European Monitoring Centre
for Drugs and Drug Addiction

Belgium

Belgium Drug Report 2018

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 2016 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

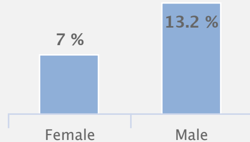
THE DRUG PROBLEM IN BELGIUM AT A GLANCE

Drug use

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

Cannabis

10.1 %



Other drugs

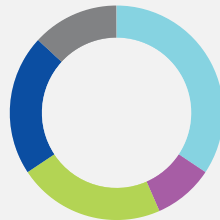
MDMA	**0.8 %**
Amphetamines	**0.5 %**
Cocaine	**0.9 %**

High-risk opioid users

No Data

Treatment entrants

by primary drug



- Cannabis, **34 %**
- Amphetamines, **9 %**
- Cocaine, **22 %**
- Heroin, **21 %**
- Other, **13 %**

Opioid substitution treatment clients

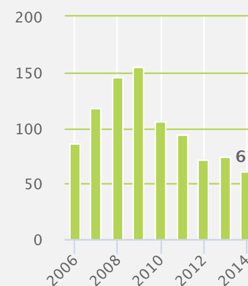
16 560

Syringes distributed

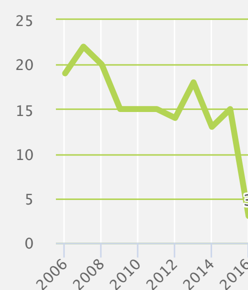
through specialised programmes

1 131 324

Overdose deaths



HIV diagnoses attributed to injecting



Source: ECDC

Drug law offences

49 416

Top 5 drugs seized

ranked according to quantities measured in kilograms

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

Population

(15-64 years)

7 326 873

Source: EUROSTAT Extracted on: 18/03/2018

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 o?ences 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.

National drug strategy and coordination

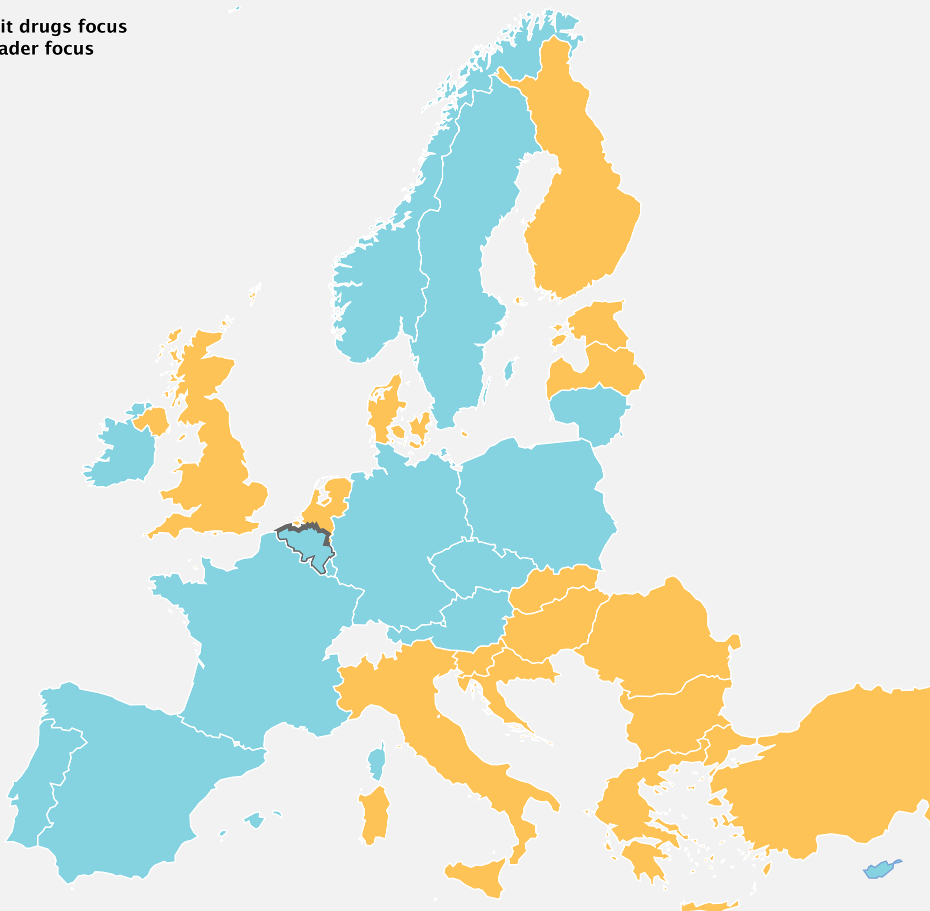
National drug strategy

The drug policy of Belgium is defined in two key policy documents, the Federal Drug Policy Note of 2001 and the Common 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 psychoactive medicines.

The main goals of this document are the prevention and reduction of risks for people who use drugs, the environment and society as a whole; these goals are organised across three pillars: prevention and early intervention in 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 problematic drug users; (iv) treatment, risk reduction and reintegration for problematic users; and (v) repression of producers and traffickers. The Common 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 Drug Research Program of Federal Science Policy. In 2014, the federal Minister of Public Health requested a technical analysis of the Belgian cannabis policy, and a future evaluation of the Federal Drug Policy Note and Common Declaration is planned in 2018–19.

Focus of national drug strategy documents: illicit drugs or broader



NB: Year of data 2016. 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). The General Drugs Policy Cell (GDPC), which is created by law and consists of representatives of all relevant Ministers on the federal and regional level, supports the IMC in the preparation and coordination of this work on Belgian drug policy. The GDPC is supported by the Federal Public Service of Health, Food Chain Safety and the 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 Belgium Drugs Policy. Whenever needed, the GDPC can establish inter-cabinet working groups to explore certain issues in depth.

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, most drug-related expenditure is not identified ('unlabelled') and must be estimated using modelling approaches.

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 substance use in Belgium was performed. Estimates were based on a well-defined methodology.

Estimates for 2012 and 2013 indicate that total public expenditure related to illicit substance use represented 0.08 % of gross domestic product, that is, more than EUR 306 million in 2012 and EUR 300 million in 2013.

Drug laws and drug law offences

National drug laws

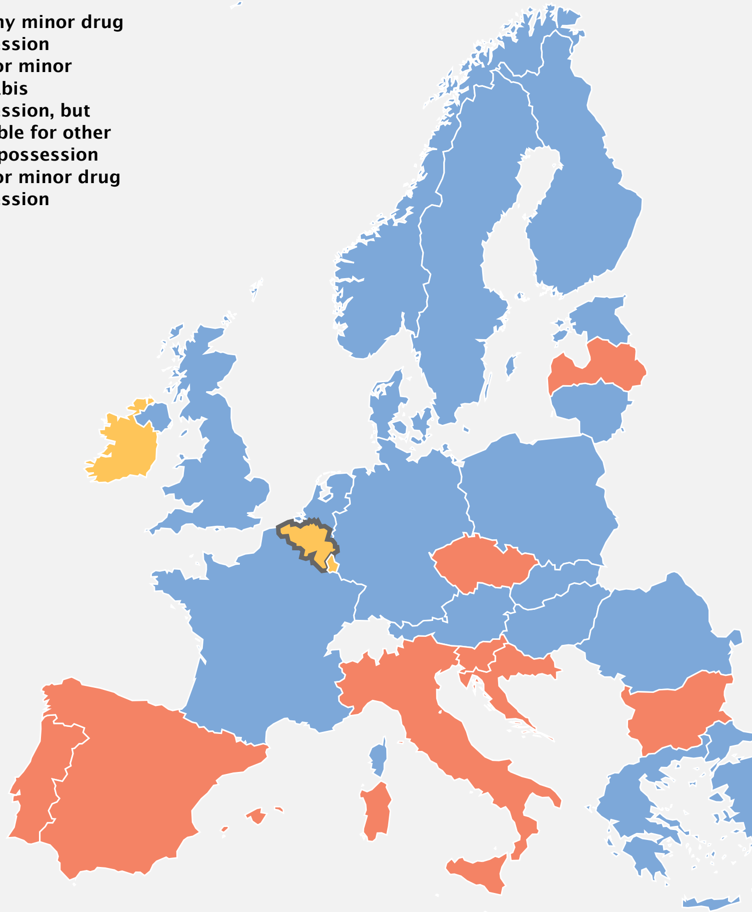
Unlike selling and/or possessing controlled substances, the use of controlled substances is not mentioned as an offence in Belgian drug laws. In 2003, personal possession of cannabis was differentiated from the possession of other controlled substances, with the result that the public prosecutor did 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 in 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 8 000 to EUR 800 000. In the absence of aggravating circumstances, possession of cannabis for personal use is punishable by a fine of EUR 120 to EUR 200, based on a simplified police report. Increased fines are imposed for second and third offences within a year of the previous offence, with up to one year in prison also possible for a third offence. (Note that all the amounts shown here have been adjusted by the official inflation figure, that is, multiplied by a factor of 8).

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 8 000 to EUR 800 000. The term of imprisonment may be increased to 10, 15 or even 20 years (with an optional fine) in various specified aggravating circumstances.

