European Monitoring Centre for Drugs and Drug Addiction

Belgium

Belgium Country Drug Report 2019

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 2017 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

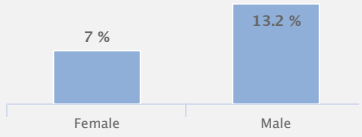
THE DRUG PROBLEM IN BELGIUM AT A GLANCE

Drug use

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

Cannabis

10.1 %

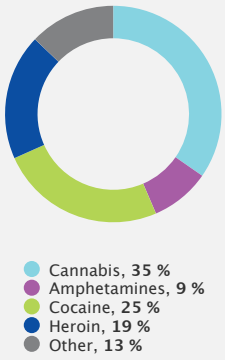


Other drugs

MDMA	0.8 %
Amphetamines	0.5 %
Cocaine	0.9 %

All treatment entrants

by primary drug



Opioid substitution treatment clients

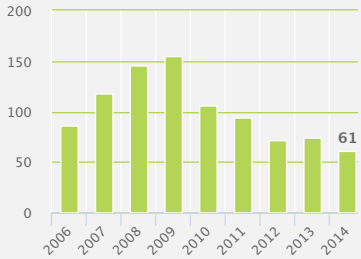
16 546

Syringes distributed

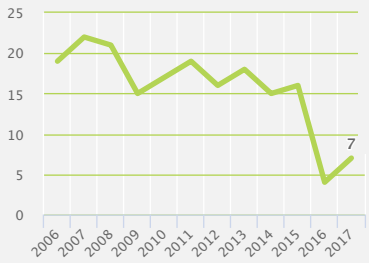
through specialised programmes

1 203 077

Overdose deaths



New HIV diagnoses attributed to injecting



Source: ECDC

Drug law offences

51 774

Top 5 drugs seized

ranked according to quantities meas
kilograms

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

Population

(15-64 years)

7 328 664

Source: Eurostat Extracted on: 18/03/2019

NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or numbers reported through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnoses, 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.

National drug strategy and coordination

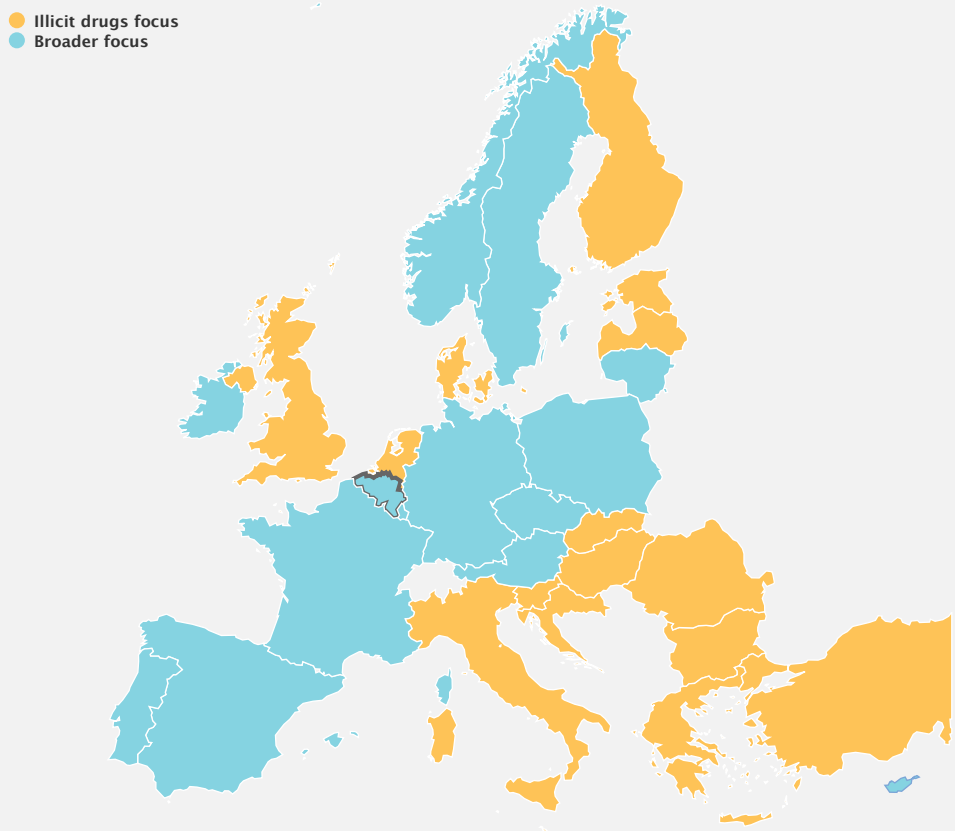
National drug strategy

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. Given this, 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 Belgian cannabis policy, and a future evaluation of the Federal Drug Policy Note and Common Declaration is planned for 2019-21.

Focus of national drug strategy documents: illicit drugs or broader



NB: Data from 2017. Strategies with a broader focus may include, for example, licit substances and other addictions.

National coordination mechanisms

The Interministerial Conferences (IMCs) are designed to promote 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), created by law and consisting of representatives from all relevant ministers at the federal and regional levels, supports the IMC in the preparation and

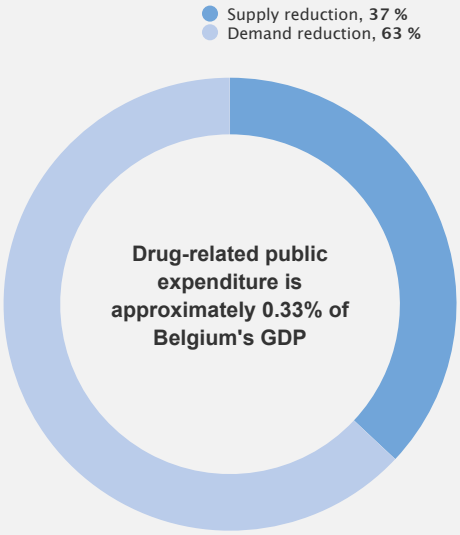
coordination of this work on Belgian drug policy. The GDPC, supported by the Federal Public Service of Health, Food Chain Safety and Environment, is involved in the operational coordination and strategic management of Belgium's drug policy and has various responsibilities related to the implementation of this 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.

Estimates for 2012 and 2013 indicate that total public expenditure related to illicit substance use amounted to 0.08 % of gross domestic product (GDP), that is, more than EUR 306 million in 2012 and EUR 300 million in 2013. In 2015, total public expenditure related to illicit substance use was estimated at almost EUR 470 million, amounting to 0.1 % of Belgium's GDP. When estimates include expenditure on initiatives also tackling alcohol and psychoactive medication, it amounted to 0.3 % of GDP.

Public expenditure related to alcohol, psychoactive medication and illicit drugs in Belgium



NB: Based on estimates of Belgium's labelled and unlabelled public expenditure in 2015. Expenditure on alcohol, psychoactive medication and illicit drugs amounted to 0.3 % of GDP.

