	2.0		0.0
Distrib.	15-24	42.5	41.9	39.6	40.0	36.0	29.3	**50.0**	**54.7**	21.0*	19.1
	25-34	46.6	50.2	46.3	47.4	48.4	**48.6**	29.3	27.0	**62.0**	**56.2**
	35-44	8.2	6.6	9.9	8.1	11.3	13.6	12.5	11.3	17.0**	21.9
	45-54	2.0	0.5	2.5	2.8	1.7	2.0	4.5	3.6		2.4
	>=55	0.7	0.2	1.2	0.7	1.1	0.5	1.5	2.3		0.5

* : <25 years; ** : > 34years

3.1.2 Hospital discharges: RCM/MKG and RPM/MPG

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 analysed. We present some results extracted from the first issue of the RCM/RPM Flash [36]. 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

TABLE 25. *Annual number of stays related to drug use in medicine/surgery (1995) and psychiatric units (1996-97) of Belgian hospitals*

	Medicine and 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

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.

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 can not be estimated as most of them are treated in emergency units, not yet covered by the RCM/MKG nor RPM/PMG systems.

3.1.3 Substitution treatment and methadone

Some data are available from treatment centres (French Community) and from the Ministry of Public Health (Inspection Générale de la Pharmacie-Service des Stupéfiants / Dienst Verdovende Middelen van de Algemene Farmaceutische Inspectie).

3.1.3.1 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, specialised centres were practically the only ones to offer methadone treatment in Flanders).
Among patients demanding treatment in the centres of the French Community [34], 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 years (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 26. *Number and characteristics of people undergoing methadone substitution treatment, French Community, CCAD, 1998* [34]

	All substitution treatments			First substitution treatments		
	Males	Females	Total	Males	Females	Total
N people	139	55	194	27	13	40

Mean age	29.0	30.0	29.3	28.2	27.1	27.8
Age distribution (%)						
<25	38.8	23.6	34.5	33.3	30.8	32.5
25-39	53.9	67.3	57.7	59.3	69.1	62.5
40 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	-	-	-

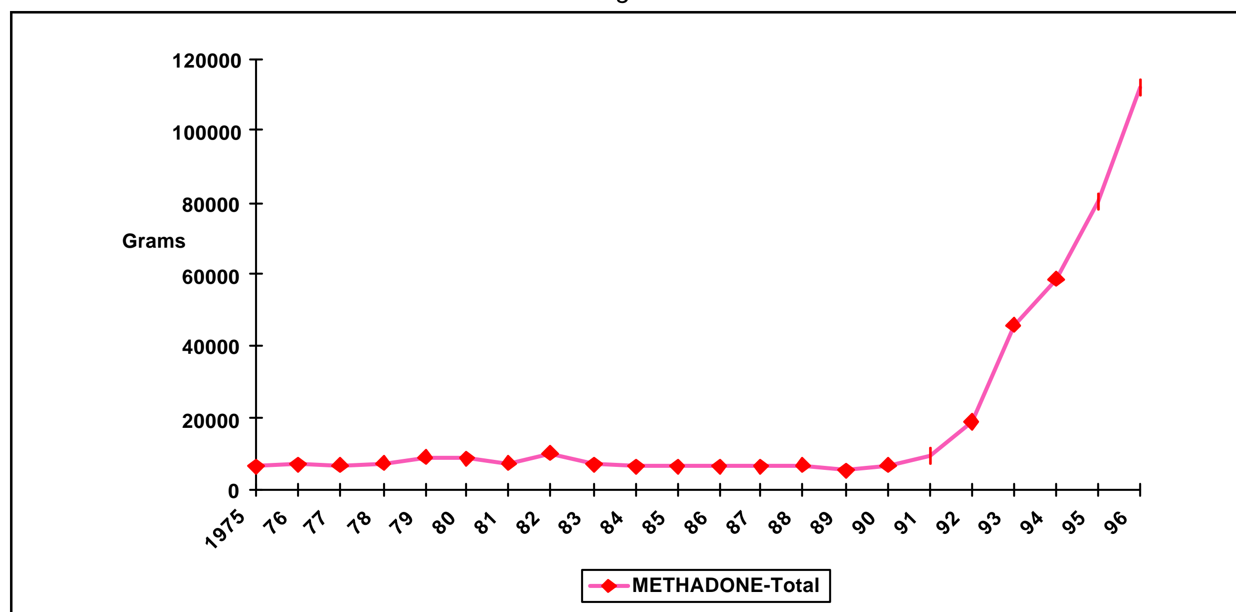
The mean age at starting methadone substitution in centres of the region of Charleroi [37] is stable (respectively 24.2, 23.3, 23.6, 13.9 and 24.1 years from 1995 to 1999) and started 4 years after the first use of methadone (4.1 to 4.8). Twelve percents of substituted patients got at least once methadone 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 [38].

3.1.3.2 Estimate of the number of people undergoing methadone substitution

Figure 7 presents the quantities of methadone sold in Belgium [39] based on data centralised by the Ministry of Public Health - General Pharmaceutical Inspectorate (Inspection Générale de la Pharmacie-Service des Stupéfiants / Dienst Verdovende Middelen van de Algemene Farmaceutische Inspectie).

FIGURE 7 : *Trend of release of methadone in Belgium from 1975 to 1996**



* : 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 mediatisation 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 7. The increasing trend is continuing in 1997 (preliminary data to be confirmed).

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,...).

3.1.4 Patterns of use

- *Treatment centres (French Community), 1995* [34]

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* [37]

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 27). The methadone first use age (it means the start of the substitution treatment) is stable : 24.1 years in 1999.

TABLE 27. *Age at first use of substances, Charleroi, 1995-1999* [37]

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

3.2. Drug-related mortality

3.2.1 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 [p], 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 underinclusivity 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 28. *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. In 1993, the responsibility of the processing of the forms moved from the federal level (NIS) to the Community levels. It could probably explain the increased number of ‘accidental poisoning’ (E850-E858) and the corresponding decrease 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 29 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 29. *Proportion of drug related deaths according to the toxicological cause, Belgium, 1991-1995*

Toxicology

1991
1992
1993
1994
1995

% of cases with known toxicology

p 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.

40%
51%
58%
56%
60%

of which

total % with opiate (+any drug)

32%
27%
47%
48%
53%

total % any drug without opiates

68%
77%
53%
52%
47%

3.2.2 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 recognised as such and recorded by the police services. Although Table 30 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 30. *Number of overdoses recorded by police services, Belgium, 1991-1995* [40]

	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

3.2.3 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 [41,42]. 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 generalisation of these results is difficult.

3.3. Drug-related infectious diseases

Epidemiological situation regarding drug-related infectious diseases is presented as special key issue (Part IV Chapter 15).

3.4. Other drug-related morbidity

3.4.1 Non-fatal drug emergencies

No information gathered.

3.4.2 Psychiatric co-morbidity

No information gathered.

3.4.3 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 [43]. 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 4 university hospitals (Gent, Leuven, Brussels, Liège) and 1 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 31 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 31. *Prevalence of detection of alcohol, medications or illicit drugs in victims of traffic road accidents, Belgium, 1995-1996* [43]

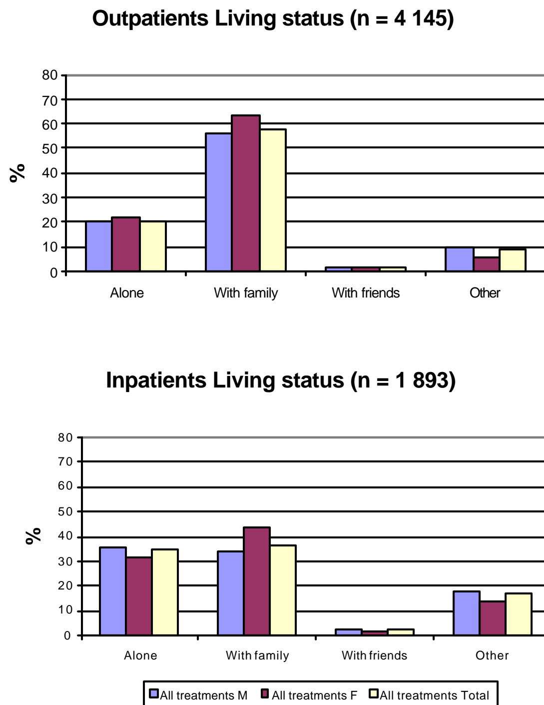
Substance (sample)	N analysed	N positive [q]	Prevalence (%)
Alcohol (blood)	1,871	529	28.3
Benzodiazepines (blood)	1,871	160	8.5
Opiates (urine)	1,879	141	7.5
Medical use		103	
Non-medical use		38	
Cannabis (urine)	1,879	113	6.0
Amphetamines (urine)	1,879	56	3.0
Barbiturates (urine)	1,879	25	1.3
Cocaine (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 benzodiazepine-positive; 8.5% of 14-17 were cannabis-positive and 12% of 18-24 years old [r].

q Limits as follows : 5 pro mille for alcohol , presence for other substances.

4.1. Social problems

4.1.1 Social exclusion (housing, unemployment)

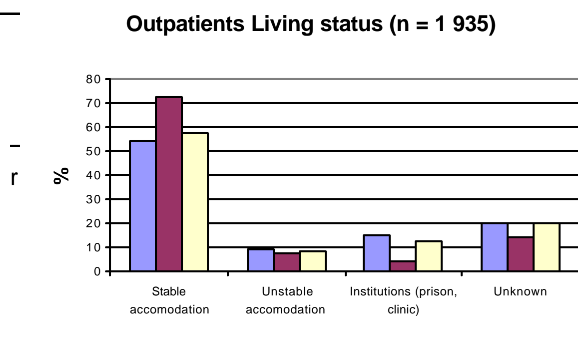


We present information based on data collected by treatment centres and the regional monitoring systems of the different parts of the country (CCAD – French Community, VAD - Flemish Community, CTB-ODB - Brussels-Capital). Through the treatment demand indicator, information on social characteristics of the patients is available.

Sixty percents of patients undergoing ambulatory treatment are living with members of their family (parents and/or partners and/or children). Among residential patients, one out of three is living alone (Figure 8). Women life more often with members of the family.

FIGURE 8 : *Distribution of the living status (alone or not) of patients undergoing residential or ambulatory treatment, CCAD, VAD and CTB-ODB monitoring systems, 1998, Belgium*

FIGURE 9 : *Distribution of the living status (stable or unstable) of patients undergoing residential or ambulatory treatment, CCAD and CTB-ODB monitoring systems, 1998, Belgium*



r ... e after several weeks of abstinence, it does not mean that

Around 22-24% of patients are living in unstable accommodations or in an institution (respectively 14 and 10% of 'residential' patients and 9 and 13% of outpatients ; Figure 9 ; VAD data not available). Women are less often living in an institution and benefit more often a stable accommodation.

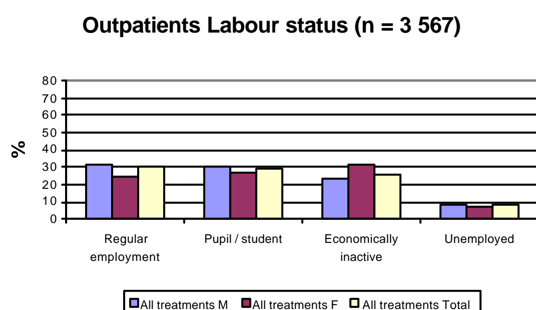


FIGURE 10 : *Distribution of the labour status of patients undergoing residential or ambulatory treatment, CCAD and VAD monitoring systems, 1998, Belgium*

Around one third of patients are economically inactive or unemployed. Comparing in- and outpatients, one observes that 60% of inpatients has a regular employment compared to 30% only among 'ambulatory' patients and that 30% of outpatients are pupils or students (only 10% of inpatients) (Figure 10 ; CTB-ODB data not available). There are no difference between males and females.

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[44]. The average age of the patients was 27.2 years (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 behaviour (in 40% of cases, this was indicated either by a suicide attempt or by a request for hospitalisation). 32% came to the department requesting hospitalisation 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.

4.1.2 Public nuisance, community problems,

No information available.

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 [s]' 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 vary largely between police units.

To distinguish between police and custom reports is not possible at the moment in Belgium.

4.2.1 '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 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.

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s 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.

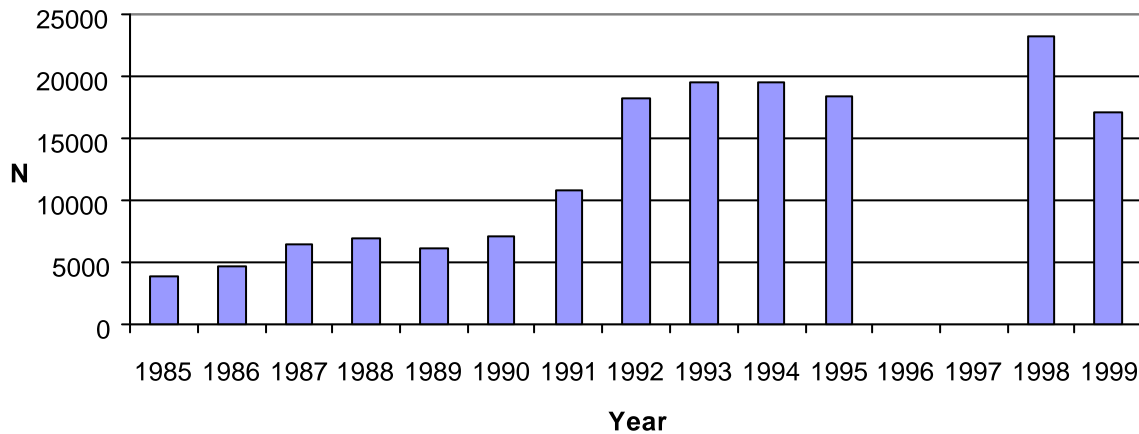


Figure 11 is based on data supplied by the police and shows the number of people involved in affairs connected to narcotics, bringing together users, as well as dealers and (international) traders.

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 11 : *Number of people involved in narcotics affairs, Belgium, 1985-1999* [45]

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 32).

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 33).

TABLE 32. *Number and proportion of infringements related to narcotics according to the type of infringement, Belgium, 1996-1998* [46]

	Possession/ Use		Trafficking		Other	Total
	N	%	N	%	N	N
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 33. *Proportion (%) of infringements or people involved in narcotics affairs (possession for abuse or trafficking) according to the type of drug, Belgium, 1995, 1997,1998 and 1999* [47]

	1995	1997	1998	1999
Unit analysed	N infringements 28,117	N infringements ?	N people 23,184	N people 17,604
Narcotics				
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**
Psychotropic substances				
Stimulants Speed	2.4	8.0	0.9	15.6
XTC	0.5		(all	
Amphetamines	0.6	8.0	stimulants)	
Depressants (including methaqualone)	0.9		0.9	2.0
LSD and other hallucinogenic agents	1.5		2.2	2.4
Other		7.0		2.0
TOTAL	100%	100%	100%	100%

Analysis based on the ‘Uniform forms’.

TABLE 34. *Number and proportion of infringements related to narcotics affairs according to the type of drug and type of infringement, Belgium, 1995* [47]

	Possession for abuse		Trafficking		Total	
	N infringements	%	N infringements	%	N infringements	%
Narcotics						
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**
Psychotropic Substances						
Stimulants 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 and other hallucinogenic agents	405	1.5	28	4.3	433	1.5
Total	26,315	100%	516	100%	26,831	100%

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 34).

4.2.2 Convictions and court sentences for drug offences and imprisonment for drug law offences

Reports of sentences are centralised 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 analysed as the required computerisation of this information system is nearly completed.

In 1994, 5,606 sentences were recorded with at least one qualification connected to "narcotics". Table 35 presents the 4,963 sentences where the information on *consumption and/or trafficking* is available.

Of the 2,016 judgements where *consumption* was the infringement, only 30% are joined with another infringement, 70% being related to *consumption* alone. Among these 2,016 judgements 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 35. *Main sentences handed down connected with narcotics, Belgium, 1994* [48]

	Fines		Custodial sentence		Suspended prison sentence		Total	
	N	%	N	%	N	%	N	%
Consumption	299	15	635	32	1,082	54	2,016	41
Trafficking	12	4	101	36	167	60	280	6
Consumption and 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.

4.2.3 Drug-related crime

4.2.4 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[t].

Table 36 shows that comparable proportions of treatment demands (respectively 18 and 19% in 1997 and 1998) were referred by Court/probation/justice services. According to the type of treatment (ambulatory/outpatient or residential/inpatient care), one observes that a fourth of patients undergoing ambulatory treatment are referred by Court/probation/justice services, what is higher than patients treated in residential centres (7%).

[t] For a description of the various registration systems, please see Part II : Epidemiology.

TABLE 36. *Source of referral (%) of patients starting treatment in 1997 and 1998, CCAD/CTB-ODB/VAD, Belgium*

	1997*			1998			1998 Outpatient **			1998 Inpatient **		
	M	F	T	M	F	T	M	F	T	M	F	T
Number of cases	4,154	1,434	5,785	4,910	1,637	6,649	3,148	1,060	4,232	1,762	637	2,417
	%	%	%	%	%	%	%	%	%	%	%	%
Self referred, family, friends	**40**	**41**	**41**	**43**	**40**	**43**	**38**	**35**	**37**	**54**	**49**	**53**
Other drug treatment centre	13	15	13	16	17	17	14	13	14	20	24	21
GP,hospital,oth.med.sources	13	20	16	12	16	13	12	14	12	14	20	16
Social service	5	5	5	3	3	3	3	4	4	1	0	1
Court,probation,justice	21	9	18	20	17	19	**25**	**26**	**25**	9	4	7
Other	7	11	8	6	6	6	7	8	8	2	3	3

* : Data from CCAD and CTB/ODB are actually 1997 treatment demands when VAD data are 1996 treatment demands.

** : Outpatient : data from centres offering ambulatory care / Inpatient : residential centres

4.3. Social and economic costs of drug consumption

a) Studies and estimates of health care costs, other social costs

No information gathered.

b) Estimates of total consumption/demand/expenditure on drugs

No information gathered.

Chapter 5. Drug Markets

5.1. Availability and supply

5.1.1 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 [45].

Based on several investigations and seizures, a new trend is 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 organisation used this kind of operating way.

5.1.1.1 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).

5.1.1.2 Cocaine

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 harbours 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.

5.1.1.3 Cannabis

Cannabis is a popular drug in Belgium. Cannabis 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.

5.1.1.4 XTC

XTC is imported especially from The Netherlands and Eastern Europe, but also Belgium is a producing country.

5.1.2 Availability of different drugs, trends and possible reasons

Information on adults perceptions about the availability of cannabis and cocaine is investigated continuously by the health behaviour monitoring carried out in the French Community. Various surveys investigated pupils about the actual availability of illicit drugs.

- Health behaviour monitoring (French Community), 1996-97 and 1998-99 [49]

The health behaviour monitoring reports that 2/3 of adults (18-49 years) believe possible to get cannabis and 45% cocaine near to their house.

- Youngsters in Brussels, 1997 [50]

In this qualitative study, 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.

- School-aged youngsters in Bruges (Flanders), 1996-97 [15]

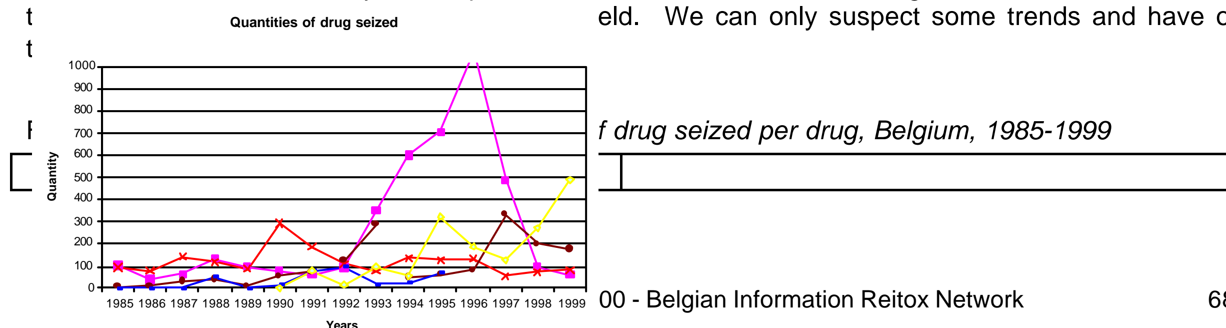
3,475 pupils aged 16-18 from 18 schools of Bruges participated in 1996-1997 in a study about the relation between the use of drugs and the environment of school-aged youngsters. There was a question about how they get their drugs.
More than one out of three (39%) of the users stated that he/she has asked himself/herself for the first product ; 28% got it from friends, 4% got it from his boy- or her girlfriend and 2% got it from another person.

- Mental health of youngsters in Brussels, 1994 [17]

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).

5.2. 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 t ... eld. We can only suspect some trends and have of t



F ... f drug seized per drug, Belgium, 1985-1999

Globally the number of drug seizures have increased in the nineties, reaching a maximum around 1995 for most narcotics (as far as we know because data of 1996 and 1997 are missing). After increasing up to 1995, the number of cannabis seizures stabilised in 1998 and decreased in 1999 (Figure 12). The number of heroin, cocaine and LSD seizures has increased up to 1992, than levelled off to decrease in 1998 and 1999.
At the opposite, those for amphetamines and ecstasy showed a higher and continuous increase up to 1998 and a slight diminution in 1999.

TABLE 37. *Number and quantity of seizures per drug, Belgium, 1996-1999* [45]

	1996		1997		1998		1999	
	N	Quantity (kg)	N	Quantity (kg)	N	Quantity (kg)	N	Quantity (kg)
Cannabis	na	106 690	na	48 705	**13 020**	9 609	**7 362**	5 847
Cocaine	na	838	na	3329	799	2 088	547	1 761
Heroin	na	133	na	55	1112	75	720	83
Amphetamines / XTC(pills)	na	184 413 pills	na	126 211 pills	2672	271 080 pills	2 163	489 566 pills
LSD (pills)	na	13 704 pills	na	621 pills	75	2 050 pills	73	1 047 pills

All seizures are included (Police, Coast Guard and Customs) / na : non available

Over the past 10 years, cannabis quantities 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 37).
The quantities of other drugs seized have been fluctuating 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.
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.

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 trafficants : the current policy/strategy when a traffic is discovered, is to postpone the intervention (arrest of the trafficants 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, 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
- specific reduction of police resources dedicated to the fight against cannabis consequently to the directive of 1998.

