European Monitoring Centre for Drugs and Drug Addiction

ISP WIV SCIENTIFIC INSTITUTE OF PUBLIC HEALTH

Belgium

Country Drug Report 2017

THE DRUG PROBLEM IN BELGIUM AT A GLANCE

Drug use

in young adults (15-34 years) in the last year

Cannabis

10.1 %

7 % 13.2 %

Other drugs

MDMA	0.8 %
Amphetamines	0.5 %
Cocaine	0.9 %

High-risk opioid users

No data

Treatment entrants

by primary drug

- Cannabis, **32 %**
- Amphetamines, **10 %**
- Cocaine, **19 %**
- Heroin, **23 %**
- Other, **16 %**

Opioid substitution treatment clients

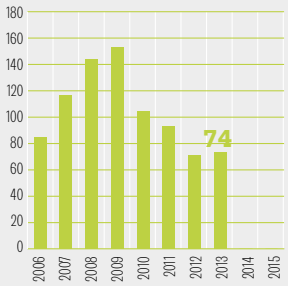
16 681

Syringes distributed

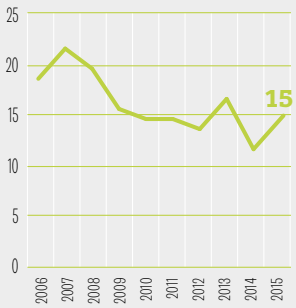
through specialised programmes

1 034 242

Overdose deaths



HIV diagnoses attributed to injecting



Source: ECDC

Drug law offences

47 083

Top 5 drugs seized

ranked according to quantities measured in kilograms

1. Cocaine
2. Cannabis resin
3. Herbal cannabis
4. Heroin
5. Amphetamine

Population

(15-64 years)

7 295 584

Source: EUROSTAT
Extracted on: 26/03/2017

NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or reported numbers through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnosis, drug law offences and seizures). Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin.

About this report

This report presents the top-level overview of the drug phenomenon in Belgium, covering drug supply, use and public health problems as well as drug policy and responses. The statistical data reported relate to 2015 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

An interactive version of this publication, containing links to online content, is available in PDF, EPUB and HTML format: www.emcdda.europa.eu/countries

National drug strategy and coordination

National drug strategy

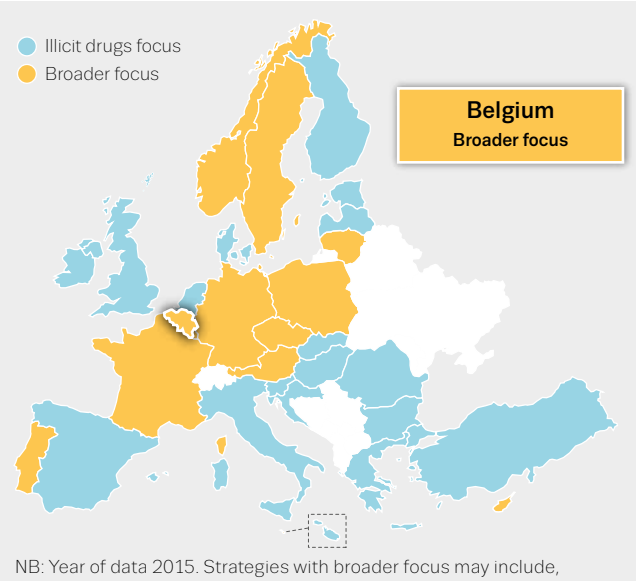
The drug policy of Belgium is defined in two key policy documents, the Federal Drug Policy Note of 2001 and the Communal Declaration of 2010. The Federal Drug Policy Note was adopted as a long-term policy document and focuses on both illicit and licit substances, including alcohol, tobacco and medicines (Figure 1).

The main goals of this document are the prevention and reduction of risks for drug users, the environment and society as a whole; these goals are organised across three pillars: prevention and early intervention of drug consumption; harm reduction, treatment and reintegration; and enforcement. The Federal Drug Policy Note also states the five main principles of Belgian drug policy, which are (i) a global and integrated approach; (ii) evaluation, epidemiology and scientific research; (iii) prevention for non-users and risk reduction for problematic drug use; (iv) treatment, risk reduction and reintegration for problematic users; and (v) repression of producers and traffickers. The Communal Declaration is a further statement and confirms the approach set out in the Federal Drug Policy Note. As such, it can be considered a more up-to-date elaboration of Belgian drug policy.

Belgium evaluates its drug policy and strategy through routine indicator monitoring and specific research projects, in a similar way to other European countries. The evaluation of specific interventions and projects is one of the objectives of the Federal Drug Policy Note. In 2014, the Minister of Public Health requested the evaluation of the Belgian cannabis policy, although no systematic evaluations of the Federal Drug Policy Note or Communal Declaration are planned.

FIGURE 1

Focus of national drug strategy documents: illicit drugs or broader



NB: Year of data 2015. Strategies with broader focus may include, for example, licit drugs and other addictions.

National coordination mechanisms

The Inter-Ministerial Conferences (IMC) are designed to improve the consultation and collaboration between the federal government, the communities and the regions. The IMC Public Health holds thematic meetings on different issues proposed by its members (e.g. the Thematic Meeting on Drugs). Whenever needed, the Thematic Meeting on Drugs can establish inter-cabinet working groups to explore certain issues in depth. The General Drugs Policy Cell supports the IMC in the preparation and coordination of this work on Belgian drug policy. The General Drugs Policy Cell is chaired by the national drug coordinator and supported by the Federal Public Service of Health, Food Chain Safety and Environment. It is involved in the operational coordination and strategic management of Belgium's drug policy and has various responsibilities related to the implementation of the Federal Drug Policy Note and Communal Declaration.

Public expenditure

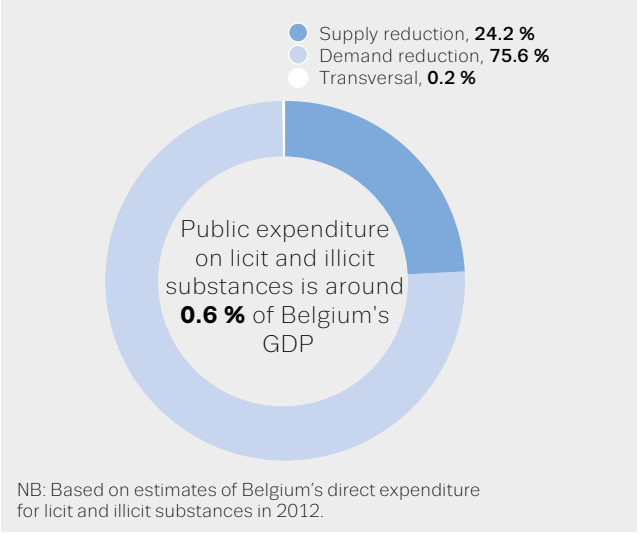
Understanding the costs of drug-related actions is an important aspect of drug policy. Some of the funds allocated by governments for expenditure on tasks related to drugs are identified as such in the budget ('labelled'). Often, however, the bulk of drug-related expenditure is not identified ('unlabelled') and must be estimated by modelling approaches.

In Belgium, the Federal Drug Policy Note of 2001 had no associated comprehensive budgets, while policy notes for some regions do have accompanying budgets. Prior to 2012, authorities funded three successive studies of drug-related public expenditure: for 2001, 2004 and 2008. In 2012, a specific study about the social costs of licit and illicit substances in Belgium was performed. Estimates were based on a well-defined methodology.

Estimates for 2012 indicate that total public expenditure for licit and illicit substances was 0.6 % of gross domestic product (GDP) or approximately EUR 2.3 billion, the majority of which was allocated to demand reduction (75.6 %). Approximately 75 % of the funds was spent on treatment, 0.5 % on prevention and 0.1 % on harm reduction. Supply reduction received 24.2 % of the funds, while coordination and research received 0.2 % and 0.1 %, respectively (Figure 2).

FIGURE 2

Public expenditure related to illicit drugs in Belgium



NB: Based on estimates of Belgium's direct expenditure for licit and illicit substances in 2012.

Drug laws and drug law offences

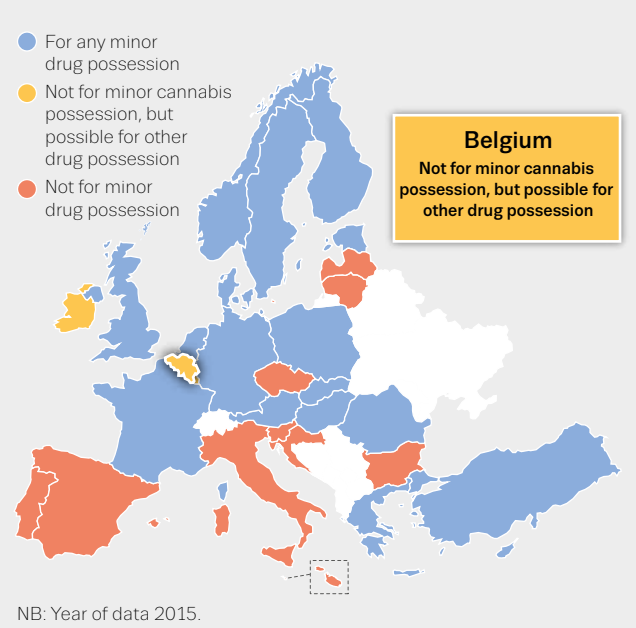
National drug laws

The use of controlled substances is not mentioned as an offence in Belgian drug laws; however, a user may be punished on the basis of prior possession. In 2003, personal possession of cannabis was differentiated from the possession of other controlled substances, whereby the public prosecutor did not have to prosecute if there was no evidence of problematic drug use or of public nuisance. After the Constitutional Court found that these terms were insufficiently defined, a new directive, issued in February 2005, called for full prosecution for possession for cases in which the 'user amount' (3 g or one plant) was exceeded, public order was disturbed or aggravating circumstances were identified. This includes possession of cannabis in or near places where schoolchildren might gather and also 'blatant' possession in a public place or building. Such cases are punishable by three months to one year in prison and/or a fine of EUR 6 000 to EUR 600 000. In the absence of aggravating circumstances, possession of cannabis for personal use is punishable by a fine of EUR 90 to EUR 150, based on a simplified police report (Figure 3). The fine increases for any offence committed within one year of a conviction. (Note that all fine amounts shown here have already been adjusted by the official inflation figure, i.e. multiplied by a factor of 6.)