Drug laws and drug law offences

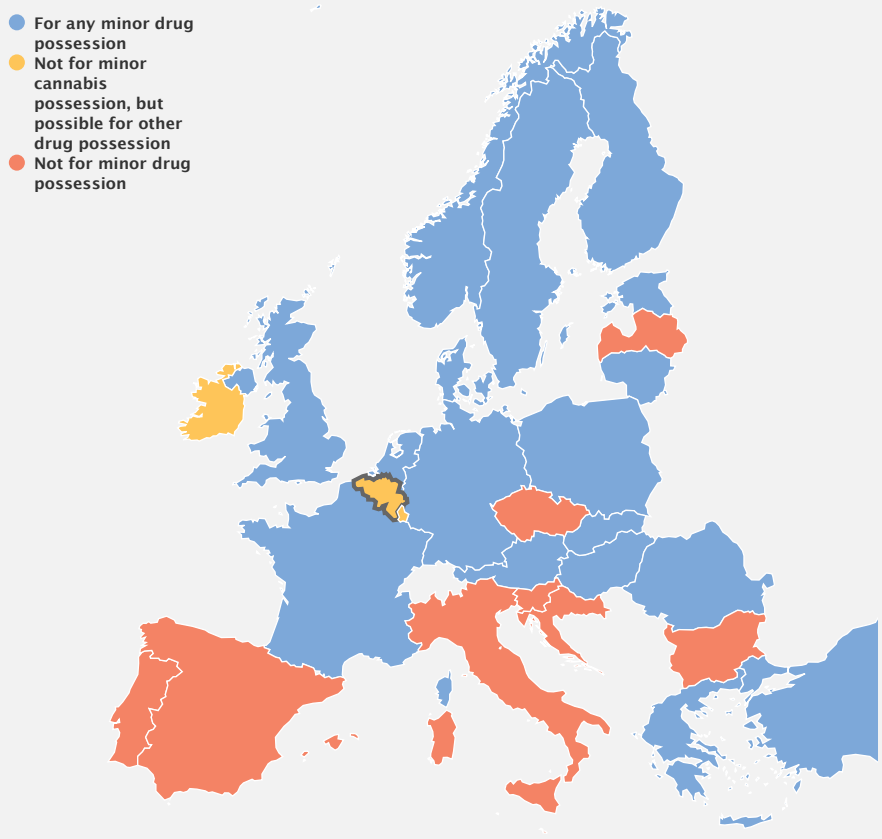
National drug laws

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. 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 1 year in prison also possible for a third offence (note that all the amounts shown here have been adjusted by the official inflation figure). A directive of 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. These include possession of cannabis in or near places where schoolchildren might gather and 'blatant' possession in a public place or building. Such cases are punishable by 3 months to 1 year in prison and/or a fine of EUR 8 000 to EUR 800 000.

For drugs other than cannabis, Belgian law punishes possession, production, import, export or sale with 3 months' to 5 years' imprisonment and an additional fine of EUR 8 000 to EUR 800 000. In various specified aggravating circumstances, the term of imprisonment may be increased to 10, 15 or even 20 years (with an optional fine).

Until 2017, new psychoactive substances were added individually to the list of controlled substances. However, 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)



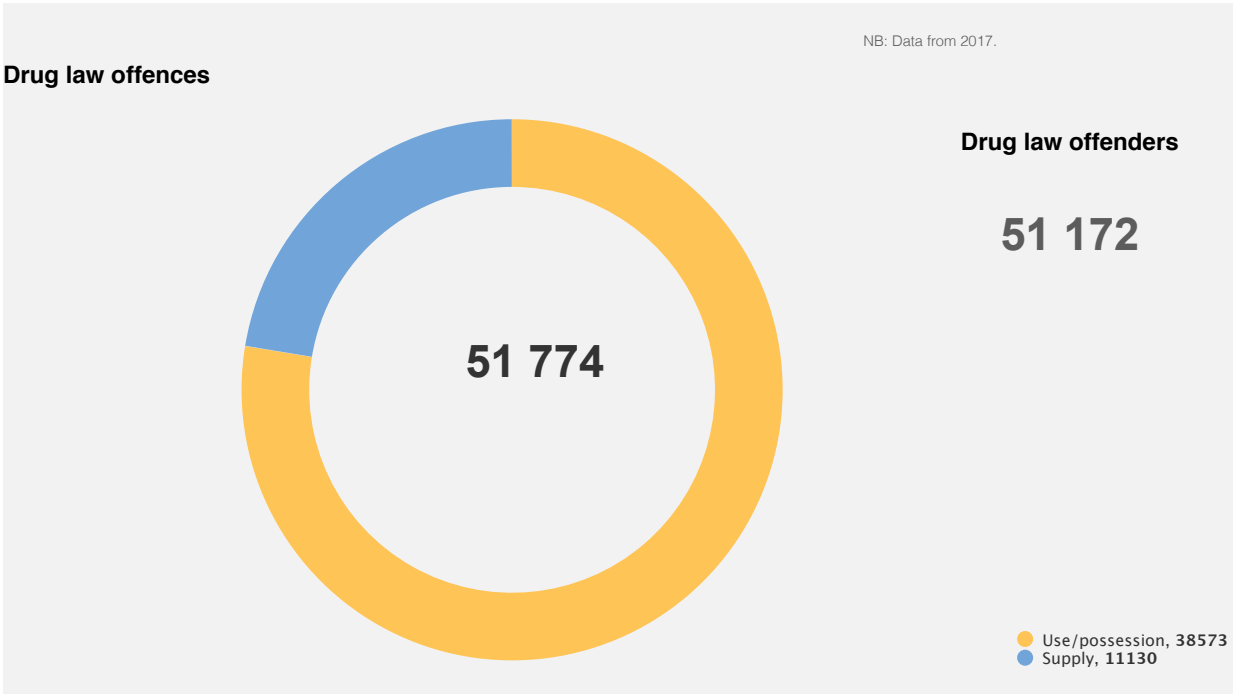
NB: Data from 2017.

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. In 2017, over 50 000 DLOs were reported, three quarters of which related to possession. Cannabis is the drug most commonly involved in DLOs, with an increase in the number of cannabis-related possession offences recorded in 2017, after a decrease found in the previous 2 years. The number of DLOs linked to MDMA/ecstasy has been increasing since 2010, while a drop in the number of heroin-related offences has been observed since 2010.

Reported drug law offences and offenders in Belgium



Drug use

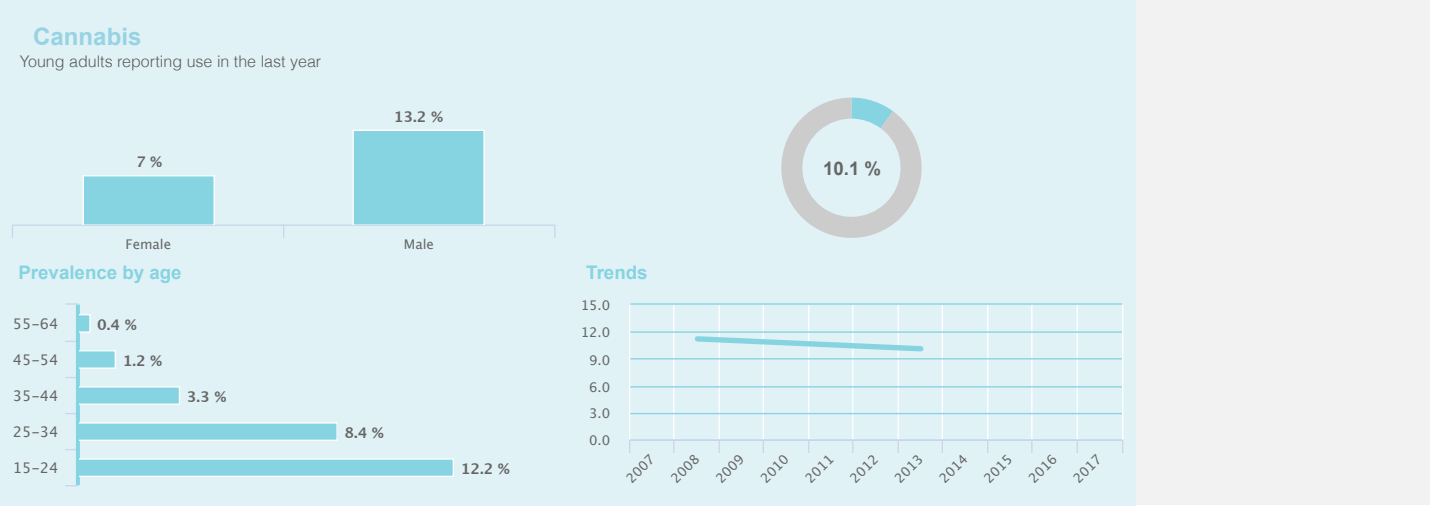
Prevalence and trends

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 carried out in 2017 suggest that the use of cannabis among university students has remained moderately stable. Findings from studies in nightlife settings in both the Flemish and the French Communities showed that cannabis is by far the most popular illicit drug, while MDMA/ecstasy has gained in popularity. Moreover, there are indications that use of new psychoactive substances (NPS) in Belgium is becoming more prevalent in nightlife settings.