5.3. Price/purity of illicit drugs

TABLE 38. *Wholesale- and retail prices (BEF) of drugs, Belgium, 1993,95,97,98,99* [51]

Products	Wholesale sale (BEF/g) (from supplier to dealer)					Retail sale (BEF/g) (from dealer to consumer)				
	1993	1995	1997	1998	1999	1993	1995	1997	1998	1999
Cannabis	65-80	30-175	60 - 100	35 - 70	35-70	200-500	150-400	100 – 600	250	250
Heroin	950	600-900	600 - 1,000	600	600-800	3,000-4,000	800-2,250	1,500	1,500	1,500
Cocaine	950-1,650	460-900	800 - 1,200	700	600-1,200	1,500-3,000	1,200-2,750	1,200-2,000	2000	1,500-3,000
Crack							1,000			
Amphetamine	120-250					1,000				
XTC (by tab)	150	120-250	20 – 100		40-50	800-1,500	500	250 – 400		300-400
LSD (per dose)			80				100-350	300		

TABLE 39. *Wholesale- and retail prices (EURO) of drugs, Belgium, 1993,95,97,98,99* [51]

Products	Wholesale sale (EURO/g) (from supplier to dealer)					Retail sale (EURO/g) (from dealer to consumer)				
	1993	1995	1997	1998	1999	1993	1995	1997	1998	1999
Cannabis	1.5-2	0.7-4.5	1.5-2.5	0.9-1.8	0.9-1.8	5-12	4-10	2.5-15	6	6
Heroin	24	15-22.5	15-25	15	15-20	74-92	20-56	35	35	35
Cocaine	24-41	12-22.5	20-30	17.5	15-30	35-75	30-68	30-50	50	35-75
Crack							25			
Amphetamine	3-6					25				
XTC (by tab)	4	3-6	0.5-2.5		1-1.2	20-37	12.4	6-10		7.5-10
LSD (per dose)			2				2.5-9	7.5		

TABLE 40. *Products seized: number of seizures and amounts (1985-1999), Belgium* [45]

	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Cannabis (N)	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
Quantity (kg)	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
Heroin (N)	321	423	507	869	887	1.045	1,732	3,316	3,082	3,024	3,158	NA	NA	1,112	720
Quantity (kg)	92	78	141	116	89	291	186	107	76	137	129	133	55	75	83
Cocaine (N)	132	226	254	380	422	375	513	933	897	927	1,046	NA	NA	799	547
Quantity (kg)	62	116	270	404	89	537	756	1,222	2,892	479	576	838	3,321	2,028	1,761
Amphet. (N)	38	54	92	151	81	66	85	92	124	106	102	see XTC	see XTC	see XTC	see XTC
Quantity (kg)	3.5	2.4	9.0	47	4.2	15	77	96	19	23	68	see XTC	see XTC	see XTC	see XTC
XTC/Ecstasy (N)						18	196	267	560	872	1002	NA	NA	2,672	2,163
Quantity (pills/tablets)						1,654	75,742	15,240	98,215	55,637	320,441	184,413	126,211	271,080	489,566
LSD (N)	38	7	32	22	22	36	88	233	254	301	281	NA	NA	75	73
Quantity (doses)	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

NA : not available / see XTC : Amphetamines and XTC have been pooled from 1996 onwards

Chapter 6. Trends per drug : overview

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 41. *Synthesis table of epidemiological indicators on CANNABIS : use in adult and school-aged population, offences, seizures, price and accessibility, Belgium, 1993-1999 (Figures are percentages except when specified)*

INDICATORS	ORGANISATION (reference nb)	1993	1994	1995	1996	1997	1998	1999	Trend
ADULT POPULATION									
Lifetime prevalence	Vlaamse G. 6		5.8						
	ULB/Promes 7					12.8		20.8	?
Last year preval.	Vlaamse G. 6		1.5						?
SCHOOL POPULATION (15 -16 y.)									
Lifetime prevalence	RUG/Publ.Hlth 9		14.9		19.6		23.7		
	VAD 11							24.1	
	ULB/Promes 10						27.9		
Last month preval.	RUG/Publ.Hlth 9		7.6		10.8		14.6		
PROBLEMATIC USE Treatment demands (% cannabis= main drug)	CCAD 34	3.8	5.7	6.2	11.9	13.2	14.0		
	VAD 33				22.0		30.3		
	CTB 35					6.6	7.6		
PEOPLE TAKEN IN for questioning (% cannabis / all offence)	SGAP 46			72.7		65.0	65.7	68.6	=
SEIZURES (N)	SGAP 47	6,380	8,628	13,379			13,020	7,362	
RETAIL PRICES (euro)	SGAP 47	8		7		9	6	6	=
ACCESSIBILITY (adults)	ULB/Promes 7				59.2	70.4	62.9	64.5	=

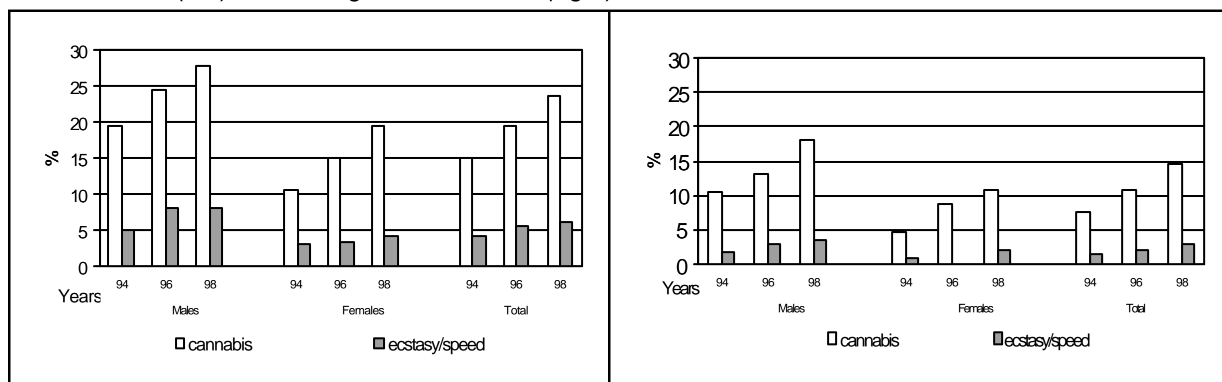
It is uneasy to generalise these figures to the whole country, to compare between data and to find out trends, nevertheless one observes that :

- the use of cannabis in adult and secondary school population is increasing over the 1990's;
- 1 in five adults (French Community) experienced cannabis at least once (corresponding to the European mean figure);
- at the age of 15-16 years, 1 in 4 already experienced (equal to the European mean figure), among which the half used cannabis during the last month. The lifetime prevalences of use of cannabis are regularly increasing from 1994 to 1998 from 15 to 25 %; respectively 20-25-30 % in boys and 10-15-20 % in girls experienced cannabis at least once. The proportion of last month users among 'lifetime' users of cannabis increases: respectively 51-55-62 %;
- 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 increased during recent years but decreased in 1999;
- 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, 1990-94-96-98 [9]

Cannabis is the most used illicit drug : 24% of 15-16 year old boys and 46% of 17-18 year old boys had ever used. Figures show an increasing 1994-1996-1998 trends for cannabis use among 15-16 year old as well in boys as in girls. Although about 50% of boys who ever used cannabis stopped, for the other products this percentage is higher. Globally and as well for boys as for girls, an increasing proportion of cannabis users (ever used) are 'regular' ones (defined as last month use): 50%, 55% and 62 % respectively in 1994, 96 and 98. It is particularly striking among youngsters of 15-16 (presented here) and also among 14 years old students (42%, 53% and 58% respectively). The age of first use for the age group 15-18 was quite similar over the 3 consecutive studies : from 15.1 year old in 1994 and 1996 to 14.8 in 1998.

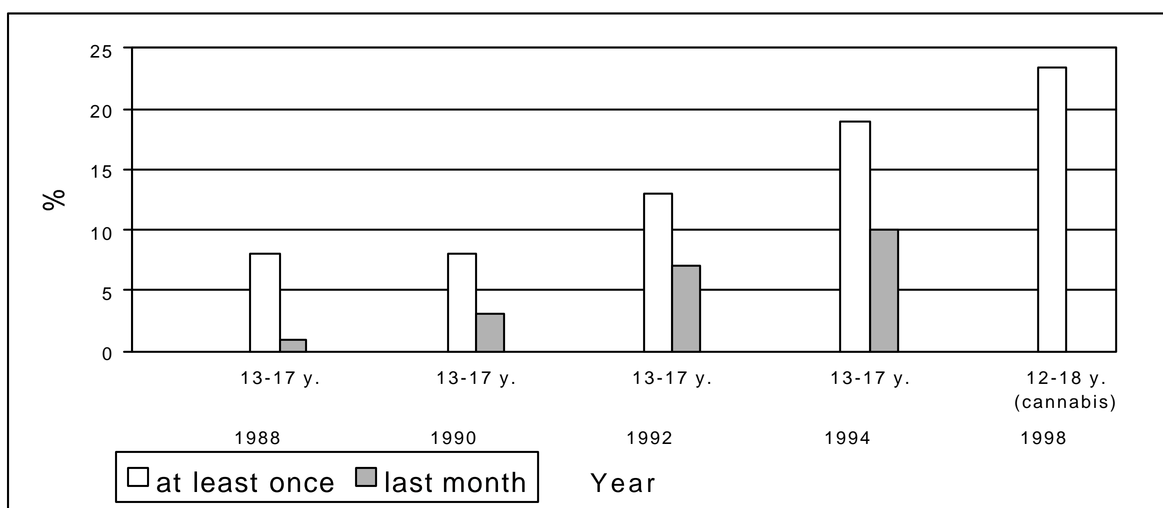
FIGURE 13 : *Proportion of students aged 15-16 years having used cannabis, XTC at least once (left) and during the last month (right), Flemish schools, 1994, 96 and 98 3*



- HBSC survey : Health behaviour and life-styles of youngsters in the French Community, 1988-1998[10]

Cannabis represents an increasing proportion of the drug used (respectively 35, 40, 40, 84% in 1988, 1990, 1992 and 1994). In 1998, 28% of 15-16 years (boys : 31% - girls : 25%) experienced cannabis. The use increases with age : from 5% among 11-12 years and 12% among 13-14 years reaching 44% in 17-18 years (boys : 51% - girls : 39%).

FIGURE 14 : *Proportion of youngsters having used a drug at least once and during the last month, French Community secondary schools, 1988, 1990, 1992 and 1994*



- Qualitative research on cannabis,1998 [52]

A qualitative exploratory survey was conducted in Brussels in July 1997. Twenty-two 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.

- Survey in Flemish Schools, 1999 [11]

In 1999, the lifetime prevalence of cannabis use is 24.1% of 15 to 16- year-olds (boys : 29% - girls : 19%) experienced cannabis. The use increases with age : from 1% among 11-12 years and 6% among 13-14 years reaching 39% in 17-18 years (boys : 48% - girls : 28%).

- Social diagnosis in 3 secondary school in Verviers (Wallonia), 1999 [13]

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).

- School survey on drugs in Charleroi (Wallonia), 1999 [14]

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).

- School-aged youngsters in Bruges (Flanders), 1996-97 [15]

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.

- Mental health of youngsters in Brussels, 1994 [17]

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.

- *Rock Festival, 1998* [31]

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).

- Treatment centres, 1993-1998

The most recent data from the treatment demand registration systems of the French Community (CCAD, 1993 to 1998), the Flemish Community (VAD, 1996 and 1998) and Brussels (CTB-ODB, 1997-1998) are compared. 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 1998 by 30% of clients in the Flemish Community, by 14% of the French Community (4% in 1993) and only by about 8% in Brussels (but cannabis is more and more often stated as 'secondary' substance). Among first treatment demands (French Community), cannabis represented 27% in 1998.

- Drug use among prisoners, 1993 [24]*,*1997 and *1999* [22]

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).

- Drug telephone line (French Community), 1997 [53]

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%).

6.2. Synthetic drugs (amphetamine, ecstasy, LSD)

TABLE 42. *Synthesis table of epidemiological indicators on XTC : use in adult and school-aged population, offences, seizures, price and accessibility, Belgium, 1993-1999 (Figures are percentages except when specified)*

INDICATORS	ORGANISATION (reference nb)		1993	1994	1995	1996	1997	1998	1999	Trend
ADULT POPULATION										
Lifetime prevalence	Vlaamse G.	6		0.5						
Last year preval.	Vlaamse G.	6		0.1						?
SCHOOL POPULATION (15-16 y.)										
Lifetime prevalence	RUG/Publ.Hlth	9		4.1		5.6		6.2		
	VAD	11							4.0	
	ULB/Promes	10						6.3		
Last month preval.	RUG/Publ.Hlth	9		1.4		2.0		2.8		
PROBLEMATIC USE										
Treatment demands (% XTC-stim. = main drug)	CCAD	34	0.6	2.0	2.7	2.8	3.2	1.5		?
	VAD	33				20.1		22.0		
	CTB	35					7.2	10.3		
PEOPLE TAKEN IN for questioning (% XTC-amph./all offence)	SGAP	46			3.5		16.0	0.9	15.6	~~
SEIZURES (N)	SGAP	47	684	978	1,002			2,672	2,163	
RETAIL PRICES (euro)	SGAP	47	28		12		8		9	
AVAILABILITY (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 XTC use in adult is out-dated : 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 15-16 years, a slightly increasing proportion of students (reaching 6% in HBSC 1998 surveys - respectively 7 % in boys and 4 % 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 34-36-45 % in 1994, 96 and 98;
- the proportion of patients starting treatment and stating XTC as their main problematic drug seems increasing; in centres participating to the Flemish VAD monitoring system, XTC and stimulants users (not including cocaine) represent 22% of clients in 1998 but only 10% in Brussels CTB-ODB (including cocaine) and around 2% in CCAD 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 9 Euro (360 BEF) for a tablet in 1999;
- no information on accessibility in adults is available.

- HBSC survey :Youngsters and health in Flanders, 1994-96-98 [9]

Globally more boys than girls used illegal drugs. Cannabis was most popular followed by speed/XTC (Fig. 2 and 3). 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 (a least once).
For XTC, a third of 15-16 year users were 'regular' in 1994 and 1996, whereas this proportion increases up to 43% in 1998 and 1999.

- HBSC survey :Health behaviour of youngsters in the French Community, 1988-98 [10]

In 1998, 6% of 15-16 years (boys : 7% - 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 : 14% - girls : 9%). The proportions are similar for amphetamines (10% among 17 to 18-year-olds).

- Survey in Flemish Schools, 1999 [11]

In 1999, 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 : 11% - girls : 5%).
The lifetime prevalence of amphetamines is slightly higher : 6% of 15 to 16- year-olds (boys : 8% - girls : 5%). Use increases with age : from 0.6% among 11-12 years and 2% among 13-14 years reaching 11% in 17-18 years (boys : 14% - girls : 8%).

- School-aged youngsters in Bruges (Flanders), 1996-97 [15]

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'.

- Mental health of youngsters in Brussels, 1994 [17]

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 15-18 age group who have tried barbiturates is higher than for boys in the same age group.

- Rock Festival (French Community), 1998 [31]

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.

- Treatment centres

In 1998, stimulants including amphetamines and XTC are considered the main drug by 30% of treatment patients of the VAD Flemish Community monitoring system, by 8% in CTB-ODB Brussels centres (including cocaine) but only by a tiny fraction of the CCAD French Community system (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 3% in 1998 (males 2%, females 5%); most of this 'stimulants' category are XTC users (males 2%, females 4%).

Among patients undergoing treatment in a centre of the Charleroi [37], the mean age at first use of LSD and XTC was respectively 19 and 20 years. XTC and LSD are less frequently daily used among patients undergoing treatment in these centres.

- *Street snowball survey, 1998* [54]

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 25%.

- *Drug consumption in prison, 1993* [24]

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.

- *Drug telephone line (French Community), 1997* [53]

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%.

- *Survey on Drug Use at mega house exhibition* [55]

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 one-page 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 (χ^2 (1) = .98, p = ns) or frequency of using amphetamines (χ^2 (1) = .01, p = ns).

XTC users go out more frequently than users of other substances or than non-users 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 whole 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 non-users 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 43. *Synthesis table of epidemiological indicators on HEROIN/OPIATES: use in adult and school-aged population, offences, seizures, price and accessibility, Belgium, 1993-1999* (*Figures are percentages except when specified)*

INDICATORS	ORGANISATION (reference nb)	1993	1994	1995	1996	1997	1998	1999	Trend
ADULT POPULATION									
Lifetime prevalence	Vlaamse G. [6]		0.04						?
Last year preval.	Vlaamse G. [6]		0.00						?
SCHOOL POPULATION (15 -16 y.)									
Lifetime prevalence	RUG/Publ.Hlth [9]		0.7		0.6		0.7		=
	VAD [11]							0.8	
	ULB/Promes [10]						3.4		
Last month preval.	RUG/Publ.Hlth [9]		0.1		0.1		0.2		=
PROBLEMATIC USE									
Heroin use prevalence (‰)	CCAD [31]		6.3						?
Treatment demands (% opiates = main drug)	CCAD [34]	86.0	85.1	77.3	74.3	67.7	69.4		
	VAD [33]				39.5		22.1		
	CTB [35]					77.1	72.7		
Injecting use (current)	CCAD [34]	35.9	40.9	39.9	37.0	37.3	35.3		=
	Coor.Drog.Charl [37]							17.1	=
	VAD [33]						26.6		
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 [46]			16.5		7.0	25.6	5.9	~~
SEIZURES (N)	SGAP [47]	3,082	3,024	3,158			1,112	720	
RETAIL PRICES /g (euro)	SGAP [47]	83		38		35	35	35	
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 out-dated : 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 3% 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 1998, heroin/opiates users represent around 70% of clients in centres participating to French Community CCAD and Brussels CTB-ODB systems but only 22% in the Flemish VAD monitoring system (these differences seems 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, 1994-96-98 [9]

As regarding other illicit drugs more boys than girls use opiates : respectively 1.2 and 2.2% of boys aged 15-16 and 17-18 years used heroin at lest once for respectively 0.3 and 0.4 in girls of the same age groups. Respectively 0.3 and 0.5% of boys aged 15-16 and 17-18 years used during the last month when nearly none girls did it.

- HBSC survey :Health behaviour of youngsters in the French Community, 1988-98 [10]

In 1998, 3% of 15-16 years (boys : 4% - girls : 2%) experienced heroin. The use increases with age : from 1.4% among 11-12 years and 3% among 13-14 years reaching 3% in 17-18 years (boys : 4% - girls : 2%). The proportions are similar for amphetamines (10% among 17 to 18-year-olds).

- Survey in Flemish Schools, 1999 [11]

In 1999, the lifetime prevalence of heroin use is 0.9% of 15 to 16- year-olds (boys : 1.1% - girls : 0.6%). Use increases with age : from 0% among 11-12 years and 0.6% among 13-14 years reaching 1.1% in 17-18 years (boys : 1.4% - girls : 0.8%).

- School-aged youngsters in Bruges (Flanders), 1996-97 [15]

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).

- Treatment centres

Opiates are reported as main drug by most people entering treatment in Brussels (77%) and in the French Community (males 72%, females 66%, all 69%), and by 40% in the Flemish Community. The proportion of opiate shows a decreasing trend in the French Community centres. Restricted to first treatment demands, opiates represent 55% (males and females comparable) among the 447 first demands registered in centres of the French Community [34]. 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 2,056 subjects (males : 72%, mean age : 29 years) having contact with French Community treatment centres in 1996, heroin constitutes the drug mainly taken by 978 individuals out of 1,987, i.e. 49% 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 centres [37] 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* [31]

In 1998, 88% of the 157 interviewed people stated to have used an illicit drug at least once (lifetime prevalence) among which 16% heroin.

- *Street snowball survey, 1998* [54]

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 (14 - 55). The main used substances were heroin (75%) and cocaine (65%).

- *Drug consumption in prison, 1993, 1999* [24]

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 user. The second main drug was heroin (28% of users)(cannabis was used by 37% of users).

- *Drug telephone line (French Community), 1997* [53]

In 1997, among 3,085 calls involving a substance, cannabis represents the most frequently mentioned (40%); heroin is the second one (14%).

6.4. Cocaine/crack

For specific information on cocaine, go to Part IV Chapter 14.

6.5. **Multiple use** (including alcohol, pharmaceutical products, solvents)

See Part II Chapter 2 – 3.3.2.a . This issue will be largely detailed in the next 2001 report.

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 ands also in adults, consistency between the various school surveys, high level of HCV among IVDUs reported by all studies. Nevertheless reliability of most data remain relatively poor and should be improved in order to take decisions on solid basis.

7.2. Implications for policy and interventions

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 [8]. 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 evolved. 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 to production (and use) of these products in Belgium and in some of the neighbouring countries.

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 risk-groups (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[56] 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 [56] ‘ 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 ready-made, 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 them-selves 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 co-operation 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 [10].

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 corner 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 and 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. Regarding information and data, the sources are also increasing. Co-ordination is necessary for both issues : co-ordination of interventions and co-ordination of data collection and surveys in order to prevent any counter-productive competition. A strategy for the data collection should be defined.

New developments such as Eco-drugs, alco-pops, smart drinks should be surveyed and investigated.

Scientific Institute of Public Health
Unit of Epidemiology

BELGIAN NATIONAL REPORT ON DRUGS 2000

PART III :

Demand Reduction Interventions

ASL

Deutschsprachige Gemeinschaft

CCAD/EUROTOX

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Région Bruxelles-Capitale Brussels Hoofdstedelijk Gewest

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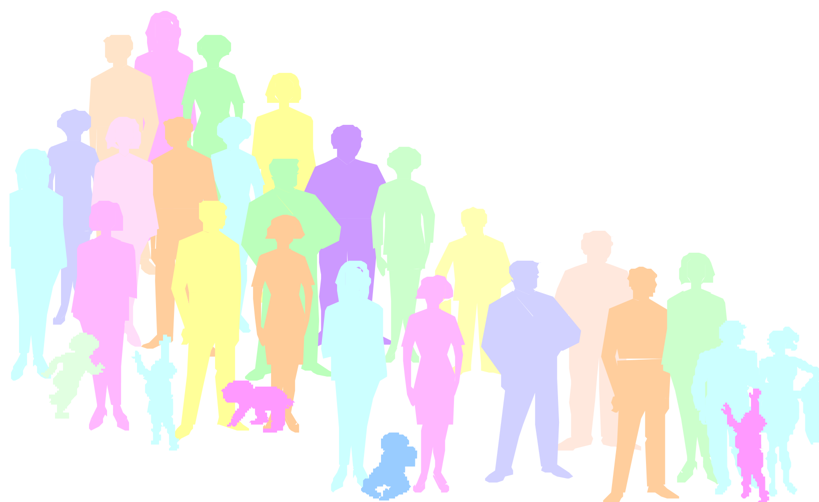

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PART III. DEMAND REDUCTION INTERVENTIONS

Chapter 8. Strategies in Demand reduction at National Level

There is no global national drug policy on demand reduction. Most demand reduction interventions are set up by the Communities and Regions. In addition, there are some interventions set up by the federal government, while several organisations participate in European programmes as well. Several organisations in the Flemish, French and German-speaking Communities are involved in European programmes. There are 'Euregio' and 'Intereg' projects involving the provinces of Limburg, Liège, East- and West- Flanders and Hainaut. The European Drug Prevention Week (EDPW) was implemented in different parts of the country. In Flanders, a co-operation was set up with the Netherlands, to organise a conference and workshops on the intersectoral and local approach of drug prevention.

National framework

At the federal level, the ministry of Internal Affairs has set up a number of demand reduction projects from a crime prevention perspective. The projects are given to local communes with higher than average crime statistics. The projects cover prevention, outreach and treatment objectives. The local authorities are responsible for the projects. The VSPP of the ministry of Internal Affairs is evaluating them. 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. The projects operate with annual contracts, which hinder them to develop a long term perspective[u].

In every province, 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 each province and provide methadone, counselling, outreach,… The centres are financed partly by the federal ministry of Health and partly by the ministry of Internal Affairs.

The federal ministry of Health also provides support to 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 recognised on an individual basis. In the Flemish Community they are organised into an umbrella organisation (*VVBV – Vlaamse Vereniging voor Behandelingscentra in de Verslaafdenzorg*).

At the level of the Communities, the demand reduction structures vary.

Flemish Community

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.

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[u] At present numerous contracts exist with different cities and municipalities to fight against drug-abuse.

In Flanders :

Volets toxicomanie:	11 contracts with cities/municipalities
Plans drogues (prevention-contracts):	10 agreements with cities/municipalities
Plans drogues (outside prevention-contracts):	6 agreements with cities/municipalities

In Wallonia :

Volets toxicomanie:	5 contracts with cities/municipalities
Plans drogues (in form of prevention-contracts):	9 agreements with cities/municipalities
Plans drogues (outside prevention-contracts):	3 agreements with cities/municipalities

In Brussels :

Volets toxicomanie:	6 contracts with cities/municipalities
Plans drogues (in form of prevention-contracts):	1 agreement

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 he federal ministry of Health.

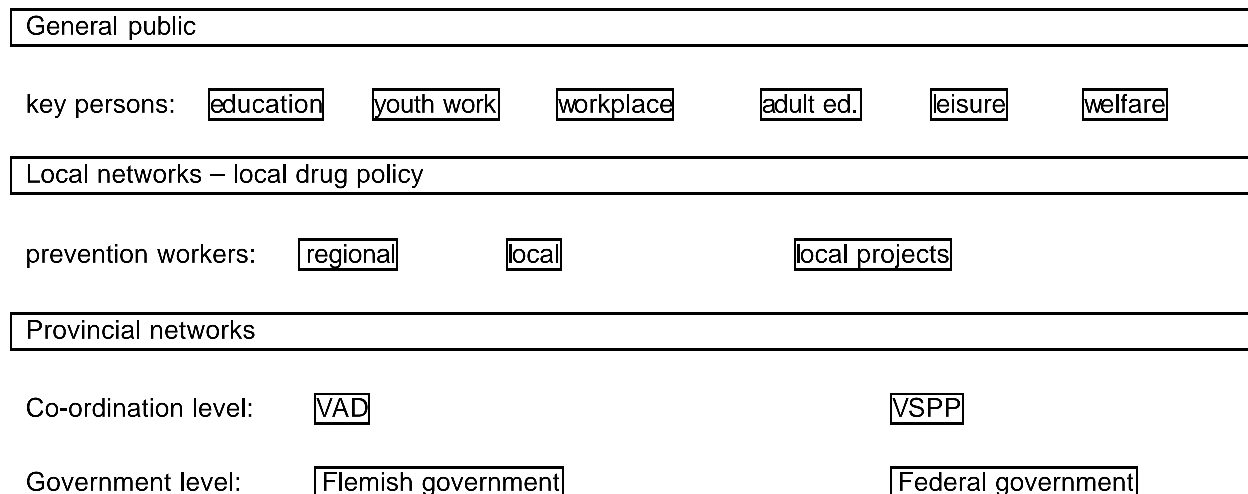
At a regional level, there is a structure of 10 prevention workers, based in centres for mental health. They are working since 1988 and have created networks and contacts with different sectors in society (education, youth work, workplace, adult education, welfare sector, leisure sector, …), to empower 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). There are 84 centres in Flanders, yet through a 'fusie' process, their number will be reduced to 24 in the course of the year 2000. The centres for mental health care are financed by the Flemish ministry of Health.