For drugs other than cannabis, Belgian law punishes possession, production, import, export or sale without aggravating circumstances with three months' to five years' imprisonment and an additional fine of EUR 6 000 to EUR 600 000. The term of imprisonment may be increased to 15 or even 20 years (with an optional fine) in various specified aggravating circumstances.

FIGURE 3

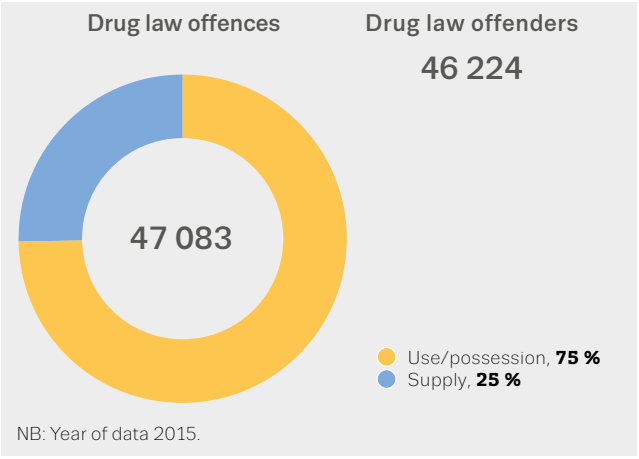
Legal penalties: the possibility of incarceration for possession of drugs for personal use (minor offence)



NB: Year of data 2015.

FIGURE 4

Reported drug law offences and offenders in Belgium



NB: Year of data 2015.

Until recently, the control of new psychoactive substances (NPS) was achieved by amending the list of controlled substances. In 2014, the law was adapted to allow generic group definitions of controlled substances to be listed. Following the Royal Decree signed by the Minister of Health in June 2015, the prescription of medicines containing tetrahydrocannabinol (THC) has been allowed in Belgium, and one formulation is currently registered for legal use and sale.

Drug law offences

Drug law offence (DLO) data are the foundation for monitoring drug-related crime and are also a measure of law enforcement activity and drug market dynamics; they may be used to inform policies on implementation of drug laws and improve strategies.

Data from the federal police indicate that most DLOs in Belgium are related to possession (Figure 4). Cannabis is the drug most commonly involved in DLOs, with some increase in the number of cannabis-related offences recorded since 2012. The number of DLOs linked to MDMA/ecstasy is also increasing. In the meantime, a drop in the number of heroin-related offences has been observed in recent years and may be attributed to the changing priorities of the National Security Plan 2012-15, namely that heroin is no longer a priority.

Drug use

Prevalence and trends

Cannabis is the most commonly used illicit drug in Belgium; its use is concentrated among young adults aged 15 to 34 years and is more prevalent among males (Figure 5).

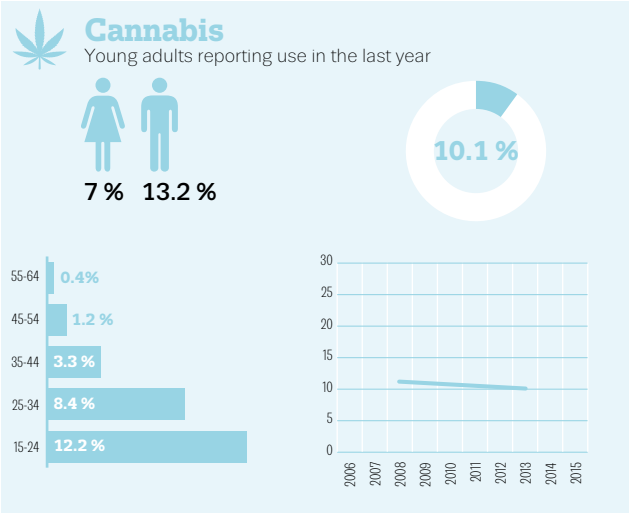
The health behaviour survey in school-aged children confirms that cannabis remains the main illicit substance used by Belgian teenagers; however, the prevalence and trends vary across the regions. The most recent studies among 15- to 16-year-olds in school settings indicate that approximately one in six students in the Flemish community and one in five students in the French community have ever used cannabis. The studies among students in the Flemish community indicate a slightly decreasing trend in cannabis use, while in the French community the trend remains stable.

The findings from studies in nightlife settings in both the Flemish and the French communities found that cannabis is by far the most popular illicit drug, while MDMA has recently gained in popularity. Moreover, nightlife settings were a common venue for the use of NPS.

Two Belgian cities (Brussels and Antwerp) participated in the Europe-wide annual wastewater campaigns undertaken by the Sewage Analysis Core Group Europe (SCORE). This study provides data on drug use at a community level, based on the levels of illicit drugs and their metabolites in sources of wastewater. The 2016 data indicate an increase in the levels of MDMA between 2011 and 2016. Levels of methamphetamine residues were very low. The levels of cocaine were higher in Antwerp than in Brussels, but the concentration of cocaine metabolites increased at the weekends in both cities.

FIGURE 5

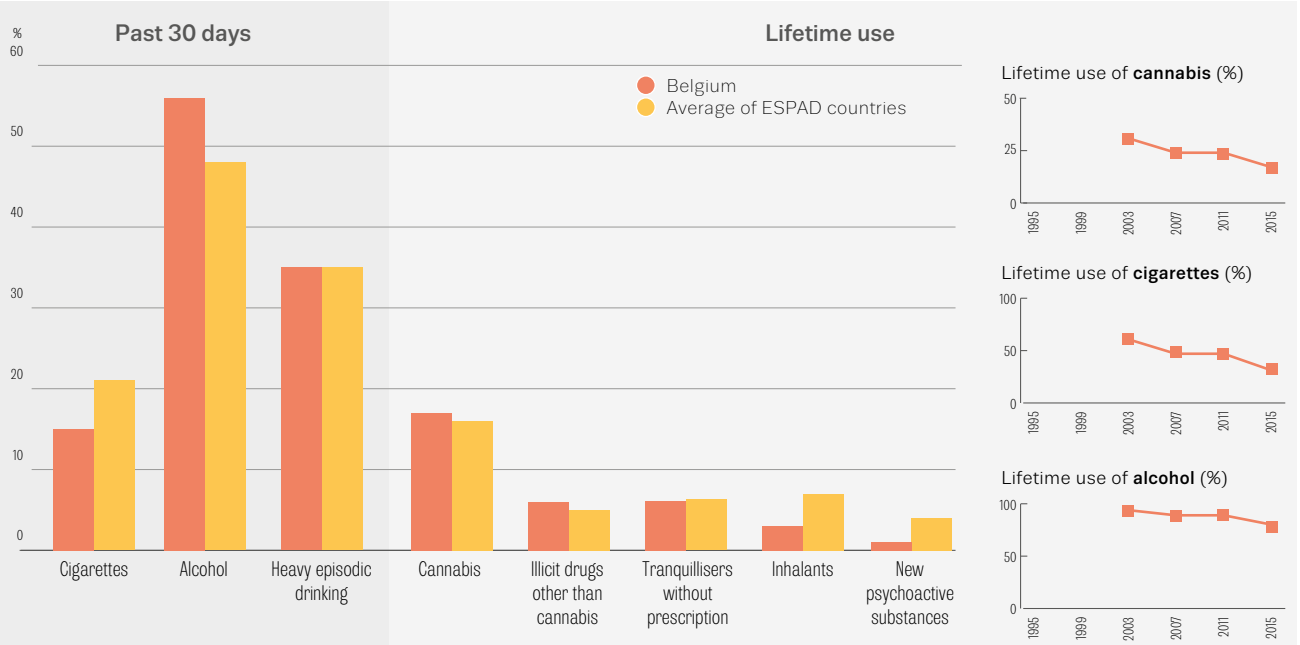
Estimates of last-year cannabis use among young adults (15-34 years) in Belgium



NB: Estimated last-year prevalence of drug use in 2013.

FIGURE 6

Substance use among 15- to 16-year-old school students in Belgium (Flemish community)



Source: ESPAD study 2015.

The European School Survey Project on Alcohol and Other Drugs (ESPAD) was implemented in 2015 in the Flemish community and the results indicate that levels of substance use among 15- to 16-year-old students are generally close to the ESPAD average. Only alcohol use in the last 30 days stands out as being higher than the overall average. However, the level of heavy episodic drinking during the last 30 days was the same as the ESPAD average. For other variables, the prevalence among the Flemish students was at the same level or below the ESPAD average (Figure 6).