Until 2014, the control of new psychoactive substances 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, and the Royal Decree of September 2017 implemented this classification with the addition of several generic groups.

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

- For any minor drug possession
- Not for minor cannabis possession, but possible for other drug possession
- Not for minor drug possession

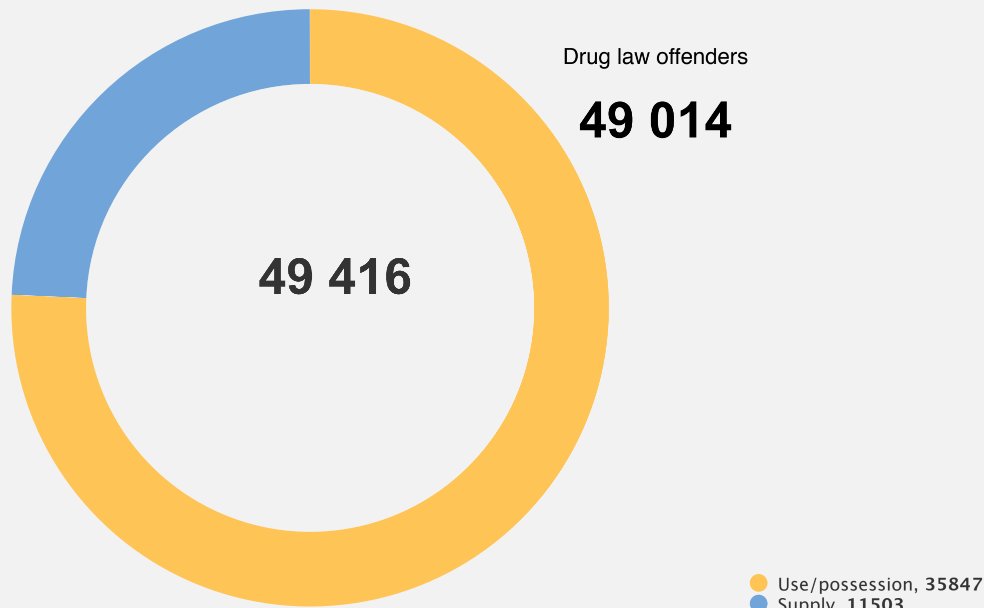


NB: Year of data 2016

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 to improve strategies.

Data from the federal police indicate that most DLOs in Belgium are related to possession. Cannabis is the drug most commonly involved in DLOs, with an increase in the number of cannabis-related possession offences recorded between 2005 up to 2014, and a decrease found in more recent years. The number of DLOs linked to MDMA/ecstasy has been increasing since 2010. In the meantime, a drop in the number of heroin-related offences has been observed since 2010 and may be attributed to the changing priorities of the National Security Plan since 2012, namely that heroin is no longer a priority.



Drug use

Prevalence and trends

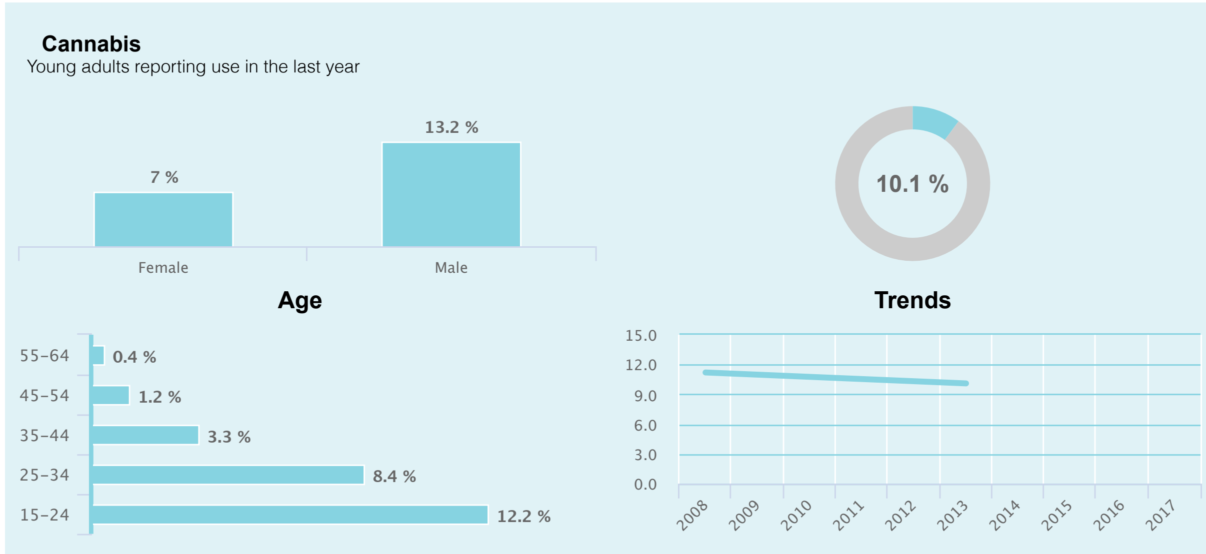
Cannabis is the most commonly used illicit drug in Belgium; its use is concentrated among young adults aged 15-34 years and is more prevalent among males.

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. 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 cCmmunity indicate a slightly decreasing trend in cannabis use compared with the 2006 study, 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/ecstasy has recently gained in popularity. Moreover, there are indications that use of new psychoactive substances (NPS) is becoming more established in nightlife settings.

A number of Belgian cities participate 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 municipal level, based on the levels of illicit drugs and their metabolites found in wastewater. The 2017 data indicate an increase in the levels of MDMA between 2011 and 2016, with a subsequent decrease in 2017 in Brussels and Antwerp. The concentration of cocaine metabolites increased at the weekends in both cities.

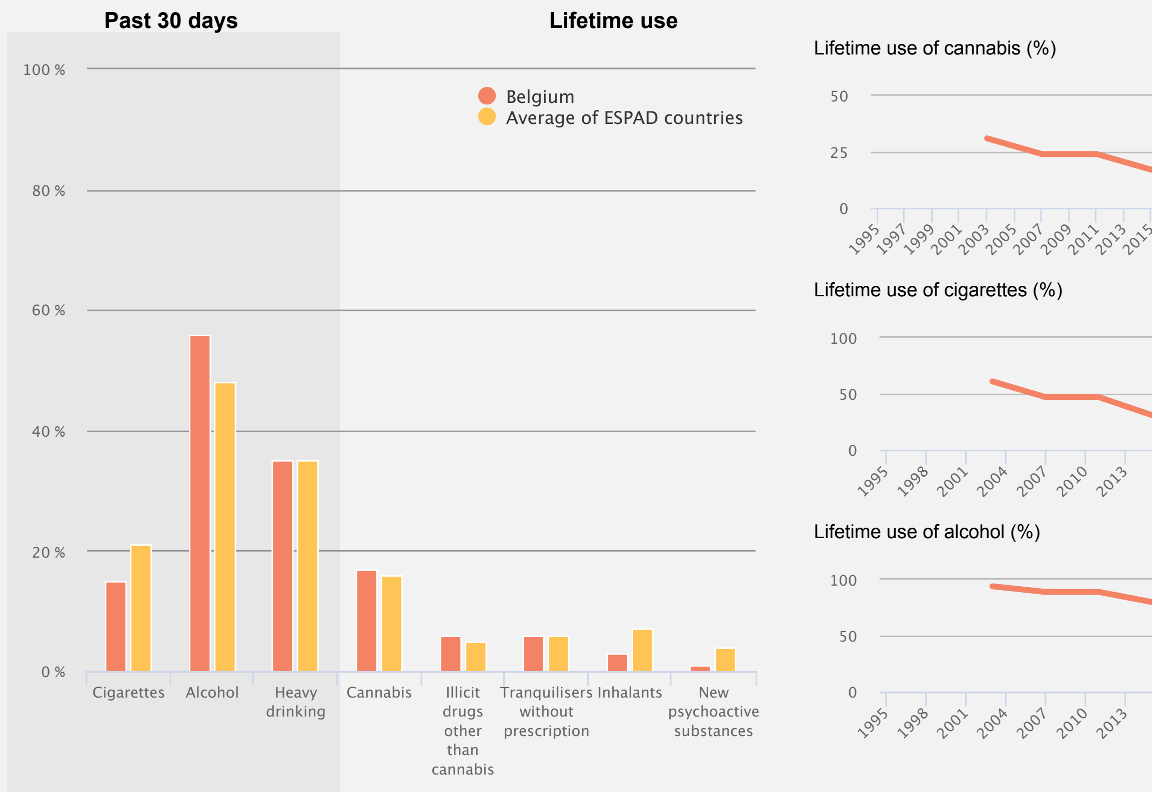
Estimates of last-year cannabis use among young adults (15-34 years) in Belgium



NB: Estimated last-year prevalence of drug use in 2013. The trend line is based on two waves of the Belgian HIS research (2008, 2013).

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, with the exceptions of cigarettes, inhalants and NPS. 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 as or below the ESPAD average.

Substance use among 15- to 16- year-old school students in Belgium



Source: ESPAD study 2015.