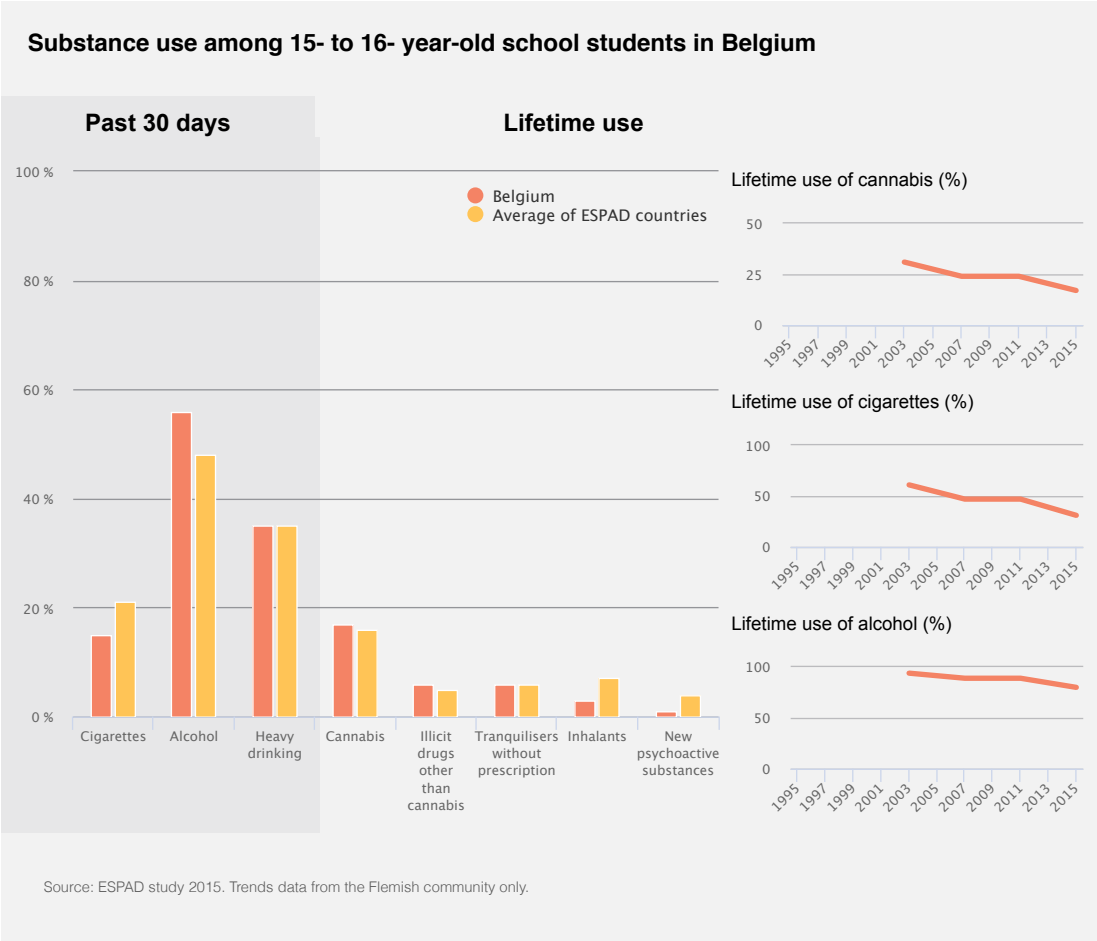
A number of Belgian cities participate in the Europe-wide annual wastewater campaigns undertaken by the Sewage Analysis Core Group Europe (SCORE). This study provides data on drug use at a municipal level, based on the levels of illicit drugs and their metabolites found in wastewater. The 2018 data indicate a stable trend in the levels of MDMA between 2017 and 2018, after a 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, use of which in Belgium is lower than 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 as or lower than the ESPAD average.



High-risk drug use and trends

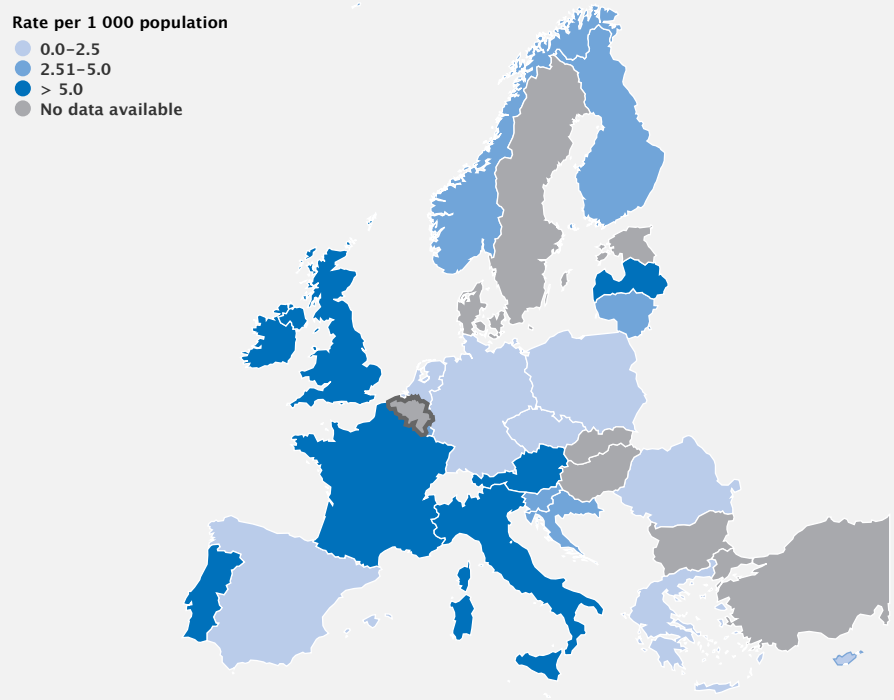
Studies reporting estimates of high-risk drug use and the numbers of people who inject drugs (PWID) can help to identify the extent of the more entrenched drug use problems, while data on first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform 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. A survey among users of needle exchange programmes in the north of the country indicates that the combined use of heroin and cocaine is common among 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 fifth of clients entering treatment, while use of heroin among first-time clients is lower.

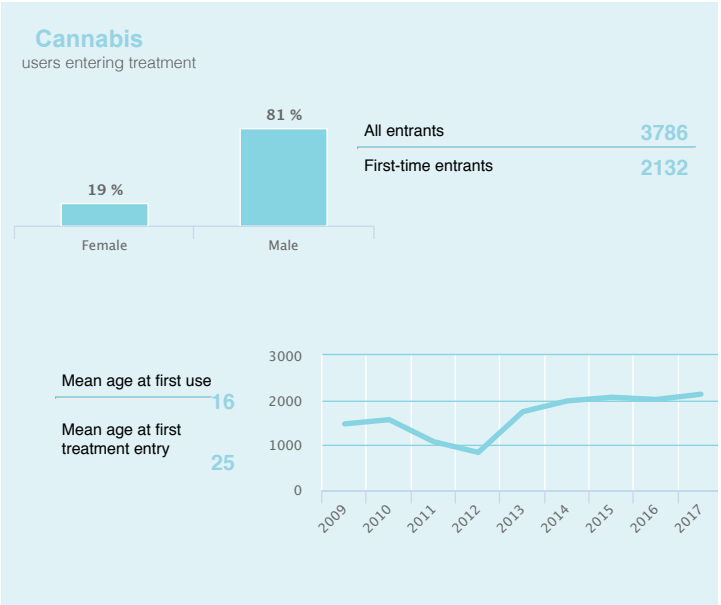
Cannabis was the most frequently reported primary substance for all clients entering treatment and was also the most common primary drug among first-time treatment clients. Approximately one fifth of the clients in treatment are female; however, the proportion varies by type of substance used.

