

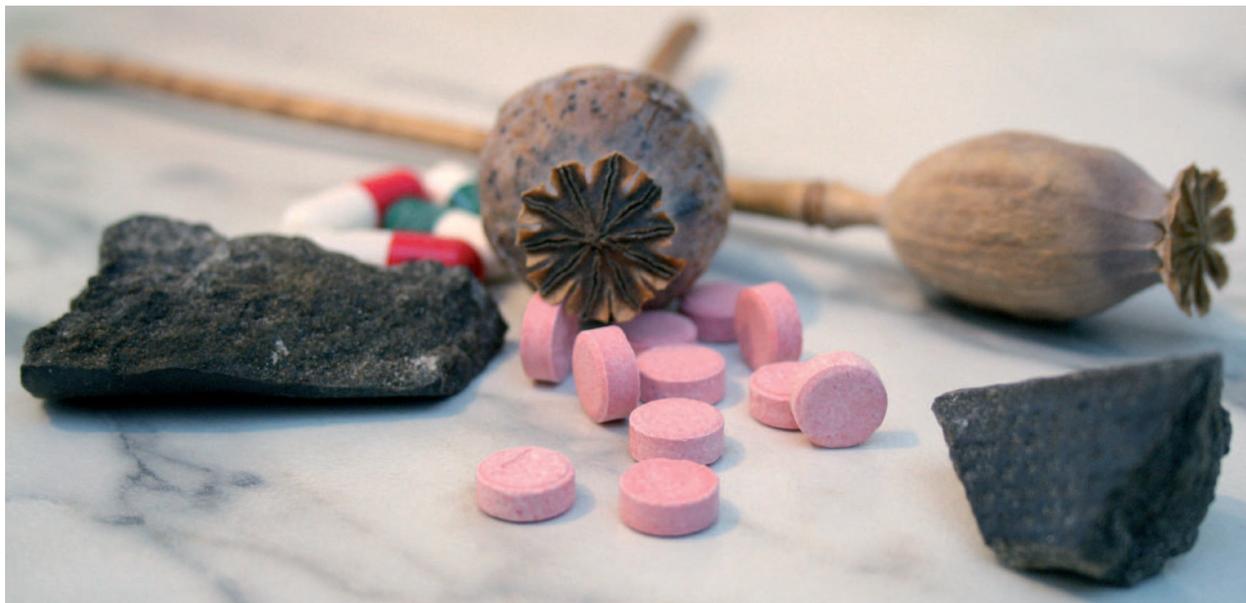


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European Monitoring Centre
for Drugs and Drug Addiction

SERVICE SURVEYS, LIFESTYLE
AND CHRONIC DISEASES



BELGIAN NATIONAL REPORT ON DRUGS 2014

NEW DEVELOPMENT AND TRENDS

.be

BELGIAN NATIONAL REPORT
ON DRUGS 2014 (DATA 2013)

NEW DEVELOPMENT AND TRENDS

Scientific Institute Public Health (WIV-ISP)

Operational Directorate Public Health and Surveillance

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CHAPTER 1.

DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS

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

1. INTRODUCTION

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

This Federal Drug Note focussed particularly on illicit drugs. Nevertheless, the fast increase of newly detected new psychoactive substances (NPS) necessitated the adaptation of the Belgian Drug law of 1921 (section 2.1). Besides the illegal drugs and NPS, the Belgian drug policy deals also with alcohol use. As a result of the call of the World Health Organization (WHO) to reduce the harmful use of alcohol, attention was given to this topic in Europe and Belgium. A common declaration of the Ministers of Public Health on the alcohol policy in Belgium was approved in 2008. However, the persistent harmful use of alcohol, necessitated

a National Alcohol Plan (NAP) 2014-2018. A draft version of a more global approach, including other areas than public health, was set up in 2013 (section 3.1.1). Nevertheless, this NAP 2014-2018 was rejected later on. In 2013, the development of a national action plan 2014-2019 for an integrated HIV policy (section 3.1.2) and the security and prevention plans 2014-2017 (section 3.1.3) were finalised.

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

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

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

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

2. LEGAL FRAMEWORK

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

2.1. ADAPTATION OF THE BELGIAN DRUG LAW OF 1921

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

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

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

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

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

3. NATIONAL ACTION PLAN, STRATEGY, EVALUATION AND COORDINATION

3.1. NATIONAL ACTION PLAN AND/OR STRATEGY

3.1.1. Rejection of the National Alcohol Plan

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

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

The measures related to prevention, treatment and monitoring of the harmful use of alcohol in Belgium were supported by all stakeholders. Nevertheless,

there was no agreement on a variety of proposals related to the availability of alcohol, such as the prohibition of happy hours or temporary price promotions. The amendments weakened the content of the NAP. In the end, no political consensus was found concerning a ban on alcohol sales in vending machines and a revision of the regulation regarding the minimum age to buy alcoholic beverages. Consequently, the NAP could not be approved by the Inter-ministerial Conference Drugs in December 2013. However, the proposed health-related measures are largely included in other action plans and continue to be applied.