High-risk drug use and trends

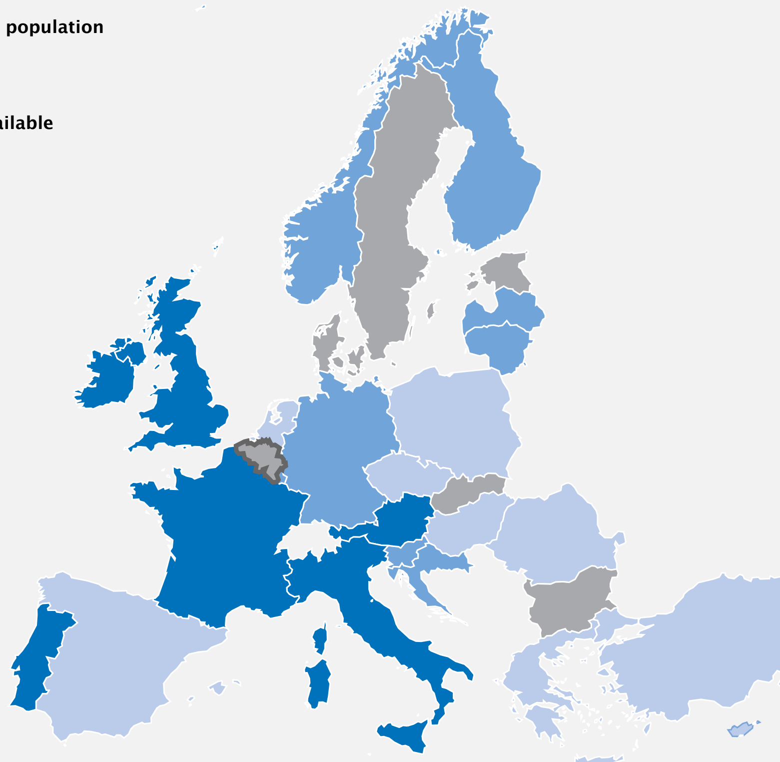
Studies reporting estimates of high-risk drug use and the numbers of people who inject drugs (PWID) can help to identify the extent of the more entrenched drug use problems, while data on first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform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

In Belgium, the estimated number of PWID is derived 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 remains the principal opioid used by PWID.

No population-wide estimate of high-risk opioid users is available for Belgium; nevertheless, data from specialised treatment centres indicate that heroin users constitute approximately one quarter of clients entering treatment, while use of heroin among first-time clients is lower. Cannabis was the most frequently reported primary substance for which clients entered treatment, and cannabis is also the most common primary drug among first-time treatment clients. Approximately one fifth of the clients in treatment are female; however, the proportion varies by type of substance used.

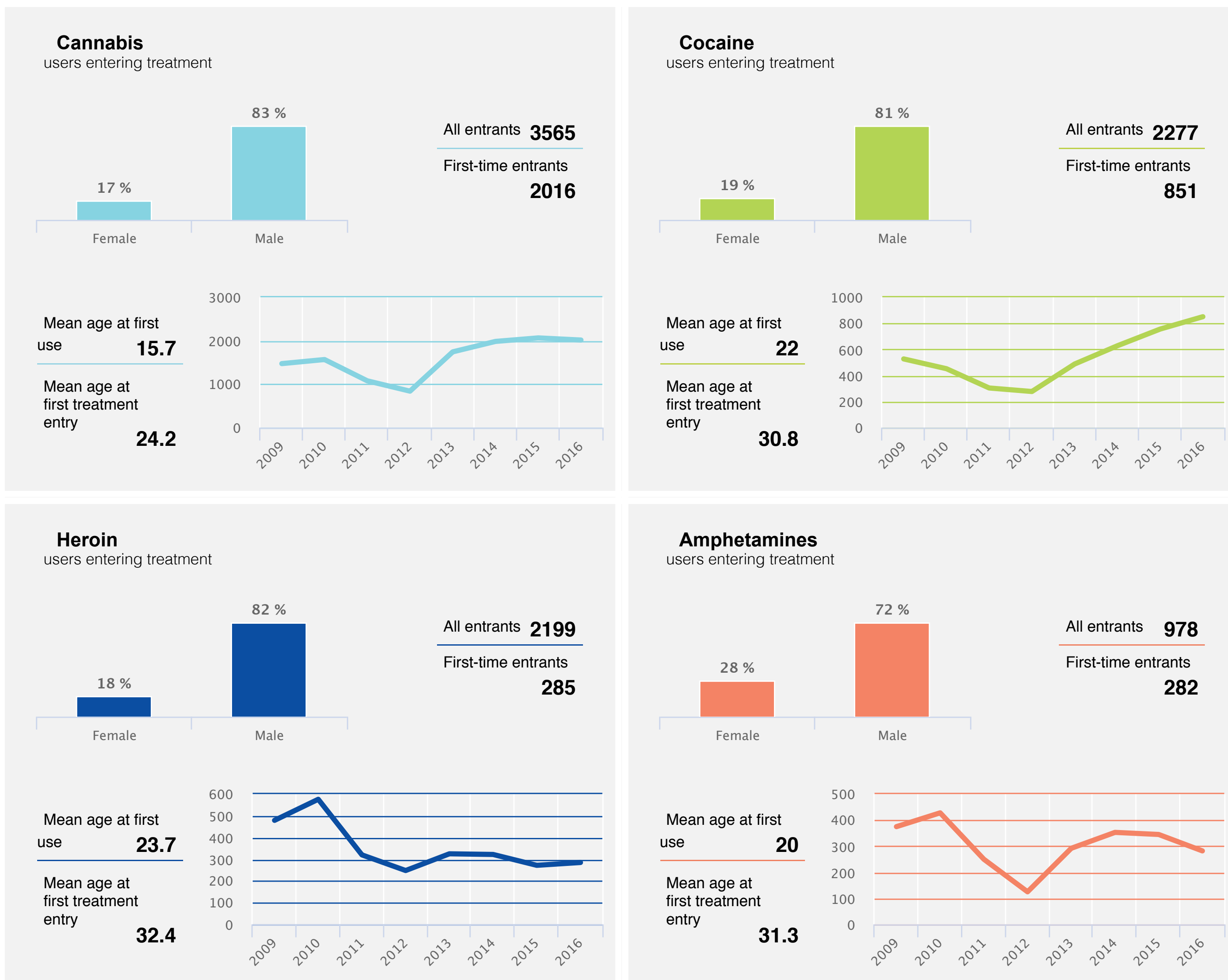
National estimates of last year prevalence of high-risk opioid use

Rate per 1 000 population
- **0.0–2.5**
- **2.51–5.0**
- **> 5.0**
- **No data available**



NB: Year of data 2016, or latest available year

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



"NB: Year of data 2016. 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 and development in data collection methodologies as from 2011."

Drug harms

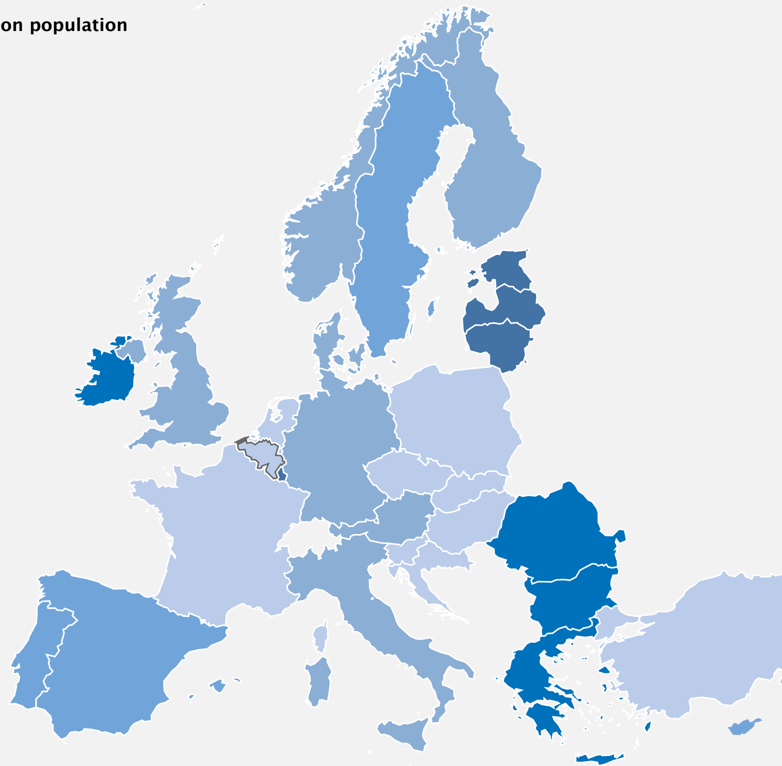
Drug-related infectious diseases

In Belgium, cases of human immunodeficiency virus (HIV) infection and acquired immune deficiency syndrome (AIDS) are registered at Sciensano.

The proportion and number of new HIV cases linked to injecting drug use have fallen since the mid-1980s, and in 2016 only three new cases of HIV or AIDS were linked to injecting drug use. In terms of HIV trends among people who inject drugs (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. Hepatitis C and B virus (HCV and HBV) prevalence rates among PWID also varied between testing sites; however, many estimates are based on relatively small samples. In 2014, HIV prevalence was reported at 5.7 % among 370 PWID attending Free Clinic (an initiative in the Flemish Community), while almost half were HCV positive. Available data suggest that, of people who have ever injected drugs, half or fewer have been vaccinated against HBV.