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



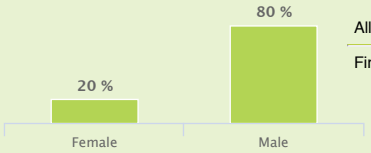
NB: Data from 2017, or the most recent year for which data are available.

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



Cocaine

users entering treatment

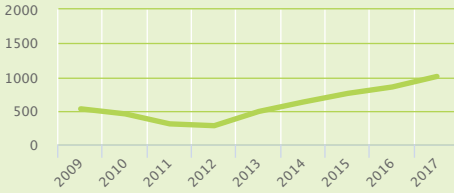


All entrants 2690

First-time entrants 1007

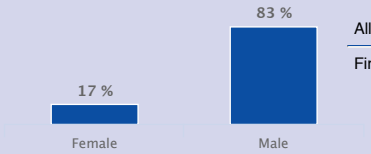
Mean age at first use 22

Mean age at first treatment entry 31



Heroin

users entering treatment

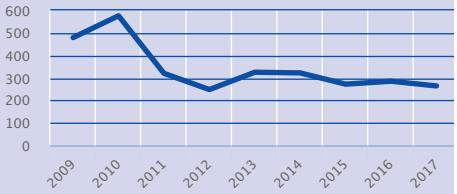


All entrants 2082

First-time entrants 264

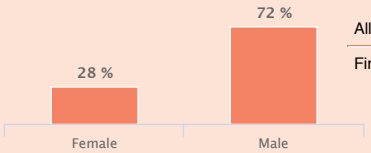
Mean age at first use 24

Mean age at first treatment entry 34



Amphetamines

users entering treatment

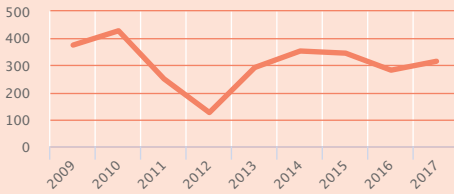


All entrants 1011

First-time entrants 315

Mean age at first use 21

Mean age at first treatment entry 34



NB: Data from 2017. Data are for first-time entrants, except for the data on gender, which are for all treatment entrants. Trends in first-time entrants should be interpreted with caution because of changes in and development of data collection methodologies as from 2011.

Drug-related infectious diseases

In 2017, seven newly diagnosed HIV cases linked to injecting drug use were reported, representing 1 % of new HIV cases with known transmission mode. The latest estimates on the prevalence of blood-borne viruses among people who inject drugs (PWID) are based on a small number of drug treatment centres in one region, with limited representativeness. To update these estimates, a seroprevalence study among PWID is being conducted in 2019.

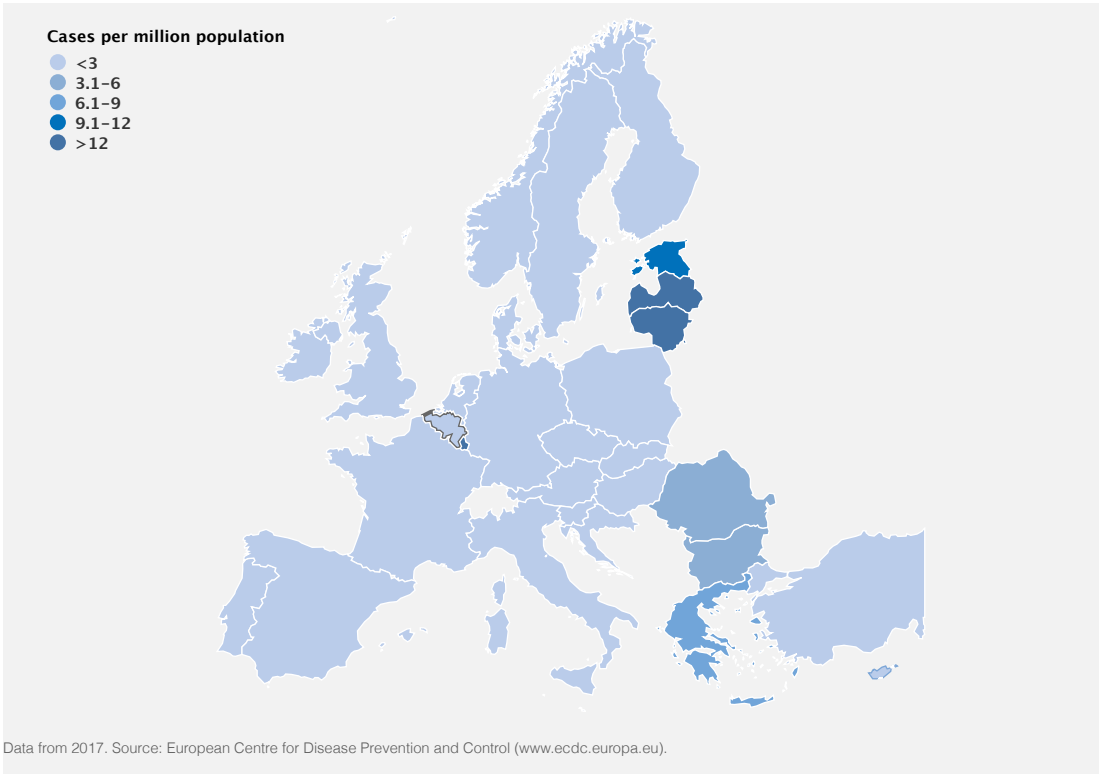
Prevalence of HIV and HCV antibodies among people who inject drugs in Belgium (%)

region	HCV	HIV
National	:	:
Sub-national	22.0 - 33.3	5.7 - 10.5

Data from 2014/15 (HIV) and from 2015/16 (HCV).

Studies indicate that some high-risk use patterns, such as the 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



Data from 2017. Source: European Centre for Disease Prevention and Control (www.ecdc.europa.eu).

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. Since 2011, the number of admissions and the length of stay for every admission in CIC have been registered on a monthly basis. The information currently available from CICs suggests stable numbers of admissions — and therefore of potential non-fatal intoxications — since 2011. In 2017, around 1 750 admissions related to illegal drugs were registered. The drugs most commonly linked to admissions are cannabis, cocaine and opiates. 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