The available data indicate that there have been no significant changes in the proportion of the population who have ever injected drugs over the last 10 years

High-risk drug use and trends

Studies reporting estimates of high-risk drug use and the numbers of people who inject drugs (PWID) can help to identify the extent of the more entrenched drug use problems, while data for first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform understanding of the nature and trends in high-risk drug use (Figure 8).

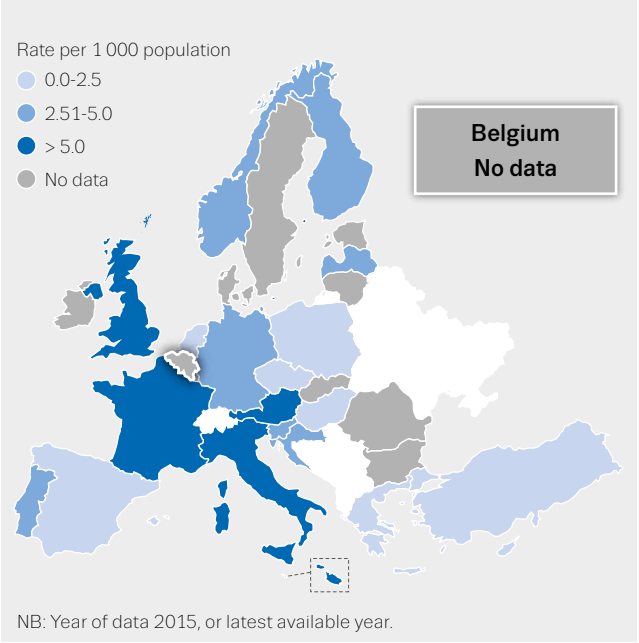
In Belgium, the estimated number of PWID is derived annually using the human immunodeficiency virus (HIV) multiplier method. The available data suggest that that there have been no significant changes in the proportion of the population who have ever injected drugs over the last 10 years. Heroin and other opioids are the main substances that are used by injecting.

No population-wide estimate of high-risk opioid users is available for Belgium (Figure 7); nevertheless, the data from specialised treatment centres indicate that heroin and other opioid users constitute approximately one third of clients entering treatment, while the importance of these substances among first-time clients is lower.

Cannabis was the most frequently reported primary substance for which clients entered treatment and was very prevalent among first-time treatment clients. Approximately one fifth of the clients in treatment are female; however the proportion varies by type of substance used (Figure 8).

FIGURE 7

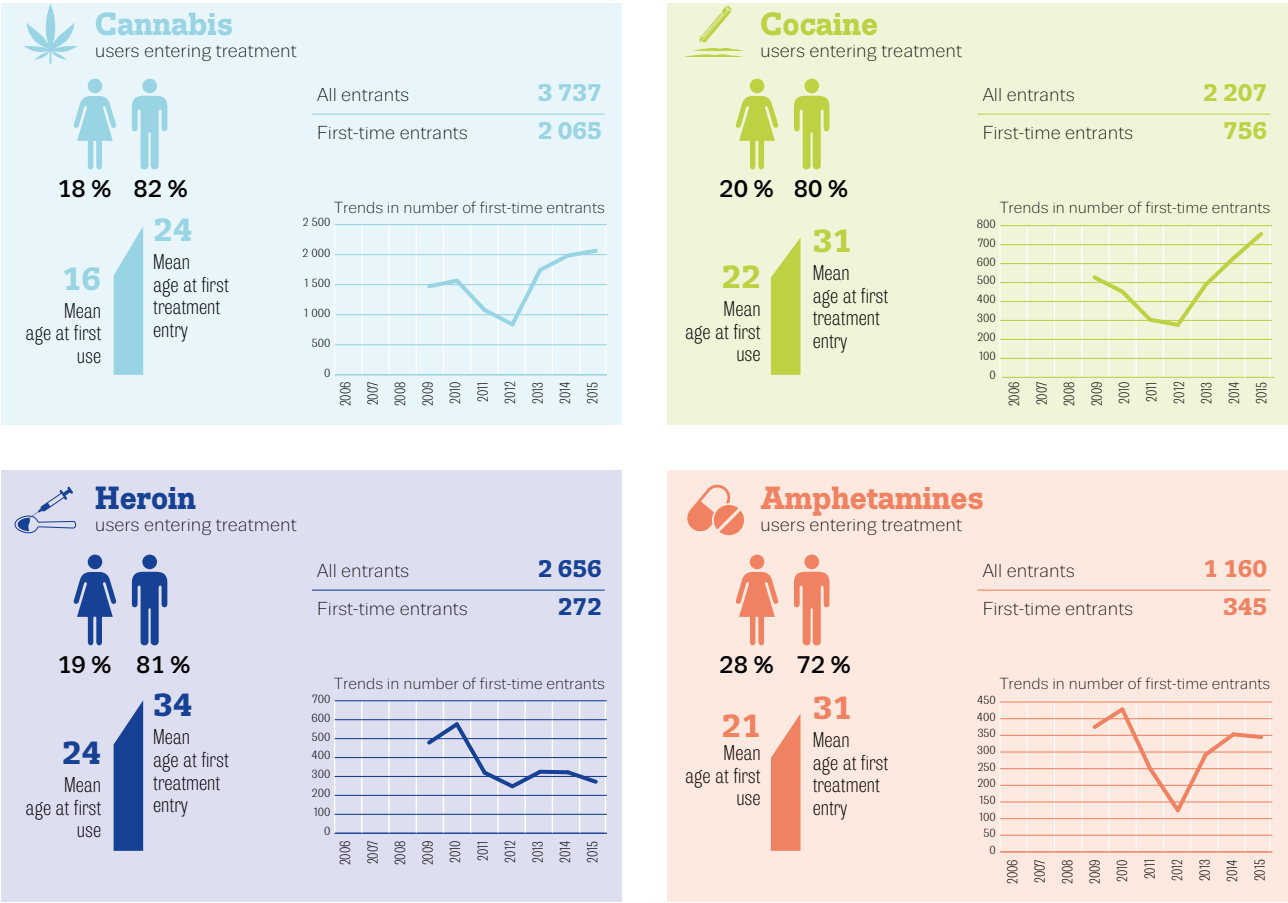
National estimates of last year prevalence of high-risk opioid use



NB: Year of data 2015, or latest available year.

FIGURE 8

Characteristics and trends of drug users entering specialised drug treatment in Belgium



NB: Year of data 2015. Data is for first-time entrants, except for gender which is for all treatment entrants. Trends in first-time entrants should be interpreted with caution due to changes in data collection methodologies.

Drug harms

Drug-related infectious diseases

In Belgium, cases of HIV infection and acquired immune deficiency syndrome (AIDS) are registered at the Scientific Institute of Public Health. Data on the prevalence of HIV and other drug-related infections are also available from studies involving different drug user groups ('ever injectors' seeking medical help or clients of outpatient services) at regional levels. The data indicate that the rates of HIV/AIDS, hepatitis B virus (HBV) and hepatitis C virus (HCV) infections among drug users in Belgium have remained stable in recent years.

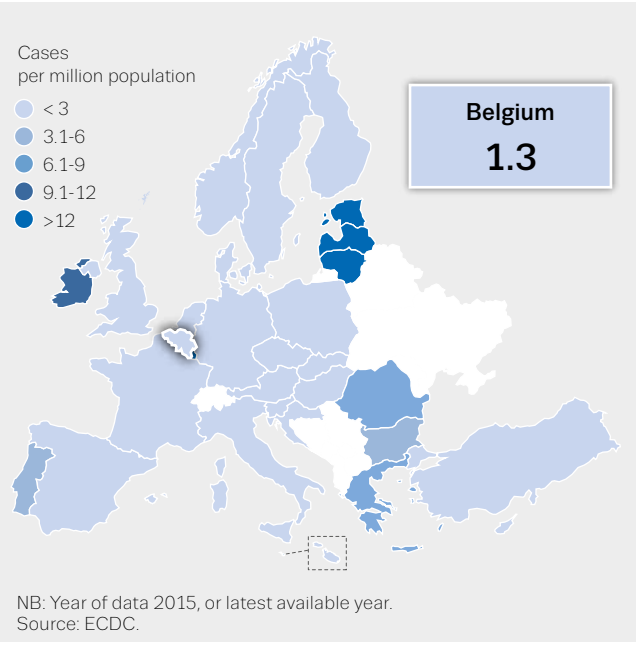
HCV and HBV prevalence rates among PWID varied between testing sites; however, many estimates are based on relatively small samples. The results do not reveal significant time trends in the last 10 years.

The proportion of the new HIV cases linked to injecting drug use has dropped since the mid-eighties and remains stable at a low level (Figure 9). In terms of HIV trends among PWID, there has been a decline in HIV prevalence rates reported by the French Community since 1994 and by the Flemish community since 1998, although, in the last 10 years, the prevalence rates have fluctuated and no clear trends are visible. In 2014, HIV prevalence was reported at 5.7 % among 370 PWID attending Free Clinics (Flemish community), while almost half were HCV positive.

In 2014, HIV prevalence was reported at 5.7 % among 370 PWID attending Free Clinics (Flemish community), while almost half were HCV positive

FIGURE 9

Newly diagnosed HIV cases attributed to injecting drug use



NB: Year of data 2015, or latest available year.
Source: ECDC.