Various data sources and additional studies indicate that some high-risk use patterns, such as sharing of needles or syringes, as well as ‘slamming’ (or injecting drugs in a sexual context) among men who have sex with men, have been observed among specific subgroups of people who use drugs in Belgium.

Newly diagnosed HIV cases attributed to injecting drug use



NB: Year of data 2016, or latest available year. Source: ECDC.

Drug-related emergencies

Information on drug-related emergencies for Belgium is available from crisis intervention centres (CICs) and the Belgian Early Warning System on Drugs. The information from eight CICs suggests that there has been a decline in admissions — and hence in potential non-fatal intoxications — since 2011. In 2016, 692 people were admitted to CICs as a result of illicit drug use. The drugs most commonly linked to admissions were opioids (involved in one third of cases), followed by cocaine, other stimulants and cannabis.

The emergency rooms of the hospitals UZ Ghent and ZNA Stuivenberg in Antwerp participate in the European Drug Emergencies Network (Euro-DEN Plus) project, which was established in 2013 to monitor acute drug toxicity in sentinel centres across Europe.

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).

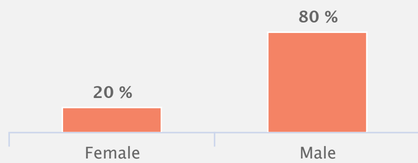
In Belgium, drug-induced deaths are recorded in the General Mortality Register located at the National Institute of Statistics and the latest available data at the national level are for 2014. Overall, the number of drug-induced deaths has been declining since 2009, with a stabilisation in numbers in 2012-14. Opioids (mainly heroin, but also fentanyl and derivatives) were involved in more than half of all toxicologically confirmed drug-induced deaths that were reported in 2014. The majority of the victims were male.

An additional source of information, the Early Warning System on Drugs, reported 60 drug-induced deaths in 2016, which were mainly caused by polydrug use, with opioids (typically heroin and methadone) being involved in more than half of those cases. New psychoactive substances, including synthetic fentanyl analogues, were implicated in at least five deaths.

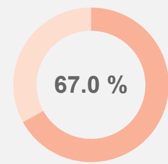
The drug-induced mortality rate among adults aged 15-64 years was 8.19 per million in 2014 (latest data available), which is below the most recent European average of 21.8 per million.

Characteristics of and trends in drug-induced deaths in Belgium

Gender distribution

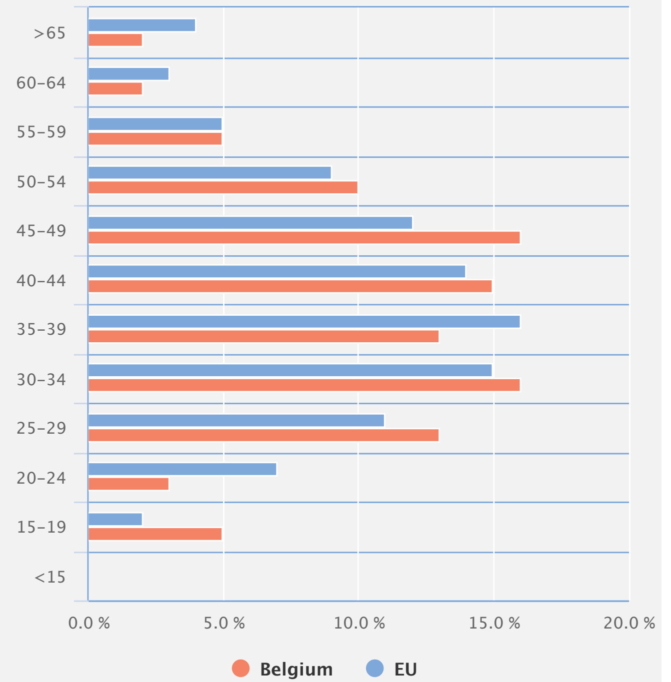


Toxicology

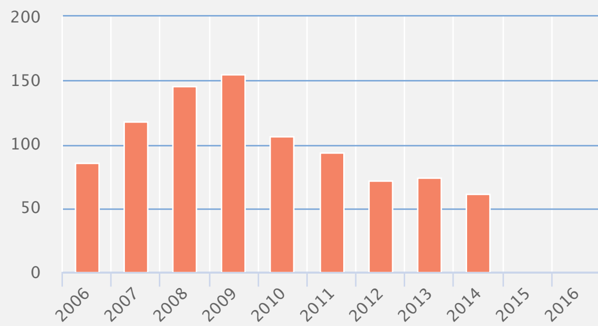


Deaths with opioids present among deaths with known toxicology

Age distribution of deaths in 2014

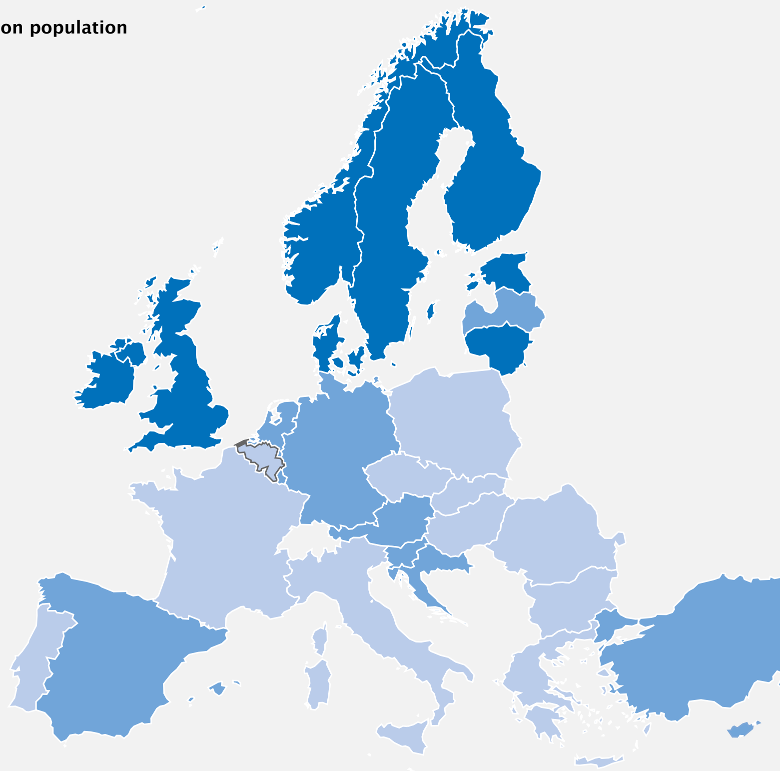


Trends in the number of drug-induced deaths



NB: Year of data 2014

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



"NB: Year of data 2016, or latest available year. Comparison between countries should be undertaken with caution. Reasons include systematic under-reporting in some countries, different reporting systems and case definition and registration processes."

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 Communities. A Flemish position paper focuses on health objectives for 2017-25, addressing, among other issues, tobacco, alcohol, drugs, psychoactive medicines, gambling and gaming. New health promotion plans have been developed in the French Community.

The Flemish Centre of Expertise for Alcohol and other Drugs (VAD — Vlaams expertisecentrum voor Alcohol en andere Drugs) is responsible for alcohol and drug prevention in the Flemish Community. In the French Community, the Common Community Commission (COCOM) and the Commission of the French Community (COCOF) are responsible for prevention and health promotion actions. There are common themes in the implementation of drug prevention policies, such as a focus on innovative programmes for children and families, and the implementation of 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 substance use problems and indicated prevention focuses on at-risk individuals.

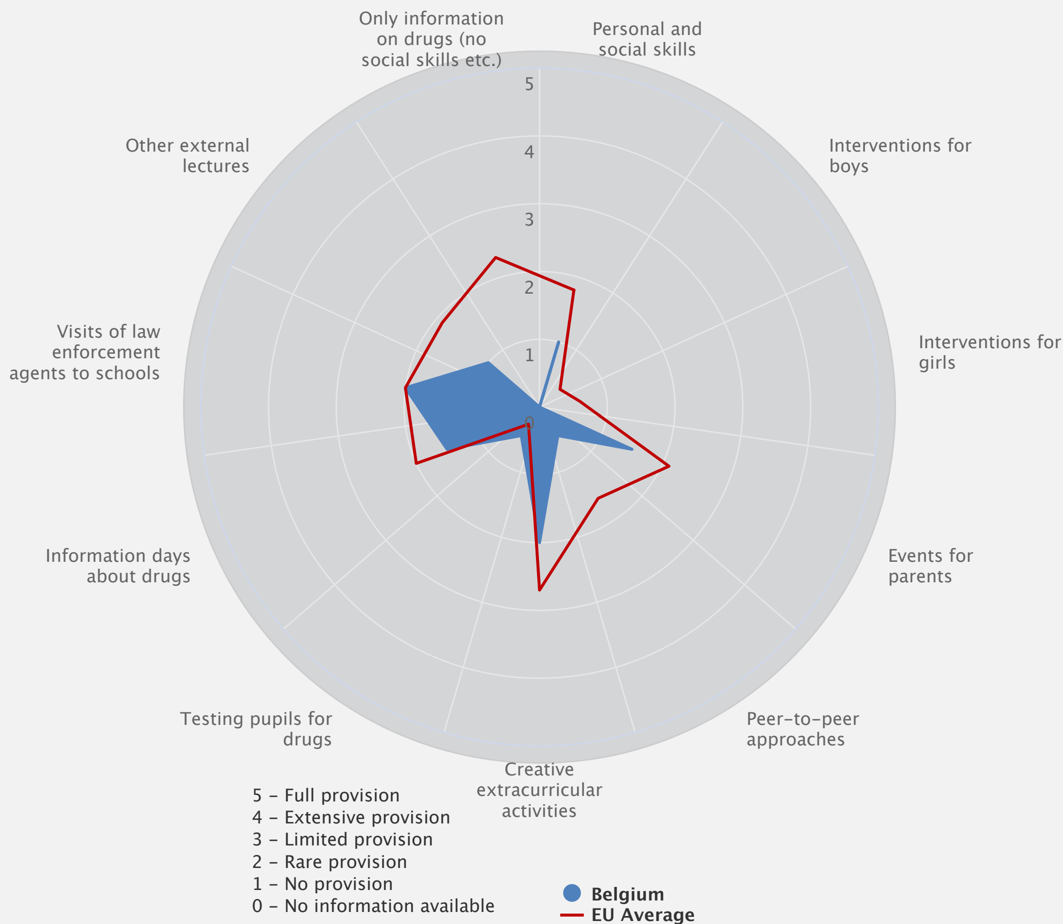
Reducing the availability of, and access to, tobacco and alcohol remains the main focus of environmental prevention in Belgium. In the last decade, there has been a new focus on delaying the onset of drinking in various groups and in society as a whole.

Universal prevention activities are mainly implemented through school-based programmes. Prevention activities in primary schools focus on licit substances, while in secondary schools the main focus of programmes differs by region. In the Flemish Community, programme-based comprehensive interventions have been adopted 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 are interfaces between schools and other structures involved in prevention activities, such as the police and municipal organisations and associations. A range of manual-based programmes is used, including Unplugged. The ASL (Arbeitsgemeinschaft für Suchtvorbeugung und Lebensbewältigung) drug prevention activities in the German-speaking Community's schools are implemented in the wider context of lectures on rights, duties and risks in society. In addition, the communities also develop and implement activities focusing on parenting skills. The French and Flemish Communities provide telephone and email helplines and are increasingly interested in online early intervention services.

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

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 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 has been developed for implementation in smaller settings and events.

Indicated prevention activities are increasingly available in Belgium. In the 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 in general hospitals integrates SBIRT (Screening, Brief Intervention and Referral to Treatment) into a care pathway and targets patients with hazardous or problematic alcohol use. A number of online self-care and self-help tools are also available in both Communities. Some early intervention and motivational interviewing programmes are available in the German-speaking Community.



Harm reduction

In Belgium, the Federal Drug Policy Note of 2001 and the Common Declaration of 2010 endorse harm reduction as one of three pillars of the national drug response. Harm reduction programmes include peer support and needle and syringe exchange programmes (NSPs). NSPs are available at low-threshold harm reduction projects and pharmacies in the French and Flemish Communities. A new health policy paper for 2017-25 for the Flemish Community addresses the issue of drugs as part of a global health action plan, highlighting health promotion and harm reduction activities in recreational settings.

In general, harm reduction projects are set up and run by non-governmental organisations; some integrate peer support initiatives and some are managed by city authorities. These projects are funded by the Communities and by the Regions.

The feasibility of establishing drug consumption rooms is being discussed and the necessary conditions for their implementation have been assessed in a recent study commissioned by the Belgian Federal Service Policy Office (BELSPO).

Harm reduction interventions

NSPs (in facilities, through mobile services or in pharmacies) are now available across the country, except in the German-speaking Community. Fixed sites offer this service in 19 cities in the Flemish Community and in 8 cities in the French Community. There are nine specialised low-threshold medical and social care centres offering this service. Harm reduction projects offer, among other things, sterile injecting material, foil, bicarbonate and containers, and they collect used syringes and needles. In addition, they facilitate the referral of people who inject drugs (PWID) to other prevention and treatment services.

From 2014 to 2016, the number of distributed syringes increased in both the Flemish and the French Communities, with over 1.1 million syringes distributed in 2016. In the French Community, syringes are distributed through pharmacies mainly as items in the subsidised ‘Sterifix’ kit. The annual survey of NSP clients in the Flemish Community indicated that around a quarter were new clients in 2016, most of them having learned about the service through drug treatment services or friends. Four out of five respondents claimed to know PWID who do not make use of NSPs. Since 2016, at least one ‘drop-box’ to collect used injection materials in public places has been available in every Flemish province.

In the prevention and control of infectious diseases among PWID, special emphasis in recent years has been given to counselling and testing for the hepatitis C virus. During the 2016 hepatitis C awareness week, information and screening were provided. Several services distribute overdose prevention information material and engage in overdose prevention assessment with their clients.

Availablity of selected harm reduction responses in Europe

Country	Needle and syringe programmes	Take-home naloxone programmes	Drug consumption rooms	Heroin-assisted treatment
Austria	Yes	No	No	No
Belgium	Yes	No	No	No
Bulgaria	Yes	No	No	No
Croatia	Yes	No	No	No
Cyprus	Yes	No	No	No
Czech Republic	Yes	No	No	No
Denmark	Yes	Yes	Yes	Yes
Estonia	Yes	Yes	No	No
Finland	Yes	No	No	No
France	Yes	Yes	Yes	No
Germany	Yes	Yes	Yes	Yes
Greece	Yes	No	No	No
Hungary	Yes	No	No	No
Ireland	Yes	Yes	No	No
Italy	Yes	Yes	No	No
Latvia	Yes	No	No	No
Lithuania	Yes	Yes	No	No
Luxembourg	Yes	No	Yes	Yes
Malta	Yes	No	No	No
Netherlands	Yes	No	Yes	Yes
Norway	Yes	Yes	Yes	No
Poland	Yes	No	No	No
Portugal	Yes	No	No	No
Romania	Yes	No	No	No
Slovakia	Yes	No	No	No
Slovenia	Yes	No	No	No
Spain	Yes	Yes	Yes	No
Sweden	Yes	No	No	No
Turkey	No	No	No	No
United Kingdom	Yes	Yes	No	Yes

Treatment

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. In Belgium, competences concerning treatment are split between the federal and federate governments, but are coordinated at the national level. A recent state reform is being applied progressively throughout the country and will affect the organisation of drug treatment facilities. 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.

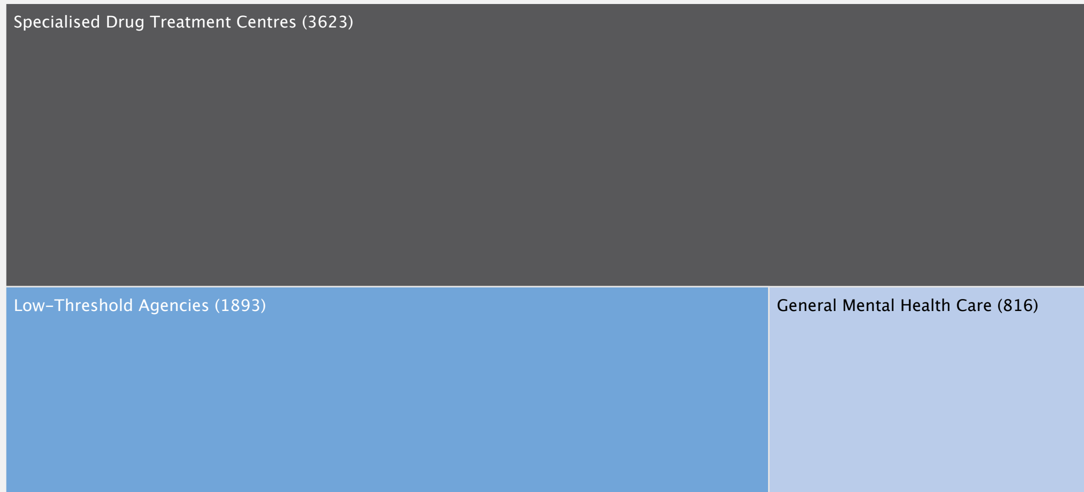
A range of services for drug use treatment and/or healthcare is available in a large part of the country, except in the German-speaking Gommunity, where there are no specialised treatment centres for drug users. Specialised outpatient care is provided by consultation and day-care centres and by medical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

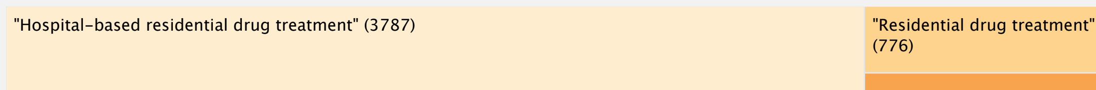
Action has recently have been taken to improve treatment for clients with a dual diagnosis or polydrug use and for children and young people. A pilot project exploring a community reinforcement approach combined with a voucher treatment method has shown promising results for the treatment of cocaine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