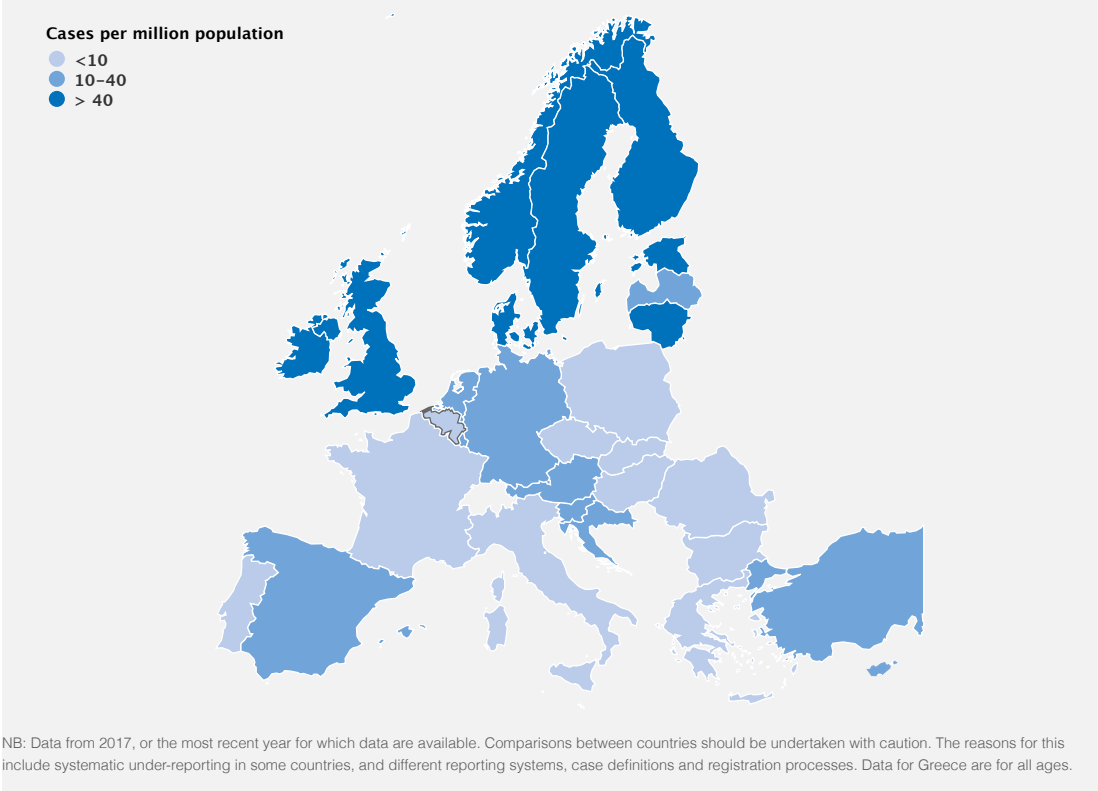
Drug-induced deaths are deaths that can be attributed directly to the use of illicit drugs (i.e. poisonings and overdoses).

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. Opioids (mainly heroin, but also fentanyl and derivatives) were involved in two thirds of all toxicologically confirmed drug-induced deaths that were reported in 2014. The majority of the

deaths were of males. The data obtained from the General Mortality Register for 2017 (data registration year 2015) did not contain drug-related deaths for the French-speaking part of Belgium; therefore, no recent national data are currently available. The drug-induced mortality rate among adults aged 15-64 years was 8.19 per million in 2014 (latest data available).

An additional and timelier source of information is the Belgium Early Warning System on Drugs, which is based on the input of a small number of laboratories mainly located in the upper part of the country. The system reported 62 drug-induced deaths in 2017, which were mainly caused by polydrug use, with opioids (typically heroin, morphine and methadone) being involved in more than half of those cases. Fentanyl was involved in six cases. New psychoactive substances, including fentanyl analogues, have been implicated in an increasing number of deaths. For instance, the fentanyl U-47700 was involved in five cases.

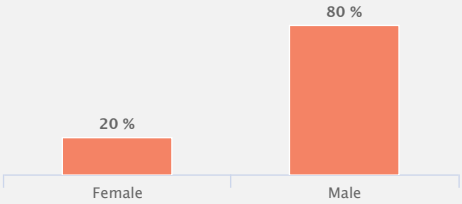
Drug-induced mortality rates among adults (15-64 years)



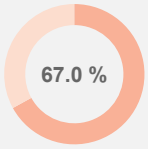
NB: Data from 2017, or the most recent year for which data are available. Comparisons between countries should be undertaken with caution. The reasons for this include systematic under-reporting in some countries, and different reporting systems, case definitions and registration processes. Data for Greece are for all ages.

Characteristics of and trends in drug-induced deaths in Belgium

Gender distribution

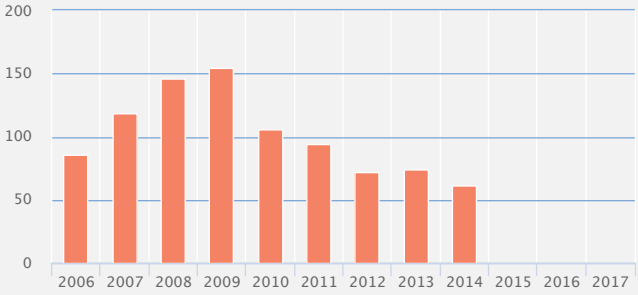


Toxicology



Deaths with opioids present among deaths with known toxicology

Trends in the number of drug-induced deaths



Age distribution of deaths in 2014

NB: Year of data 2014

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 also been developed in the French community.

The Flemish Centre of Expertise for Alcohol and other Drugs (VAD) 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. In the Flemish community, programme-based comprehensive interventions have been adopted within the framework of the health-promoting school environment and a number of evidence-based programmes are being implemented, such as life skills education, the Good Behaviour Game and Unplugged. 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 and recently aiming to improve school climate and environments. Addiction Support Points are interfaces between schools and other structures involved in prevention activities, such as the police and municipal organisations and associations. 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 learning disability; ethnic minorities; and marginalised people.

In recreational settings, selective prevention is mostly focused on the dissemination of information through information stands, peer prevention and websites targeted at partygoers or mobile teams who 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.

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. 'Friends & fun!' in the Flemish region is a didactic package for 15- to 18-year-olds with risky substance use. Some early intervention and motivational interviewing programmes are available in the German-speaking community.

Provision of interventions in schools in Belgium (expert ratings)

NB: Data from 2015.

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 programmes (NSPs). NSPs are available at low-threshold harm reduction projects and pharmacies in the French and Flemish Communities. The different Communities and regions in Belgium address 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. Nine medical and social care centres (MSCCs) across Belgium play a key role in delivering harm reduction services. These low-threshold centres often deliver substitution treatment as well. In both Wallonia and Brussels regions, harm reduction services are mostly provided by non-governmental organisations.

Harm reduction interventions

NSPs (in facilities, through mobile services or in pharmacies) are available across the country, except in the German-speaking community. Fixed sites offer this service in 20 cities in the Flemish community and in nine cities in the French community. There are nine specialised low-threshold MSCC offering this service. All harm reduction projects offer various sterile injecting materials 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. Only services in Brussels and Wallonia offer non-injecting paraphernalia as well as HIV home-testing kits.

From 2014 to 2017, the number of distributed syringes increased in both the Flemish and the French Communities, with over 1.2 million syringes distributed in 2017. In the French community, syringes are distributed through pharmacies. The annual survey of NSP clients in the Flemish community indicated that about one in six clients were new to the service in 2017, most of them having learned about the service through drug treatment services or friends. In total, 68 % of 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. Syringe collection policies vary considerably within the French community, with Brussels also providing syringes to users who do not return used materials and Wallonia requesting one-to-one exchange.

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. A peer support project about hepatitis — the hepatitis C buddy project — aims to generate interest among people who use drugs in getting tested and treated for hepatitis C and to provide tailored peer support to assist with navigating the health system.

Several services distribute overdose prevention information material and engage in overdose prevention assessment with their clients. The first supervised drug consumption facility was opened in the city of Liège in September 2018.

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	Yes	No
Bulgaria	Yes	No	No	No
Croatia	Yes	No	No	No
Cyprus	Yes	No	No	No
Czechia	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 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. In Belgium, competences concerning treatment are split between the federal and federate governments, but they are coordinated at the national level. The last 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.

A range of services for drug use treatment and/or healthcare are available in a large part of the country, except in the German-speaking 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 care centres. In general, these centres provide low-threshold help or social reintegration services, including a wide range of psychosocial, psychological and healthcare services, such as 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 users to access drug treatment, while in the French Community they also play a central role in diagnosis and the prescription of OST. Both methadone and buprenorphine are available for OST. Recently, online treatment interventions have also become available.

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 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

NB: Data from 2017. Data from GPs (who are the main providers of OST) and long-term treatment clients are not systematically collected; the overall number of clients in treatment is thought to be higher.