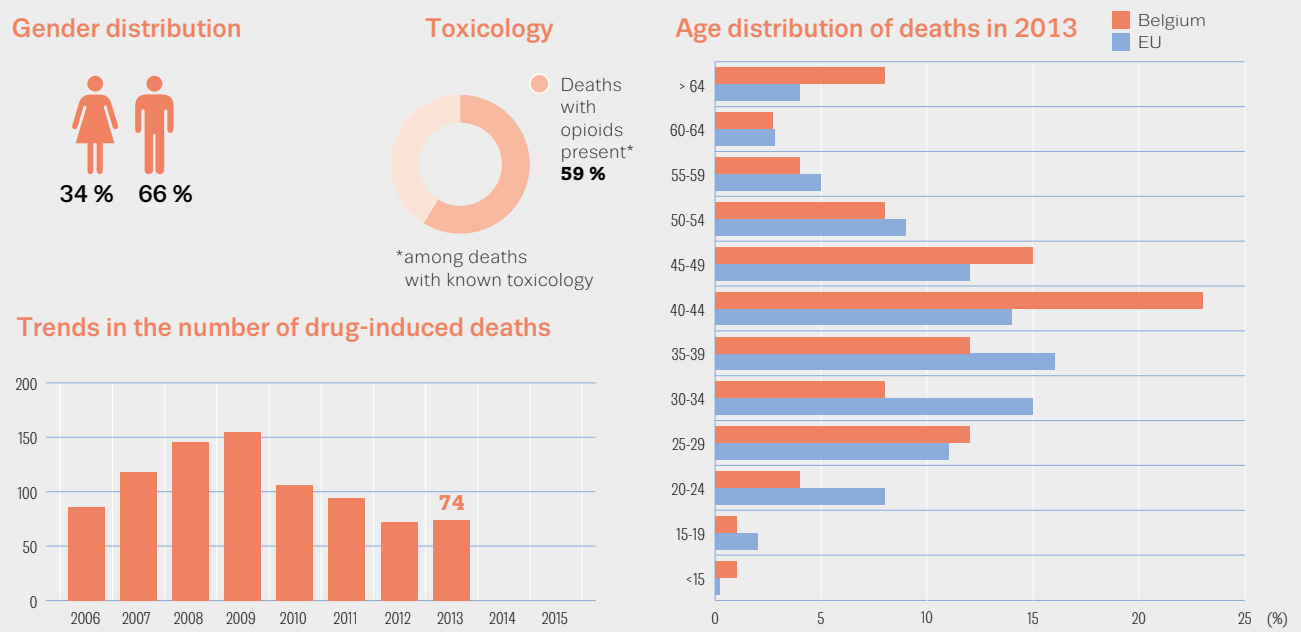
Drug-related emergencies

Currently, information on drug-related emergencies for Belgium is available only from crisis intervention centres (CICs) and the Belgian Early Warning on Drugs system. The information from eight CICs suggests that there has been a decline in non-fatal intoxications since 2011. In 2015, almost 900 people were admitted to CICs as a result of non-fatal intoxications related to illicit drug use. The drugs most commonly linked to admissions were opioids, followed by cocaine, other stimulants and cannabis. In general, the number of opioid-using clients in CICs has decreased over the years, while number of those seeking help because of cocaine and other stimulant use has increased.

UREG (Enregistrement des urgences), which has been operational since 2016, is the real-time registration system for data from emergency cases in Belgium and is mandatory for all Belgian hospitals with a specialised emergency room service or a first 'reception of emergency cases'. The first data from this system are expected in 2017.

FIGURE 10

Characteristics of and trends in drug-induced deaths in Belgium



NB: Year of data 2013.

Drug-induced deaths and mortality

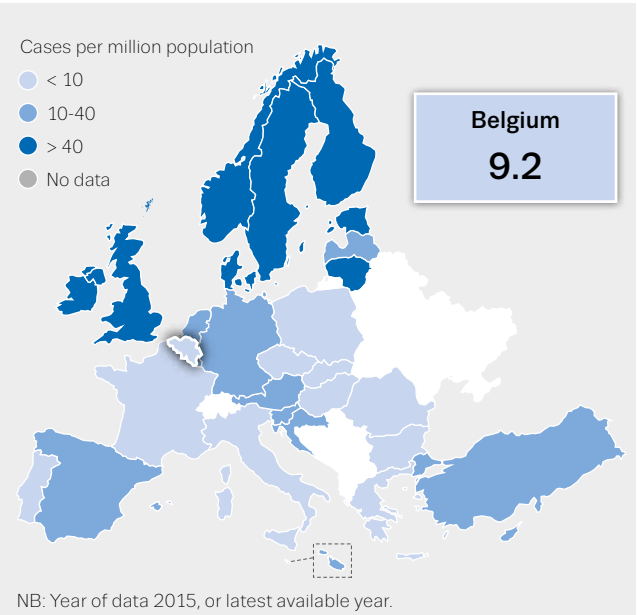
Drug-induced deaths are deaths that can be attributed directly to the use of illicit drugs (i.e. poisonings and overdoses).

In Belgium, drug-induced deaths are recorded in the General Mortality Register located at the National Institute of Statistics and the latest available data at the national level are for 2013. Overall, the number of drug-induced deaths has been declining, with a stabilisation in numbers in 2012-13 (Figure 10). Opioids (mainly heroin, but also fentanyl) were involved in 59 % of all toxicologically confirmed drug-induced deaths that were reported in 2013. The majority of the victims were male.

The drug-induced mortality rate among adults aged 15-64 years was 9.2 per million in 2013 (latest data available), which is below the most recent European average of 20.3 per million (Figure 11).

FIGURE 11

Drug-induced mortality rates among adults (15-64 years)



NB: Year of data 2015, or latest available year.

Prevention

The organisation, implementation and monitoring of prevention activities is the responsibility of Belgium's communities and regional governments and, for this reason, strategies for drug prevention differ significantly across the three language communities. For example, in the Flemish community, substance use prevention is carried out following a Flemish tobacco, alcohol and drugs action plan for 2009-15 and is oriented towards actors in the education and health sectors, in workplace, recreational and local settings. In the French community, the approach is one of global health promotion, which is implemented through community plans, with a focus on social integration and access to housing and health services. In the German community, the Association for Addiction Prevention and Life Management (ASL) is responsible for all prevention activities. There are also common themes in the implementation of drug prevention, such as a focus on strengthening the network of field workers available to young people, innovative programmes for children and families and robust efforts to implement environmental strategies in recreational settings.

Prevention interventions

Prevention interventions encompass a wide range of approaches, which are complementary. Environmental and universal strategies target entire populations, selective prevention targets vulnerable groups that may be at greater risk of developing drug use problems and indicated prevention focuses on at-risk individuals.

Reducing the availability of, and access to, tobacco and alcohol remains the main focus of environmental prevention in Belgium.

Universal prevention activities are mainly implemented through school-based programmes, and differences between the language communities are particularly noticeable in this area. The prevention activities in primary school settings focus on licit substances, which have recently become more common. In the Flemish community, programme-based comprehensive interventions have been adopted in secondary school settings within the framework of the health-promoting school environment. The French community follows a model in which specialised associations or internal services provide awareness raising, training or counselling in schools, mostly targeting educators and teachers. Addiction Support Points, created in 2007, are interfaces between schools and other structures involved in prevention activities, such as the police, municipal organisations and associations. A range of manual-based programmes is used, including 'Unplugged'. The ASL drug prevention activities in the German community's schools are implemented in the wider context of lectures on rights, duties and risks in society.

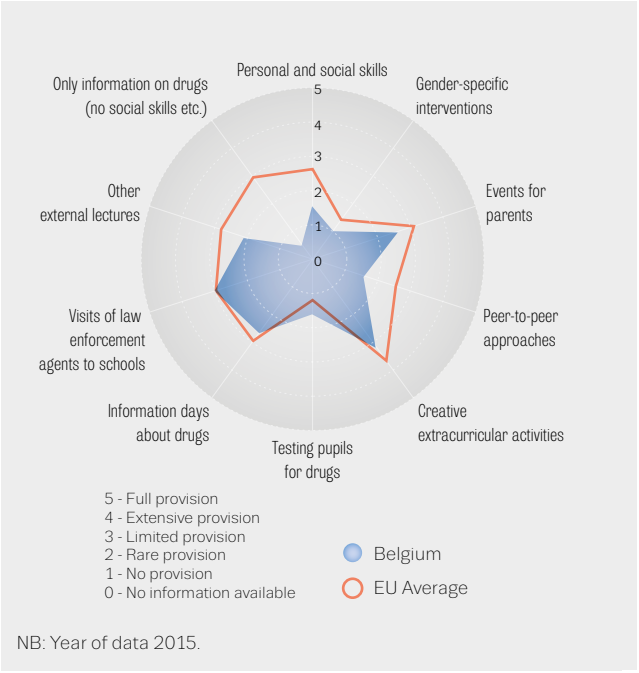
In addition to school-based universal prevention interventions, the language communities also develop and implement activities focusing on parenting skills; the French and Flemish communities provide telephone and email helplines and increasingly develop online early intervention services that are easily accessible (Figure 12).

In Belgium, selective prevention activities are mainly oriented to ethnic minorities; young people with special needs and a mild mental disability; marginalised people; drug-using parents and their children; and people in recreational settings.

In recreational settings, selective prevention is limited mostly to the dissemination of information through information stands, peer prevention and websites targeted at partygoers or through mobile teams whose aim is to intervene at locations (generally at large festivals) where there is significant (often synthetic) drug use. The Quality Nights Charter is a health promotion label in recreational settings, used in both the Flemish and the French communities, and is part of a European network of 'safer party' labels. It aims to improve the health and safety of people attending festivals, parties, etc., by certifying that the organisers and operators of events have complied with specific health and welfare standards. A simpler version of Quality Nights is being developed for implementation in smaller settings and events. A number of other projects also operate in recreational settings and events in these communities. Indicated prevention activities are increasingly available in Belgium. In the

FIGURE 12

Provision of interventions in schools in Belgium (expert ratings)



NB: Year of data 2015.