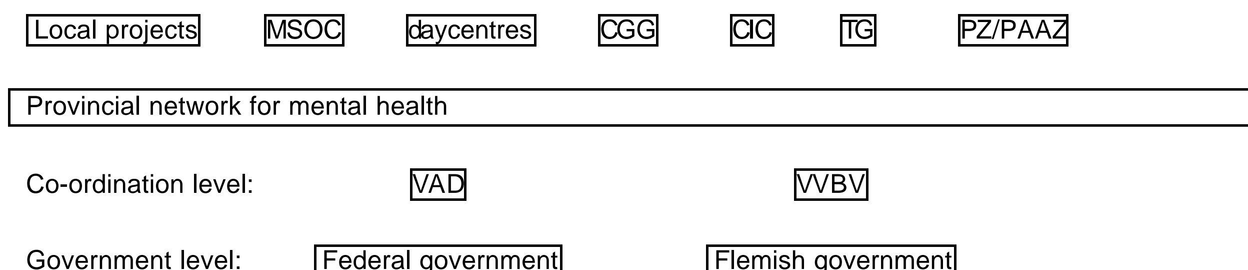
Inpatient treatment is offered by psychiatric hospitals and psychiatric wards of general hospitals. Some of them have a drug specific unit. The hospitals are financed by the federal government but recognised by the Flemish Community.

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. Some are financed by the Ministry of Internal Affairs, 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.

Organisational framework of PREVENTION in the Flemish community



Organisational framework of TREATMENT in the Flemish community



8.1. Major strategies and activities

As mentioned before, there are no major national strategies.

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). 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 8 areas of work are:

- ✧ Information
- ✧ Sensibilisation
- ✧ Co-ordination of prevention and treatment
- ✧ Representation
- ✧ Consultancy and support
- ✧ Training and education
- ✧ Development of concepts and methods
- ✧ 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, 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.

The treatment sector in the Flemish Community has started to organise themselves in the area of crisis intervention. Some regions have set up a 'crisis network' in which they are organising crisis interventions. The networks developed as a result of complaints mainly by police who could not find a solution for drug users whom they come across during their activities (often during evening hours when most centres are closed). These voluntary networks are in an experimental phase in some regions in Flanders.

Another recent trend in treatment is the setting up of case management and 'zorgcircuits' (treatment networks). The main aim of these networks is the provision and continuation of care for drug users. The case manager follows the client during the care 'traject'. Different treatment centres in a region define their treatment and care offer according to the specific needs of this 'help seeking' population. This should result in a co-ordinated treatment network in every region. This approach has started in different regions in the Flemish Community, all on an experimental basis.

The Ministry of Health of the **French Community** has supported 34 drug prevention and research programmes in 1996-97. 22 services were subsidised for local community approach programmes in the French Community provinces. These various programmes focus on drug primary prevention, health education, leisure time and prevention, key-persons training, prevention by peer groups, prevention tools construction, etc. Harm reduction activities are supported. A specific budget for primary drug prevention in secondary schools of urban areas was given by the federal Ministry of Internal Affairs and co-managed by the VSPP and the French Community.

The Ministry of Social Affairs of the Walloon Region supported 27 services involved in drug prevention programmes, for their activities focusing on welcome, information and orientation of drug users, out-patient treatment, key-persons training and research.

In **Brussels**, the support of these activities (22 services) came from the Ministry of the French Community Commission of Brussels (Cocof).

The **German-speaking Community** funds a primary prevention project as well as a mental health centre for secondary and tertiary prevention. At this place should be mentioned that, for linguistic reasons, (70,000 inhabitants live in the German-speaking part of Belgium) some people have to be sent to neighbouring 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 this neighbouring countries.

8.2. Approaches and new developments

8.2.1 New and innovative approaches

- Development of a 'local drug policy'
- Crisis network
- Circuit of care/case management
- Provision of treatment for inmates: circulaire (2000)

8.2.2 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 realise 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 is 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.

8.2.3 Developments in public opinion

- Outing of 'Famous People' (*BV- Bekende Vlaming*) about their drug use in popular media
- Adults are still worried about drugs: they view drugs as the problem n°1 in national (Flemish) surveys.

8.2.4 New research findings

- Cocaine research – Dr. Tom De Corte (see Part IV Chap 13 : Key issue Cocaine).

8.2.5 Specific events during the reporting year

- The set up of a federal working group (spring 2000) with representatives of different federal cabinets (Health, Social Affairs, Interior, Justice) to evaluate the existing drug policy and to prepare the set up of a 'Central Drug Cel' that will develop a national drug strategy.
- Conference : Drug Policy 2000 (Drugbeleid 2000/Gestion des Drogues en 2000) Brussels, 22-23 November 2000 : Annual national conference in which different topics are discussed and presented from different perspectives (policy, prevention, treatment, repression, international perspective,...).
- Study day "Ecstasy and harm reduction".

EUROTOX (umbrella organisation composed of Infor-Drogues, Modus Vivendi and Prospective Jeunesse) organised a study day (03.12.1999) concerning the new development of the knowledge about the dangerosity of the ecstasy and the "new synthetic drugs". Prevention and harm reduction (like the pills testing) strategies were also discussed. Confrontation between the French and the Dutch approaches were presented by Prof. B. Roques and Prof. P.J. Parquet for France, and Dr E. Fromberg and Prof. P. Cohen for the Netherlands.

Around hundred professionals, scientists and representatives of Administration and Ministers participated at this reflection day.

Paper of this event were published by Prospective Jeunesse : "De la prévention des risques aux risques de la prévention : confrontation et débats sur les drogues de synthèse", Les Cahiers de Prospective Jeunesse, Numéro double 1-2, Volume 5, 2000.

8.2.6 Dissimination of information on demand reduction among professionals (networks, Internet,..)

- In the Flemish Community an EWS-network was set up with 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 co-ordinated measures beyond national borders.

Chapter 9. Intervention areas

9.1. PREVENTION

9.1.1 Infancy and family

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 '*Elterntraining*' was set up in the German-speaking Community.

Flemish Community

- Leaflets for parents. Several services provide leaflets on drugprevention and adolescents specially for parents

- Training programmes for parents
  Ouders en drugspakket (three evenings): trainersmanual
  Lindestraat 14 (one evening): trainersmanual 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 is a telephone information service for all questions or problems relating tot 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

The different organisations recognised by the French Community of Belgium in the field of Health Promotion are regularly working with parents, mainly in the framework of students parent associations.

9.1.2 School programmes

9.1.2.1 Primary schools

Flemish Community

New programmes :

- '***Drugpreventieproject***' (municipal police) : voluntary, general (life skills and drugeducation). Teacher gives 4 lessons, the police gives 1 lesson, meeting with a former drug user in prison. Parents get information about the project. Productevaluation.
- Schooladoptieproject '***Doe eens normaal***' : (='Schooladoptionproject behave normal) (municipal police) : voluntary, general (life skills and drugeducation, focus on prevention of criminality). The police gives the lessons, the teacher can elaborate some subjects. Parents get information about the project. Productevaluation.

Following programmes are still performed :

- ***DONNA / OSER*** (='Drugeducation to just say no') is a new programme for primary schools and was introduced in 1998, initiated by the federal police (Rijkswacht/Gendarmerie). The programme consists of lessons given by the teachers and some lessons given by the police in the classroom.
- '***Gezondheid, je kan er zelf iets aan doen***' (='Health, you can do something about it') (VIG VZW Vlaams Instituut voor Gezondheidspromotie) is a comprehensive health education programme,

starting from kindergarten and including topics such as health risks, etc. This programme, which was initiated in 1985, was updated and revised and this new edition was again introduced to the primary schools in 1998.

- '***Contactsleutels***' (De Sleutel VZW) : lifeskills in primary school (8-12 years): manual for teachers.
- project '***Verbondenheid***' (='Joint') (Katholieke Universiteit Leuven)
- Principes voor drugpreventie in de basisschool (Principles for drugprevention 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.

French Community

- Teachers' new package to help the primary prevention of drug addiction : in the scope of the European Drug Prevention Week (November 98), the previous package made for the 94 E.D.P.W was reactualised and completed by a few new tools. Distribution of a new teachers' package for the prevention of drug addiction in primary school intended for teachers in 1400 primary schools which were not reached during the previous phase in the French Community.
- The new package encloses different documents: theoretical documents (for teachers) : ***'Guide de prévention primaire des toxicomanies à l'usage des enseignants'*** (Guide to primary prevention of drug addiction, for teachers) (CCAD, May 1994)
- '***A l'école du risque'*** (Risks at school) (Prospective Jeunesse, 1992)
- ***'Quelques données sur les comportements de consommation des jeunes'*** (Data on the consumption patterns of young people) (Promes,1990).

German-speaking Community

- '***Bevor es zu spät ist***' (Before it's too late) is addressing primary school teachers. Various materials were developed as exercise books: '***Gesünder und bewusster leben***' 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.

9.1.2.2 Secondary schools

Flemish Community

New programmes :

- '***Leefsleutels plus***' (12-15 years), 'Leefsleutels in actie plus' (15-18 jaar) en 'Omgaan met risico's plus' (interactive game for 12-15 years) : programmes for special education (Leefsleutels VZW) : voluntary, general (life skills and drugeducation), teacher gives the lessons.

Various short programmes (1 day or less) performed by external organisations :

- ***Projectdagen*** (=projectdays) (De Sleutel VZW) : information, former drug users relate their experience and life skills training.
- ***Forumtheater*** (De Kiem VZW) (Klap Klap VZW).
- Workshops on groupdynamics (Klap Klap VZW).
- CD-Rom en exhibition (MJA VZW Jongerenbeweging van de Socialistische Mutualiteiten).

Following programmes are still performed :

- '***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 schools'. *'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.

- **Europeers** (=peerproject), CAD, Limburg VZW
  Europeers is a new 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 are 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.
- '***Lindestraat 14***' (=parents training programme) (VAD VZW) manual for trainers and video.

Previous materials developed

- '***Een drugbeleid op school'*** (A drug policy at school): global framework for schools to develop policy: manuals and training
- 'Een beleid van tabakspreventie in de schoolomgeving'. Manual on smoking policy in the schools
- '***Leefsleutels voor jongeren'***: Life skills programme for 12-14 years old, training programme for teachers, manual, students' materials
- '***Als dat niet geweldig is***': video production and manual on alcohol prevention for 14-16 years old
- '***De Uitdaging***': social skills programme for 16-18 years old: training programme for teachers and manual
- '***Sleuteltreinen***': programme for trips with school children: discussions
- '***Motivational interviewing'***: training programme for teachers, school health services to support experimental drug users in school setting
- '***Ouders and Drugs pakket'***: parents training programme: manual for trainers and newspaper for parents
- Various other programmes are being used. An inventory is made to give an overview of all available materials which can be used in a school setting[57].

French Community

The different organisations recognised by the French Community of Belgium in the framework of the Health Promotion Decree propose counselling, advice, support, information and trainings to the school workers (teachers, direction, educators, etc.). One of the mains aim is to engage schools in long term prevention. The "Programme quinquennal de la Promotion de la Santé de la Communauté française, 1998-2003" (five years programme) contains the strategies defined for the prevention of drug addiction.

- The information brochure for students updated in 1998 was reprinted in 1999 because of its success with youth and adults : "Un autre regard sur les drogues" (Infor-Drogues).
- The different other tools mentioned past years are for the most of them always used.
- New videotape '***La Bande à Simon***' produced by the 'CLAV' and the related user's guide ***Sur la Piste de Simon***' realized by AVAT (Aide Vervietoise aux Alcooliques et Toxicomanes)
- '***Drôles de Nectars***' (strange Nectar) (made by Fondation de France and included in the French community school package in 1994)

- 'Des grilles au pays des merveilles' (CCAD, August 1994)
- '***Fichier de jeux et activités***' (Play and Activity Pack) (CCAD, August 1994)
- Evaluation - Needs and presentation of needs : video "recreation"
- These tools were created by the CERIS, Faculté des Sciences Psycho-Pédagogiques of the University of Mons/Hainaut and are based on the "Needs Theory" of Prof. Pourtois. The first tools aim to draw a picture of the pupils of the class as a living entity. The videotape, which is mostly teacher-oriented aims at focusing on interactions that 'freetimebreaks' create at school and also at making teachers be aware of their pupils behaviours
- '***Mes amis, mon jardin***' (My friends, my garden) promoted by CAPA (Centre d'Actions de Prévention des Assuétudes), this health promotion/education programme is based on a Canadian programme which aims at developing good health, oriented behaviour in young people's mind
- '***Génération sans Tabac***' (generation without Tobacco) : realised by the 'FARES', is a health promotion programme especially oriented against tobacco consumption

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.

9.1.3 Youth programmes outside schools

Flemish Community

9.1.3.1 Types, settings of activities

- Support of youth work in working towards prevention of alcohol- and other drugproblems by following working groups and by developing workshops in youth movements (VVKSM scouting, KSA-KSJ-VKSJ), youth clubs, youth houses and young people's services.
- Sensibilisation of sports clubs for alcohol and other drug problems by developing material and by running a campaign on a provincial level. Within a global approach towards a local alcohol and drug policy (a project introduced in the European drug prevention week 1998), a new publication was developed which summarises the global philosophy of drug prevention in sports, the existing materials and training opportunities and the support systems from within the sector and from outside, which are available for local trainers. This publication forms part of a series of 9 publications towards 9 different sectors. Within the framework of the campaign posters and leaflets are developed for sport clubs so that they can show their concern for this topic to the public. For the trainers of the sports club we developed a manual.

9.1.3.2 Peer-to-peer approaches

- Europeers (CAD) and Jeugdadviseurs (In Petto): training programmes for peer education approach.

9.1.3.3 Target groups

- Most activities, materials and interventions are developed for youth workers (youth leaders,…) and trainers of sport clubs, but also for the policymakers in the youth work or the sports.

9.1.3.4 Specific research results, statistics and evaluation results : -.

9.1.3.5 Specific training

- The VAD organised different training weekends for coaches to develop a framework of coaches in Flanders which is available for local youth workers to support them in the implementation of a prevention policy and in the intervention phase at times when drug use is detected.
- The VAD is developing a training programme for trainers in the sports club to help them how to go about with young people drinking alcohol, smoking or taking drugs. It also gives guidelines for the implementation of a prevention policy.

9.1.3.6 Existing materials and interventions

- '***Drugbeleid in jeugdhuizen: hoe deal je ermee?***' drug policy in youth clubs: manual for key persons in youth clubs to develop a drug policy, '***Drugbeleid in jeugdbewegingen: hoe deal je ermee?***' drug policy in youth movements: manual for leaders in youth movement to develop policy
- Training programmes for coaches in youth work, '***Drugtoestandjes***' exhibition on drug use, '***Drink wijs***': exhibition on alcohol prevention, exhibition of the Druglijn (telephone help line), '***Jeugdadviseurs***': training programme for peer education approach, '***Drugs, een ramp op kamp***': drugprevention on youthcamp: manual for monitors, '***Europeers***': training programme for peer education approach.
- '***Hip zonder trip***': a game concerning drug. Active city game for 14-18 years, '***Grenzen stellen***': training programme how to handle aggressive behaviour from youngsters, '***Drugs, maak er (g)een spel van***': drug prevention on youthcamp: guide including different games, '***Omgaan met risico's***' : prevention package for poorly educated. ***'Leefsleutels in het jeugdwerk'*** Life skills programma, ***'Een lokaal alcohol- en drugbeleid: op elk vlak de juiste aanpak. Het jeugdwerk'***, a publication summarising the philosophy of drug prevention in youth work. .
- 'Een lokaal alcohol- en drugbeleid: op elk vlak de juiste aanpak', a publication summarising the philosophy of drug prevention in sports, 'Sport is genot zonder middelen, sport als preventie-middel', a manual for trainers.

French Community

- The Health Direction of the French Community produced an information brochure '***Pour l'amour du sport***' to increase public awareness about doping. The target is the adults in charge of young people practising a sport. The brochure gives a synthesis of the knowledge about doping and arguments to refuse it. It's a tool to help these adults to prevent the doping by discussing with young people in a confident relation. Ministère de la Communauté française, Direction générale de la santé, "*Pour l'amour du sport*" – Brochure d'information et de sensibilisation sur le dopage. 48 pages. 1999.
- '***Tele-Jeunes***', a non-specific telephone help line for young people, 24/24 was locally (Liège) set up between May and November 97. The aim was to orient young people with drug problems to specific facilities. No evaluation has been done.
- The French Community also supported in 96-97 the realisation of a short film called '***No Problemo'*** focus on daily life of teenagers. This film will be useful in the future as prevention support activities among 17-18 years old adolescents.

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.

9.1.4 Community programmes

Flemish Community

- By the end of '98, the project '***A local alcohol and drug policy. Join in!***' was launched. In 1999 the project was implemented. Therefore a permanent support system was worked out. This support system consists of:

  a. people/structures where one can get answers

The regional prevention workers based in a Centre for Mental Health and local prevention workers were available for further support and follow-up with a municipal working group, made referrals to other agencies in the field of prevention, participated in informative and educational seminars.

Consultation and co-ordination between these various prevention workers was organised on the provincial level in the Provincial Prevention Platforms.

b. specific support programme

In each region, a specific support programme was developed, taking into account the local needs for support. In concrete terms: training, workshops, coaching, meeting days,… were organised on a continuous basis.

c. VAD (the Organisation for Alcohol and other Drug Problems)

VAD brought together the various regional and local prevention workers and the regional co-ordinators who carry out the project to exchange experiences and to work out further support.

- 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 the national Police services was added to the 8 original sector brochures (November 1999). 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.

French Community

- Local '***drug prevention workshop***' in Tournai, was set up by the municipality in cooperation with various prevention organisations.

German-speaking Community

- Each community organises staffs of voluntaries coached by community responsibles. 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 seven other European regions and resulting in the set up of such voluntary groups.

9.1.5 Telephone help lines

Flemish Community

- There is one central Flemish helpline '***De DrugLijn***' which was set up in 1994. In 1999 the Druglijn received 12,044 calls, which resulted in 5,814 effective communications. The line is open daily from 12 to 9 p.m., except on Saturday (open 15-21 pm). The telephone call is not charge free, but people pay for a local call, wherever they call from in Flanders. People call anonymously, and will not be judged. 25% of the callers are users (alcohol and/or (illicit) drugs), 50% are relatives (mostly parents). For each DrugLijn-member there is a basic training (3 Saturdays, 5 evenings, a listen-programme and an exercise-program, and further every 6 weeks a seminar about 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 1999, the service received 4.640 calls ; through these calls 8.836 demands were registered (information 26 %; demands of prevention activity 4 %; advice demands 27 %; demands of listening 5 %; help demands 30 %; demand of people for the counselling service 5 %; no explicit demand 3 %). 17% of the callers are users, 41 % are relatives (82 % are members of the family), 13 % are professionals, 17 % "other" persons and 3 % unknown.

The products usually mentioned by the callers are cannabis (38,8 %), heroine (13,3 %), cocaine (10 %), XTC (7,8 %), alcohol (7,3 %), methadone (6,2 %), medication (5,1 %). The statistical report 1999 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 intervision are part of the permanent training of the staff.

German-speaking Community

- Special messages were available for two weeks during the Tobacco-day period and during the EDPW (but without free access).

9.1.6 Mass media campaigns

- No large media campaign were carried out in recent years. There are interviews and debates in the media at a regular interval.

Flemish Community

- The Flemish Government organised its second '***Opkikker***'. This is a mass event for young people in schools. In preparation of the event, a call for projects/examples of good practice is being launched in the schools, in which schools present their approach towards drug prevention. A committee studied the projects and selected some 120 schools from which 4000 pupils were invited to a mass event. Famous 'cult figures' were bringing music, quiz, show, which was highly valued. The general message is positive with the slogan: '***drugfree is better***'. The 1998 edition was the second version of this event.
- VAD published a new 'Catalogus' with an overview of the available materials (leaflets, posters, gadgets, but also education packs, reports, etc.) at Flemish level. The materials are targeted at a general population as well as at specific groups.
- During the European Drug Prevention Week 1998, different initiatives were taken by local communities (theatre, mass events, …) and by the Flemish government and VAD (press conference) to get the message across about intersectorial co-operation and local action. The slogan : « ***talking is the first step*** », was used by the various organisations to support their activities. The activities were concentrated during the week, but attention was given to continuity and follow up after the week.

French Community

- In the field of health promotion a co-ordinated drug prevention action, between seven partners, took place during the 3 days French song festival '***Francofolies 96***' in the city of Spa.
- A great number of representations of the play '***La fleur dont on fait l'Héro***[v]' by the Pocket Theatre of Brussels took place in a theatre preventive approach. Each representation was systematically followed by a debate with the spectators, co-animated by prevention workers and the actors.
- In order to circulate information on the '***Opération Stérifix***' (see 10.3.3), a press campaign was organised in March 1998. General public's newspapers (*Le Matin, la Dernière Heure, la Lanterne…*.) as well as specialised journals for pharmacists and GPs (*Le Journal du Pharmacien, Le journal du généraliste,…)* agreed to participate and to include this type of information.

[v] Héro : based on a confusion between heroes (in French : héros) and heroin (called in French : héro)

German-speaking Community

- Different campaigns were organised: a one-week campaign in newspapers for the 20th anniversary of ASL and a press and radio campaign during the European Drug Prevention Week 1998.

9.1.7 Internet Website

Flemish Community

- Prevention
- The website contains the catalogue of VAD-publications. These publications are aimed at the general public as well as at professional prevention workers (intermediairen?) working with different target groups (schools, youthwork, labour, social-cultural work, local authorities, …). An important chapter of the website is dedicated to our library.

- 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:

  At this time, the website only provides statistics on the DrugLijn, the Flemish drug helpline. However, we plan to extend our website with other statistics and evaluation results in the near future.

French Community

- The first website of the French Community was opened by Prospective Jeunesse in 1997. The site will be updated in 2001. The target are the users of the Internet and especially the professionals of school, social helps and care, students and pupils.

  The web site contains : information on drugs, the Belgian law, information about the training activity, their publications, the presentation of the "Cahier de Prospective Jeunesse" (quarterly publication) with abstracts of the articles and a questionnaire concerning a research about the ecstasy. Http://www.prospective-jeunesse.be.

- Infor-Drogues and Modus Vivendi will also open a website in 2000.

9.2. Is not existing in EMCDDA Report structure

9.3. Reduction of drug related harm

These issues are developed in Part IV Chapter 15 .3 (Key issue Infectious diseases).

9.3.1 Outreach work

9.3.2 Low threshold services

9.3.3 Prevention of infectious diseases

9.4. Treatments

There is an evolution going to:

- a broader offer of shorter treatment programmes
- more substitution programmes
- a broader offer of low threshold help
- more attention to parents (parent groups)

9.4.1 Treatments and Health care at national level

a) 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

Crisis centres, 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

Flemish Community

- Centres for mental health care, 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

- An assessment survey of the role of the Liège-based drugs reception centre as "an intelligent signpost" was conducted regarding residential or outpatient orientation [58]. At a preventive level, the results showed a correlation between the nature of the intervention and the subject of the request: requests for survival assistance mainly led to interventions either of the outpatient type for heroin users, or the residential type for people addicted to medical substances. On the other hand, requests from families or from the therapeutic sector mainly led to interventions of the information/prevention type.