3.1.2. A national action plan for an integrated HIV policy

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

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

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

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

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

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

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

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

3.2. EVALUATION OF THE FEDERAL DRUG POLICY

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

BELSPPO invests in the research projects that contribute to the support and improvement of the efficiency of the Belgian drug policy. Four new projects related to social costs, quality standards for the reduction of drug demand, illicit cannabis cultivation and alcohol use disorders were started during 2013-2014. In 2013, two projects with a focus on the evaluation of Belgian drug

treatment initiatives were completed. Two other projects were finalized in 2013 as well; one related to supply indicators of illicit drugs and the other to cannabis production (described in chapter 9 and 10). Additionally an evaluation of the Belgian cannabis policy was started at the beginning of 2014.

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

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

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

Drug treatment Court Ghent, qualitative outcome evaluation (QUALECT)

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

The qualitative outcome evaluation of the DTC Ghent is a continuation of previous research projects in this area. In 2007, a first study was finalised on alternative sanctions to divert drug dependent offenders to treatment. This

Belgian effect study showed that the levels of offending and drug use decreased and that drug-related life domains improved after an alternative sanction (De Ruyver et al., 2007). Between May 2008 and May 2009, a process evaluation study was conducted by Ghent University and the Service on Criminal Policy. Although some weaknesses were addressed, the overall evaluation was positive. The DTC Ghent provides the opportunity to address problems in different life domains (Colman et al., 2011).

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

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

3.2.2. On-going evaluation of the Belgian cannabis policy

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

In the past years, the public debate on the regulation of possession and use of cannabis has been vividly fed; among others by the recent changing policies towards legislation in several other countries such as Uruguay, Colorado and Washington, USA (Pardo, 2014), but also by the discussed changes towards a more restricted cannabis policy in our neighbouring country The Netherlands. In this light, by the end of 2013, the Minister of Public Health requested a global evaluation of the Belgian cannabis policy. To this end, an ad hoc working group was established by the General Cell Drug Policy, comprising different experts involved in the field. The main aim of the group is to offer a state of affairs on the current cannabis policy, by indicating deficiencies and to provide recommendations on the feasibility of alternatives to the enforced cannabis prohibition. The conclusions of this assessment will serve as a basis for further political consultation.

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

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

3.3. COORDINATION ARRANGEMENTS

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

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

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

The most important drug treatment facilities involved in the sixth state reform are the low threshold medical social treatment centres, day care centres, crisis intervention centres and therapeutic communities. The transfer of competences

from the federal level to the federate levels also has an impact on the addiction fund and the TDI project.

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

The transition period for the transmission of the TDI project to the Communities is defined from the 1st of July of 2014 until the 31th of December 2017. Due to the importance of national and European comparable data, the WIV-ISP will still guarantee the TDI registration and the analysis of the results during this transition period. Moreover, this uniform registration system is applied to support drug policy makers. As such, the contract with the WIV-ISP concerning the TDI registration is automatically renewed each year, also after the transition period. The Inter-ministerial Conference Public Health, however, still has the possibility to decide whether the Communities should guarantee the TDI registration instead of the WIV-ISP. In case this decision should be made, similar as for the projects of the addiction fund, the systematic financing and course of registration of TDI may be hampered.

Table 1.1 | Financed projects of the addiction fund, Belgium, 2013

Title of the project	Organization	Main objective
Project to support drug using parents considering their children	Bogolan	Support future of young addicted parents and their children younger than three years old.
Evaluation and support of adolescents who are confronted with problems of cannabis use	Hospital University centre Brugmann	A multi-dimensional-family therapy is implemented for adolescents experiencing problems due to cannabis use and their environment
Alcoholhulp.be – Cannabishulp.be – Drughulp.be	CAD Limburg	Online support and distribution of information through the internet of problems related to alcohol, cannabis and other drugs
Project of withdrawal of alcohol dependence at home	La Caho asbl	Implementation of an outreach project to encourage withdrawal of alcohol dependence in a familiar environment
Mighties	Centre for mental health Eclips	Development of psycho-educative material and a specific methodology for youngsters who aren't qualified for classic treatment projects because of reasons of motivation, language or mental limitations