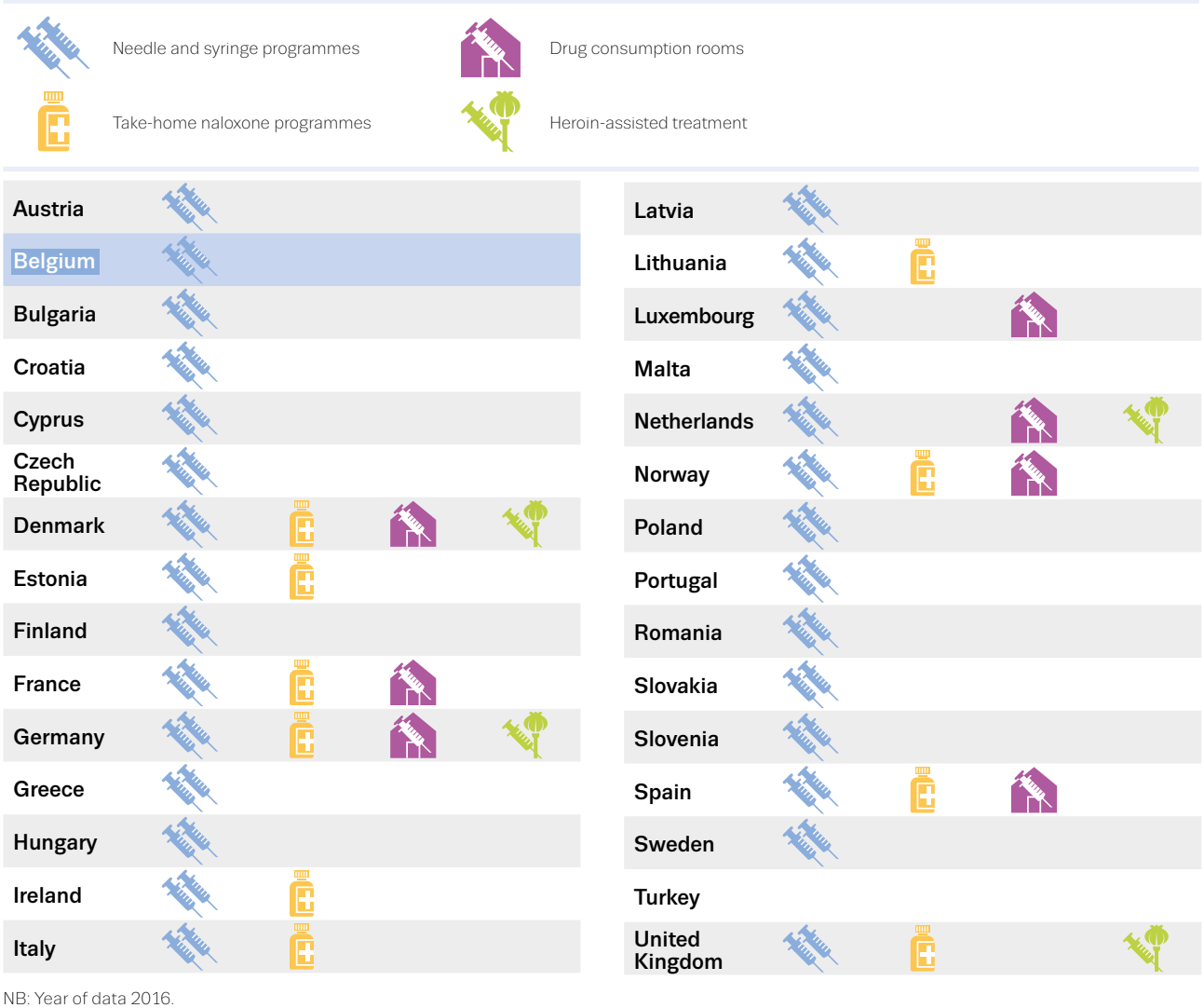
Flemish community, these include promoting screening and early interventions at the primary healthcare level using the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) instrument. Another project, Screening, Brief Intervention and Referral to Treatment (SBIR) focuses on brief interventions and referrals to treatment for young people who have been admitted to emergency departments with substance use problems. An early intervention in other settings for young people has also been developed and a number of online self-care and self-help tools are available in the Flemish and the French communities. Some early intervention and motivational interviewing programmes are available in the German community.

Harm reduction

In Belgium, the Federal Drug Policy Note of 2001 and the Communal Declaration of 2010 endorse harm reduction as one of three pillars of national drug response. The range of officially endorsed harm reduction programmes includes, among others, peer support, needle exchange programmes, drug consumption rooms and heroin-assisted treatment. Nevertheless, the two last programmes are not presently available in Belgium. In addition, the Belgian Early Warning on Drugs system can also be considered as a harm reduction approach. Needle and syringe programmes (NSPs) at low-threshold harm reduction projects have existed in the French community since 1994. In 1998, a law was adopted allowing needle exchange in pharmacies. In 2000, the Flemish community made the necessary legislative adaptations, and from 2001 such programmes have also officially been implemented there.

FIGURE 13

Availability of selected harm reduction responses



NB: Year of data 2016.

NSPs (stationary, mobile or in pharmacies) are now available across the country, except in the German community (Figure 13). In general, harm reduction projects are set up and run by non-governmental organisations, and some are managed by city authorities. These projects are funded by the community and by the regions.

Between 2011 and 2013, an open-label randomised controlled trial was carried out comparing heroin-assisted treatment and methadone maintenance treatment in the city of Liège. The study concluded that the use of heroin-assisted treatment should remain a second-line treatment in patients who have resistance to methadone and recommendations were provided for setting up such a programme. Since then, discussions have been undertaken in order to proceed with this project.

The introduction of drug consumption rooms has been brought up and was also discussed at a political level. A working group of the General Drugs Policy Cell has been mandated to assess the necessary conditions for the introduction of drug consumption rooms.

Harm reduction interventions

The harm reduction projects offer, among other things, sterile injecting material (syringes, filters, ascorbic acid, spoons, alcohol swabs and injectable sterile water), foil, bicarbonate and containers, as well as collecting used syringes and needles. In addition, they facilitate the referral of PWID to other prevention and treatment services.

Over the years, the number of distributed syringes has increased in both the Flemish and the French communities, with over 1 million syringes distributed in 2015 across the country. In addition to syringe provision by low-threshold harm reduction projects, pharmacies in the French and the Flemish communities distribute a substantial number of syringes. In the French community, syringes are distributed mainly as part of the subsidised 'Sterifix' kit. In 2015, 11 077 kits were dispatched to pharmacies, in addition to the syringes that were distributed. Annual evaluations of the NSPs in the Flemish community indicate that pharmacies can play an important role in the provision of injecting materials, as 9 out of 10 NSP clients report purchasing injecting material from pharmacies. It is important to note that not every province has a good geographical spread of NSPs.

In the prevention and control of infectious diseases among PWID, special emphasis in recent years has been given to HCV counselling and testing.

Treatment

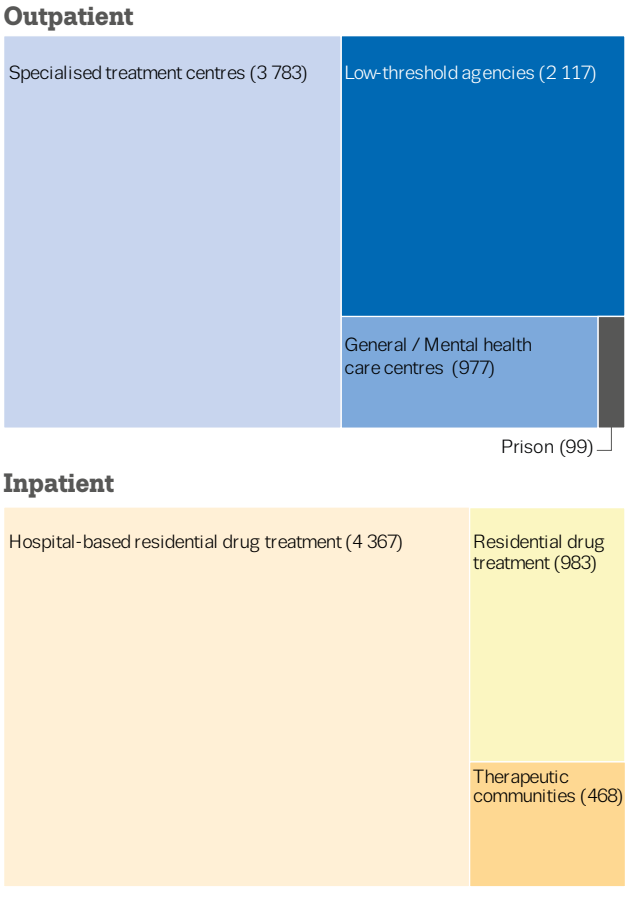
The treatment system

The Federal Drug Policy Note of 2001 specifies that treatment services should be based on a multidisciplinary approach that is adapted to the complex bio-psychosocial problem of drug dependency. This approach was further emphasised in the Communal Declaration of 2010 and elaborated in the Joint Statement of the Inter-Ministerial Conference on Drugs held in 2010. In Belgium, competences concerning treatment are split between the federal and federate governments, but are coordinated nationally. A new state reform is being applied progressively throughout the country and will impact the organisation of drug treatment organisations. In Flanders, the specialised drug treatment sector will become part of the general mental health sector with a strong emphasis on cooperation and networking, which may also influence the organisation of drug treatment within the sector.