German-speaking Community

- Usually outpatient treatments are offered by specialised German centres (Rhenanie-Westphalie).

b) 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.

c) Criteria of admission

There are no uniform criteria of admission. They depend from the setting itself and eventually agreements with other centres forming part of a network (care-circuit).

d) Involvement of public health services and GPs

- **GENERAL HEALTH CARE**

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 focus group 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.

Flemish Community

GPs have a role to play in drug treatment. However, their role is not yet clearly defined and their is no general approach within the primary care setting.

French Community

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.

e) Co-ordination between public health services and other community drug services : -.

f) Special services : -.

g) Financing

Financing sources are diverse and the finance structure is complicated.

- The centres forming part of VVBV (daycentres, TG's, MSOC's) have a RIZIV-convention (revalidation), except RKJ-De Sleutel (minors) who is financed by the sector special youth care.
- The Centres for mental health (CGG) are financed by the Flemish community (department of health)
- The psychiatric hospitals and the psychiatric wards of a general hospital (PAAZ) are financed by the federal government.

Clients and patients have to be in order with their social security for getting help in private settings. For people who are not, there exist 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.

h) Statistics and evaluation results

i) 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’.

9.4.2 Substitution and maintenance programmes

In Belgium, methadone programmes are still waiting for a legal basis to broader operate.

Flemish Community

- Many centres and GPs provide methadone to drug users.

French Community

- ***R.A.T.*** (Réseau d’Assistance des Toxicomanes - Assistance Network for Drug Addicts) : methadone substitution therapy by a group of doctors in Brussels. A first evaluation survey of the outcome of treated patients suggested a spectacular improvement in the index of severity during the first six months, which was then stabilised [59]. Over a maximum period of two and a half years, it would appear that nearly 50% of patients totally abstained from heroin.

German-speaking Community

- Methadone substitution is offered to some drug users under the control of SPZ (psycho-social centre).

9.5. 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 offerd are: special assistance for finding a job or education and/or lodgement, advise to older drug users and their families.

9.6. Interventions in the Criminal Justice System

From 1998 to 1999, in the number of people questioned by police services for crimes linked to abuse of cannabis has risen by 20%. The age of the offenders is constantly decreasing. Many of them are between 12 and 15.
The central medical service of the penitentiary administration has just changed its name. It is called now the " Penitentiary Health Service ".
Since 1998, medical services are undergoing major reorganisation : the authorities take into account the advice of the Council of Europe.
In penitentiaries, the situation varies from one prison to another with the local management, experience, investments in health care personnel and the way the health care services are organised.
A drug monitoring group was created in 1998 to develop an action programme. This became a necessity after they had to state the use of drugs by 50 prisoners at the time they were actually jailed. The programme has not yet been finalised.

a) Interventions

❖ Medical (detoxification, drug substitution)

- Most drug addicted prisoners are lodged in the psychiatric departments, which exist in eleven prisons. Generally treatment consists of gradual detoxification with the help of methadone, except for pregnant women and people jailed for short periods of time.

- The interruption of substitution treatments in effect at the time of arrest is still an unresolved problem.
- Gradually more and more specialised external services are intervening to offer and organise aid (and subsequent follow-up) for drug addicted prisoners.

❖ Drug-free programmes

- So-called drug-free sections are in an experimental phase but their future is still uncertain.
-

❖ Self-help groups

- 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 centres.

❖ Relapse prevention

- A note of the Ministry of Justice in the year 2000 specifies that drug addicted prisoners have the right to the same care, guidance and, if necessary, the same therapy as free citizens. This note is based on three main principles: no interruption in the treatment; in the case of treatment, continuity should be ensured in the same way; similar care outside of penitentiaries and within them. This note opens the possibility to the temporary liberation of drug addicted prisoners in order to give them adapted treatment and/or guidance. This liberation implies a series of conditions.
-

❖ HIV/Hepatitis prevention (needles and syringe exchange)

- The Minister of Justice is the only competent authority regarding health in general, and prevention and assistance of prisoners with AIDS or HIV infection in penitentiary system. There is neither prevention policy nor AIDS/HIV prevention programme. Essentially thanks to the initiatives of NGO's, and where there is good collaboration with prison authorities, local AIDS/HIV prevention actions exist in prisons.

  The Law of November 17th, 1998 allows the exchange of syringes and needles outside the pharmaceutical sector. Today there are no distribution or exchange programmes for syringes within the penitentiary institutions.

b) Drug testing : -.

c) Release: referral to treatment, aftercare, probation

See Part I 1 1.2.2.b.

'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.

d) Statistics and evaluation results : -.

e) Specific training

- Training programmes have been organised for penitentiary officials on the following topics: drug addiction, drugs, hepatitis. It is nevertheless difficult to apply public health criteria in an environment that remains dominated by the dogma of security, punishment and social control. There are real problems in coordinating the various internal services of the prisons (on one hand, the medical service, on the other, the psycho-social service); coordinating internal and external services is also difficult, especially when the number of external services increases; this kind of a situation leads to problems if you want to establish an efficient and consistent health policy, despite the willingness of the participants.

The law of March 16th, 1999, organises the control of motor vehicle drivers under the influence of drugs. A training for police services has been organised for this purpose.

Flemish Community

- There are some pilot projects of drug free departments in prisons. A training programme for guards and prison personnel is realised.

French Community

- In co-operation with the prison authorities of St-Gilles, 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 counselling is provided by a specialised social worker.

- ***TIMC*** (Toxicomanies et Interventions en Milieu Carcéral) is an EC collaborative network involving participants from Belgium, France, Luxemburg and The Netherlands[60]. Its 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).

9.7. SPECIFIC TARGETS AND SETTINGS

9.7.1 GENDER SPECIFIC ISSUES

Flemish Community

- There is one project in a therapeutic community (***De Kiem***) for pregnant women and women with children.

9.7.2 PARENTHOOD AND DRUG USE - CHILDREN OF DRUG USERS

- Early interventions among children

  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 '***Elterntraining***' was set up in the German-speaking Community.

Flemish Community

- Few centres are specialised in parental drug use. There is one outpatient centre (Free Clinic) and a new project in a therapeutic community (***De Kiem***): pregnant women and women with children.
- In two Centres of Mental Health Care a project for children of parents with psychological/psychiatric problems (***KOPP-project***) 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.

French Community

- Substitution programme for pregnant women : a young pregnant heroine addict women programme was set up in Tournai besides the classic methadone program. The acceptance in this programme is subordinate to acceptance of criteria proposed by a 3 professionals team : a medical doctor, a psychologist and a social worker. Individual and family counselling help to take the decision. This programme is not yet evaluated.
- The previous programme "Treatment and rehabilitation for parents who are drug users" included : counselling and methadone maintenance, parents groups, social, cultural and sporting activities. To implement this program, a psychotherapist and a rehabilitation professional completes the team to develop this programme inside of the prisons. The intervention allowed specific actions on harm reduction in women, pregnant and/or young mothers.
- 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.

9.7.3 PARENTS OF DRUG USERS

Flemish Community

- 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.

French Community

- A programme for provision of a help to parents of drug users has been initiated during the past year.

9.7.4 DRUG USE AT THE WORKPLACE

Flemish Community

- There is a long tradition in developing prevention programmes in the workplace. 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.
- A new publication was developed about legal issues concerning the use and abuse of alcohol and other drugs at the workplace.

  Within a global approach towards a local alcohol and drug policy (a project introduced in the European drug prevention week 1998), a new publication was developed which summarises the global philosophy of drug prevention in the workplace, the existing materials and training opportunities and the support systems from within the sector and from outside, which are available for this sector. This publication forms part of a series of 8 publications towards 8 different sectors.
- Training programmes (for company doctors, nurses, social workers and supervisors) are available.

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.

German-speaking Community

- There are programmes to prevent and fight alcohol abuse at the work place.

9.7.5 ETHNIC MINORITIES

No information collected.

9.7.6 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.

German-speaking Community

One group of parents of drug users exists as well as groups oriented to alcohol problems and medicine addictions (AA approach).

9.7.7 GROUPS EXPERIMENTING WITH DRUGS

Flemish Community

- 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.

French Community

- ***DELTA*** communities approach as low threshold programme is addressed to drug users, principally who injected. This programme is currently evaluated.

9.7.8 OTHER ACTIVITIES

Regular actions on alcohol and driving are carried out at the national level especially during the New Year period. The '***Bob'*** system (at least one people identified before the feast who will not get any alcohol-drink and who will drive when coming-back home) and free-alcohol drinks,… are promoted through media campaigns.

Flemish Community

- Programmes for special youth care have been developed in recent years. A policy for the centres for special youth care as well as training programmes for the personnel have been developed. A training programme for trainers to provide continuous training in this sector and a manual were developed.
- Courses on drinking and driving were provided.

German-speaking Community

- Special actions on alcohol and driving during the Carnival time including promotion of the ***Bob'*** system, promotion of free-alcohol drinks,… and actions in secondary schools were organised.

Chapter 10. Quality Assurance

10.1. Quality assurance procedures

a) Formal requirements for quality assurance : -.
b) Criteria and instruments applied in quality assurance : -.

10.2. Treatment and prevention evaluation

10.2.1 Treatment and prevention evaluation

The following information is related to prevention evaluation only.

a) 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 counter-productive. Very often, however, the end result is a mixture of positive and negative effects [61].

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 co-ordinating 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.

b) Requirements for evaluation (e.g. for funding) and d) 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 (2000-2001).

c) Use of evaluation results : -.

10.3. Research

a) Demand reduction research projects: objectives, structure and organisation

Research on drug policy is available only on a limited scale. Economical research has not been carried out. At best, the subject has been dealt with as a minor part of research design.

Some results presented in this report have been extracted from various researches conducted in the different part of the country and/or at a European collaborative level. As example, public health schools of French Community universities have participated in epidemiological researches focus on

health behaviours among young people and in the multi-city study (Liège) of the Pompidou Group (Council of Europe).

At national level, the research priorities are e.g. :
- to investigate why people take drugs
- to initiate evaluation research of treatments
- not to limit research and policy only to illicit drugs.

b) Relations between research and drug services : -.
c) Funding of demand reduction research : -.
d) Training in demand reduction research : -.

10.4. Training for professionals

a) Training in quality assurance and evaluation: type and structures : -.

Flemish Community

Training for teachers and guidance centres :

- New programmes :
- 'Leefsleutels voor jongeren plus' (life skills for adolescents in special education) (Leefsleutels VZW) :
  training for teachers
- 'Aan de slag met de leerlingenbevraging' (='Get to work with the questionnaire of students in connexion with a drug policy at school') (VAD in co-operation with regional preventionworkers) :
  training programme for principals and school personnel to use the results of the questionnaire to optimise the drug policy in the school.

- Following programmes are still performed :
- 'Contactsleutels' (=life skills) (De Sleutel VZW)
- 'Drug policy in schools' (VAD in co-operation with regional preventionworkers)
- 'Leefsleutels voor Jongeren' en 'Leefsleutels in actie' (life skills) (Leefsleutels VZW)
- 'Training for school health personnel' (VAD in co-operation with regional preventionworkers)
- 'Training programmes for parents' (VAD in co-operation with regional preventionworkers)

French Community

Various awareness campaigns are organised by centres working in prevention or treatment for social workers, physicians, psychiatrists, teachers, instructors.

- *Training for Social Workers*
  This training was launched in the region of Liège in order to get in touch through them with the target groups that are usually not readily accessible. This training tackles with the theme of Harm Reduction by proposing a psychodynamic approach of the drug phenomenon. An evaluation of the results was performed.

- *Antares*
  Antares is both a teaching and an support programme whose aim is the secondary prevention of dependencies at school. It is a voluntary Health Promotion programme especially oriented at drugs and that started this year in the area of Charleroi. It includes Teacher Training, drawing up some guidelines to work out prevention policies within the education field, and supporting those actions

taken. The project's main aim is to allow and help secondary schools to deal with delicate situations related to drug use.

The Antares programme objectives are as follows : to help the institution and its manpower to define their values and limits, to enhance communication and encourage feelings expression, to set up a consistency within the school and to arouse a collaboration with some drug field professionals, to make up a shift team that will work as an intermediate with regard to the prevention actions that will be performed.

This programme is also about giving the education team some help in making an accurate decision in case of a consumer discovered in the school, and so avoiding as well to delegate the problem systematically by handing it over to specialists only. The two Antares responsible persons (one has a degree in Law and the other one in Clinical Psychology) offer an analysis of both practice and policy prevention that go on within the school. They help in clarifying the request or the situation, in refining an existing prevention action or in working out a project, and they also give some support in the implementation and the evaluation of it.

- *Prison team training*

  In 1996-97, a programme of Quality Insurance was launched. It includes three training parts in the drug field. Firstly, the prison teams training of the prisons of St Gilles and Forest (Brussels). Secondly, the prison's psychologists and nurses' training in the prisons of the French Community. Thirdly, the prison's teams training in the GERRMM's frame. It's an exchange group of teams, like scolarship trainee, between diverse prisons of the axe Rhin-Meuse-Moselle. This programme concerns the prisons of Verviers, Lantin, Tongres, Hasselt (for Belgium), Strasbourg, Metz, Nancy (for France) and Maastricht (for The Netherlands). The Brussels co-operation to this network has extended in 1996-97 with the prison of St-Gilles.

German-speaking Community

ASL provide training aiming to get the skills and the necessary background to conduct in a good way primary prevention actions: they are offered to community voluntaries and to teachers of the primary and the secondary schools.

The training 'Ecole de prévention' was organised from January to April 1997: "Comment gérer une dépendance ?, Comment gérer la relation avec les dépendants ?" (how to manage an addiction? How to manage addicts ?). Five types of addiction were tackled.

b) University training, non-university vocational training, in-service training

French Community

Two universities are developing their post-graduate courses :
- Université de Liège (Ecole de santé publique) : Degree in public health science & drug addiction (3 years)
- Université de Mons (Faculté des sciences psychologiques) : Post-graduate in consciousness modification & drug addiction (1 year).

c) Statistics and evaluation results : -.

Chapter 11. Conclusions : future trends

In Belgium, prevention is becoming more and more organised. Treatment and prevention activities are being developed in various sectors mostly based on a **local approach**. Initiatives are taken by the sectors themselves, supported by prevention experts. Participation and emancipation are central.

The organisation of demand reduction activities is improving. **Co-ordination** at all levels is developing. **Networks** are set up to co-ordinate the different activities in the sectors. For prevention : development of local policy, set up of local networks with key persons of different sectors, implementation of local actions. For treatment: development of networks for crisis intervention and co-ordination of care at local/regional level. There are co-ordination structures that support the local level with training, materials and registration.

The reduction in the demand for drugs, whether or not they are socially accepted, includes the various approaches which range from general educational prevention to various specific modalities with regard to information, counselling, guidance, care, treatment and after-treatment.

Parents, teachers, monitors of sport clubs or youth movements can work with young people towards educational prevention which will encourage communication between adults and young people, and which will give them the tools and the means to efficiently resolve the conflicts or problems encountered in everyday life. This education will also teach them how to manage anxiety and stress and will help them to develop their critical faculties and their creativity. It will help them learn to resist peer pressure and the onslaught of advertising, the model of addiction par excellence. These “primary addiction prevention” activities must be part of an ongoing process. It is a long-term process which will develop social skills.

Psychosocial workers and health workers who work in the various health centres, psycho-medico-social centres, school medical inspection centres, guidance centres or specialised mental health care services contribute to the development of general or specific programmes. Their interventions, whether ad hoc or long-term, should preferably be geared towards the accompaniment and guidance of natural intermediaries such as parents, teachers, etc.

A number of **new concepts**, based on the needs from the field workers, are under preparation : children of alcoholics, drug users with young children, prevention and treatment for migrants, gambling.
It is important to promote varied initiatives among populations at risk, other than among young people as a whole. All the initiatives undertaken to combat social exclusion, marginalisation and even crime will reduce drug-related risks. The co-operation of social workers and of young people themselves will be particularly beneficial in the context of this type of prevention through specific initiatives that are gradually set up in the country.

There is a growing demand 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, … A tailor made approach for specific target groups, based on research findings, is necessary for different aspects of the drug problem.

Scientific Institute of Public Health
Unit of Epidemiology

BELGIAN NATIONAL REPORT ON DRUGS 2000

ASL

Deutschsprachige Gemeinschaft

PART IV :

Key Issues

CCAD/EUROTOX

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Vlaamse Gemeenschap

The present Report,

short versions in Dutch and French

and additional information on the activities of the BIRN

are available on demand
and on the Belgian Focal Point Web site

REITOX Belgian Focal Point

at

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

PART IV. KEY ISSUES

Chapter 12. Drug Strategies in European Union Member States

12.1. National policies and strategies

In **2000**, an inter-ministerial working group was set up in order to re-design the drug policy in Belgium. The group is coordinated by the federal Minister of Health and involves the federal Ministers of Justice and of Internal Affairs : this group works in close collaboration with Community and Region Ministers. The proposals for a new drug plan will be submitted by the federal government at the end of the year 2000.

Up to now, at federal level, more than a real global strategy, one should talk about a global philosophy (see112c).

The current outline of the policy are based on the work of a federal parliamentary group that was set up in 1996 to study the drug problem, in particular the situation of soft drugs. Many experts from the field of prevention, treatment and repression were heard. The conclusions of this working group have been adopted by the Parliament in June 1997.

Between an approach strictly repressive and a tolerance policy, a third way should exist, called 'normalisation' policy. The three main tools of the drug policy are prevention, treatment and repression. The priorities are as follows :

7. to prevent and reduce drug use and particularly to reduce the number of new drug users
8. to offer a large panel of treatment methods and to guarantee to drug users a better quality of life despite their drug use
9. to protect the community and its members who are facing the drug phenomenon and its consequences
10. to consider the judicial approach, particularly imprisonment, as an 'ultimum remedium'.

Action plan in different fields

At political level

Given the federal structure of Belgium, the co-ordination of the different departments involved in the drug issue required an interministerial conference (around 15 different cabinets). 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 and the ministry of Social Affairs and Public Health, and on the other hand at federate levels : the communities and regional governments (Flemish, French and German-speaking Communities, Brussels-Capital Region). Different departments have their own policy papers and documents.

It is the objective of the interministerial current working group initiated by the Minister of Health in 2000 to re-design the drug policy and to co-ordinate the approaches of the various governments (federal, Communities, Regions) and their ministers.

At justice level :

The aspects of repression and supply reduction are an exclusive federal competence. The ministry of Foreign Affairs is the main responsible. Regarding drug users, the approach is avoiding that drug users who, apart from possessing drugs, committed no other infringement, get into prison; the judicial approach, particularly imprisonment, should be the 'ultimum remedium' in order to deal with problematic use of drug.

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 [w]). 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'. More there is a obvious willingness to develop diversion to treatment and alternative measures and to make easier the links between the judicial system and the health care system.

Demand reduction level

There is no global national drug policy on demand reduction. Most prevention interventions are set up by the Communities and Regions. In addition, there are some interventions set up by the federal government : demand reduction projects from a crime prevention perspective, medical social low threshold centres (MSOC-MASS), support to a number of Therapeutic Communities, Crisis Centres and Day Centres…

For information on the drug Policy of the Flemish Community Government : see Part I 1.1.3.c.

12.2. Application of national strategies

a) Organisational framework

FEDERAL GOVERNMENT

MINISTRY FOR FOREIGN AFFAIRS

The ministry for Foreign Affairs is in charge of international relationships. Meanwhile relationships to some organisations (UNDCP for example) were delegated to the ministry of Justice.

MINISTRY OF JUSTICE

By virtue of the mandate given in the context of national co-ordinators of the European Union and Article 17 of the United Nations Convention of 1961, the Justice Department 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.

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).

MINISTRY OF FINANCE

Customs is charged to control all imports including illicit ones (actually a large part of seizures are performed by customs).

MINISTRY OF INTERNAL AFFAIRS

The ministry of Internal Affairs is co-ordinating (via the VSPP) projects in the framework of crime prevention. The VSPP, which is a federal governmental administration created in 1993, is in charge of the analysis and the follow-up of these projects. In these projects, the municipalities decide upon policies and strategies.

The VSSP also forms prevention professionals and assists them in their work. It mainly concerns the prevention of criminality, using the most creative and efficient techniques.

A transit centre and the MASS/MSOC were created thanks to funds from the ministry and from the INAMI/RIZIV.

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

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w Ministry of Justice site : http://www.just.fgov.be/html/nb2.htm in Dutch or http://www.just.fgov.be/html/fb2.htm in French.

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).

COORDINATION BETWEEN POLICE DEPARTMENTS (ministry of Justice and ministry of Internal Affairs)
A new legal framework (police law of 7/12/1998) lead to a uniform police on 01.01.2001. The aim of the reform is the improvement of the efficiency of-, collaboration and co-ordination between the police services and particularly to ensure a better dissemination of and access to information. Indeed dissemination of information and access to the right information has been sometimes prevented by the existence of different police services differently organised and controlled by different authorities.
Up to end 2000, the *'Police Judiciaire/Gerechtelijke Politie'* was controlled by the judicial authorities and the Minister of Justice; The '*Gendarmerie/Rijkswacht'* was under the authority of the Minister of Internal Affairs. The *'Police Judiciaire/Gerechtelijke Politie"* and the *'Gendarmerie/Rijkswacht'* were competent on the whole territory. In so far as keeping law and order, and crime prevention are concerned, the '*Gendarmerie/Rijkswacht'* acted under the supervision of the Minister of Internal Affairs. With regards to repression, the *'Gendarmerie/Rijkswacht'* reported to the judicial authorities and the Minister of Justice. The 589 Belgian municipalities all had their own police force under the authority of the municipality mayor, and under the orders of a chief of police. To a certain extent, the SGAP/APSD (*Service Général d'Appui Policier / Algemene PolitieSteunDienst)* which run the central offices of Interpol, Europol and Schengen in Belgium, centralised data and documents communicated by all the local police forces, the *'Police Judiciaire/Gerechtelijke Politie'*, the *'Gendarmerie/Rijkswacht'*, the Department of Economic Affairs and the customs.

MINISTRY FOR SOCIAL AFFAIRS, PUBLIC HEALTH AND ENVIRONMENT
By the terms of the international conventions, the administration charged with the control of licit trade is the Department of Narcotic Drug of the General Pharmaceutical Inspectorate [x] (ministry of Public Health) (art. 18,1d of the Single Convention (1961) as such as modified by the protocol 72 (1972), art. 16,2 of the Convention on psychotropic substances (1971) and UN convention on illicit traffic in narcotic drugs and psychotropic substances (precursors) (1988)).
In the context of the preparation of meetings for the Pompidou Group, co-ordination meetings are held by the Permanent Correspondent from the ministry of Public Health.
The ministry of Social Affairs funds treatment centres. 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.

Flemish Community

Flemish Minister of Health

The Minister of Health of the Flemish Community has the competence in the field of drug prevention policy. At the end of 1995 a drug policy paper (Drugnota) within the general policy of health and health promotion was presented. The programme runs for three years (till October 1999) and consists of seven actions: development of a uniform registration system in treatment and in prevention, training of prevention workers, training of key persons in relevant sectors, provincial co-operation, regional networking in treatment and a major event for secondary school children (de Opkikker).
The co-ordination of the prevention activities is given to VAD (operating within a broader framework of the Flemish Institute of Health Promotion (VIG)). The main task of VAD is to co-ordinate and support the many structures, workers and projects at provincial, regional and local level. VAD is the Sub-Focal Point for the Flemish Community.

For all prevention activities taking place in education, a Commission is installed within the Flemish Education Council (VLOR). The Minister of Education and the Minister of Health are represented.

x Ministère de la Santé publique, Service des stupéfiants de l'Inspection générale de la pharmacie / Minister voor Volksgezondheid, Departement verdovende middelen van de Algemene pharmaceutische inspectie.

The Flemish Government decided in 1998 to implement a 'participatory risk-analysis' in education. VAD developed a questionnaire for pupils aged 12-18 to evaluate existing drug policy in school. After a pilot phase, this questionnaire became a major project in secondary schools.
During the second half of 1998, the Flemish Government developed a policy plan with VAD, which outlines the drug policy for the next 3 years. At the end of 1998 a 'agreement' was signed between the Minister of Health and VAD, which became the organisation responsible for the development of a Flemish drug policy.
For the treatment sector, the role of the Flemish Minister of health depends on the agreements between the federal government and the Communities. The Flemish ministry subsidises the centres for mental health, in which out-patient treatment is organised. As for psychiatric hospitals, there is a joint competence between the federal and community level.
At the provincial level, prevention platforms are set up by the provinces, with the financial support of the Flemish ministry of Health.
In addition, these provincial prevention platforms and the platforms for mental health are stimulated to formulate joint projects in which prevention and treatment at a provincial level are being linked. Each province can get a financial support for these projects.
At a regional level, 'LOGO's' were created in 1998 (per region of approx. 250,000 inhabitants) for the implementation of Flemish health targets. Drug problems are not among the five priority targets for 1999-2002.
At the local level, prevention initiatives are the responsibility of the municipalities and cities, with the financial support of the federal ministry of Internal Affairs.

French Community

French Minister of Health

Since 1995, the French Community's health authorities are competent for health promotion policy. A new Decree, taken on the 14th of July 1997, reforms and reorganises the structure of health promotion in the Community. Drug prevention - sense largo - will be a part of the next five years programme and the Community Plan. Its action focuses mainly on primary prevention.
The previous Decree - November 1988 - of the French Community recognised several structures as "thematic service to the educators". As umbrella organisation, CCAD is co-ordinating drug prevention activities and carries out the collection of epidemiological data related to addictions and psychotropic products consumption.
As "service to the educators", CCAD gives scientific and logistic support to the field workers and services involved in primary prevention of alcohol and drug problems.
At the present time, negotiations are going on to adapt the missions of the CCAD in the terms of the new Decree. A temporary agreement was accorded to the CCAD till the end of August 1998.
The French Community delegated to the Walloon Region and to the French Community Commission of Brussels its competencies regarding the levels of secondary and third prevention and regarding outpatient treatment, rehabilitation, re-socialisation and harm reduction policies.
The Sub-Focal Point for the French Community was CCAD until August 2000 and EUROTOX since.

Brussels-Capital Region

Brussels-Capital Ministry of Health

The CTB/ODB "Brussels Drug Addiction Concertation" programme started on the initiative of the two Ministers competent for questions of Public Health. This initiative came shortly after the creation of the Brussels-Capital regional government, as a result of the new breakdown of responsibilities in Belgium. The programme is supported by the entire "Collège Réuni/Verenigd College" of Brussels-Capital which includes all the regional bi-community Ministers. The programme is also co-ordinated by two other Ministers, competent for health questions specifically concerning Dutch-speaking citizens and French-speaking citizens.
A co-ordinator is appointed to implement the programme. He regularly reports to a Supervising Committee made up of two representatives of the association 'Plate-forme de santé mentale pour Bruxelles-Capitale/Overlegplatform voor geestelijke gezondheid voor Brussel-Hoofdstad', one

representative of each of the two competent Ministers, two representatives of the "Concertation and Co-ordination Committee" (see below) and observers representing respectively the Minister-President of the Region and the two Ministers competent for Assistance to persons.

The concertation and co-ordination committee of the CTB/ODB programme has met every month since the programme was launched. A ministerial Decree dated 15 September 1994 has officially set its duties and membership. This committee includes experts in the field (health and social aspects) as well as lawyers, representatives of the Courts, the Prosecution, the national and local police.

As Sub-Focal Point of the Belgian REITOX network, CTB/ODB supervises the collection and transmission of information to the Belgian Focal Point and EMCDDA and to the Brussels institutions working directly in the field.

The Brussels programme covers the following eleven objectives:

- systematical collection of statistical data;
- drafting and distribution of a vademecum of existing services and persons;
- support and co-ordination of prevention;
- encouraging the reception of drug addicts by front-line, non-specialised institutions;
- development of support for reinsertion;
- establishment of an integrated co-ordination of interventions of the various governmental authorities;
- collaboration with international co-ordination;
- improvement of specialised centres;
- taking action with the national Medical Association and the national Pharmaceutical Association;
- creation of a concertation and co-ordination committee and appointing the head of the "Brussels Drug Addiction Concertation" project;
- support to harm reduction activities.

German-speaking Community

The government of the German-speaking Community authorises the Centre for mental health 'Sozial Psychologisches Zentrum' (SPZ) to give ambulatory therapy to individuals with addiction problems. The German-speaking Community also subsidises the ASL for the co-ordination of the actions.

As Sub-Focal Point of the BIRN for the German-speaking Community, ASL has to co-ordinate drug prevention activities and to collect epidemiological data related to drug use.

b) Main results achieved

12.3. Evaluation of national strategies

a) Evaluation plan:

Description of criteria, activities, implementation

The conclusions of the parlementary working group adopted by the Parliament and approved by the Council of Ministers in June 1997 mentioned the importance of the evaluation : 'If we want to adapt the drug policy to the context of the societal evolution, regular evaluations of the results of the applied measures are needed'.

Several evaluations are currently in progress :

Evaluation of the Directive of 1998 modifying the action of the judicial authorities establishing *a distinction between possession of cannabis for personal use and other illegal drugs with non acceptable risk for health*.

Variable and heterogeneous enforcement of the directive in the different judicial districts

In principle, should place cannabis users outside off the judicial field…

Message not understood by youngsters that believe that cannabis was legalized..

Evaluation asked for by the Minister of Justice. In progress.

- Evaluation of Mass/Msoc's

In 1996, medico-social relief centres for illicit drug users (MASS/MSOC) were initiated by the federal ministry of Internal Affairs. An evaluation was asked for by the Scientific services of the prime Minister. In progress. Expected final report by April 2001.

b) Principal results: need of changes, new trend : -.

At Belgian level, more than actual results there are many expectations about pending issues

- results of the evaluation of the Mass/Msoc's ?
- results of the evaluation of the directive ?
- new drug plan for Belgium ? co-ordination between levels ?
- effects of the police reform ?

Chapter 13. Cocaine and base/crack cocaine

Regarding this issue we shall often refer to the recent thesis of Dr. Tom Decorte 'Informal control mechanisms among cocaine and crack users in the metropolitan area of Antwerp'[56]. Indeed this study made an original contribution to the field of drug epidemiology by describing a sample of 111 cocaine users from within their culture rather than from outside, and to present their world as they see it (the in-sider's view). Decorte said '*official statistics, population surveys, and utilisation studies, are useful indicators of drug use, but they are often biased, partial, and focused on the best known, most visible, accessible, and perhaps most marginalized subgroups of drug users. Moreover, observing or interviewing respondents with the intent of helping, controlling or treating them probably biases the research findings as well* '.

As multiple references will be made to the thesis of Decorte, every sentence extracted from the thesis will be mentioned between quotation marks and in italic.

' To make the sample comparable to the 1987 Amsterdam community sample of cocaine users studied by Dr. Peter Cohen (Centre for Drug Research, University of Amsterdam), Dr. Tom Decorte defined identical sample acceptability criteria: (1) cocaine as a main drug; (2) a minimum lifetime experience of 25 instances of cocaine use; (3) a mini- mum age of 18 years; (4) not having been found guilty of a felony; (5) not having participated in any drug treatment program. Furthermore, some social groups, such as Street junkies, prostitutes, professional criminals, secondary school pupils and youth club members were explicitly eliminated as target populations, in order to obtain information about 'hidden' and 'non-captive' subpopulations of cocaine users'.

'Using a snowball sampling procedures, 111 experienced cocaine users were recruited from the metropolitan area of Antwerp. They participated in a double interview : a semi-structured questionnaire and a open biographical interview'.

' The cocaine users found in Antwerp differed markedly from drug users as they are depicted by the non-using public, health care professionals, law enforcement officials, other research projects (especially in utilisation studies), and the media. Drug users who do not confirm to the stereotype of 'worst-case scenarios' are less likely to come to the attention of health practitioners or the police, and ordinary citizens rarely identify them as drug users. The study demonstrates that it is possible to recruit a group of 'invisible' cocaine users who do not fit the stereotype of drug use as heavily associated with deprivation, ill health and crime. Indeed, in other research projects the main barrier to finding such 'hidden populations' may consist in failing to seek them'.

13.1. Different patterns and users groups

a) Administration and effects sought

From Decorte study : '*Our data show that cocaine produces a wide range of positive effects on those who use it in moderation: more energy, a certain intellectual focus, enhanced sensations, and increased sociability and social intimacy. Social, sexual, or recreational activities and work can be enlivened, and many respondents use the drug not only in pleasurable but also in productive ways. Typically, interviewees perceive the financial consequence of their cocaine use as a more important disadvantage than whatever physical or psychological adverse effect they report. Most participants were prepared to live with the unappealing aspects of cocaine, which were outweighed by its appealing factors.*

b) Prevalence, patterns and frequency of consumption

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 out-dated : 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 3% in the French Community HBSC survey) experienced cocaine.

TABLE 44. ***Prevalence of use (%) of cocaine in adult and school-aged population Belgium, 1994-1999***

INDICATORS	ORGANISATION (reference nb)	1993	1994	1995	1996	1997	1998	1999	Trend
ADULT POPULATION									
Lifetime prevalence	Vlaamse G. [6]		0.5						?
Last year preval.	Vlaamse G. [6]		0.2						?
SCHOOL POPULATION (15 -16 y.)									
Lifetime prevalence	RUG/Publ.Hlth [9]		0.9		0.6		1.3		?
	VAD [11]							1.9	
	ULB/Promes [10]						3.5		
Last month preval.	RUG/Publ.Hlth [9]		0.1		0.3		0.3		?

- HBSC survey :Youngsters and health in Flanders, 1994-96-98 [9]

Respectively 1% and 4% of students aged 15-16 and 17-18 years used cocaine at least once (respectively 2% and 4% in boys and 0.7% and 4% in girls) ; only 0.3% and 1% of students aged 15-16 and 17-18 years used cocaine during the last month.

- HBSC survey :Health behaviour of youngsters in the French Community, 1988-98 [10]

In 1998, 4% of 15-16 years (boys : 5% - girls : 3%) experienced cocaine. The use increases with age : from 2% among 11-12 years and 3% among 13-14 years reaching 4% in 17-18 years (boys : 6% - girls : 4%).

- Survey in Flemish Schools, 1999 [11]

In 1999, the lifetime prevalence of cocaine use is 2% of 15 to 16-year-olds (boys : 2% - girls : 1%). Use increases with age : from 1% among 11-12 years and 13-14 years reaching 4% in 17-18 years (boys : 5% - girls : 2%).

- School-aged youngsters in Bruges (Flanders), 1996-97 [15]

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.

- Mental health of youngsters in Brussels, 1994 [17]

Out of 2209 pupils of the Brussels secondary schools, trying and using cocaine (as well as crack and heroin) is limited.

- Rock Festival (French Community), 1996-98 [31]

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%).
1999 ??

- Street snowball survey, 1998 [54]

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 (14 - 55). The main used substances were heroin (75%) and cocaine (65%) when crack was used by 5%.

- *Drug consumption in prison, 1993* [24]*, 1997-99* [62]

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 user. The main drugs were cannabis (37% of users), heroin (28%) and cocaine (16% of users).

From Decorte study : *' Three in four respondents were '**snorters**' at the time of the interview. In all three periods (initial period, period of heaviest use, and most recent period) snorting was practised by an overwhelming majority of the respondents. The proportion of injecting respondents was relatively small. Seventy-three respondents (65.8% of the Antwerp sample) kept a stable route of ingestion (mostly snorting). Thus, the initial snorter (or chaser) is not merely a cocaine user who has not yet injected but will inevitably do so. And the cocaine injector is not bound to continue as an injector for the entire duration of his/her cocaine career '.*

*' The Antwerp cocaine users sample have a lot of experience with **all kinds of drugs**. Only a minority use cocaine by itself, whereas most combine the use of cocaine with the use of other drugs. Yet, it would be wrong to conclude that our respondents are permanently taking 'drug cocktails' (i.e. combining several types of drugs at the same occasion of use). They have clear ideas (and informal rules) about which drugs can be combined, and which substances should not be combined '!*

*' Respondents experience their cocaine use career as a dynamic, often irregular, pattern, subject to many changes. In all community samples, the proportion of respondents reporting a **discontinuous or irregular pattern of use** (in the Antwerp sample almost 90%) is larger than the proportion of those reporting a continuous one. Moreover, most respondents report a preference for weekends, and more than 70% report a low rate of use at a typical occasion (non-bingers) '.*

*' A very large proportion of the Antwerp respondents report having stopped for more than one month (86.5%). Nearly 60% of the total sample report more than 5 **abstinence periods** of one month or longer. The average duration of the longest period of abstinence was 15 months. Seventy-one respondents (64%) report having cut back on their cocaine use. About half of the respondents who had temporarily abstained or cut back on their cocaine use, did not experience any problems with it. Most others qualify these 'problems' as minor discomforts that manifest themselves initially and fade away after a few days or weeks. Thirty-two respondents (29.7% of the total sample) report having quit cocaine, 6 of whom did so without consciously reflecting on it '.*

*' More than three in four respondents (77.6%) perceive themselves as '**controlled' users**. The most important indicators of 'controlled' use according to the Antwerp respondents were: periodical abstinence, refusing cocaine when it is offered (in other words: resisting craving), small doses and/or low frequency of use (and consequently, low level of use), fewer active efforts to obtain cocaine, other activities taking priority over cocaine use, positive reasons for using cocaine. Most respondents report a sense of increased mastery and control over the product. Many users have to go through a period of loss of control over the substance, or to learn about the negative and dangerous aspects, but in the end they are able to use the substance more consciously and to prevent cocaine from interfering with relationships and activities that take priority (such as a job, family life, etc.) '.*

' However, the user may reach a stage where he/she is no longer able to conform to the others' expectations and starts to lie about his/her cocaine use. Almost half of the respondents who report having lied state they concealed their illicit drug use from non-using friends to minimize the risk of police attention, to avoid being labelled a 'drug user' or 'addict', or to avoid concern anxiety, disappointment, shock, etc. in significant others. Almost one in three of the respondents who report having lied state they lied about the quantity of cocaine they had with them to other users. These lies are typically meant to avoid sharing the drug with others, because it is hard to obtain, or expansive, or because these respondents simply want all the cocaine for them. One in five of the respondents who had lied acknowledge having done so about the frequency of use to friends, because they wanted to avoid informal social control by others (social disapproval), or because they wanted to mask their own inability to control the substance' .

c) Social groups, geographical factors

From Decorte study : '*Fewer than 5% of the total sample report feelings of being 'pushed' and almost all respondents report that trying out cocaine was their own (often conscious) choice. The stereotype of the drug dealer or drug pusher actively recruiting new cocaine users to expand his market did not feature in our sample. Curiosity about cocaine and association with significant others who use it, bring the uninitiated in a situation where cocaine is being used* '.

' *Informal comments can provoke a wide range of reactions, from aggression and indifference, to feigned consent and simulated remorse, to indulgence and behavioural change. Whether or not a remark or comment from another person is perceived as well-founded, depends on many factors: the source or maker of the remark (non-user or user), the (perceived) pattern of his/her cocaine use, the form and content of the remark (serene versus paternalistic, joking versus angry, verbal versus non-verbal), the situation in which the comment is made, the emotional state of the receiver, whether the receiver is under the influence of cocaine, etc. Most of the respondents' accounts show that a prerequisite for effective informal social control is a strong or intimate bond between the maker of the comments and the receiver. Our participants emphasize that only the remarks of close friends can help to adjust their cocaine use. Comments by acquaintances, strangers, and non-users in general go in one ear and out the other* '..

13.2. Problems and needs for services

a) Health consequences and negative effects

TABLE 45. *Problematic use of cocaine : treatment demands, intravenous administration, taken in for questioning, Belgium,1993-1999*

INDICATORS	ORGANISATION (reference nb)	1993	1994	1995	1996	1997	1998	1999	Trend
PROBLEMATIC USE Treatment demands (% cocaine = main drug)	CCAD [34] VAD [33]	2.3	2.5	2.7	2.9 7.1	3.8	5.9 9.0		
Current injecting use (%)	CCAD [34] Coor.Drog.Charl [37] VAD [34]	22.2	25.9	34.6	22.9	34.8	29.5 8.9	 10.8	
PEOPLE TAKEN IN for questioning (% cocaine/all offence)	SGAP [46]			5.9		5.0	4.6	4.3	=

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 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 non-injectable drug) and varies between monitoring systems (remaining lower to heroin injecting behaviour though almost equal in French Community reporting systems).

- Treatment centres

The most recent data from the treatment demand registration systems of the French Community (CCAD, 1993 to 98), the Flemish Community (VAD, 1996 and 98) and Brussels (CTB-ODB, 1997 and 98) were compared. In 1998, cocaine was considered the main drug by 9% of treated patients of the VAD Flemish Community database and by 6% of the French Community (increasing trend from 2% in 1993) where this proportion is higher in males (6.8%) than in females (3.2%). In Brussels, cocaine is

registered together with 'stimulants' and represented 10%. Among first treatment demands (French Community), cocaine as main drug is 8% in 1998 (males 10%, females 2%).

Among patients undergoing treatment in centres of Charleroi [37], the average age at the first use of cocaine was 20.2 years (1997). The proportion of daily users among cocaine users for the years 1995-96-97 were respectively 13, 15 and 18%.

From Decorte study : *' A large majority of the respondents (80%) did* ***not have any contact with drug treatment agencies*** *or with medical doctors for a drug problem. Only two respondents of the Antwerp sample (n=111) had sought help for cocaine-related problems '.*

' It is striking that in the case of an ***overdose*** *or emergency, most respondents indicate they prefer to look for solutions themselves, rather than appear to a general practitioner or a first-aid-team, or call for an ambulance. Most bystanders try to reassure the one who has an overdose: they try to 'talk him/her down', give him/her something to drink, keep him/her company, etc. Some respondents, however, report particular ploys to put someone back on his/her feet after an overdose (a glass of milk, a glass of orange or lemon juice, a glass of salty water). These 'detoxification techniques' are probably part of user lore about adverse effects and how to 'treat' them, but they are relatively ineffective and sometimes even counterproductive' .*

' Cocaine use ***may escalate, but it does not do so endlessly****. About half of all users reach a high use level in their period of heaviest cocaine use, but only 5% had stayed at that level in the three months prior to interview. Almost 1 in 5 Antwerp respondents had not used at all during the last three months. A proportion of cocaine users (18% in the Antwerp sample) is able to maintain a low level of use throughout their whole use career. Furthermore, high-level use of cocaine during certain (top) periods of use does not exclude later abstinence or decreased frequency of use at all '.*

' Most of the risks (binge use, feelings of craving, obsession, unpleasant mental and physical effects, difficulties with periodical abstinence or cutting back, ...) are related to more direct routes of ingestion, such as ***freebasing or injecting****. Furthermore, it was shown that the number of negative effects increases with level of use. A level of* ***use higher than 2.5 grains a week*** *definitively asters the balance between positive and negative effects '.*

b) Social consequences

Cocaine is the cause of a low proportion of the cases in which people are taken in for questioning : stable from 1993 to 1999 around 5% (Table 45).

From Decorte study : *' It has been suggested that the desire for a drug may be so strong that many, if not most, people are unable to resist, even if they have to engage in criminal activities to buy or use it. Yet, three in four respondents had* ***never engaged in any criminal activity*** *to obtain (money for) cocaine. The activities most frequently mentioned by the Antwerp respondents were: tolerating the presence of unpleasant persons to obtain cocaine and selling cocaine (usually to friends). One third of all crimes reported had been committed only 'once', indicating opportunistic and accidental criminal behaviour. Most of these crimes had been committed by a small group of 12 respondents, who were mainly recruited from snowball chains with higher proportions of registered respondents, regular injections, and respondents reporting difficulties with abstaining or cutting back '.*

13.3. Market

a) Physical description, b) Price/Purity at user's level, Availability

TABLE 46. *Cocaine seized: number of seizures and quantities, Belgium, 1985-1999* [45]

	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Seizures (N)	132	226	254	380	422	375	513	933	897	927	1,046	NA	NA	799	547
Quantity (kg)	62	116	270	404	89	537	756	1,222	2,892	479	576	838	3,321	2,028	1,761

TABLE 47. *Prices of (EURO) and accessibility to cocaine, Belgium,1993-1999* [45]

INDICATORS	ORGANISATION (reference nb)	1993	1994	1995	1996	1997	1998	1999	Trend
PRICES : Wholesale	SGAP	32		18		25	18	22	=
Retail		55		49		40	50	55	=
AVAILABILITY (% adults)	ULB/Promes				45.6	50.8	41.1	40.0	=

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 number of seizures seems decreasing during recent years [y];
- the wholesale and retail prices have been stable since 1993;
- the accessibility to cocaine in adults is strikingly high : nearly half of adults stated that they could get cocaine quite easily near to their home.

c) Open scenes, local markets, trafficking/dealing/distribution patterns, supply routes/countries

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 harbours 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.

13.4. Intervention projects

❖ Recommendations for policy making

From Decorte study : *' The data of the study suggest that the view that pharmacology is somehow an instantly addicting destiny is an oversimplification, given the many complex patterns of use and outcomes '.*

Dr. Tom Decorte therefore proposes *: ' 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 us to assess the overall impact of any substance, without overreacting to the dangers it poses. It does not downplay the pharmacological power of drugs, but it does not consider them the only important factor either. It accepts that drag use does not occur in a social vacuum, and that psychological, social, economic, and cultural factors play important roles in shaping a person's drug use behaviour. 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. We should study both the conditions under which dysfunctional or 'hard' use occurs and how these can be modified, and the conditions that maintain control for the 'soft users' and how these can be promulgated. To study the conditions of use for each drug will require consideration of the following*

[y] Additionnaly to elements for discussion of the trends in term of number of seizures, one should mention that the large variation between years in the quantities seized in Belgium could be the result of the collaboration between countries in the fight against trafficants : the current policy/strategy when a traffic is discovered, is to postpone the intervention (arrest of the trafficants and seizure of the drugs) and to follow the travel in order to be more efficient by discovering the organization of the distibution, the partners in crime… So such data on quantities will be better interpreted at larger (European) level.

topics: dosage, method of administration, pattern of use (including frequency), and social setting, as well as the pharmacology of the drug itself '.

' 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 ready-made, nor can formal policy create them '.*

' The sudden ***legalization*** *of cocaine, for instance, would leave in limbo those who have not yet had the time to internalise information social controls. There are, however, several steps that can be taken to demystify drug use and thus to encourage the development of informal control mechanisms.*
These steps include disseminating realistic information (education), less police activity towards users, decriminalizing all use of any drug, correcting negative attitudes toward drug users, and undertaking legal reform. In the long run a more liberal and tolerant drug policy should remove drugs from their criminal context and make users themselves responsible for their drug use, rather than the State. However, such a tolerant policy must include state-controlled availability and purity of drugs, while at the same time it must discourage the use of drugs in general '.

- Services (Prevention, Treatment interventions, Harm reduction)

From Decorte survey : *' Treatment agencies could develop models of informal control mechanisms, and 'types' of drug users based on the social rituals and sanctions they have adopted. A better understanding of the genesis and transfer of informal control mechanisms among drug users, may help the treatment specialists to draw lessons from those who are able to control their cocaine use ('soft users') for the benefit of those who seem unable to manage their use ('hard users') '.*

Research and evaluation : -.

14.1. Prevalence and of HIV, HBV and HCV among drug users

14.1.1 HIV/AIDS

14.1.1.1 AIDS and HIV-seropositives register

There are eight AIDS-reference laboratories in Belgium. One of their duties is to perform confirmation tests on sera found positive during the screening tests. Since they are the only laboratories subsidised for these tests, their reporting of new HIV-positive individuals gives a global picture of the total number of newly diagnosed seropositives in Belgium.

The AIDS-patients are reported in an independent way by the doctor who provides treatment. These reports which are anonymous, are also written on a standardised form, and sent to a commission of clinicians, virologists and epidemiologists. This Commission guarantees data confidentiality.

The current AIDS-definition in Belgium is the one proposed by the Centres for Disease Control and Prevention (CDC) in 1987 (modified in 1993).