Title of the project	Organization	Main objective
Network Recovery Antwerp	CISO	Evaluation with patients and their network in order to determine an individual treatment trajectory
Free medical consultations and nursing care for drug users	Comptoir	Medical consultation and nursing for somatic problems
Reinforcement of the syringe exchange programme and street corner work in Brussels-Capital	DUNE	Reinforcing syringe exchange programme, street corner work, nursing care on the street and try to direct people to treatment
DocA-Project youth Antwerp	Free clinic	Specific project for vulnerable youth age 15-25yrs who have been admitted to the residential sector of youth assistance and will not accept treatment. Development of a brief intervention to work on motivation and stimulate the organization of free medical consultations.
Specific intervention for alcohol problems in emergency services	IDA	The development of a specific intervention model for emergency services to handle alcohol-related problems
National information and raise awareness project: no alcohol below the age of 16	IDA	Project to improve the knowledge in the sales sector about the change in the law which forbids selling alcohol to youngster under the age of 16
Raising awareness and give information to pharmacists on the consumption of alcohol and medicines to encourage discussions with patients	IPSA-APB-SSPF	Education of pharmacists to create a state of awareness for patients who are combining medicines and alcohol
Education within the specialised network Bruxelles-cannabis	Interstices Bruxelles	Education of professionals to tackle problems related to the consumption of cannabis use
Project Liaison alcohol	Interstices Hospital University centre St. Pierre	Raising awareness and education of professionals working at hospitals to give information and to offer guidelines about alcohol-related problems. Also support is offered for the most difficult situations
Outreach work in crisis situations	Kompas	Support in crisis situations towards minors and their family. An intensive follow up is offered at home during 6 weeks. The main objective is to stabilize the patient, search for the most appropriate orientation and evaluate thoroughly the familial context
Clinical case management and interventions to health care providers of pregnant drug users or drug using parents with young children	MSCC Ghent	Raise awareness to professionals
Guide and support pregnant drug users or women with young children		
Assertive community treatment	MSCC Ostend	Outreach project to support drug using parents, drug using pregnant women and their children up to 12 years old in an intensive and integrated way.
Education project of drug using parents and promotion of expertise of help	MSCC Flemish Brabant	Project related to parenthood to support parents using drugs and their children. The objective is to decrease the risk of drug consumption and the negligence of the children

Title of the project	Organization	Main objective
Development of a nursing and medical team within syringe exchange programmes	Namur Entraide Sida	The objective is to grant first care related to problems of injecting drug use
Online help for people facing problems with alcohol and their environment	Pelican	French version of the website alcohol.be in order to provide information and therapeutic counselling
Outreaching psychiatric counselling for youngsters (16-35yrs)	Psychiatric centre OLV	which are confronted with a psychiatric problem combined consumption of drugs (alcohol or illegal drugs)
Synersanté	Les petits riens	Creation of a mobile health cell to support persons with a drug problem and coordination of intervention of different organizations
Improvement of care for persons having a mental handicap in combination with drug problems	PopovGGZ	The main objective is to improve the collaboration with specialised drug treatment centres, services for persons with a mental handicap and sheltered workplaces
Intensive outreach project to follow-up for persons with a alcohol dependence	Psychiatric Hospital St. Camillus	In three hospitals a case manager is assigned in order to decrease the duration period of hospitalisation and to improve the quality of life of persons with an alcohol problem
Social counsellor for the réseau HCV Bruxelles	Réseau HCV	Individual counselling for patients in HCV treatment
Global and integrated support to reintegrate young adults with a dual diagnosis	Neuro-Psychiatric Hospital St. Martin	Project for young adults with a drug problem and psychiatric co morbidity. Global and integrated support which involves different sectors and the environment of the youngsters
Training of general practitioners and other health care services about benzodiazepines	ULB & collaborators	Training and raising awareness of doctors and pharmacists to promote the rational use of benzodiazepines
Implementation of guidelines	VAD	Guidelines in order to support patients with ADHD and addiction
Equipment in order to develop an modular offer of motivational interviewing	VAD	Optimization of training on the motivational interviewing (specificity addiction) and development of didactic and audio-visual material
Implementation of guidelines related to the already developed ASSIST screening instrument	VAD	Support the implementation of the ASSIST instrument and a short term counselling intervention
Quality promotion of drug treatment	VAD	Development of methods to evaluate the efficiency of different services?
Implementation of a specific treatment programme for cocaine use: CRA+ vouchers	De Kiem	Specific programme to treat problems of cocaine use through the method of Community Reinforcement Approach
Promotion of a more efficient and effective use of psychotropic substances for persons living in a rest and care home	Residential treatment centre Leiehome	Raise awareness to support rational use of psychotropic substances
TADAM project	Liège	Pilot project heroin (diacetylmorphine) assisted treatment
CASA: Outreach counselling project for (ex) addicts	Ellipse	Personal and individualised counselling at home for (ex-)alcohol and drug users

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

4. CHALLENGES AND OPPORTUNITIES

Reflection by Vander Laenen F., IRCP Ghent University

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

Since 2012, the Inter-ministerial Conference Drugs agreed to make the Federal Public Service Health, Food chain safety and Environment responsible for the

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

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

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

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

First, the 6th state reform in Belgium, which is in preparation since 2012 and in full operation in 2014 and beyond, will impact in particular on the specialised drug treatment field in Belgium. This shift in drug-related competences not only defers new political and policy initiatives by the federate levels. It also leads to unrest in people in the drug treatment work field. To these professionals it is not clear yet what the drug policy priorities of the federate governments will be and whether or not they will be able to at least continue the current treatment offer for problem drug users. Moreover, unrest is augmented since public expenditures are increasingly a subject of discussion in view of the

economic crisis and austerity. The anticipated cuts in government spending may affect substance abuse treatment (Lievens et al., 2014), particularly at times of transfer of competencies. However, the transfer of competencies also provides an opportunity for the federate governments to develop a fully integrated drug policy that is based on the analysis and the monitoring of problems at federate level and that can be adjusted if an evolution in these problems occurs.

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

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

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