A range of services for drug use treatment and/or healthcare is available in a large part of the country, except in the German community, where there are no specialised treatment centres for drug users. Specialised outpatient care is provided by consultation and day-care centres and by medical and social

FIGURE 14

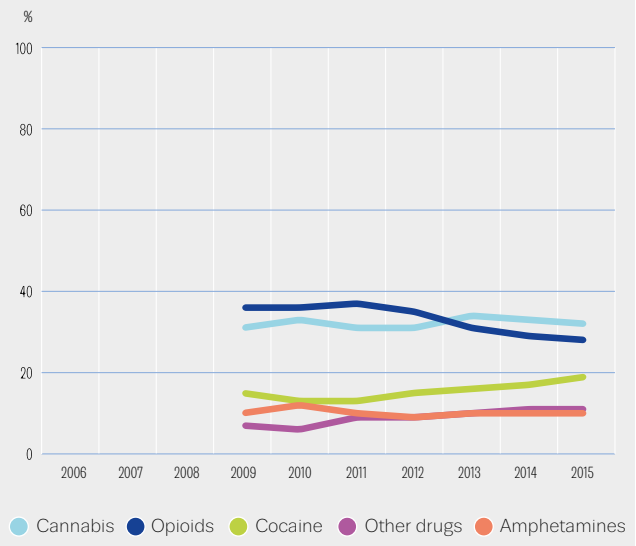
Drug treatment in Belgium: settings and number treated



NB: Year of data 2015.

FIGURE 15

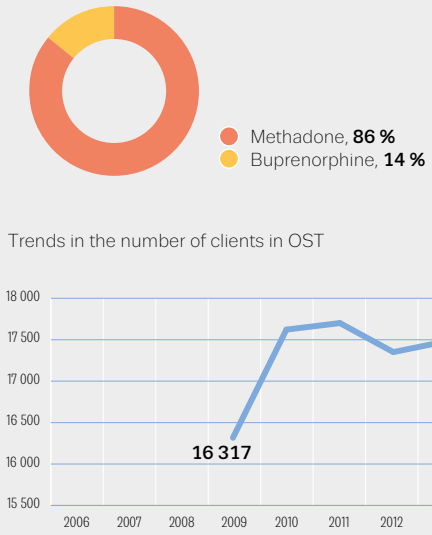
Trends in percentage of clients entering specialised drug treatment, by primary drug in Belgium



NB: Year of data 2015.

FIGURE 16

Opioid substitution treatment in Belgium: proportions of clients in OST by medication and trends of the total number of clients



NB: Year of data 2015.

care centres. In general, these centres provide low-threshold help or social reintegration services, including a wide range of psychosocial, psychological and healthcare services, including opioid substitution treatment (OST). General and mental healthcare, based on psychosocial interventions, is provided by centres for mental health, sometimes with a specialised focus on drug dependence. In Belgium, general practitioners (GPs) remain the first-line health services for accessing drug treatment, while in the French community they play a crucial role in diagnosis and the prescription of OST. Both methadone and buprenorphine are available for OST. Recently, online treatment interventions have become also available (online help and chat).

Inpatient treatment consisting of detoxification, stabilisation and motivation, and social reintegration is offered at hospital-based residential drug treatment units and specialised CICs, which provide care based on case management principles at specialised hospital units or through long-term residential treatment services. Aftercare and reintegration programmes are delivered in outpatient and inpatient settings. Examples include halfway houses in therapeutic communities, day treatment in drug centres and employment rehabilitation programmes.

Action has recently have been taken to improve treatment for clients with a dual diagnosis or polydrug use and for children and young people. A pilot project exploring a community reinforcement approach combined with a voucher treatment method has shown promising results for the treatment of cocaine users. A new treatment programme for young cannabis users has also been piloted.

Treatment provision

Available data from the treatment demand register in Belgium indicate that slightly more than half of all clients enter treatment at outpatient specialised drug treatment centres. However, the overall number of clients in treatment is estimated to be higher, since the register does not collect data from GPs and does not report on long-term treatment clients (Figure 14).

In general, an increase in cannabis and cocaine treatment demands and a reduction in opioid treatment demands have been observed in Belgium among all treatment clients in specialised treatment services since 2011 (Figure 15).

In Belgium, the estimated number of OST clients has declined since 2013, and the most recent data indicate that majority of OST clients receive methadone (Figure 16). Between 2011 and 2013, an open-label randomised controlled trial was carried out comparing heroin-assisted treatment with methadone maintenance treatment. The study concluded that the use of heroin-assisted treatment should remain a second-line treatment for patients who are resistant to methadone, and it was recommended that a heroin-assisted treatment programme be set up.

Drug use and responses in prison

The Directorate General of the Penitentiary Institutions is responsible for the Belgian Prison system. The Ministerial Circular Letter of 18 July 2006 regulates the principles of an integral and integrated prison drug policy as implied by the Federal Drug Policy Note of 2001. It also stresses the importance of the active detection of drug problems and related health and psychiatric problems.

The latest survey on drug use prevalence among prison inmates in Belgium dates from 2009. The data were collected in two Belgian prisons and showed that approximately 71 % inmates had used an illicit drug prior to imprisonment, and 60 % had done so while in prison. One quarter of the inmates who used drugs at least once during imprisonment reported almost daily use inside prison. Cannabis was the most commonly used drug, and a majority of those who used cannabis prior to imprisonment continued to do so while in detention.

Healthcare in prison is the responsibility of the Federal Public Service of Justice. Members of the medical staff are responsible for the provision of information about drugs, drug-related infectious diseases and treatment options to every person entering prison and for checking whether or not a prisoner had been treated prior to detention.

The central service for healthcare provides healthcare to inmates, while the psychosocial service provides medical and psychosocial advice as part of security measures in prisons and for those on probation.

Steering groups with the aim of targeting drug use and related problems have been established both at a central level and in each prison. Services for drug users in prison are provided by prison health teams and external caregivers.

Material giving information on the effects of different drugs and on drug-related health problems and risk behaviour in prison is available. Different drug-related health services, such as support from a psychologist, cognitive-behavioural interventions, OST, therapeutic communities and drug-free programmes are available, although coverage of many interventions remains limited. Drug treatment is often restricted to those with medical indications for treatment. OST can be either initiated or continued in prison, and methadone and buprenorphine are also available. Psychosocial treatment is not yet systematically available.

With regards to the prevention of drug-related infections, voluntary testing for hepatitis and HIV is available in some Belgian prisons. Treatment for infectious diseases is available in all prisons. Condom distribution takes place at health services and through small vending machines.

Aftercare and referral to community services after release are undertaken by central intake units, but the future funding of these units is uncertain.

Data collected in two Belgian prisons in 2009 indicate that approximately 71 % of inmates had used an illicit drug prior to imprisonment and 60 % had done so while in prison

Quality assurance

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. For this reason, the research programme on drugs of the Federal Science Policy Office (BELSPO) annually supports funding for several projects that contribute to the evaluation of the global and integrated Belgian drug policy. More specifically, BELSPO funds drug prevention, treatment and harm reduction initiatives. In the Flemish region, VAD (Vlaams expertisecentrum voor Alcohol - en andere Drugs or the Flemish centre of expertise for alcohol and other drugs) promotes evidence-based practice in alcohol and drug prevention and treatment. In 2013, VAD published a manual for quality improvement in substance abuse treatment, focusing on the implementation of evidence-based guidelines and outcome management.

Although neither an accreditation system for intervention providers nor a specific academic curriculum for professionals working in the field of demand reduction exists, several organisations provide specific continued education and specialisation courses.

In 2014-15, BELSPO funded a study on consensus building vis-à-vis minimal quality standards for drug demand reduction in Belgium. The aims of the study were to document the critical ingredients and prerequisites for the successful implementation of these standards, based on selected good practices; to assess the acceptability and actual implementation of the minimal standards for drug treatment, prevention and harm reduction; and to specify and put into operation the consensus minimal standards and develop standards of excellence that can be used as measures and benchmarks for monitoring and evaluating prevention, treatment and harm reduction intervention.

The research programme on drugs of BELSPO annually supports funding for several projects that contribute to the evaluation of the global and integrated Belgian drug policy

Drug-related research

In Belgium, the responsibilities for research are divided between Belgium's communities and the federal state. The budget for scientific research in the drugs field is provided under the Federal Drug Policy Note, and is managed by BELSPO through a research programme that supports federal policy. Most studies that are funded through this programme are carried out by networks of researchers. The national focal point collects information on ongoing and completed studies in Belgium and disseminates information on drug-related research findings to audiences through a variety of channels.

Recent drug-related research in Belgium mainly includes studies on basic biological, neurobiological and behavioural aspects and population-based and clinical studies of epidemiology.

Recent drug-related research in Belgium mainly includes studies on basic biological, neurobiological and behavioural aspects and population-based and clinical studies of epidemiology

Drug markets

Belgium has an important position in the production of cannabis and synthetic drugs (mostly MDMA, amphetamines) and, recently, in the distribution of NPS, with strong connections to drug production in the neighbouring Netherlands. Cannabis-growing operations and clandestine laboratories are most often concentrated in the border region, sometimes with common production chains.