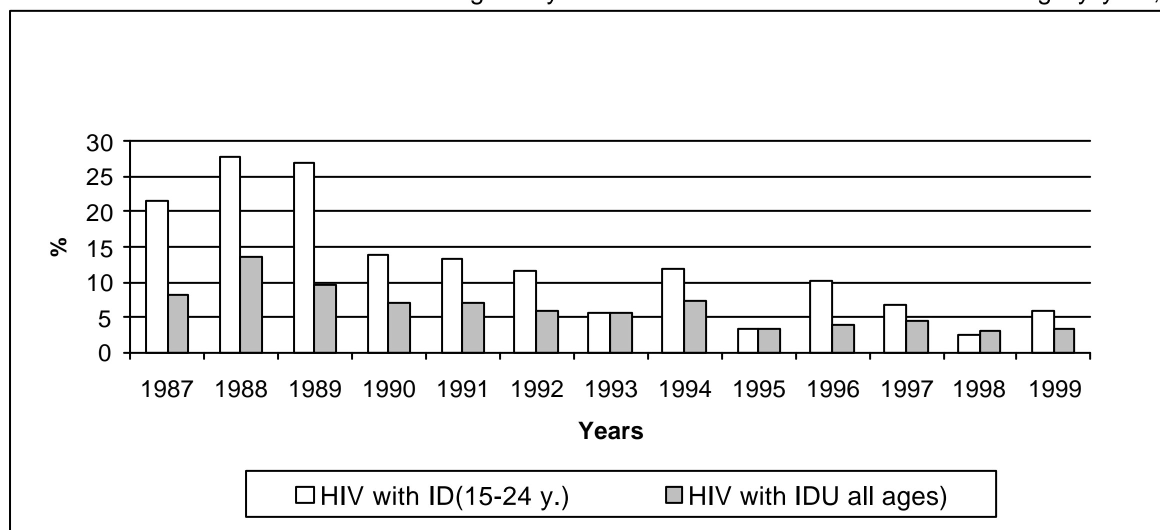
Since a common code is used to record each case, whether HIV-positive or AIDS, it is possible to avoid multiple counting and also to link the two databases.

From the beginning of the epidemic till December 1999, 11 891 HIV infected patients have been registered. Among these, 2 670 have reached the clinical stage of AIDS [63]. Between 1987 and 1999, the average number of new HIV-cases registered were 1.9 to 2.7 per day.

TABLE 48. *Number of new HIV-cases, number of new cases with IVDU as risk status and proportion of IVDU risk status among all new cases, in Belgium, per year, from the beginning of the epidemic to 1999* [63]

Year	Total HIV-diagnosis (N)	HIV with IVDU (N)	(HIV with IVDU) / all HIV+ with information on risk status (%)	HIV with IVDU 15-24 y. (N)	(HIV with IVDU) / all HIV+ with information 15-24 y. (%)
1986 and before	1 393	102	10.1	64	34.8
1987	929	47	8.2	17	21.5
1988	747	65	13.6	20	27.9
1989	752	55	9.6	19	26.9
1990	809	41	7.1	9	13.8
1991	803	38	7.1	11	13.3
1992	977	37	6.0	9	11.5
1993	944	31	5.5	5	5.7
1994	802	38	7.2	7	11.7
1995	765	15	3.4	2	3.4
1996	717	14	3.8	4	10.3
1997	690	16	4.5	3	6.8
1998	750	11	2.9	1	2.4
1999	795	12	3.4	2	5.9
Total 1987-1999	10 480	420	6.6	109	13.4

Information on the risk factor status is globally available for 63% of cases. Considering by year, the



number of new HIV-cases in relation to intravenous drug use (IVDU) among heterosexuals, homosexuals and bisexuals is slightly decreasing reaching 16, 11 and 12 new IVDU-HIV-cases respectively in 1997, 98 and 99.

The number of HIV infected people is much greater among males than among females. Infection via intravenous drug use is the highest among young people. Meanwhile among infected people aged between 15 to 24 years the number of new cases stating IVDU is quite low, respectively 3, 1 and 2 cases in 1997, 1998 and 1999. Although the proportion of intravenous drug users was higher than in older age groups, it becomes more comparable in the last three years (Table 48). This declining trend will have to be confirmed in the long run.
The proportion of IVDU-HIV-cases decreased reaching 3.4% in 1995 and then remain relatively stable (2.9% in 1998 and 3.4% in 1999). 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) [64].

FIGURE 15 : *Proportion (%) of IVDUs among new HIV-cases from 1987 to 1999 in Belgium*

14.1.1.2 HIV sero-positivity among treated patients

Most of monitoring systems register information on the infectious status of their patients. Usually the information is reported by the patient him/her-self. We present data of the CCAD and VAD systems and from other sources.
De Sleutel [38] is an organisation with several ambulatory and residential treatment centres in Flanders (1997 : 862 unique and new clients; 1998 n=1186; 1999 n=1945) (prevention interventions are also conducted). According to the information required for this 'Infection' synthesis, only a part of clients have been selected combining data from different files and mainly the medical file : criteria for seeing a doctor are not linked to the type and/or the way of product-use, but it is sure that all clients getting substitution and/or other medication do see a doctor. Biological testing was performed for these patients. There is an overlapping between the data of 'De Sleutel' and data of VAD, but its extent is not estimated.
GEMT (Groupe d'Etude des Maladies liées à la Toxicomanie) is a group of GPs with family practice and caring also for drug user patients (mostly by methadone maintenance) in Charleroi (Wallonia). Biological testing was performed for the GEMT studies (1992-93 [65] and 1995 [66]).

In the framework of the Flemish GIG project (health and injecting drug users), a six-month study was conducted in 1996-97 [67] : 248 IVDUs were interviewed according to an European questionnaire on AIDS and IV 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 positive (2.2%) (all five had stated that they were HIV-seropositive).

n 1994, 523 questionnaires were filled in by drug users treated by general practitioners participating in the ALTO programme [68]. Patients (males:78%) were mainly heroin users (mean age: 26 years, mean age at start: 20 years, mean duration of use: 6,2 years). 77% (n=348) stated that they have been tested for HIV : 2,2% stated to be HIV-positive. In this study, there was no association with IVDU.

TABLE 49. *Proportion (%) of HIV- infected patients among IVDU* patients starting treatment (numbers into brackets), reported by various systems, in Belgium, from 1992 to 1999*

Source	Ref	Area	Method	IV drug use	1992	1993	1994	1995	1996	1997	1998	1999
GEMT – Charleroi	65,66	French Com.	Biological Diagnosis	At least once	1.6 (249)			0.9 (228)				
ALTO	68	French Com.	Self-report	All users			2.9 (348)					
CCAD	34	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)	
GIG-project	67	Flemish Com.	Biological diagnosis	At least once					2.2 (225)			
De Sleutel	38	Flemish Com.	Biological Diagnosis	At least once						0.8 (120)	5.4 (56)	0.5 (186)
VAD	33	Flemish Com.	Self-report	Last 12 months							1.9 (373)	

* : except in the ALTO study

Underlining that caution should be taken as the numbers of tested IVDUs are low, Table 49 shows relatively comparable HIV-infection rates among IVDUs. Meanwhile the GEMT studies reported low rates in 1992 and 1995, one observes a declining trend in the CCAD figures that is compatible with recent data of VAD and De Sleutel, except the figure of 1998 (5.4%) but this is calculated on a low number of patients (n=56).
Table 50 presents the proportion of self-reported HIV-seropositive among users demanding for treatment in centres in the French Community [34].

TABLE 50. *Proportion of self-reported HIV-seropositive among IVDUs starting treatment in centres of the French Community for years 1993-1998* [34]

Year	1993	1994	1995	1996	1997	1998
Number of treatment demands[z]	1,618	1,212	1,176	1,570	1,681	1,466
Number tested IVDUs (self-reported)	245	230	230	284	270	252
Number of HIV+ (self-reported)	12	13	7	4	7	4
% HIV+ of tested IVDUs	4.9%	5.7%	3.0%	1.4%	2.6%	1.6%
% in males	5.2%	5.5%	2.9%	0.9%	2.1%	1.5%
% in females	3.9%	6.3%	3.6%	2.7%	3.8%	7.7%
% in age <25	4.0%	2.4%	2.6%	1.2%	0.0%	2.5%
% in age 25-34	5.6%	8.7%	3.1%	1.7%	3.2%	2.5%
% in age >34	5.0%	4.5%	4.3%	0.0%	4.3%	2.3%
% in opiate using IVDUs	3.8%	7.3%	4.5%	1.8%	0.8%	4.4%
% in IVDUs not using opiates	5.5%	4.2%	1.7%	0.9%	4.3%	1.4%
% in capital/metropolitan area	5.6%	7.9%	12.5%	0.0%	0.0¨%	9.1%
% outside capital/metrop. area	4.7%	4.2%	1.7%	0.8%	2.2%	2.2%

14.1.1.3 HIV sero-positivity among prisoners

The health service of the penitentiary administration provides figures about the HIV infection among prisoners [69].
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 IVDU status are 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), testing are performed when asked for by 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 668 having been tested (1.2%).

In 1997, a study was carried out in the prison of the city of Namur [62]. Among 175 prisoners, 115 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 (0%).

In 1997, the penitentiary administration estimated that the prevalence of HIV among prisoners was 2% [70]. In 1987, it was estimated as 1.3% [71]. Two studies carried out in 1992 and 1993 produced similar prevalences : the one in Antwerp (prevalence 1.2%) [24], the other in 14 Belgian prisons (0.8% among males and 1.7% among females) [72]. Besides differences according to sex, this second study showed the highest prevalence among the 25-34 age group (2.2%).

z Demands for which alcohol is the main subtance were excluded.

14.1.2 Hepatitis B and C

The IV use of drugs and transfusion of blood and its derivatives, are the two main risk factors associated with the transmission of hepatitis C. In Belgium, IV drug use seems to be the first cause of HCV contamination at this time [73]. The other sources of transmission, such as mother-child exchanges, sexual and family contamination and medical care are less frequent. It is estimated that a cirrhosis will occur in 20% of patients with hepatitis C after a mean delay of 15 years. Patients with cirrhosis are exposed to liver cancer that occurs in 3%.

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) based on a survey carried out in 1993 [74]. HCV seroprevalence associated with defined risk groups would be a better set of data to use.

14.1.2.1 HBV- and HCV sero-positivity among treated patients

Since 1997 information on hepatitis status of drug user starting a treatment is registered in centres of the French Community (CCAD monitoring system) [34] 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 organisations are given in 3.3.a.2).

Hepatitis C virus is more prevalent among IVDUs than HBV. Although based on different methods, respectively self-reports and biological diagnosis, the CCAD and De Sleutel figures are quite similar without any particular trend over the last 3 years : for HBV around 20-25% and for HCV 40-50% of patients have been infected (Table 51). The prevalence rates reported by the GEMT studies are higher particularly for HCV : the explanation could be due to a selective recruitment of patients or to a true local higher level of the HCV epidemics among the IVDUs of Charleroi.

TABLE 51. *Proportion (%) of HBV- and HCV- infected patients among IVDU patients starting treatment (numbers between brackets), reported by various systems, in Belgium, from 1992 to 1999*

Source	Ref	Area	Method	IV drug use	1992	1993	1994	1995	1996	1997	1998	1999	Trend
H B V													
GEMT – Charleroi	65 66	French Com.	Biological Diagnosis anti-HBc	At least once	16.0 (232)			36.0 (238)					
CCAD	34	French Com.	Self-report	At least once							22.4 (107)	23.6 (237)	=
De Sleutel	38	Flemish Com.	Biological Diagnosis anti-HBc	At least once						20.5 (73)	24.1 (54)	23.9 (155)	=
H C V													
GEMT – Charleroi	65 66	French Com.	Biological Diagnosis	At least once	82.0 (181)			78.0 (244)					
ALTO	68	French Com.	Self-report	At least once			56.0 (252)						
CCAD	34	French Com.	Self-report	At least once							46.7 (107)	51.9 (237)	=
De Sleutel	38	Flemish Com.	Biological Diagnosis	At least once						39.5 (114)	46.4 (56)	37.9 (195)	=

Figures were also collected by the VAD system [33] (Flemish Community) showing the same higher prevalence of HCV compared to HBV : 7 patients stated HBV- and 19 HCV- seropositivity among 619 patients but the number of tested patients is not known.

In 1997 and 1998 respectively 22% and 24% of tested IVDUs registered by the CCAD system (having injected at least once) were infected by hepatitis B (Table 52). The proportion of HBV infected is higher in females (29%) than males and increases with age (one out off three among patients aged 35 or more).

In 1997 and 1998 respectively 47% and 52% of tested IVDUs (having injected at least once) were infected by hepatitis C (Table 53). Contrary to HBV, the proportion of HCV infected patients is more comparable between males and females and between the different age groups.

TABLE 52. *Proportion of hepatitis B infected among IVDUs asking for treatment, in centres of the French Community, 1997-1998* [34]

HBV	1997	1998
Number of treatment demands [aa]	1,681	1,466
Total number tested IVDUs (self-reported)	107	237
Number hepatitis+ (self-reported)	24	56
% hepatitis+ of total IVDUs	22.4%	23.6%
% infected in males	18.8%	22.0%
% infected in females	28,9%	29.4%
% infected in age <25	14.3%	18.9%
% infected in age 25-34	22.5%	21.6%
% infected in age >34	33.3%	35.6%
% infected in opiate using IVDUs	22.5%	26.8%
% infected in IVDUs not using opiates	22.4%	20.8%
% infected in capital/metropolitan area	25.0%	23.1%
% infected outside capital/metrop. area	23.6%	22.8%

TABLE 53. *Proportion of hepatitis C infected among IVDU asking for treatment, in centres of the French Community, 1997-1998* [34]

HCV	1997	1998
Number of treatment demands [bb]	1,681	1,466
Total number tested IVDUs (self-reported)	107	237
Number hepatitis+ (self-reported)	50	123
% hepatitis+ of total IVDUs	46,7%	51.9%
% infected in males	46,4%	48.9%
% infected in females	47,4%	60.8%
% infected in age <25	42,9%	48.6%
% infected in age 25-34	47,9%	49.3%
% infected in age >34	46,7%	57.8%
% infected in opiate using IVDUs	37,5%	53.6%
% infected in IVDUs not using opiates	52,2%	50.4%
% infected in capital/metropolitan area	37,5%	38.5%
% infected outside capital/metrop. area	48,3%	51.0%

aa Demands for which alcohol is the main subtance were excluded.

bb Demands for which alcohol is the main subtance were excluded.

In 1994, 523 questionnaires were filled in by drug users treated by general practitioners participating in the ALTO programme [68] Among the 366 IVDUs (at least once) 69% stated that they have been tested for HCV : 56% stated to be HCV-positive. The association with IVDU was obvious : only 9% of non IVDUs were infected.

14.1.2.2 HBV- and HCV sero-positivity among prisoners

The health service of the penitentiary administration provides figures about the HIV infection among prisoners [69] (see 3.3.a.3).
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 consequently IVDU status are not known. Only the last test for each patient was taken into account. In 1999, 7 patients were HBV (HBs ag)-positive among the 314 tested (2.2%). 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 as drug use) 56/321 (17%) were positive (13% in 1998).

In the prison of Lantin (Wallonia), testing are performed when asked for by 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 51/692 prisoners (8%) and 191/692 (a very high proportion of 28%) were diagnosed HBV- (HBs ag) and HBC-positive.

In 1997, a study was carried out in the prison of the city of Namur [62]. Among 26 prisoners, 10 (38%) were HCV-positive based on saliva test.

14.1.3 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 Gezondheidzorg en Tuberculosebestrijding).
In Belgium, 1,270 new cases with tuberculosis were registered in 1999 (incidence rate : 12.5/100,000 inhabitants) [75]. Risk factors were recorded: drug addiction was stated for 9 cases, representing 0.7% of new tuberculosis cases. Table 54 indicates that the number and proportion of drug users among new cases of tuberculosis is stable over the recent years. 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%) and 4 cases (1.5%) for years 1994 to 1999.

TABLE 54. *Number and proportion of drug addicts among new cases with tuberculosis, Belgium, 1994-1999* [75]

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

14.2. Determinants and consequences

Injecting and sharing

- *Treatment centres, 1993-1998*

Injecting behaviour is asked to patients starting treatment and in 1998 this information is available for 4,182 patients of the VAD and CCAD databases (66%). A third (35%) of patients, males more than

TABLE 55. *Intravenous administration in users at the time of starting treatment according to gender and first or not first treatment, CCAD[34] and VAD[33] databases, 1998*

	All treatments			First treatments		
	M	F	T	M	F	T
N with information on IVDU	3,196	980	4,182	1,378	446	1,825
Currently injecting any drug (%)	9.6	7.2	9.0	7.5	4.9	6.9
Ever injected any drug but not currently (%)	27.4	20.3	25.7	14.7	15.7	14.9
Ever injected any drug (%)	37.0	27.6	34.8	22.1	20.6	21.8

females, injected a drug at least once among which a quarter was 'current injector' (last month IVDU) at the time of the contact for treatment (Table 55). Among people undergoing a treatment for the first time, these proportions were lower : respectively 22 and 7%.

The CCAD database contains data from 1993 to 1998. Globally, the proportion of IV drug use in users undergoing treatment shows a decreasing trend from 30% in 1993 to 20% in 1998 [34] (Table 56). However, it seems that the main cause of this trend is the change in the pattern of the drugs (increasing relative proportion of cannabis and stimulants) used by patients starting a treatment : indeed, IV route among opiate users is nearly stable and fluctuating (maybe increasing) among cocaine users.

The proportion of current IV use stated by patients treated in Flemish centres is lower [33]: respectively 27 and 9% of heroin and cocaine users.
Since 1999, injection behaviour is recorded in the medical database of the centres of De Sleutel : 51% of the patients undergoing medical treatment had injected at least once [38].

TABLE 56. *Intravenous administration in users at the time of starting treatment, French Community of Belgium, 1993-1998* [34]

	1993	1994	1995	1996	1997	1998
Nr. of treatment demands	1,618	1,212	1,176	1,570	1,681	1,466
Current IV route of ad. main drug (%)	30.2	34.3	28.7	24.0	24.0	19.9
Ever injected any drug (%)	35.1	45.0	45.0	44.0	43.2	37.9
Opiates (total) % IVDU	34.4	39.1	36.2	32.1	34.3	32.9
Heroin	35.9	40.9	39.9	37.0	37.3	35.3
Cocaine	22.2	26.9	34.6	22.9	34.8	29.5

Restricting to patients starting a drug treatment for the first time (446 in 1998), one observes a lower proportion of 'current injectors' (10%) as well as 'ever injected' (16%): 'only' 18% of heroin users and 12% of cocaine users were currently injecting their drug.

TABLE 57. *Intravenous administration in users at the time of starting the first treatment, French Community of Belgium, 1993-1998* [34]

	1993	1994	1995	1996	1997	1998
Nr. of first treatment demands	507	381	338	483	517	446
Current IV route of ad. main drug (%)	18.2	23.8	21.5	13.6	13.9	9.5
Ever injected any drug (%)	22.8	30.6	31.8	22.5	22.0	16.5
Opiates (total) % IVDU	20.9	30.1	28.8	22.1	24.6	17.1
Heroin	21.4	30.8	29.7	23.7	24.5	17.9
Cocaine	13.6	12.5	33.3	19.0	14.3	12.1

- *Rock festival, 1996-1999* [31]

In 1998, the intravenous drug users (IVDUs) represented 13% of users. The proportion of IVDUs corresponds to 1997 (13% injected, of whom half shared) and is lower than the figure of 1996 (25% injected).

TABLE 58. *Proportion of IVDUs, Rock festival, French Community of Belgium, 1996-1999* [31]

	1996	1997	1998	1999
N interviews	123	167	157	686
Drug use (%)	87	96	88	88
IVDU / users (%)	25	13	13	4

The lower % of IDU among observed in 1999 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, the survey was carried out in the whole festival and not in the camping only.

- *Snowball survey (French Community), 1993-1998* [76]

Snowball surveys were carried out in 1993-94, 94-95, 96, 97 and 98 : drug use, its pattern and some knowledge and attitudes were investigated. In 1998, 1,243 users were interviewed : 370 in Brussels, 501 in Charleroi, 254 in Liège, 118 in Namur. The mean age is 28 years ; females represent 33%, migrants 31%, homeless 17% and users without any social welfare allowances 26%. 65% used drug by IV at least once (of whom 46% shared syringes) and 43% during the last 6 months. The mean age at first injection is 20 years.

In 1996, injection rate was quite similar : 1,294 users were contacted [77] in Brussels, Liège, Charleroi, Namur, Verviers and Wavre, among which nearly 80% used heroin and half used cocaine. 68% used IV at least once; current IV use (last 6 months) was 53%.

In 1996, half of users lend often or occasionally their syringes. The frequency of borrowing is slightly lower. Only 40% of users never share. In 1997, this proportion was a little bit higher : 50% of IV users reported never sharing (borrowing or lending) syringes [78].

TABLE 59. *Proportion of current IVDU (injection during the last 6 months) and sharing of syringes among current IV users, French Community, 1993-1997* [77]

	1993-94	1994-95	1996	1997
N users	456	1,123	648	1,247
IVDU/drug users	69%	57%	56%	46%
Sharing/IVDU	-	60%	60%	54%

- Treatment centres (Charleroi), 1995-1997 [37]

Half the heroin users have at least once injected and figures of 1995-1999 do not show any trend, as well as regarding cocaine users (40% injecting). In 1999, current or past injection behaviour is recorded : 32% of heroin injectors are still currently injecting, representing 17% of heroin users.

TABLE 60. *Proportion of injecting users, Charleroi, 1995-1999* [37]

Drug	N cases with information					Injecting (%)					
						Ever					Current
	95	96	97	98	99	95	96	97	98	99	99
Heroin	554	481	531	588	660	52.5	54.7	50.3	56.3	53.2	17.1
Cocaine	286	320	350	465	547	36.7	30.6	37.4	42.6	40.8	10.8
Medicines	163	233	226	93	230	1.2	1.3	1.8	5.4	2.6	-

- ALTO GPs (French Community), 1994 [79]

In 1994, 523 questionnaires were filled in by drug users treated by general practitioners participating in the ALTO programme. Patients (males:78%) were mainly heroin users (mean age: 26 years, 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). 46% of the last 6 months IV drug users shared some material and 30% of the last month IV drug users.

14.3. **New developments and uptake of prevention, harm reduction and care**

- Legislation regarding harm reduction and access to material : see Part I Chapter 2 - 2.1.c
- Legal basis for substitution treatment : see Part I Chapter 2 - 2.1.h
- Epidemiological data on substitution treatments : see Part II Chapter 3 - 1.4
- Substitution and maintenance interventions : see Part III Chapter 9 - 4.2
- Criteria for starting a substitution treatment : see Annex D.

14.3.1 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. ***Vlastrov*** 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 transfrontier 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.

- The '***Opération BOULE DE NEIGE***', programme oriented to drug users, aims to reach target groups not easily reachable, by the snowball's effect, in other words, by the peer prevention's method. It means to employ former drug users in short-term contracts ('jobist'), training them to drug prevention and harm reduction. After some time, they go back to the " drug stage " to make an underground work with drug users. In some cities the intervention includes an evaluation activity about behaviour's changes among the drug users or the 'jobists'.

14.3.2 Low threshold services

Flemish Community

- Some shelter houses accept drug users in their setting.
- In 1997, 4 medico-social centres (MSOC/MASS) have started their activities in Ghent, Antwerp, Genk and Ostend. They offer low-threshold medical and social assistance : their activities are linked with the treatment facilities which are available in the province or region where they are situated. Methadone programmes are offered.

French Community

- The medico-social centres (MASS/MSOC) started their activities in Charleroi (1997), Liège (1998) and Mons (1998). They offer low-threshold medical and social assistance : their activities are linked with the treatment facilities which are available in the province or region where they are situated. Methadone programmes are offered.
- ***DELTA*** community approach as low threshold programme is addressed to drug users, principally who injected. This programme is currently evaluated.

14.3.3 Prevention of infectious diseases

Flemish Community

- '***Omgaan met risico's***' (Free Clinic): educational package for low educated youngsters (game, video and manual).

Free Clinic is a low threshold drug service integrating prevention, drug related research and care (medical care, methadone programs, psycho-social follow-up).
Stategies : harm reduction methodology (Prevention in the Flemish region, care only in the Antwerp region).

Principal interventions

- ***Needle and syringe exchange*** *:* though the legal framework has now been established (law of 23/12/1998, implementation modalities on 07/07/2000) there is, as yet, no funding for needle exchange. More clarity regarding funding by the Ministry of Health from the Flemish community is expected in September 2000. Free Clinic is chairman of the steering group to implement needle exchange in the city of Antwerp. Prevention material (a.o. a safer injecting leaflet, prevention messages on 'Sterikits' to be distributed by pharmacists, …) has been developed.