Drug treatment in Belgium: settings and number treated

Outpatient



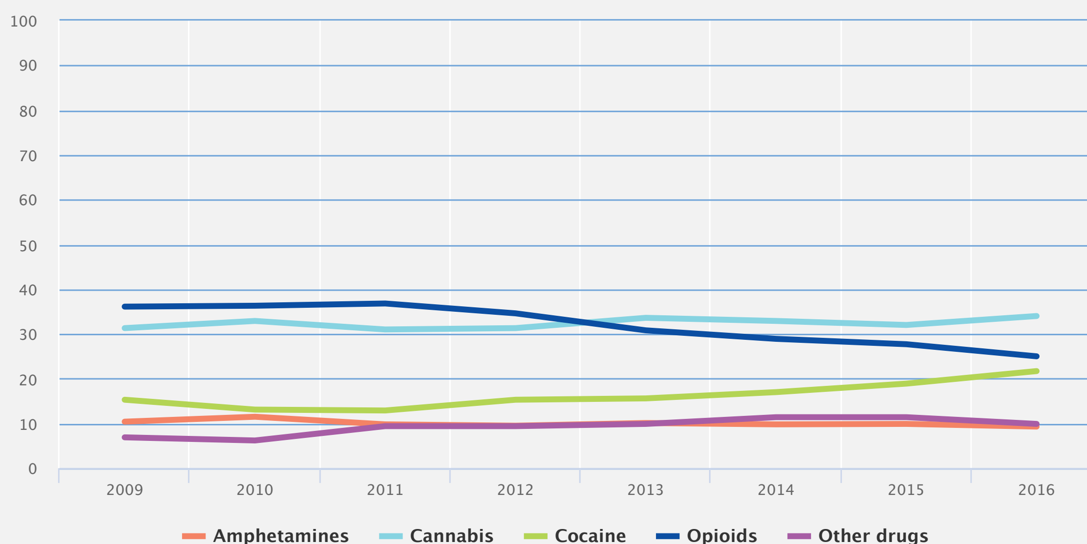
Inpatient



Prison

NB: Year of data 2016

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



NB: Year of data 2016.

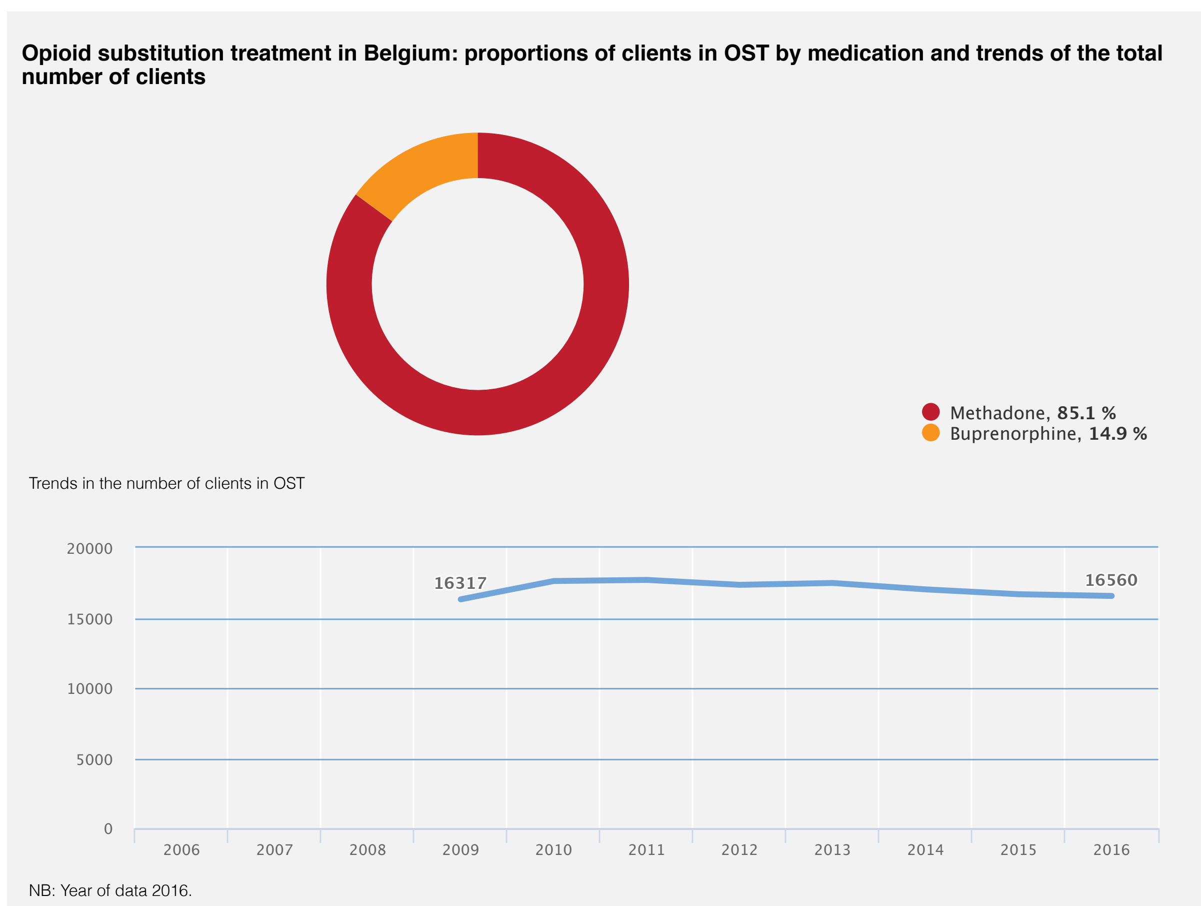
Treatment provision

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

Of the total treatment entrants in 2016, approximately one third were treated for cannabis-related problems, one third for cocaine and other stimulants and one third for opiates and hypnotics/sedatives. The long-term trend indicates that the proportion of opioid clients has been decreasing since 2011, whereas the proportion of cocaine and cannabis clients is increasing.

Accordingly, the number of people receiving OST has been falling in Belgium since 2013, and an estimated number of 16 560 people received OST in 2016. The majority of OST clients receive methadone.

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



NB: Year of data 2016.

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 use and related health and psychiatric problems.

In 2009, data on drug use among prisoners were collected in two Belgian prisons and showed that approximately two thirds of inmates had used an illicit drug prior to imprisonment and 6 out of 10 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.

Services for drug users in prison are provided by prison health teams and external caregivers. Information materials on drugs, harms and risk behaviour are available. The availability of drug-related health services, such as support from a psychologist, cognitive behavioural interventions, opioid substitution treatment (OST), therapeutic communities and drug-free programmes, varies among prisons. Drug treatment is often restricted to those with a medical prescription. OST can be either initiated or continued in prison; both methadone and buprenorphine are available.

With regard to the prevention of drug-related infections, voluntary testing for hepatitis B and hepatitis C viruses and human immunodeficiency virus (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.

Referral to community services after release is available only in prisons in the Flemish Community.

Quality assurance

In Belgium, efforts have been made to develop an integrated, balanced and evidence-based drug policy. In the Flemish Community, the Flemish Centre of Expertise for Alcohol and Other Drugs (VAD) promotes evidence-based practice in alcohol and drug prevention and treatment.

In 2014-15, the Belgian Federal Science Policy Office (BELSPO) funded a study on consensus building vis-à-vis minimum 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 minimum standards for drug treatment, prevention and harm reduction; and to specify and put into operation the consensus minimum standards and develop standards of excellence that can be used as measures and benchmarks for monitoring and evaluating prevention, treatment and harm reduction interventions. As a result, 32 prevention, 24 treatment and 20 harm reduction quality standards were identified. The next step will be to translate them into measurable indicators and create a connection with the VIP²-project (Flemish Indicator Project for Patients and Professionals), which is currently developing generic quality indicators for mental health care in Belgium.

EBMPracticeNet, founded in 2011 and consisting of Belgian organisations active in evidence-based medicine (EBM), has produced a vision paper on how Belgian EBM organisations can support the quality of Belgian healthcare in 2016-20. EBMPracticeNet is currently focusing on offering evidence-based information to general practitioners and other first-line caregivers .

Several organisations provide specific continuing education and specialisation courses in the field of drugs and related subjects, although there is no specific accreditation system for intervention providers, and nor is there an academic curriculum for professionals working in the field of demand reduction.

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 the Belgian Federal Science Policy Office (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 for the EMCDDA 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 population-based and clinical studies of epidemiology and treatment interventions. National scientific journals in Belgium publish drug-related research.

Drug markets

Belgium has an important position in the production of cannabis and synthetic drugs (mostly MDMA/ecstasy and amphetamines) and, recently, in the distribution of new psychoactive substances (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. While in 2016 the overall number of cannabis plantations shut down decreased by approximately 15 %, this was mainly owing to reduced numbers of mini- and micro-sites (fewer than 50 plants) identified; an increase in large plantations (500-999 plants) identified and shut down was observed compared with previous years. Most herbal cannabis consumed in Belgium is domestically produced, and domestic production is supplemented by imports from Spain, the Netherlands and some African countries. Cannabis resin, mostly of Moroccan origin, is trafficked into the country mainly by road via Spain and France. Cannabis is also trafficked to markets in the Netherlands, the United Kingdom and other EU countries.