Cannabis remains the most frequently seized illicit substance in Belgium. In recent years, there has been an increase in the amount of cannabis seized from micro- and mini-plantations in the country, which has been attributed to higher restrictions on cannabis sales in the Netherlands and might indicate the expansion of the non-commercial segment of the domestic cannabis market. Belgium also remains a transit country for herbal cannabis trafficking from the African countries, intended predominantly for markets in the Netherlands, the United Kingdom and other EU countries. Cannabis resin, mostly of Moroccan origin, is trafficked into the country mainly by road, and seizures have not indicated a particular trend over time. However, in 2015, an exceptionally large seizure of 6 tonnes of cannabis resin entering Belgium from France was reported (Figure 17).

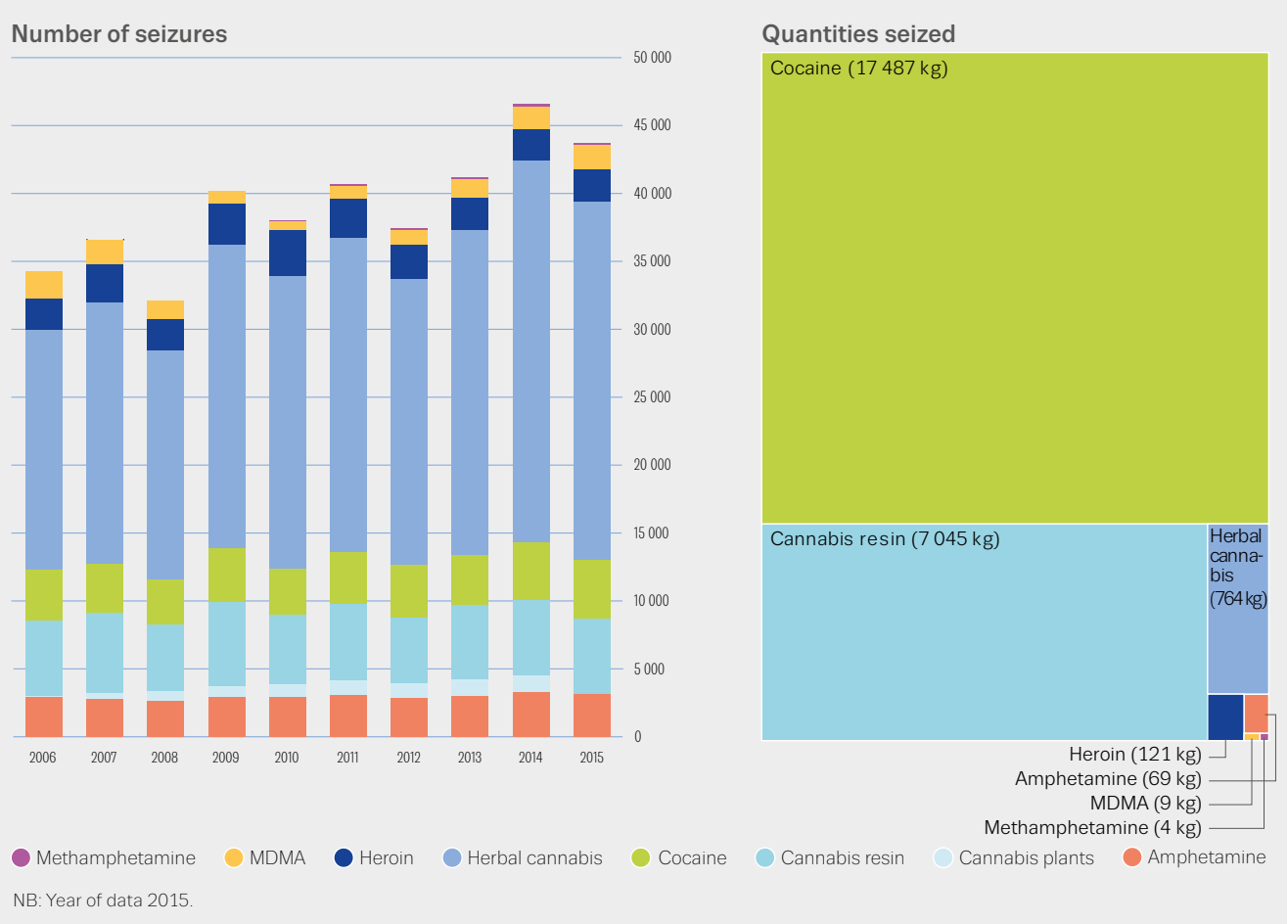
With regards to the production of synthetic drugs, an increase in the number of dismantled drug laboratories has been noted in recent years, some of which were using novel precursors. The local production of these substances is deemed to satisfy primarily the domestic market, while the United Kingdom and some Scandinavian countries remain popular export destinations for these substances.

For MDMA, slight increases in the number of seizures and the quantities seized have been reported in recent years, indicating that there is further recovery in the MDMA market. At the same time, seizures of amphetamines do not present clear time trends and seizures of methamphetamine remain at marginal levels.

The port of Antwerp is one of the largest container ports in the world and is significant in international drug trafficking, primarily for cocaine, as are the airports of Brussels and Liège. Cocaine is the second most frequently seized illicit substance, but the quantities seized show large annual fluctuations. It is smuggled into Belgium predominantly by air or sea

FIGURE 17

Drug seizures in Belgium: trends in number of seizures (left) and quantities seized (right)



NB: Year of data 2015.

FIGURE 18

Price and potency/purity ranges of illicit drugs reported in Belgium

NB: Price and potency/purity ranges: EU and national mean values: minimum and maximum.
Year of data 2015.

from South and Central America, and also, in recent years, by express mail companies. Most of the cocaine arriving in Belgium is destined for the Netherlands or other EU countries.

Belgium is also a transit zone for NPS, which frequently originate in China and are destined for neighbouring countries or other EU countries, although limited local synthetic cannabinoid blending has been reported.

Heroin seized in Belgium often originates in Turkey, but African countries, India and Iran are also mentioned. The number of heroin seizures has declined in the last five years.

The retail price and purity of the main illicit substances are shown in Figure 18.

KEY DRUG STATISTICS FOR BELGIUM

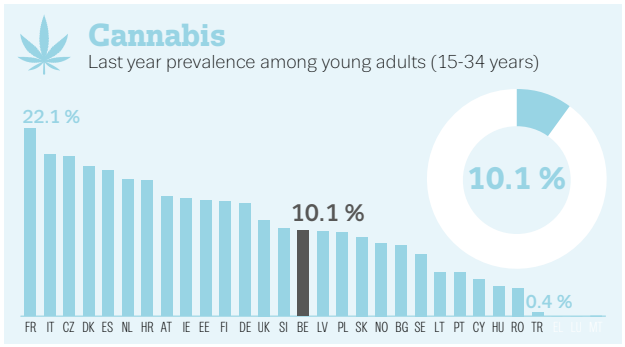
Most recent estimates and data reported

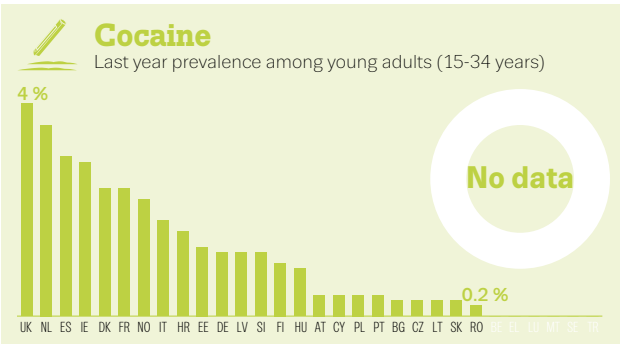
	Year	Country data	EU range Minimum	EU range Maximum
Cannabis				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	17.3	6.5	36.8
Last year prevalence of use — young adults (%)	2013	10.1	0.4	22.1
Last year prevalence of drug use — all adults (%)	2013	4.6	0.3	11.1
All treatment entrants (%)	2015	32	3	71
First-time treatment entrants (%)	2015	52	8	79
Quantity of herbal cannabis seized (kg)	2015	764	4	45 816
Number of herbal cannabis seizures	2015	26 401	106	156 984
Quantity of cannabis resin seized (kg)	2015	7 045	1	380 361
Number of cannabis resin seizures	2015	5 569	14	164 760
Potency — herbal (% THC) (minimum and maximum values registered)	2015	0.8-24.7	0	46
Potency — resin (% THC) (minimum and maximum values registered)	2015	3.6-30.9	0	87.4
Price per gram — herbal (EUR) (minimum and maximum values registered)	2015	3-20	0.6	31.1
Price per gram — resin (EUR) (minimum and maximum values registered)	2015	3.2-20	0.9	46.6
Cocaine				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	2.6	0.9	4.9
Last year prevalence of use — young adults (%)	2013	0.9	0.2	4
Last year prevalence of drug use — all adults (%)	2013	0.5	0.1	2.3
All treatment entrants (%)	2015	19	0	37
First-time treatment entrants (%)	2015	19	0	40
Quantity of cocaine seized (kg)	2015	17 487	2	21 621
Number of cocaine seizures	2015	4 330	16	38 273
Purity (%) (minimum and maximum values registered)	2015	1-90	0	100
Price per gram (EUR) (minimum and maximum values registered)	2015	20-116.7	10	248.5
Amphetamines				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	2	0.8	6.5
Last year prevalence of use — young adults (%)	2013	0.5	0.1	3.1
Last year prevalence of drug use — all adults (%)	2013	0.2	0	1.6
All treatment entrants (%)	2015	10	0	70
First-time treatment entrants (%)	2015	9	0	75
Quantity of amphetamine seized (kg)	2015	69	0	3 796
Number of amphetamine seizures	2015	3 110	1	10 388
Purity — amphetamine (%) (minimum and maximum values registered)	2015	2.1-74	0	100
Price per gram — amphetamine (EUR) (minimum and maximum values registered)	2015	2.5-20	1	139.8

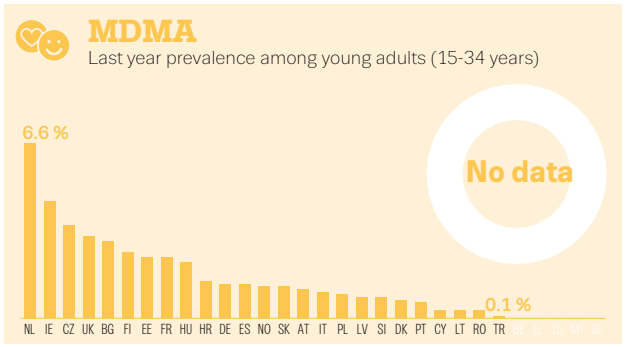
	Year	Country data	EU range Minimum	EU range Maximum
MDMA				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	3.2	0.5	5.2
Last year prevalence of use — young adults (%)	2013	0.8	0.1	6.6
Last year prevalence of drug use — all adults (%)	2013	0.3	0.1	3.4
All treatment entrants (%)	2015	0	0	2
First-time treatment entrants (%)	2015	1	0	2
Quantity of MDMA seized (tablets)	2015	59 696	54	5 673 901
Number of MDMA seizures	2015	1 739	3	5 012
Purity (mg of MDMA base per unit) (minimum and maximum values registered)	2015	6.6-240	0	293
Price per tablet (EUR) (minimum and maximum values registered)	2015	1-10	0.5	60
Opioids				
High-risk opioid use (rate/1 000)	No data	No data	0.3	8.1
All treatment entrants (%)	2015	28	4	93
First-time treatment entrants (%)	2015	10	2	87
Quantity of heroin seized (kg)	2015	121	0	8 294
Number of heroin seizures	2015	2 375	2	12 271
Purity — heroin (%) (minimum and maximum values registered)	2015	3-73	0	96
Price per gram — heroin (EUR) (minimum and maximum values registered)	2015	6.4-66.7	3.1	214
Drug-related infectious diseases/injecting/deaths				
Newly diagnosed HIV cases related to injecting drug use (cases/million population, Source: ECDC)	2015	1.3	0	44
HIV prevalence among PWID* (%)	No data	No data	0	30.9
HCV prevalence among PWID* (%)	No data	No data	15.7	83.5
Injecting drug use (cases rate/1 000 population)	2015	3.3	0.2	9.2
Drug-induced deaths — all adults (cases/million population)	2013	9.2	1.6	102.7
Health and social responses				
Syringes distributed through specialised programmes	2015	1 034 242	164	12 314 781
Clients in substitution treatment	2015	16 681	252	168 840
Treatment demand				
All clients	2015	12 794	282	124 234
First-time clients	2015	4 415	24	40 390
Drug law offences				
Number of reports of offences	2015	47 083	472	411 157
Offences for use/possession	2015	33 782	359	390 843

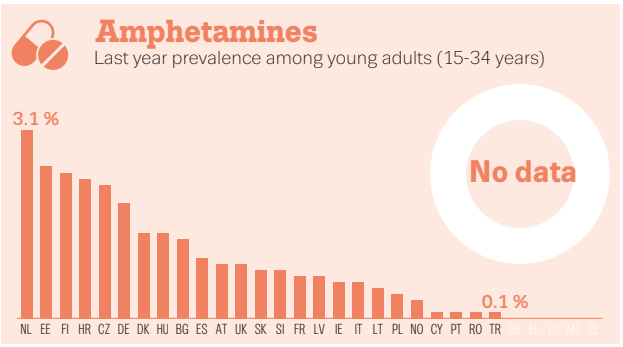
* PWID — People who inject drugs.

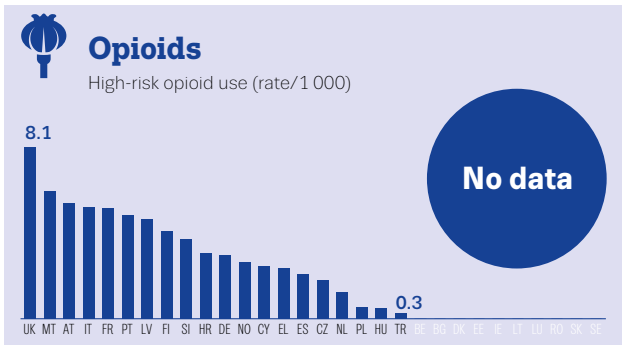
EU Dashboard

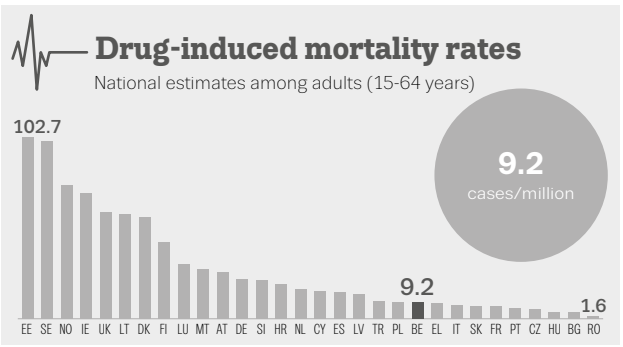


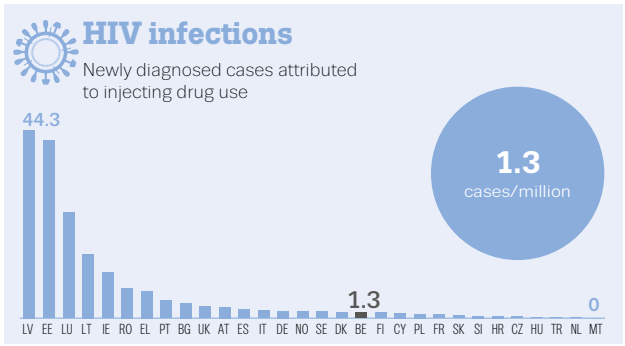


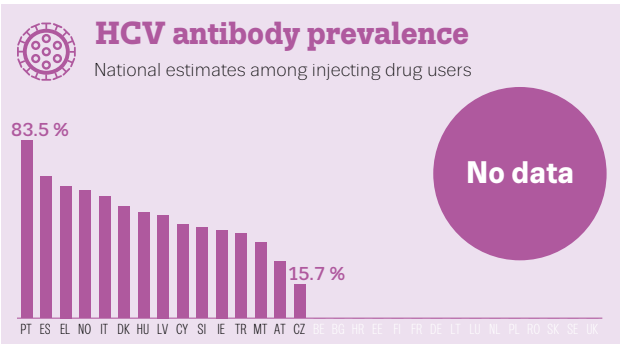












NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, differences may be due to reporting practices. Detailed information on methodology, qualifications on analysis and comments on the limitations of the information available can be found in the EMCDDA Statistical Bulletin. Countries with no data available are marked in white.

Recommended citation

European Monitoring Centre for Drugs and Drug Addiction (2017), *Belgium, Country Drug Report 2017,* Publications Office of the European Union, Luxembourg.

About the EMCDDA

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the central source and confirmed authority on drug-related issues in Europe. For over 20 years, it has been collecting, analysing and disseminating scientifically sound information on drugs and drug addiction and their consequences, providing its audiences with an evidence-based picture of the drug phenomenon at European level.

The EMCDDA's publications are a prime source of information for a wide range of audiences including: policymakers and their advisors; professionals and researchers working in the drugs field; and, more broadly, the media and general public. Based in Lisbon, the EMCDDA is one of the decentralised agencies of the European Union.

About our partner in Belgium

The national focal point is located within the Epidemiology Unit of the Scientific Institute of Public Health (WIV-ISP). The WIV-ISP is a state (federal) scientific organisation and implements policies in response to the legal framework and priorities of the Federal Minister for Health and the President of the Federal Public Service for Health, Food Chain Security and the Environment. The WIV-ISP is the scientific reference in the field of public health. WIV-ISP supports health policy and policy-making through innovative research, analyses, monitoring activities and expert advice. In this way, WIV-ISP contributes to a healthy life for all. The main tasks of the drugs programme of the WIV-ISP include the monitoring, collection, analysis and dissemination of drug-related information. In order to dispose of national drug-related data, cooperation and coordination with 4 regional partner organisations is vital due to the assigned responsibilities regarding health policy.

Scientific Institute of Public Health

(Institut scientifique de santé publique/Wetenschappelijk Instituut Volkgezondheid)
Rue Juliette Wytsman 14
B-1050 Bruxelles/Brussels
Belgium
Tel. +32 26425034
Fax +32 26425001
Head of national focal point: Ms Lies Gremeaux — Lies.Gremeaux@wiv-isp.be

Luxembourg: Publications Office of the European Union
doi: 10.2810/840990 | ISBN 978-92-9168-952-1

This publication is available only in electronic format.

EMCDDA, Praça Europa 1, Cais do Sodré, 1249-289 Lisbon, Portugal
Tel. +351 211210200 | info@emcdda.europa.eu
www.emcdda.europa.eu | twitter.com/emcdda | facebook.com/emcdda