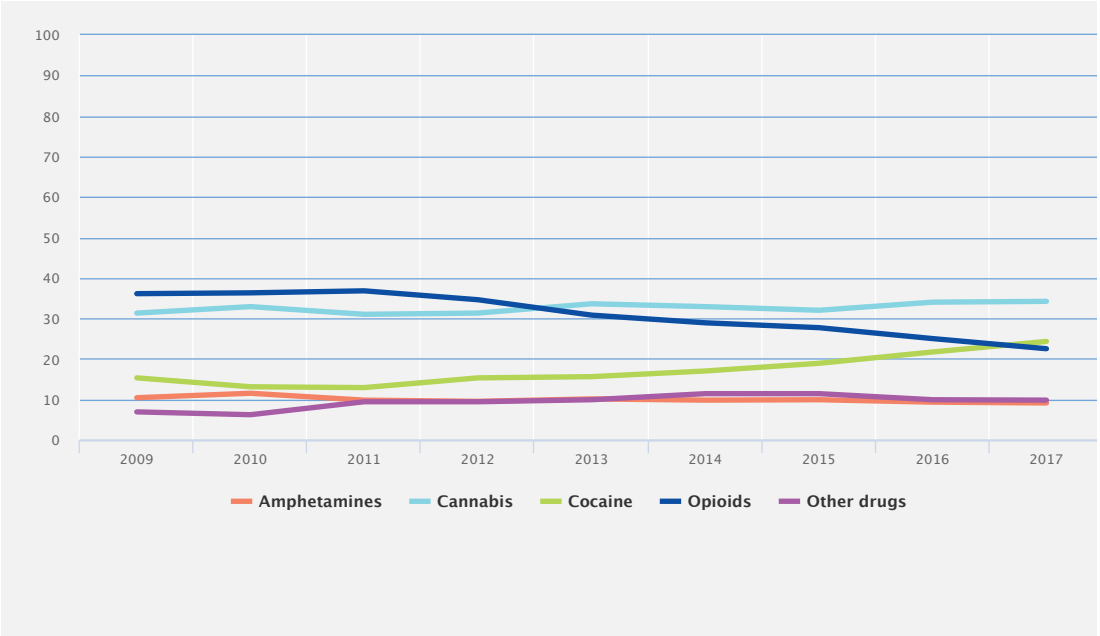
Treatment provision

Available data from the treatment demand register in Belgium indicate that over 12 000 clients entered specialised drug treatment in 2017. However, the overall number of clients in treatment is estimated to be higher, since the register does not yet systematically collect data from GPs (who are the main providers of OST in the French Community) and does not report on long-term treatment clients.

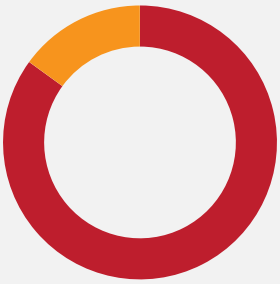
Of the total treatment entrants in 2017, more than 30 % were treated for cannabis-related problems, one quarter for cocaine and one quarter for opioids, mainly heroin. The long-term trend indicates that the proportion of opioid clients has been decreasing since 2011, while the proportion of cocaine clients has been increasing.

The number of people receiving OST has been decreasing in Belgium since 2013, and it is estimated that around 16 500 people received OST in 2017. The majority of OST clients receive methadone.

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

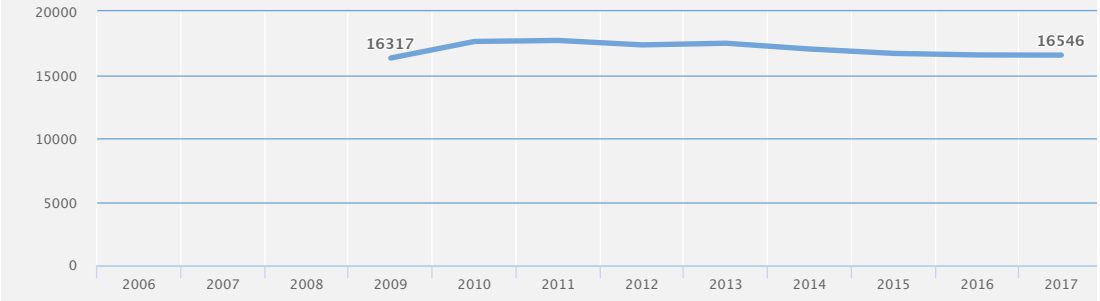


Opioid substitution treatment in Belgium: proportions of clients in OST by medication and trends of the total number of clients



Methadone, **85 %**
Buprenorphine, **15 %**

Trends in the number of clients in OST



NB: Data from 2017.

Drug use and responses in prison

The Belgian prison system comprises 34 prisons, two specific psychiatric centres and three closed centres for minors. 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.

Based on the latest available data from a survey conducted in 15 Flemish prisons between 2015 and 2016, more than half of prisoners used illicit drugs in the year prior to imprisonment. More than one third of the respondents declared having used drugs during imprisonment. Of those who did not use drugs in the year prior to imprisonment, 14 % started using drugs while in prison.

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 has been treated prior to detention. The Central Service for Healthcare provides healthcare services 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.

In 2017, a pilot project aiming to develop a decision model to improve the treatment trajectory for inmates with drug-related problems, suicidal behaviour and dual diagnosis was implemented in three Belgian prisons.

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 (i) to document the critical ingredients and prerequisites for the successful implementation of these standards, based on selected good practices; (ii) to assess the acceptability and actual implementation of the minimum standards for drug treatment, prevention and harm reduction; and (iii) 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. As a next step, these will be translated into measurable indicators, among other things, through the VIP^2-project (Flemish Indicator Project for Patients and Professionals), which is currently developing generic quality indicators for mental health care in Belgium.

EBMPracticeNet consists of Belgian organisations active in evidence-based medicine (EBM) and is currently focused on offering evidence-based information to general practitioners and other first-line caregivers. The Belgian Centre for Evidence-Based Medicine (CEBAM) — Cochrane Belgium — is the institution recognised by the federal government for the promotion of evidence-based medicine for care providers in Belgium.

Several organisations — some of which are active at the regional level to support professionals belonging to different linguistic communities — provide specific continuing education and specialisation courses in the field of drugs and related subjects. To date, 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 funded through this programme are carried out by networks of researchers. The national focal point for the EMCDDA may also be a partner in these studies and is often involved in guidance committees. In addition, the national focal point collects information on ongoing and completed studies in Belgium and disseminates information on drug-related research findings to different audiences through a variety of channels.

Recent drug-related research in Belgium includes population-based and clinical studies of epidemiology, treatment interventions and drug market analysis. Drug-related research is frequently published in national and international scientific journals.

Drug markets

In Belgium, the production of cannabis, synthetic stimulant drugs and drug precursors is frequently reported. Cannabis cultivation sites and synthetic drug laboratories are often concentrated near Belgium's border with the Netherlands, and synthetic drug production is mostly connected to Dutch organised crime groups, with different stages of the production process separated between the two countries.