In 2016, 10 illicit synthetic drug laboratories were reportedly shut down, fewer than reported in the previous three years. Eight of these were linked to the synthesis of amphetamine and/or the conversion of alpha-phenylacetoacetonitrile (APAAN) (a precursor used in the illicit synthesis of amphetamine).

In recent years, Belgian law enforcement organisations have reported increases both in the numbers of seizures and in the seized quantities of MDMA. In 2016, the quantity of seized MDMA tablets was three times those reported in 2015, and the highest since 2008. No clear time trends can be observed regarding amphetamine seizures; in 2016, the amount of methamphetamine seized more than tripled.

The year 2016 was a record one for cocaine seizures in the country. The port of Antwerp is significant in international drug trafficking, primarily of cocaine, as are the airports of Brussels and Liège. The most common countries of origin for cocaine are Colombia and Brazil, with much of the cocaine that arrives in Belgium being destined for the Netherlands or other EU countries.

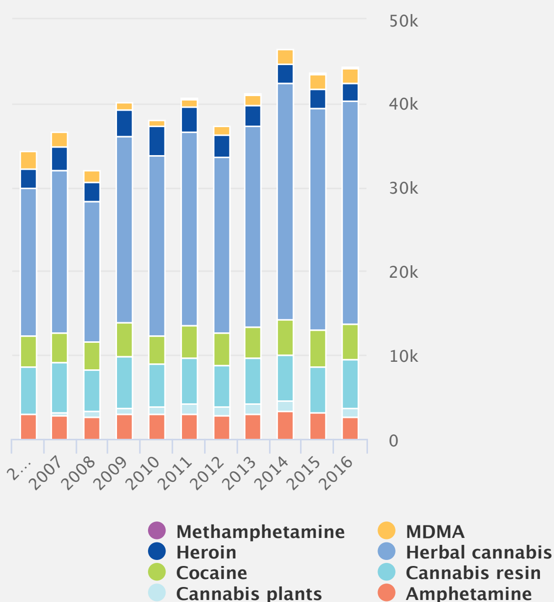
Belgium is also a transit zone for NPS, which frequently originate from China, although local synthetic cannabinoid blending and packaging have been reported.

Heroin seized in Belgium often arrives from countries of the sub-Saharan Africa, and is intended for further trafficking to the Netherlands. The number of heroin seizures and quantities seized have declined in the last five years.

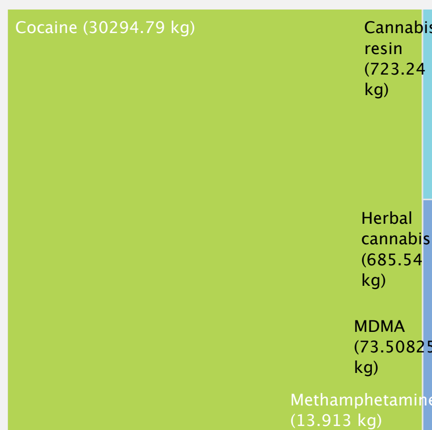
Current law enforcement priorities in Belgium aim to ensure public safety and order through enhanced intersectoral cooperation, with a focus on consistent enforcement of criminal justice measures in the field of drugs. Moreover, the police focus their activities on large-scale production of illicit substances.

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

Number of seizures



Quantities seized



NB: Year of data 2016

Key statistics

Most recent estimates and data reported

	Year	Country data	EU range Min.	EU range Max.
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	21.5
Last year prevalence of drug use - all adults (%)	2013	4.6	0.3	11.1
All treatment entrants (%)	2016	33.9	1.0	69.6
First-time treatment entrants (%)	2016	51.7	2.3	77.9
Quantity of herbal cannabis seized (kg)	2016	685.5	12	110855
Number of herbal cannabis seizures	2015	26587	62	158810
Quantity of cannabis resin seized (kg)	2016	723.2	0	324379
Number of cannabis resin seizures	2015	5706	8	169538
Potency - herbal (% THC) (minimum and maximum values registered)	2016	1.1 - 23	0	59.90
Potency - resin (% THC) (minimum and maximum values registered)	2016	0.3 - 33	0	70
Price per gram - herbal (EUR) (minimum and maximum values registered)	2016	2 - 35	0.60	111.10
Price per gram - resin (EUR) (minimum and maximum values registered)	2016	2.8 - 20	0.20	38.00
Cocaine				
Lifetime prevalence of use - schools (% , Source: ESPAD)	2015	2.5	0.9	4.9
Last year prevalence of use - young adults (%)	2013	0.9	0.2	4.0
Last year prevalence of drug use - all adults (%)	2013	0.5	0.1	2.3
All treatment entrants (%)	2016	21.7	0.0	36.6
First-time treatment entrants (%)	2016	21.8	0.0	35.5
Quantity of cocaine seized (kg)	2016	30294.7	1	30295
Number of cocaine seizures	2015	4369	19	41531
Purity (%) (minimum and maximum values registered)	2016	0.18 - 98.1	0	99
Price per gram (EUR) (minimum and maximum values registered)	2016	22.2 - 125	3.00	303.00
Amphetamines				
Lifetime prevalence of use - schools (% , Source: ESPAD)	2015	2	0.8	6.5
Last year prevalence of use - young adults (%)	2013	0.5	0.0	3.6
Last year prevalence of drug use - all adults (%)	2013	0.2	0.0	1.7
All treatment entrants (%)	2016	9.3	0.2	69.7
First-time treatment entrants (%)	2016	7.2	0.3	75.1
Quantity of amphetamine seized (kg)	2016	28.6	0	3380
Number of amphetamine seizures	2015	2675	3	10388
Purity - amphetamine (%) (minimum and maximum values registered)	2016	0.29 - 72.43	0	100
Price per gram - amphetamine (EUR) (minimum and maximum values registered)	2016	5 - 30	2.50	76.00
MDMA				
Lifetime prevalence of use - schools (% , Source: ESPAD)	2015	3.1	0.5	5.2
Last year prevalence of use - young adults (%)	2013	0.8	0.1	7.4
Last year prevalence of drug use - all adults (%)	2013	0.3	0.1	3.6
All treatment entrants (%)	2016	0.5	0.0	1.8
First-time treatment entrants (%)	2016	0.8	0.0	1.8
Quantity of MDMA seized (tablets)	2016	179383	0	3783737
Number of MDMA seizures	2015	1692	16	5259
Purity (MDMA mg per tablet) (minimum and maximum values registered)	2016	9.14 - 241.58	1.90	462
Purity (MDMA % per tablet) (minimum and maximum values registered)	2016		0	88.30
Price per tablet (EUR) (minimum and maximum values registered)	2016	1 - 15	1	26.00
Opioids				
High-risk opioid use (rate/1 000)			0.3	8.1
All treatment entrants (%)	2016	25.0	4.8	93.4
First-time treatment entrants (%)	2016	9.4	1.6	87.4
Quantity of heroin seized (kg)	2016	98.9	0	5585

Number of heroin seizures	2015	2098	2	10620
Purity - heroin (%) (minimum and maximum values registered)	2016	0.4 - 62.4	0	92
Price per gram - heroin (EUR) (minimum and maximum values registered)	2016	7.7 - 100	4.00	296.00
Drug-related infectious diseases/injecting/death				
Newly diagnosed HIV cases related to Injecting drug use -- aged 15-64 (cases/million population, Source: ECDC)	2016	0.3	0	33.00
HIV prevalence among PWID* (%)			0	31.50
HCV prevalence among PWID* (%)			14.60	82.20
Injecting drug use -- aged 15-64 (cases rate/1 000 population)	2015	3.28	0.10	9.20
Drug-induced deaths -- aged 15-64 (cases/million population)	2014	8.19	1.40	132.30
Health and social responses				
Syringes distributed through specialised programmes	2016	1131324	22	6469441
Clients in substitution treatment	2016	16560	229	169750
Treatment demand				
All entrants	2016	11258	265	119973
First-time entrants	2016	4105	47	39059
All clients in treatment	2016	28483	1286	243000
Drug law offences				
Number of reports of offences	2016	49416	775	405348
Offences for use/possession	2016	35847	354	3929000

* PWID — People who inject drugs.