- ***Safer sex/safer education*** *:* prevention material (leaflets on safer injecting, hepatitis C, cocaine, woman and drugs, speed and overdoses) has been developed and is regularly updated. A leaflet on methadone is under preparation.
- All materials focuses on risk reduction and safer use/ safer sex and is also integrated (with more information) in a so-called ‘Peer Support handbook’. This harm reduction handbook is used within the peer support-network started by Free Clinic, from whom the participants are low threshold workers (drug workers, street corner workers) and drug users themselves.
- There is no funding by the Flemish Aids coordination for HIV-prevention by drug users. Condoms are supplied if possible (depending on the available budget).

- ***Testing, vaccination*** *:* are not done by the prevention service. Testing and hepatitis B vaccination are sometimes done by the care services.

- ***Treatment*** *:* Treatment occurs on a occasional basis. HIV-positive drug users are admitted in the methadone programme on a preferential basis

Training sessions (using a.o. slides) focusing on HIV and hepatitis B and C prevention are organised on a regular basis for drug users and personnel. A lot of the attention has been given during the past years on prisons (inmates and personnel). Free Clinic is also member of the Belgian Hepatitis C forum.
An epidemiological research tool has been developed for the prison focusing on health problems, with a large attention on infectious diseases (HIV/Hepatitis)

French Community

Several actions are conducted regarding harm reduction.

Modus Vivendi is a NGO mainly in charge of harm reduction in Brussels and in the Walloon Region. Various specific interventions : syringe exchange, providing equipment, harm reduction in prison.

Principal interventions

- Modus Vivendi set up an ***exchange desk*** in Brussels.

  In 1998, the number of syringes distributed (20,423) increased when comparing with previous data [80]. The evaluation showed that the age of the users contacting the exchange desk is also increasing. Consequently it was decided to better circulate information on the existence of the desk which should also specially focus on younger users. Considering the same period (November 1997 - October 1998), 20,423 syringes were distributed by the CCLA [cc] exchange desk through 1 300 contacts (mean age : 33 years - range : 20-55). Compared to 1997, this corresponds to an increase of 47% in the number of distributed syringes.

  11,967 syringes were recovered, corresponding to 53% of distributed syringes. The difference between the numbers of distributed and recovered syringes is increasing, which is opposite to the expected results. More qualitative research in order to explain these trends are in progress.

- An intervention called '***Opération Stérifix***' was initiated in Brussels by Modus Vivendi that is a NGO mainly in charge of harm reduction. *Stérifix* aims reducing infections transmitted by sharing of syringes. The objectives are the improvement of access to syringes, the improvement of relationships between pharmacist and drug users, and the promotion of the citizenship of drug user[81].
- *Stérifix* is a package containing 2 syringes/needles and information on the risk of transmission by syringe sharing. The package is distributed by pharmacies (491 pharmacies -excluding hospital

[cc] CCLA: Citoyen Comme Les Autres (citizens as others) is a non-profit organisation fighting against the segregation towards drug users.

pharmacies- in the Region of Brussels) and by one exchange desk. The price is 20 BEF (0.5 EURO).

- An evaluation was performed covering the period November 1997 - October 1998. The participation rate of pharmacies was 29% and is quite comparable to previous years (1997: 30% and 1996: 31%). As a global result of the *Operation Stérifix*, 49 277 syringes were sold or distributed : 57% by pharmacists, 41% by an exchange desk and around 2 % by other activities (snowball interventions). This represents 8% increase compared to the previous period. Compared to previous years (1996 and 1997), an obviously increasing proportion (67%) of IV drug users interviewed (snowball enquiry) stated having purchased a *Stérifix* (40% often purchase, 28% rarely).
- The non-access to *Stérifix* during the night is one of the main limits stated by interviewed drug users. It is the reason why alternative solutions are being investigated (automatic distribution of syringes, exchange desk available by night).

- For harm reduction activities, the ***DELTA*** programme concerns syringe/needle exchange and information diffusion about HIV and Hepatitis virus.

- In 1996-97, a new programme in the framework of the '***Opération BOULE DE NEIGE*** ' carried out by Modus Vivendi was set up about infectious diseases prevention : it recommended regular detection testing and gave preventive information about risk behaviours. The leading principle was the concept of health education and promotion. Particular attention was also given to the basic psychological needs. The programme provided few material for the drug users, but allowed their orientation to drugstores and needles exchange desks that already exist (see Part epidemilogy : risk and protective factors). The results of this programme were evaluated.

- A programme about infectious diseases prevention in the judicial system was also initiated by prisoners in Brussels aiming to facilitate the circulation of information leaflets about those diseases and the availability of preservatives. These tools were available at the prison of St Gilles (Brussels). The programme was leaded by Modus Vivendi in co-operation with the prison's management and with other institutions in the field of prevention and harm reduction activities.

- Most institutions working in the drug field have participated actively to the ***ELEWYT*** program, an up to date of actual knowledge about hepatitis C, prevention, treatment and epidemiology, and information about foetal risks. This program, against hepatitis C permits to vaccinate drug users (or addicts), their husband or wife and their children.

- Against hepatitis B, hepatitis C, and HIV virus, about 60 pharmacists have agreed to hold a deposit of prevention packages. The collection of used syringes and needles was also organised in this ELEWYT project.

- For AIDS prevention, several associations have co-operated to the dissemination of information leaflets.

Scientific Institute of Public Health
Unit of Epidemiology

BELGIAN NATIONAL REPORT ON DRUGS 2000

ASL

Deutschsprachige Gemeinschaft

Annexes

CCAD/EUROTOX

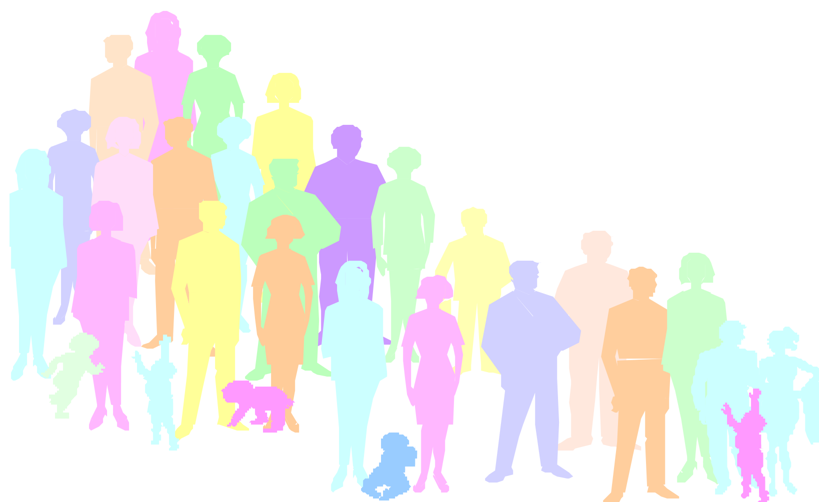
Communauté française

CTB-ODB

Région Bruxelles-Capitale
Brussels Hoofdstedelijk Gewest

VAD

Vlaamse Gemeenschap



The present Report,

short versions in Dutch and French

and additional information on the activities of the BIRN

are available on demand
and on the Belgian Focal Point Web site

REITOX Belgian Focal Point

at

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

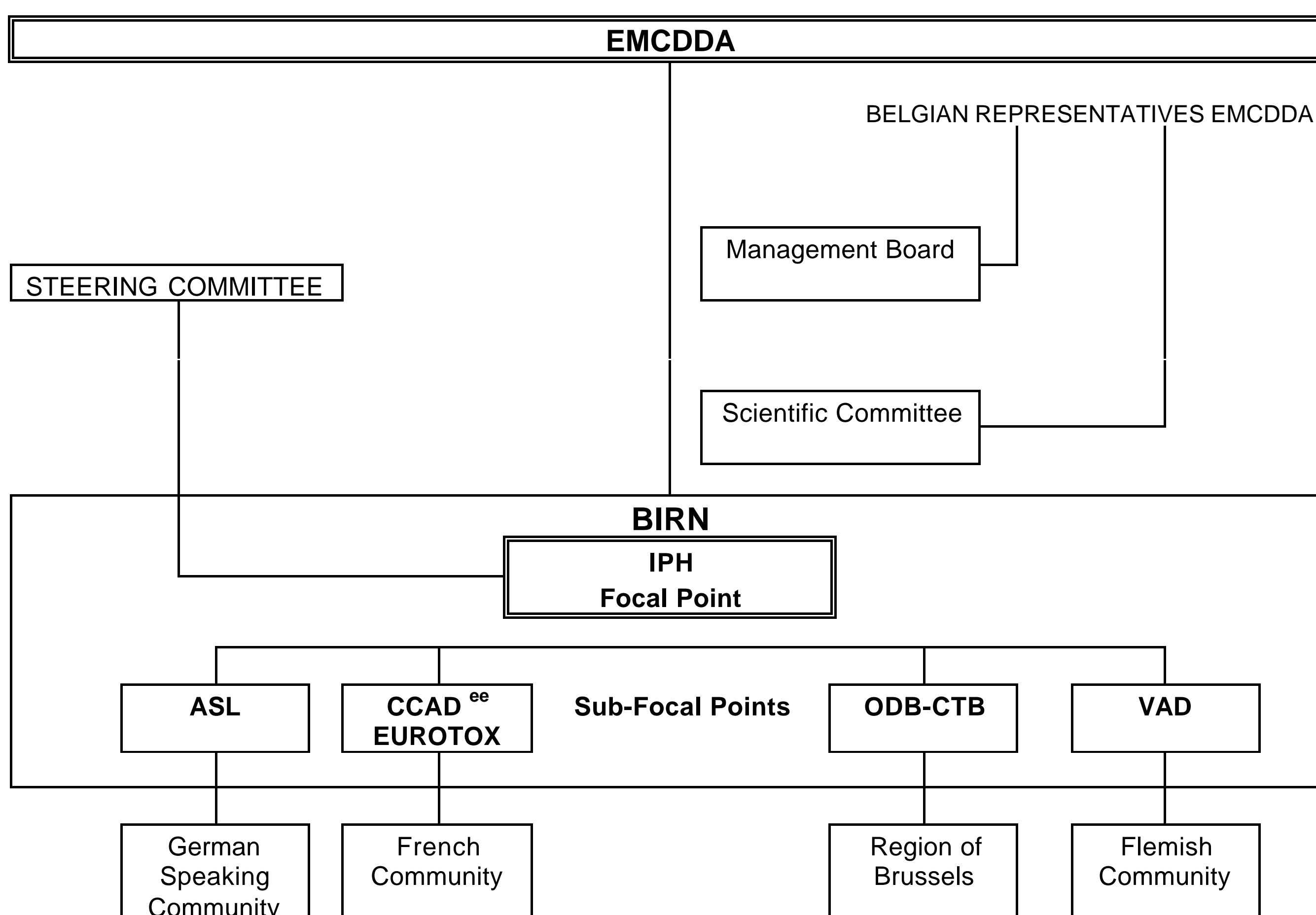
ANNEX A : Description of the Belgian National Focal Point and partners

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 **B**elgian **I**nformation **R**EITOX **N**etwork **(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

dd UNDCP : United Nations for Drug Control Programme.

ee 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 Sub-Focal 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 Sub-Focal 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 Pöint 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, Infor-Drogues, 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 Sub-Focal 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**

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 core-tasks.

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.

ANNEX B : Alternative measures : diversion to treatment and alternatives to prison

AT POLICE LEVEL[82] : THE THERAPEUTICAL ADVICE

'Therapeutical advice' is a practice/method of early detection in which police services offer drug users, who have been arrested, the possibility to go in a Centre for Mental Health Care for one or more exploring conversations. Nevertheless the public prosecutor has to decide (article 29 of the Code of criminal law making compulsory the police to refer to the judicial authority) whether the drug user can take advantage of an alternative measure.

Some public prosecutor's departments (among others Mechelen and Hasselt) work differently. They have developed a system of «therapeutical advice» enabling police services to propose, for defined categories of delinquents, an alternative treatment, when remaining under the supervision and the responsibility of the public prosecutor's department.
When the drug user agrees, he/she is summoned to the mental health care centre for a first interview. If the treatment is possible, the care centre notifies the public prosecutor's department, to which further reports will be forwarded at the end of the first and the sixth month. If the treatment works out, the case file will be terminated [83].

AT PUBLIC PROSECUTOR'S DEPARTMENT LEVEL

Praetorian probation (probation prétorienne / pretoriaanse probatie)

This measure (progressively developed since 1950) is also called 'judicial contract'. It intends to stop judicial prosecutions if the user agrees to change his/her behaviour (not to use any drug, to accept urine control, to look for a job, to have active leisure time, to get treatment aiming at definitely stopping drug use...). If the user agrees, the public prosecutor transmits his/her file directly to a care service.
This extension of possibilities for the individualisation of judicial measures (and this is applicable to all alternative measures and penalties) makes it possible to avoid short term imprisonment, which goes against social rehabilitation, and enables the judicial power to take action on the causes of the criminality by means of individualised clauses and to support the social rehabilitation of the delinquent.

Penal mediation (mediation pénale / strafbemiddeling) [ff] [gg]

This measure can be applied by the public prosecutor (Art. 216 ter of rules of criminal (Code d'instruction criminelle/Wetboek van strafvordering) and aims at settling a difference without the judge's intervention. It is a voluntary procedure requiring the agreement between the perpetrator of the offence and the victim and active participation of all parts (the victim is actively associated).
Requirements:

- offence for which the public prosecutor should not call for a imprisonment penalty longer than 2 years
- having reached one's majority.

The system of praetoriane probation provides large possibilities for individualisation and makes it possible to act quickly taking into account the individual circumstances. Together with the mediation process aiming at making atonement to the material or moral damage, additional clauses can be specified : treatment or other relevant therapy (maximal duration: six months), unpaid work for the benefit of the community (duration : max 120 hours in one to six months), training (duration : max 120 hours in one to six months) or combination of these measures.
The respect of the agreement automatically results in the definite and complete termination of the public prosecution. The non-respect justifies the forwarding of the file to the Court.

Alternative measures at the juvenile court level (mesures de diversion / diversiemaatregelen) [hh]

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ff Circulaire Ministérielle du 12 septembre 1995 remplaçant la circulaire du 7 mars 1995 relative au recrutement par les communes de personnel supplémentaire pour l'encadrement des mesures judiciaires alternatives au sein du Plan global pour l'emploi, la compétitivité et la sécurité; Moniteur belge / Belgisch Staatsblad, 09/11/1996.

gg Arrêté Royal 24/10/1994 in Moniteur belge / Belgisch Staatsblad, 01/11/1994.

The public prosecutor (juvenile court public prosecutor) can decide not to prosecute if the youngster (under 18 years of age) agrees to execute a diversion measure as to make atonement to the damage, to perform a small unpaid work for the benefit of the community, or to participate in a measure with a socio-educative effect.

Alternative to detention on suspicion [ii]

The alternative to (first order or maintenance) detention on suspicion is a release on licence. Requirement: offence for which the public prosecutor should call for an imprisonment penalty of one year or more.
During the first five days of the detention on suspicion, the examining magistrate decides to apply or not the alternative measure. After the decision can be taken by the 'Chambre du conseil/Raadkamer' which re-evaluates the situation every month. The Court (judge) can also take alternative measures to detention on suspicion.
The duration of the release on licence is 3 months at the maximum, but can be extended up to the judgement by 3-month periods. A social enquiry is often performed regarding personal, relational, and social aspects.
The measures (that can be stopped, extended or modified) can be :

- mandatory or prohibition measures (supervision made by the police)
- compulsory treatment or assistance.

During the 'alternative' period, interviews with the perpetrator of the offence (eventually relatives) are regularly held with the help of specialised services if necessary. Regular reporting is made. An active involvement can influence the judge's decision. However the release on licence is not an alternative measure as such and cannot cause an extinction of the public prosecution. On the other hand a lack of collaboration can cause the arrest of the person and influence negatively the judgement.

At the level of the judgement (Court)

Suspension, reprieve and 'probation'

The ' simple suspension ' is a way to test the delinquent giving his/her approval. The judge can state the fact proved without any verdict. The 'simple suspension' stops the prosecution as long as the decision of the judge is not modified.
Regarding the ‘simple reprieve’, the penalty is inflicted but is not carried out.
The terms of the law dated 29/06/1964 [jj] regarding the suspension, the retrieve and the ‘probation’ have been made specifically more flexible for drug users by the law dated 9/07/1975 modifying the law dated 24/02/1921 [kk].
In all cases, the suspension, the reprieve and the 'probation' can be applied only if the offence cannot cause a criminal penalty longer than five years of imprisonment. Concerning drug users, previous judgements are not taken into account regarding the suspension, the reprieve and the ‘probation’ (in other cases, the perpetrator cannot have been previously sentenced to more than a 2-month imprisonment in order to obtain the suspension, to more than a 12-month imprisonment concerning the reprieve).
In both cases (suspension, reprieve), the judge decides the duration of the test period (from at least one to five years). Some clauses can be added: active collaboration in the social guidance, treatment or other relevant therapy, unpaid work for the benefit of the community, training, not drinking in a bar... A social enquiry is often performed regarding personal, relational, and social aspects.
During the 'suspension/reprieve' period, interviews with the perpetrator of the offence (eventually relatives) are regularly held with the help of specialised services if necessary. Regular reporting is made to a 'probation' commission. The commission can adapt the clauses (but without making them more severe).

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hh Circulaire Ministérielle du 12 septembre 1995 remplaçant la circulaire du 7 mars 1995 relative au recrutement par les communes de personnel supplémentaire pour l’encadrement des mesures judiciaires alternatives au sein du Plan global pour l’emploi, la compétitivité et la sécurité; Moniteur belge / Belgisch Staatsblad, 09/11/1996.

ii Articles 35 to 38 of the law dated 20/071990 in Moniteur belge / Belgisch Staatsblad, 14/08/1990.

jj Moniteur belge / Belgisch Staatsblad, 17/07/1964.

kk Moniteur belge / Belgisch Staatsblad, 26/09/1975.

When the evolution is positive, the prosecution stops at the end of the test period. Nevertheless in the reprieve situation, the sentence is maintained in the conviction record. When the evolution is negative the public prosecutor can forward the file to the Court.

Works for the benefit of the community and trainings in the framework of the law on 'probation' [ll]

Concerning suspension and reprieve[mm], the Court[nn] can decide to impose an unpaid work for the benefit of the community (duration from 20 to 240 hours to be executed in 12 months), or an occupational or socio-educative training (undetermined duration)[oo].
The socio-educative training is particularly relevant for experimental users. Information is given on drugs as well on health risks, legislation, consequences of addiction and assistance resources. Another objective is the correction of the system of social values and of legal rules.

The level of the enforcement of the penalty [82]

The fact that problematic drug users are imprisoned is largely contested by prevention and treatment actors as well as by authorities. Nevertheless one notices that the prison environment is more and more confronted to the drug problem : in Belgian prisons, 30% of prisoners (even 50% in some prisons) are imprisoned because of a drug offence [82].
On the other hand, it is not recommendable to sentence fines to delinquent having committed a drug offence because it leads to a down spiral phenomenon.

Release on licence (libération conditionnelle/voorwaardelijke invrijheidstelling)

Release on licence means that a person sentenced to prison is released earlier under specified clauses. Release on licence is not automatic : it is a favour measure.
A first sentenced person should have spent at least a third of the duration; a recidivist at least two-thirds; a person sentenced to imprisonment for life at least 10 years and, if recidivist, at least 14 years.
Different partners are involved in the release process. The prisoner him/herself proposes a rehabilitation plan. The prison staff and a steering multidisciplinary staff express some advice and then the public prosecutor and the Minister of Justice. Based on this advice, the final decision is taken by a commission that can eventually also consult the victim and other people.
The commission determines the clauses associated to the release (good behaviour, collaboration with the judicial assistant, not to get in contact with former prisoners, to work or look for a job, ambulatory or residential treatment...) and is responsible for the follow-up.
If the evolution is positive, the definite release is awarded. If not, the release on licence can be rescinded, suspended or revised.

Confinement

The Court [pp] (usually with the help of a psychiatrist) sentences the confinement if the offence perpetrator is a danger for the community being his/her incapacity to control his/her actions.
The confinement is not a penalty but a measure (judicial measures are not notifies in the certificate of good character).
The commission of social defence decides the way and clauses of the confinement (from maintenance in freedom to internment in a psychiatric hospital) and can modify them (lighter or more severe).
The confinement aims at improving the mental status of the person as well as the development of necessary status for his/her rehabilitation. The justice assistant co-ordinates the follow-up, involves specialised services and regularly reports to the commission.
The commission can decide a test release associated to clauses (treatment or therapy).

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ll Circulaire Ministérielle du 12 septembre 1995 remplaçant la circulaire du 7 mars 1995 relative au recrutement par les communes de personnel supplémentaire pour l'encadrement des mesures judiciaires alternatives au sein du Plan global pour l'emploi, la compétitivité et la sécurité; Moniteur belge / Belgisch Staatsblad, 09/11/1996.

mm Law 10/02/1994 in Moniteur belge / Belgisch Staatsblad, 27/04/1994.

nn cour d'appel, du tribunal correctionnel ou du tribunal de police

oo Arrêté Royal 24/10/1994 in Moniteur Belge / Belgisch Staatsblad, 15/10/1994.

pp Examining magistrate room or tribunal court.

TABLE 61. *Expected attitudes/decisions of the various actors involved after a drug related offence in Belgium*

Scenarios	Involved actors				
	Police	Public prosecutor	Examining magistrate	Judge	Prison staff Commissions
Isolated (first arrest) use/ possession for personal use of cannabis	**Simplified policeman's report** → police listing→→→ OR (decision of the policeman) ↓	Checks the persons listed → no prosecution (case definitely disposed of) OR if recidivist… →→→→→→ (see Prosecution)	-	-	-
Use/possession for personal use of cannabis - associated with other infringement or nuisance OR - recidivist OR Use/possession for personal use of other drugs OR Property crime related to drug use OR Retail distribution of drugs	**Policeman's report** →→→→ (individual) + seizure + corporal search + search of the vehicle + house search (with perpetrator's agreement) + phone call to the public prosecutor OR ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ Compulsory **treatment** in a specialised centre + phone call →→	No prosecution (mostly for the first infringement) OR ↓ **Prosecution** → OR ↓ **Mediation** - **Mediation** perpetrator-victim - **Treatment** - **Work** for the community - **Training** In collaboration with the public prosecutor	- **Arrest mandate** → OR ↓ **Alternative** to detention on suspicion - **Mandatory or prohibition measures** - **Treatment**	- **Judgement** → OR ↓ - **'Simple' suspension** (test delay) - **Suspension or reprieve 'to the test'** - **Work** penalty - **Training** penalty - **Treatment**	- **Prison / fine** OR ↓ - **Probation** - **Release** on licence - **Confinement**

Comments : Large variations in the appreciation of the situation by the policeman and in the implementation of the alternative measures and penalties between judicial districts !!

TABLE 62. ***Differences** in expected attitudes/decisions of the various actors involved after a drug related **offence by a minor (less than 18 years old)** in Belgium*

Scenarios	Involved actors				
	Police	Juvenile court public Prosecutor	~~Examining magistrate~~	Juvenile court Judge	Institution
Isolated (first arrest) use/possession for personal use of cannabis	**Simplified police report** → police listing→→→ OR (decision of the policeman) ↓	Checks the persons listed → no prosecution (case definitely disposed of) OR if recidivist,… →→→→→→ (see Prosecution)		-	-
Use/possession for personal use of cannabis - recidivist OR - associated with other infringement or nuisance OR Use/possession for personal use of other drug OR Property crime related to drug use OR Retail distribution of drugs	**Policeman's report** →→→→ (individual) + seizure + corporal search + search of the vehicle + house search (with parents' agreement) + phone call to the public prosecutor	No prosecution (case definitely disposed of) OR ↓ **Meeting/ Interview with the perpetrator + parents** → serious warning	-	-	-
		If recidivist or severe →→→→ OR ↓ **Diversion measures** - atonement - small unpaid work - socio-educative action	→→→→→→→ (no examination)	Meeting/ →→ interview minor + parents + juvenile court public prosecutor OR ↓ Supervision by the judge until majority →→	Placing in an institution

ANNEX C : National Monitoring and Information Systems

The institutional structure of the Belgian State comprises the federal level (House of Representatives, Senate), the Community level (Flemish, French, and German Community Council) and the Region level (Flemish and Walloon Region, Brussels-Capital). Each entity has its own government. Each government has variable competencies in the different areas related to drug policy.

In order to conduct their drug policies, the different Communities and Regions (Flemish, French and German-speaking Communities and Brussels Region) need data on treatment and prevention interventions and developed their own monitoring system. At the moment, a national monitoring system does not exist.

Current efforts are focused on the set up of a global (at national level) data base in order to obtain the required data for the valorisation of the EMCDDA treatment demand indicator. Of course this development will be helpful for the health authorities. This global system is to be build upon the existing treatment demand databases. **Preventing any duplication of registration systems and collaborations between the different systems is stressed**.

In 1998, in the framework of the Belgian Information REITOX Network a feasibility study of the pooling of the data from the centres of the different parts of the country started. The aim is to provide figures on the situation at national level. Data registered by 3 systems (VAD, CCAD, CTB/ODB) were compared by analysing the questionnaires and the definitions of the variables. The next steps will be the selection of the variables according to the EMCDDA request and their precise definitions.

In 1999, the Belgian Focal Point co-ordinated the participation of the Belgian registration systems (VAD, CCAD, CTB/ODB) in the field trial of implementation of a standard protocol to collect information on treatment demand in the EU Member States.

RELEVANT INSTITUTIONS IN CHARGE OF DATA COLLECTION, PROCESSING AND REPORTING AT NATIONAL LEVEL

The two institutions involved in data collection, processing and reporting at national level belongs to the Federal Ministry of Social Affairs, Public Health and Environment.

The Belgian National Focal Point

The objective of the Focal Point is to provide a global view on the drug situation in Belgium based on objective, reliable and comparable data at Belgian level but also at European level.

Two of its main current tasks are:

- to collect and synthesise epidemiological data as well as to harmonise the data produced in the country;
- to implement European standard epidemiological indicators in Belgium about drug use in the general population, the prevalence of problematic drug use, as well as the mortality and infectious morbidity related to drug use.

The Direction of Health Care Policy processes data from hospital discharges: RCM/MKG and RPM/MPG

RCM/MKG (Résumé Clinique Minimum / Minimale Klinische Gegevens / minimal clinical data set) and RPM/MPG (Résumé Psychiatrique Minimum / Minimale Psychiatrische Gegevens / minimal psychiatric data set) are registration systems operating respectively in general hospitals, and in psychiatric hospital and psychiatric units of general hospitals.

The data of RCM/MKG of 1995 and RPM/MPG of 1996-1997 were analysed and published as the first issue of the RCM/RPM Flash [36]. The hospital stays where the diagnoses (main or associated) are related to the use of illicit drugs, amphetamines or solvents were selected. This figure based on hospital stays may represent an over-estimate of the number of patients as one patient can stay several times in hospital during one year.

There are several limitations. It was designed for clinical and administrative purposes and some items are based on different definitions (compared to those used by regional systems (see hereafter)). It is

a compulsory notification (that can create some underreporting as most of drugs are illicit). Probably as a consequence, a large part of the data are not well specified (e.a. the type of drug). The used unit is the hospital stay and not the person.
On the other hand, efforts are made to ensure as well as possible the reliability and completeness of the data (the data are randomly checked by health administration inspectors at hospital level).
The use of this source of information from an epidemiological point of view should be evaluated.

The RTM project

The Laboratory of Medical Psychology (ULB) is charged by the federal Minister of Public Health to study the feasibility of RTM (Résumé Toxicomanie Minimum / minimal drug addiction data set): this summary should be integrated in the RPM/MPG for cases related to drug addiction in order to improve the demand reduction policy based on detailed and accurate information from patients in treatment. An inventory of epidemiological tools used in Belgium and in European (and other) countries is in progress. EMCDDA requirements are taken into account. Comparisons will be performed and degree of compatibility will be analysed. Proposals and recommendations will be provided.

RELEVANT COMMUNITY OR REGIONAL TREATMENT INFORMATION SYSTEMS

Flemish Community

In 1996, the Flemish Minister of Health has developed her policy priorities. Among them is registration of treatment contacts. The goal of the project (started in 1996) is to collect data at the start of treatment. The number of (new) patients starting treatment in specialised settings for drug related problems (alcohol, medicines, and illicit drugs) and their characteristics are registered. The project integrate most of the variables from the Pompidou Protocol on the 'First demand and treatment demand' indicator in the existing computerised systems.
The first data (1996) were collected in 10 specialised residential settings (therapeutic communities and crisis centres) and in 83 outpatient settings (centres for mental health) : among these 83 mental health care centres there are 5-10 centres in charge of most of outpatient treatment demands [84].
Collaboration with other settings was developed (Table 63). MEDAR, DARTS and a number of MPG-services have agreed to register a common database (VRM). This is co-ordinated by VAD. In 1998, 15 psychiatric hospital joined and so did 24 additional psychiatric hospitals in 1999, as well as outreach work programmes and medico-social relief centres. General practitioners working in health centres of large cities have been contacted for participation. The system is called VRM (Vlaamse Registratie Middelengebruik - Flemish Registration of (il)licit drug use). By the beginning of 1999 about 135 services are participating.
On top of this, a computer programme to register prevention activities is developed. Prevention workers from the mental health care centres took part in the VAD project. Provincial and local actions will join later. The project has also links with the European EDDRA project (Exchange on Drug Demand Reduction Actions).
The coverage of the system is being estimated in the framework of the Treatment Demand Indicator-EMCDDA project.

French Community

The system (called Fiche Commune CCAD) is operational since 1992. It has been set up according to the Pompidou Protocol on the 'First demand and treatment demand' indicators [qq]. Participants are using paper or computerised forms. The registration form was computerised in 1996 and tested among 10 treatment services during 1997. The last version EPITOX 2.0 (Version 2.17) was made available in 1998 and treatment centres were encouraged to use it instead of the paper version.

qq In 1994 the epidemiologists of the Pompidou Group finalised a definitive protocol for drug treatment reporting systems. It is based on the results of the collaborative pilot projects conducted in 11 European cities from 1989 to 1992 and on the Multi-City-Project from 1982 onwards.

TABLE 63. *Evolution of the number of treatment units participating in VAD(1996-99), CCAD (1995-98) and CTB/ODB (1996-97)registration systems, Belgium*

	CCAD				CTB/ODB		VAD		
Years	1995	1996	1997	1998	1996	1997	1996	1998	1999
Number participating centres	28	35	36	34	11	14	92	107	135
Residential centres									
Specialised centres			7	7		4	6+3[rr]	6+3	6+3+4[ss]
Hospitals						3		15	39
Out-patient centres									
Specialised centres			22	21		10			
Mental health centres			1	1			83	83	83
General practitioners			3	2		1			
Low threshold/street			2	2					
Prison			1	1		1			

For the year 1998, 34 centres or services located in the French Community (Walloon Region and French Brussels Region) participated in the registration (Table 63). Most of them are specialised outpatient services (n=21), the half being specialised mental health services. Two facilities are low threshold services. As inpatient services, there are 3 therapeutic communities and 4 psychiatric hospitals or services. At last, 2 organised GPs networks, 2 day centres and 1 structure that works inside of the prisons are covered. The city of Charleroi developed its own registration system but the CCAD receives each year the output of data provided by the 10 participating services [37].

In the registration process, to avoid double or multiple counting, a patient code was used till the end of 1996, built in from the name and Christian name initials, gender and date of birth; sometimes the residential postcode was added to better identify actual multiple counting. The new Belgian law about private life protection obliged CCAD to eliminate this patient code. In the protocol "Fiche Commune", version 1998, the initials and the day of birth are not used any longer. The CCAD hopes soon to adopt a common process - based for example on an algorithm - which would be suggested by EMCDDA.
It is quite difficult to give, for all the French Community, an estimation of the registration coverage by the CCAD system. The specialised centres which are subsidised by the Ministry of the French Community or the Walloon Regional Ministry of Social Affairs are obliged, by Decree, to participate to the registration of this indicator. More than 80 % of those centres are participating, but this figure varies from one province to another. For example, the coverage for Liège is higher than 95%, which represents more than 55 % of the total treatment demands in the French Community.

Brussels-Capital Region

Brussels programme developed its own registration system : some 29 core items are recorded by the participants, using similar definitions, criteria and coding instructions. Most items are compatible with those recorded by other registration systems used throughout the country.
The coverage of the Brussels area was progressively extended (14 out of 16 specialised centres in 1997). For the implementation of the EMCDDA treatment demand indicator, the coverage of the system (coverage of the different types of treatment unit, overlapping with other -CCAD-VAD-systems) should be assessed.
In Brussels, ADDIBRU software has been modified according to the recommendations of the 1996 working group 'Toxicomanie'. Those modifications took effect on 1 January 1997 [35].

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rr Crisis centre.
ss MASS/MSOC.

German-speaking Community

In the German-speaking Community, the centre for mental health care registers the requests for ambulatory and stationary treatment using its own system (based on the system used in the country Luxembourg) and has done so since its creation.
At the request of the Ministry of the German Community, the Centre for Mental Health and the physicians are preparing the implementation of a registration system 'RELIS/LINDDA' developed by the Luxembourg information network on drugs and drug addiction.
The coverage of the system (geographical coverage, coverage of the different types of treatment unit, eventual overlapping with CCAD system) should be assessed.

TABLE 64. *Typology of treatment units participating in VAD, CCAD and CTB/ODB registration systems, Belgium*

TYPE OF TREATMENT UNIT	VAD 1998 [84]		CCAD 1998 [34]		CTB/ODB 1998 [35]	
	N of units covered	% of cases Registered	N of units Covered	% of cases registered	N of units covered	% of cases registered
1. Specialised residential				Res : 29%		-
1. hospital inpatient unit			4 units		3 units	7 %
2. therapeutic community	7 units	10%	3 units			
3. other specialised residential	3 units	22%			4 units	19%
2. Specialised non-residential				Non-Res : 58%		
1. hospital outpatient treatment centre						
2a. structured day care centre/day hospital			2 units			
2b. specialised outpatient treatment centre			12 units		10 units	74 %[tt]
3. local health centre/social service centre			4 units			
4. low threshold/drop-in/street agency			2 units	LT : 5%		
5. other specialised non-residential			2 units			
3. Based in general Services						
1. inpatient psychiatric hospital						
2.outpatient mental health care centre	83 units	68%	1 unit	Incl. in NR		
3a. primary health care service (+G.P.)						
3b. General Practitioners (GP)			3 units	GPs : 6%	1 unit	-
4. residential social care facility						
5. non-residential social care facility			1 unit	Incl. in NR		
6. other non-specialised residential						
7. other non-specialised non-residential						
4. Treatment Unit in Prison			1unit	Pris. : 1%	1 unit	-
5. Other (self-help service)			1 unit	Incl. in NR		

Comparison of Community/Regional systems

Table 64 compares the type of centres covered by VAD, CCAD and CTB/ODB systems. In the three systems, around one third of treatment demands are located in specialised residential centres. Most of patients (68%) registered by VAD in 1998 demanded for treatment in units based in general services (mental health care centres) whereas 63% and 74% of patients registered respectively by CCAD (1998) and CTB/ODB (1997) are treated in specialised non-residential centres.

The geographical coverage of the different systems, the coverage of the types of treatment unit and the eventual overlapping between CCAD-, VAD-, CTB/ODB- and RELIS-systems are currently being assessed in the framework of the Treatment Demand Indicator - EMCDDA project.

tt All ambulatory facilities together including specialised outpatient treatment centres, the general practitioner unit and the unit active in prisons

ANNEX D : Criteria for substitution treatment

LEGAL BASIS FOR SUBSTITUTION

An official reference document related to the methadone substitution treatment was prepared by the experts of the Sub-Committee on Addiction of the Hygiene High Council (Health Council - Ministry of Social Affairs, Public Health and Environment) and published in 1994 [uu]. The four-page document 'Consensus Conference sur la Méthadone/Consensusconferentie over Methadon ' (Consensus Conference on methadone substitution treatment) presents the benefits and limits of the methadone treatment and the indications and rules to be followed.
A follow-up of the 'Consensus Conference on methadone substitution treatment' 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 [vv]. Therapeutic efficiency of methadone was reassessed.

The limited and minor changes in the 'Conférence 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.

The basic assumptions of the 'Consensus de Conference' text are as follows:
- Methadone is an effective medicine for the treatment of the addiction to heroin and other opiates
- Methadone substitution treatment
  - reduces the heroin use and the intravenous drug use
  - reduces the mortality associated to heroin use
  - reduces the risk of transmission of the HIV and hepatitis B and C virus
  - improves the general physical condition of the heroin user patient
  - makes it easier to find out problems associated to the heroin use and facilitates the development of health education strategies
  - is associated with an improvement of the socio-occupational skills and with a reduction of drug related public nuisance

CRITERIA AND TARGET GROUPS FOR SUBSTITUTION TREATMENT

The rules and indications of the prescription of the methadone substitution treatment were determined by a group of experts in 1994 ('Conférence de Consensus sur la méthadone / Consensusconferentie over methadon').

Target groups

uu Traitement de substitution à la méthadone : Conférence de Consensus du 8 octobre 1994. Conseil Supérieur d'Hygiène-Commission des Médicaments. Ministère de la Santé Publique et de l'Environnement, 1994.

vv Suivi de la conférence de consensus méthadone de 1994 : évaluation des recommendations formulées en 1994 et propositions complémentaires. Conseil Supérieur D'hygiène, Sous-Section I.1.1 Assuétude, Ministère des Affaires Sociales, de la Santé Publique et de l'Environnement. Novembre 1999.

The substitution treatment is indicated for patients addicted to heroin or to other strong opiate-agonists. The dependence diagnosis should be based on intake and on clinical examination and supported by additional investigations if necessary (urine dosages for example).

Criteria for inclusion

The criteria are as follows:

the patient should be aged 18 years or over

a confirmed history of addiction longer than a year

with failure of spontaneous or assisted tentative of withdrawal.

Exceptionally, in case of specific assistance and with advanced expertise, these requirements can be rejected (substantiate documentation is necessary).

There are no contraindications but associated psychiatric morbidity (alcoholism, polyaddiction, depression, psychosis...) requires a specific approach and adapted treatment.

The pregnancy is not a contraindication : it is not recommended to interrupt the substitution treatment, but it requires a specific expertise. The issues related to substitution and pregnancy, breastfeeding,.. are tackled in the key-issue 3 'Women, children and drug use'.

CHOICE AND DOSAGE OF DRUGS FOR SUBSTITUTION

Choice of drugs

In the document 'Conférence de Consensus sur la méthadone / Consensusconferentie over methadon', substitution refers to the use of methadone or buprenorphine. This choice was limited to methadone and buprenorphine (Temgesic®) because the experts observed that no other medicine was convincingly experimented and cannot be recommended for usual practice at the moment.

Special limitation is mentioned for the prescription of psychotropes other than methadone or buprenorphine : these substances are to be avoided for a substitution treatment (except when the case is a double diagnosis requiring a treatment with specific psychotropes). Some psychotropes are immediately dangerous and are susceptibly causing dependence. In particular, Flunitrazepam (Rohypnol®) or Vesparax® induce unwanted paradoxal effects (mainly excessive stimulation on addicts) should be proscribed. Moreover, the prescription of theses substances is not at all a substitution treatment.

Actually the main substance used for substitution in Belgium is methadone. This is confirmed by a questionnaire survey on substitution treatment conducted in 7 Flemish treatment centres [ww] (4 MSOC/MASS and 3 low-threshold treatment centres were interviewed on several aspects related to their substitution treatment programmes). Temgesic®, Naltrexone® of Depronal® are exceptionally prescribed.

Sometimes short-term reduction treatment are used, mainly on request of the patient or after a short relapse : for this indication, methadone is generally used but occasionally Codicontin® or Buprenorphine® is prescribed.

Combination with other psychotropes are restricted to indications other than 'isolated' addiction, mainly for patients with a double-diagnosis.

Dosage

It is recommended to start treatment with a methadone dosage of about 30 mg/day. The patient should be examined the same day or the day after (at the latest 48 hours after the first administration) in order to evaluate the effect on the patient and eventually to adjust the dose.

If the patient has been highly sleepy, it indicates that there is no severe dependence to heroin. The physician should then modify his/her pharmacological approach. This could be an indication to prescribe Buprenorphine as this psychotrope combines agonist and antagonist effects towards opiates.

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ww Wydoodt JP. Personal communication.

Usually the mean stabilization dose will be higher around 60 to 80 mg/day. It should be adapted to the individual evolution. Some medicine associations call for a dose adjustment.

Based on the survey in the 7 Flemish treatment centres, methadone was always orally administrated as a syrup. For most cases, the daily dose was between 40 en 70 mg (range : 14 - 150 mg).

CHARACTERISTICS AND EXTENT OF SUBSTITUTION PROGRAMMES

Location of delivery

At the beginning of the treatment and until stabilization, it is recommended that the patient gets his/her daily dose in the pharmacy or in the treatment centre. The prescription of take home doses should be avoided at least during the first 6 weeks (the concept of 'beginning of the treatment' is precariously defined -as well as 'stabilization'-; . however, a minimal term of 6 weeks seems reasonable to define the concept of 'beginning of the treatment).
Exceptions are meaningful, a.o. in order to maintain the social insertion of the patient.

The survey in the 7 Flemish treatment centres confirms that the doses are provided daily at the pharmacy or in the centre : methadone is taken on the spot. A convenience is offered to patients whose urine tests have been negative during one month : these patients can then take away their methadone 3 times a week (with spot check urine analysis).

Patient information

The patient and his/her environment should always be informed about the risks of accidental use of methadone for him/herself and for his/her circle of acquaintances (particularly children).

Duration

The duration of methadone substitution treatment is mid-term (2-5 years) or undetermined. A medium or long period of treatment is necessary for a positive evolution and the practitioner should strengthen therapeutic compliance of his/her patient.

The short-term reduction treatments (3 weeks - 3 months) are frequently associated with a change of the environment with a reduction of the exposition of the patient to heroin.

ORGANISATION, REGULATION AND MONITORING OF DELIVERY SYSTEMS

Organisation and accessibility to the delivery system

The type of approach and the psychosocial support are the basic determinants for improved therapeutic results of methadone substitution treatments. The assistance should fit the individual needs of each patient.
The accessibility to methadone substitution treatment should be increased according to the needs. It should involve all primary level actors (GPs, psychiatrists, pharmacists, health centres). Substitution treatments are offered by specialized centres but a large proportion are actually provided by GPs. Progressively since 1995, 10 low-threshold centres have been set up (MSOC/MASS). One of their roles is to provide low-threshold care to users of illicit drugs : methadone substitution treatment is one of their therapeutic tools.
From a public health point of view, local pharmacists are full actors in the assistance to addicts. The front role of the local pharmacist is an asset in the development of a positive evolution of the patient, for example as a “ gate keeper ” between the practitioner, the patient and the community.
The communication between the penitentiary physician and the medical network outside the prison (at least the physician in charge of the patient) is stressed. Moreover the contacts between the imprisoned patient and his/her usual physician should be facilitated.

The number of patients treated by a physician cannot be determined with authority. Nevertheless a number too high of patients (around several dozens) usually causes an exhaustion of the physician also harmful for the patients. This practice should be avoided.

The survey in the 7 Flemish treatment centres confirms that contacts all involve multidisciplinary teams with which patients have regular contacts (mainly weekly). Contacts between the teams of the centres and the external actors were also established.

Regulation : exclusion of the patient

The occasional use of heroin could not be a reason to interrupt the treatment or to reduce the dose.

The exclusion criteria varied between the interviewed Flemish centres. Repeated offences to the known internal rules usually lead to exclusion. The consumption of additional substances is generally not an exclusion criteria, but produces an intensification of the treatment programme.

Regulation : exclusion of the physician

The physicians, consulted as expert during the work of the 'Consensus Conference', are of the opinion that one should react (repressive or disciplinary measures) to eventual serious discrepancies of practitioners towards the rules of the 'Consensus Conference'.

Data registration, monitoring and evaluation

Lastly, the continuous evaluation of therapeutic practices can only be efficient with a parallel development of recording systems through the voluntary participation of all concerned professionals (doctors, pharmacists, specialised treatment settings). They should participate by handling out relevant data in a concerted way, in due respect of the patient’s private life.
It is recommended that a standardized registration system should be developed (useful at federal level). The global system should involve the data of the 'General Pharmaceutical Inspectorate (Ministry for Social Affairs, Public Health and Environment) and from the 'Provincial Council of Doctors', both are not yet systematically computerized. Data from pharmacists should also be integrated in the system.

Education and networking

The scattering of the patients means that a large number of physicians have relatively low numbers of addicted patients. Nevertheless these physicians treating addicted patients should be appropriately educated and trained. They should be supported through exchanges with a specialized centre or through a network of other therapists in order to avoid any isolation that is harmful to a good medical practice.
Continuous professional education and training should be developed, taking into account the need of 'light' education programme (for physicians with a few addicts undergoing treatment). Forums, symposiums and workshops should be developed. The information on public health strategies should be improved, and particularly, its diffusion should reach all involved actors.
Networking and consultation (concertation) between practitioners sharing their mutual experiences is stressed. Such a network (ALTO) is involving around 600 GPs giving care to drug users in the French part of Belgium (more than 3000 patients are undergoing a substitution treatment, basically methadone).

ANNEX E : List of Standard Epidemiological Tables

Table	AREA COVERED	PERIOD COVERED
01a- Population Surveys	French Community	1996-97 and 1998-99
01b- Population Surveys	Flemish Community	1994-95
02a- School Surveys	Flemish Community	1999
02b- School Surveys	Flemish Community	1998
02c- School Surveys	Flemish Community	1996
02d- School Surveys	Flemish Community	1994
02e- School Surveys	French Community	1998
03a - Treatment	Belgium	1998
03b - Treatment	French Community	1997-1998
03c - Treatment	Flemish Community	1998
03d - Treatment	Brussels-Capital Region	1998
04a - Treatment Evolution	French Community	1993-1998
04b- Treatment Evolution	Flemish Community	1996,1998
04c - Treatment Evolution	Brussels-Capital Region	1997-1998
05 - Deaths Direct	Belgium	1995
06 - Deaths Evolution	Belgium	1991-1995
07 - National Prevalence	Belgium	1995
08 - Local Prevalence	French Community	1993-94
09a - Infections	French Community	1993-1998
09b - Infections	Flemish Community	1998
09c - Infections	Area of Charleroi	1992,1995
09d - Infections	Flemish Community	1997-1999
09e - Infections	Prisons / Flemish Community	1998-1999
09f - Infections	A prison / French Community	1999
09g - Infections	A prison / French Community	1997
10a - Harm Reduction Infect	Belgium, mainly French Com.	
10b - Harm Reduction Infect	Flemish Community	
10c - Harm Reduction Infect	Charleroi (French Community)	
11 - Arrests	Belgium	1998-1999
12a - Prison	Belgium	1999
12b - Prison	French Community	1997
13 - Seizures	Belgium	1995-99
14 - Purity		Not available
15a - Tablet Contents	Belgium	1999
15b - Tablet Contents	French Community	1998-1999
16 – Price	Belgium	1995-99

LIST OF ABBREVIATIONS

APSD/SGAP	Algemene Politiesteundienst / 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 *(Communauté française à Bruxelles)*
CPAS/OCMW	Centre Public d'Aide Sociale / Openbaar Centrum voor Maatschappelijk Welzijn
CTB/ODB	Concertation Toxicomanies Bruxelles / Overleg Druggebruik Brussel
CFWB	Communauté française Wallonie Bruxelles
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/RijksInstituut voor Ziekte- en Invaliditeitsverzekering
IPH/ISP/WIV	Scientific Institute of Public Health/ Institut Scientifique de la Santé Publique/ Wetenshappelijk Institut Volksgezondheid
ISP/WIVIPH	Institut Scientifique de la Santé Publique/Wetenshappelijk Institut Volksgezondheid/ Scientific Institute of Public Health
IVDU	Intra-Venous Drug Use
IVDUs	Intra-Venous Drug Users
LOGO	Loco-regionaal Gezondheidsoverleg en -Organisatie (*Flemish Community*)
MASS / MSOC	Maison d'Accueil Socio-Sanitaire / Medisch-Sociale Opvang Centra
MKG/RCM	Minimale Klinish 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 (*Flemish Community*)
PAAZ	Psychiatrische Afdeling van een Algemeen Ziekenhuis
RCM/MKG	Résumé Clinique Minimum / Minimale Klinish 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 Politiesteundienst
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
VSPP	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	Wetenshappelijk Institut Volksgezondheid/ Institut Scientifique de la Santé Publique// Scientific Institute of Public Health

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