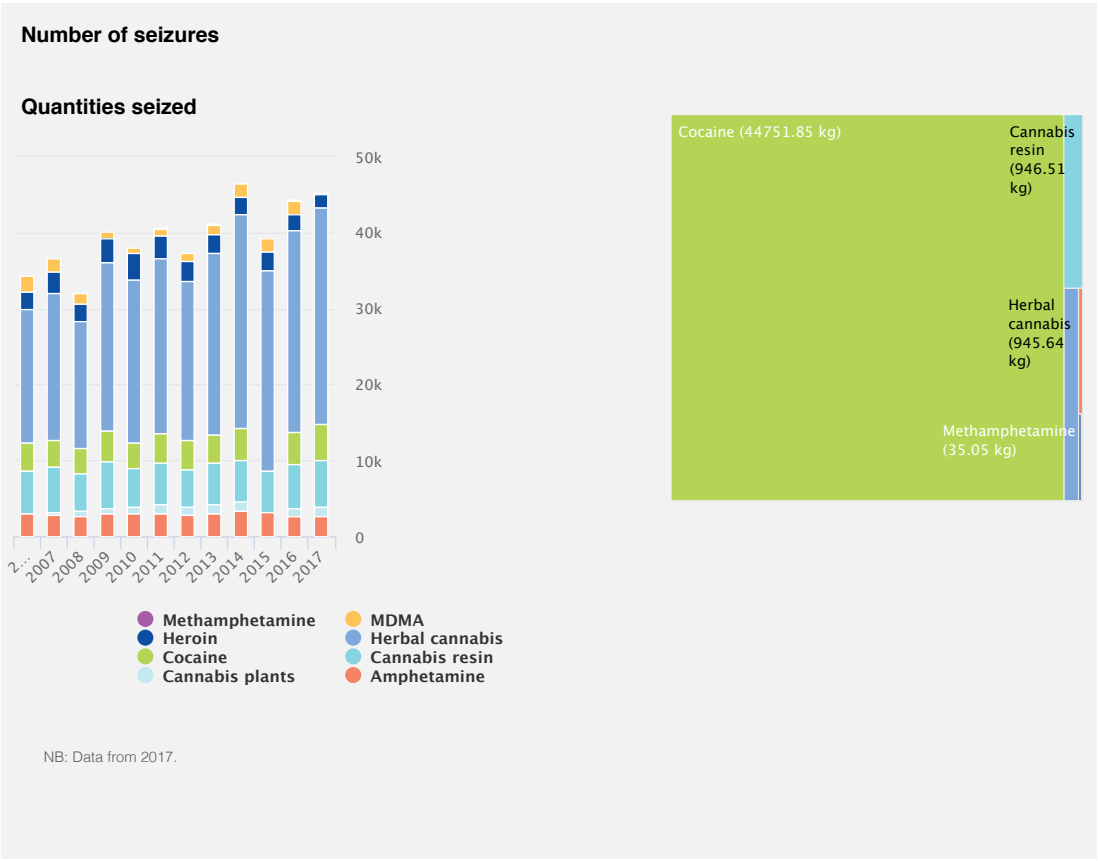
The number of dismantled cannabis cultivation sites remained stable in 2017, although an increase in large-scale plantations (500-999 plants) was observed in comparison with previous years. Most herbal cannabis consumed in Belgium is grown locally or imported from Spain, the Netherlands and some African countries. Belgium is also a transit country for cannabis destined for markets in other EU countries. Cannabis resin mostly comes from Morocco and is trafficked mainly by road via Spain and France.

The port of Antwerp has emerged in recent years as a significant international drug trafficking hub, primarily for cocaine, while the airports of Brussels and Liège have also become significant. The most common points of origin for cocaine arriving in Belgium are Colombia and Brazil, with much of the cocaine that arrives being destined for the Netherlands or onward transportation. In 2017, record seizures were made for cocaine (the highest in Europe), MDMA/ecstasy tablets and also methamphetamine. Belgium is also a notable transit zone for new psychoactive substances coming from China, although the processing of synthetic cannabinoid products has been documented in Belgium. The number of heroin seizures and quantity seized has declined in the last 5 years.

Current law enforcement priorities in Belgium aim to ensure public safety and order through enhanced interagency cooperation, with a focus on consistent enforcement of criminal justice measures in the field of drugs. While particular emphasis has been placed on the port of Antwerp in recent years, the police mainly focus their activities on the large-scale production of illicit substances.

Data on the retail price and purity of the main illicit substances seized are shown in the 'Key statistics' section.

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



NB: Data from 2017.

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	17.32	6.51	36.79
Last year prevalence of use — young adults (%)	2013	10.1	1.8	21.8
Last year prevalence of drug use — all adults (%)	2013	4.6	0.9	11
All treatment entrants (%)	2017	34.6	1.03	62.98
First-time treatment entrants (%)	2017	51	2.3	74.36
Quantity of herbal cannabis seized (kg)	2017	945.6	11.98	94 378.74
Number of herbal cannabis seizures	2017	28 519	57	151 968
Quantity of cannabis resin seized (kg)	2017	946.5	0.16	334 919
Number of cannabis resin seizures	2017	6 133	8	157 346
Potency — herbal (% THC) (minimum and maximum values registered)	2017	1.1 - 29	0	65.6
Potency — resin (% THC) (minimum and maximum values registered)	2017	0.1 - 35.6	0	55
Price per gram — herbal (EUR) (minimum and maximum values registered)	2017	3 - 12.5	0.58	64.52
Price per gram — resin (EUR) (minimum and maximum values registered)	2017	3 - 20	0.15	35
Cocaine				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	2.55	0.85	4.85
Last year prevalence of use — young adults (%)	2013	0.9	0.1	4.7
Last year prevalence of drug use — all adults (%)	2013	0.5	0.1	2.7
All treatment entrants (%)	2017	24.6	0.14	39.2
First-time treatment entrants (%)	2017	24.1	0	41.81
Quantity of cocaine seized (kg)	2017	44 751.8	0.32	44 751.85
Number of cocaine seizures	2017	4 695	9	42 206
Purity (%) (minimum and maximum values registered)	2017	4 - 100	0	100
Price per gram (EUR) (minimum and maximum values registered)	2017	30 - 100	2.11	350
Amphetamines				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	2.04	0.84	6.46
Last year prevalence of use — young adults (%)	2013	0.5	0	3.9
Last year prevalence of drug use — all adults (%)	2013	0.2	0	1.8
All treatment entrants (%)	2017	9.2	0	49.61
First-time treatment entrants (%)	2017	7.5	0	52.83
Quantity of amphetamine seized (kg)	2017	127.6	0	1 669.42
Number of amphetamine seizures	2017	2 655	1	5 391
Purity — amphetamine (%) (minimum and maximum values registered)	2017	0.29 - 58	0.07	100
Price per gram — amphetamine (EUR) (minimum and maximum values registered)	2017	3 - 30	3	156.25
MDMA				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	3.17	0.54	5.17
Last year prevalence of use — young adults (%)	2013	0.8	0.2	7.1
Last year prevalence of drug use — all adults (%)	2013	0.3	0.1	3.3
All treatment entrants (%)	2017	0.5	0	2.31
First-time treatment entrants (%)	2017	0.8	0	2.85
Quantity of MDMA seized (tablets)	2016	491 183	159	8 606 765
Number of MDMA seizures	2016	1 692	13	6 663
Purity (MDMA mg per tablet) (minimum and maximum values registered)	2017	18 - 236.7	0	410
Purity (MDMA % per tablet) (minimum and maximum values registered)	n.a.	n.a.	2.14	87
Price per tablet (EUR) (minimum and maximum values registered)	2017	1 - 10	1	40
Opioids				
High-risk opioid use (rate/1 000)	n.a.	n.a.	0.48	8.42
All treatment entrants (%)	2017	22.8	3.99	93.45
First-time treatment entrants (%)	2017	8.3	1.8	87.36
Quantity of heroin seized (kg)	2017	52.6	0.01	17 385.18
Number of heroin seizures	2017	1 790	2	12 932
Purity — heroin (%) (minimum and maximum values registered)	2017	0.4 - 66	0	91
Price per gram — heroin (EUR) (minimum and maximum values registered)	2017	5 - 100	5	200
Drug-related infectious diseases/injecting/death				
Newly diagnosed HIV cases related to injecting drug use (cases/million population, Source: ECDC)	2017	0.6	0	47.8
HIV prevalence among PWID* (%)	2014/2015	n.a.	0	31.1
HCV prevalence among PWID* (%)	2015/2016	n.a.	14.7	81.5
Injecting drug use (cases rate/1 000 population)	2015	3.28	0.08	10.02
Drug-induced deaths — all adults (cases/million population)	2014	8.19	2.44	129.79
Health and social responses				
Syringes distributed through specialised programmes	2017	1 203 077	245	11 907 416