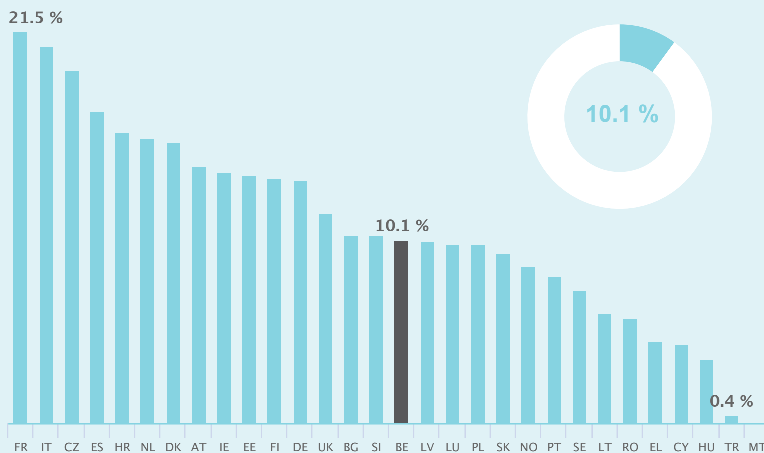
Data for Purity of MDMA available for powder: 0.7% - 82.4%

EU Dashboard

EU Dashboard

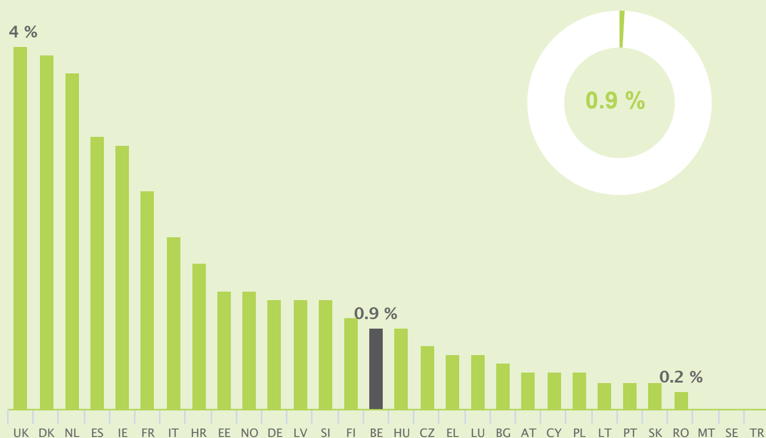
Cannabis

Last year prevalence among young adults (15-34 years)



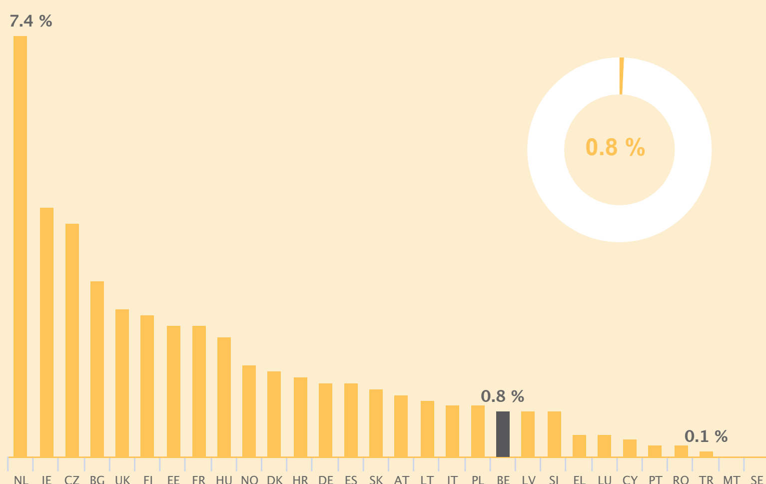
Cocaine

Last year prevalence among young adults (15-34 years)



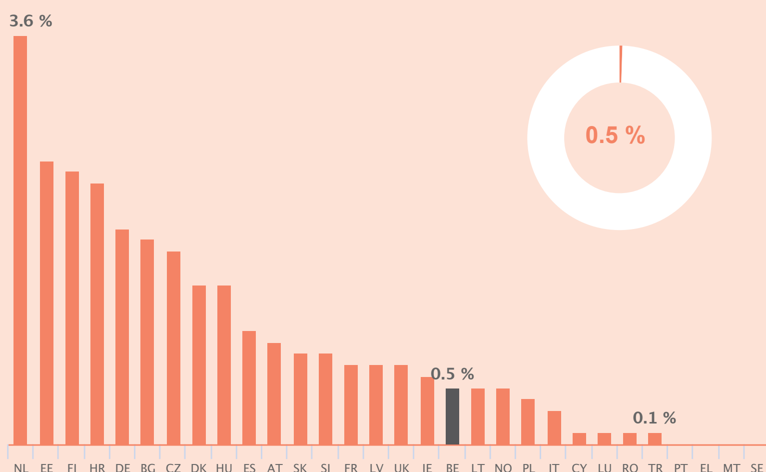
MDMA

Last year prevalence among young adults (15-34 years)



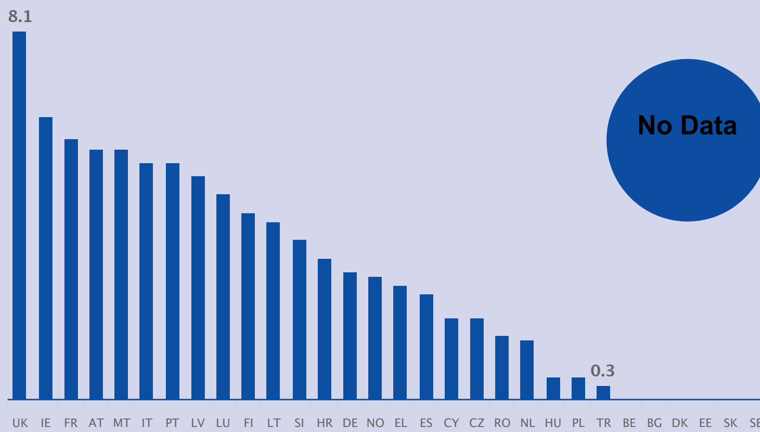
Amphetamines

Last year prevalence among young adults (15-34 years)



Opioids

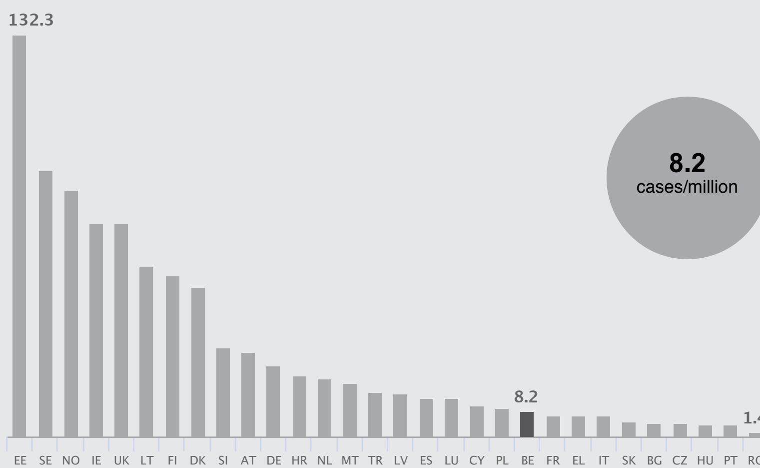
High-risk opioid use (rate/1 000)



No Data

Drug-induced mortality rates

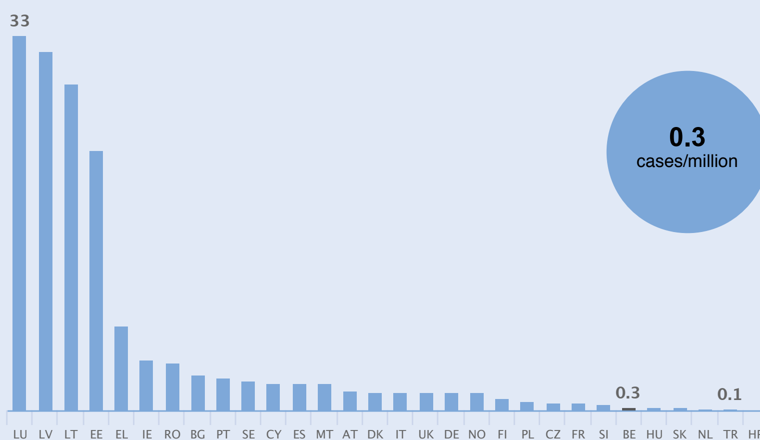
National estimates among adults (15-64 years)



8.2
cases/million

HIV infections

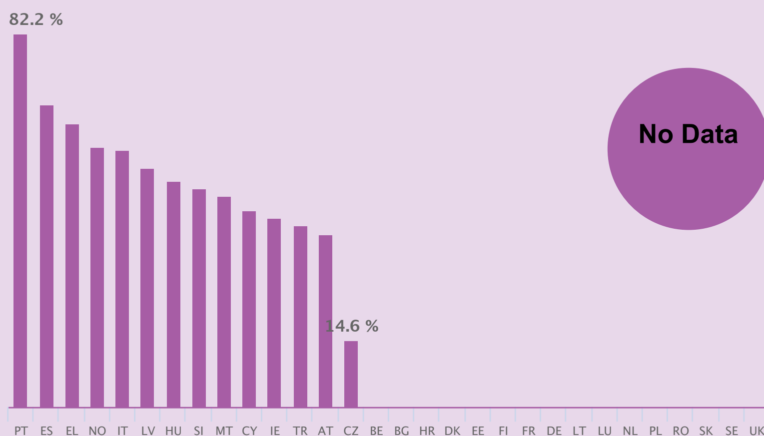
Newly diagnosed cases attributed to injecting drug use



0.3
cases/million

HCV antibody prevalence

National estimates among injecting drug users



NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, di?erences may be due to reporting practices. Detailed information on methodology, qualifcations 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.

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.

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