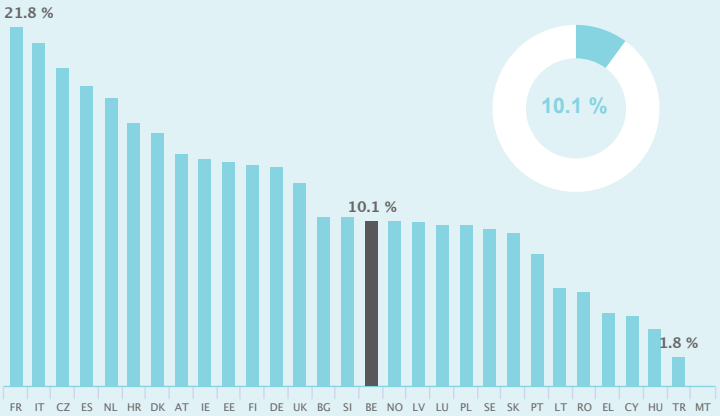
Clients in substitution treatment	2017	16 546	209	178 665
Treatment demand				
All entrants	2017	12 037	179	118 342
First-time entrants	2017	4 550	48	37 577
All clients in treatment	2017	29 289	1 294	254 000
Drug law offences				
Number of reports of offences	2017	51 774	739	389 229
Offences for use/possession	2017	38 573	130	376 282

EU Dashboard

EU Dashboard

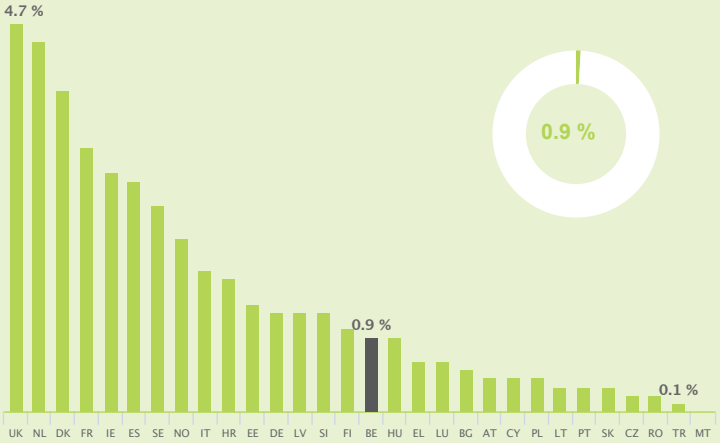
Cannabis

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



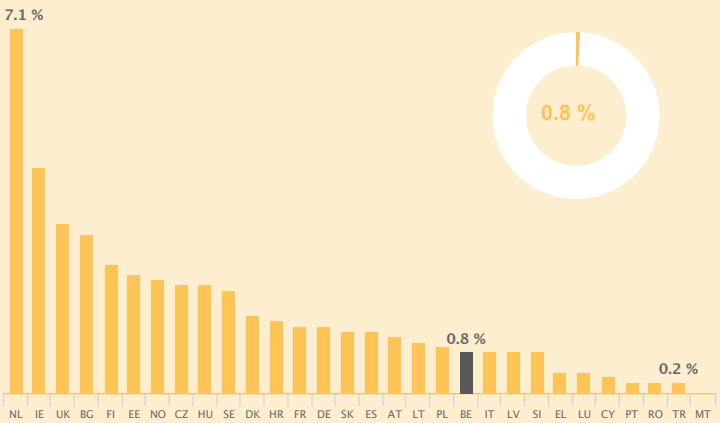
Cocaine

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



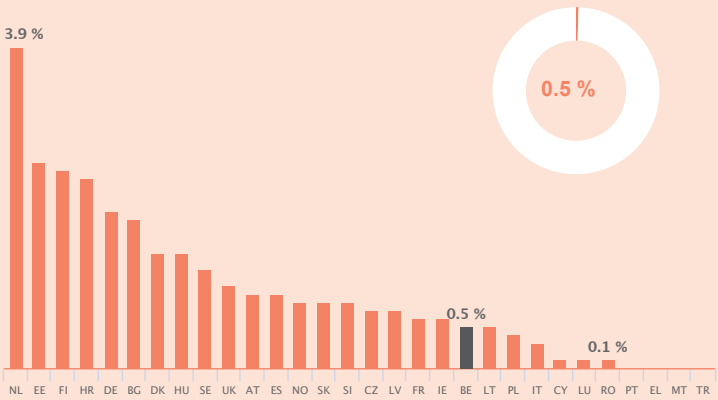
MDMA

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



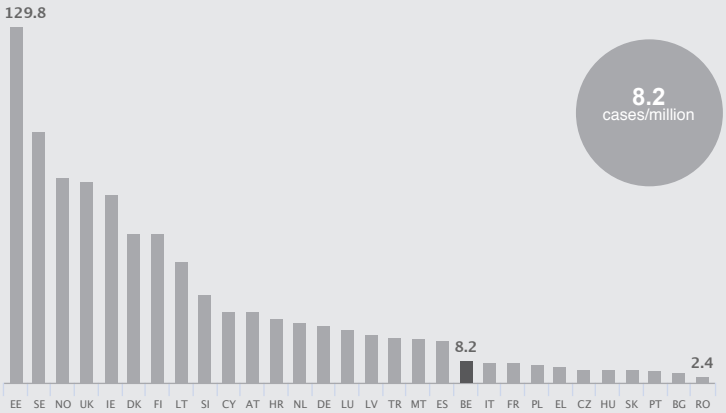
Amphetamines

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



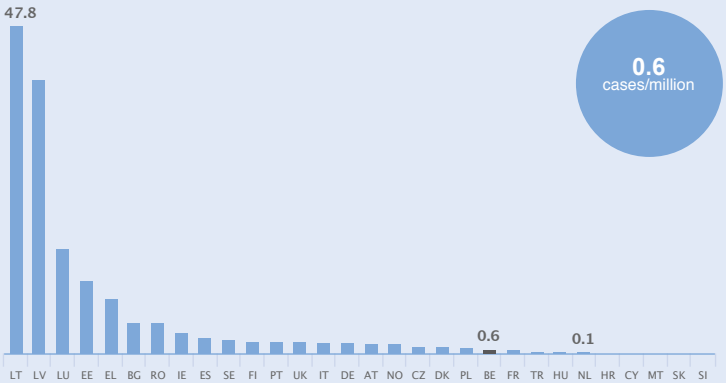
Drug-induced mortality rates

National estimates among adults (15-64 years)



HIV infections

Newly diagnosed cases attributed to injecting drug use



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. Last year prevalence estimated among young adults aged 16-34 years in Denmark, Norway and the United Kingdom; 17-34 in Sweden; and 18-34 in France, Germany, Greece and Hungary. Drug-induced mortality rate for Greece are for all ages.

About our partner in Belgium

The national focal point is located within the Epidemiology and Public health division at Sciensano, the Belgian Health research Institute. Sciensano implements policies in response to the legal framework and the priorities of the Federal Minister for Health and the President of the Federal Public Service for Health, Food Chain Security and the Environment. The institute is the scientific reference in the field of public health and supports health policy and policymaking through innovative research, analyses, monitoring activities and expert advice. In order to make use of national drug-related data, cooperation and coordination between the NFP and many different regional partner organisations is vital owing to the assigned responsibilities regarding health policy.

Click here to learn more about our partner in Belgium .

Belgian national focal point

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Methodological note: Analysis of trends is based only on those countries providing sufficient data to describe changes over the period specified. The reader should also be aware that monitoring patterns and trends in a hidden and stigmatised behaviour like drug use is both practically and methodologically challenging. For this reason, multiple sources of data are used for the purposes of analysis in this report. Caution is therefore required in interpretation, in particular when countries are compared on any single measure. Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin .