Pompidou Group - Integrated Policy Expert Group

COUNTRY REPORT BELGIUM

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1. The drug phenomenon in Belgium: a late discovery

In Belgium, the drug phenomenon became apparent rather late. By the end of the 1980's and in the beginning of the 1990's, some of the major cities were confronted with a steep increase of frequently occurring crime, the so-called 'petty crime', which caused a great deal of discontentment and which seriously affected the livability in a number of impoverished neighborhoods. The idea was (not backed up by data though) that problem drugs users, and in particular the acquisitive crimes they committed, caused the rise in crime and in nuisance. An extreme rightwing political party used these feelings of insecurity in their election campaign in 1991 resulting in their breakthrough in November of that year. The traditional political parties were suddenly confronted with a serious political problem, a problem that was moreover augmented by a societal phenomenon they were for the most part unfamiliar with, let alone that there was even a hint of a drug policy at the time. In Belgium, like in many other European countries, a Drug law was in force. This law dated from 1921 and it was installed to fulfill Belgium's international obligations set forth in the 1912 The Hague Treaty. In 1975, this drug law had been adapted, again partly to fulfill international obligations (namely the UN Single Convention of 1961 and the UN Drug Convention of Vienna of 1971). The Minister of Justice at the time, acting as a moral crusader, overzealously endorsed the prohibitionist philosophy of the UN Treaties. On the up-site, the adaptation of the drug law in 1975 did expand the possibilities for probation measures for drug users enabling a faster and swift diversion towards drug treatment. At the time, the prevention and treatment offer was scare though. The few initiatives that did exist were private initiatives that based their treatment methods on the ones used in the Netherlands.

It was only after the societal and political changes occurred at the beginning of the 1990's the Belgian government took numerous initiatives. At that time, they were undirected, although they proved to be necessary later on. Firstly, the government tried to gain insight into the nature and extent of the drug phenomenon through (limited) scientific research. In 1992, the safety- and prevention contracts were established to sustain the local government in their reaction towards crime and nuisance. In 1993, subsidies for drug prevention, street corner work, drug treatment and

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local drug coordinators added a specific focus to the drug phenomenon. In 1994, a methadone consensus conference involving all relevant actors in the field (doctors, drug treatment and justice) established guidelines for good practices with regards to methadone substitution.

In 1995 the Medical Social Treatment Centres were established in the nine provinces of the country. These law threshold centres worked with a multidisciplinary team and were aimed at the most problematic drug users. Again, these centres were based upon the way in which low threshold drug treatment was organized in the Dutch city of Amsterdam. Indeed, quite a lot of methods in drug prevention, drug treatment as well as with regard to the cooperation between justice and treatment and with regard to the local drug coordination that were elaborated in Belgium were based upon the good practices established in the Netherlands.

In retrospect, the late 'discovery' of the drug phenomenon proved to have an important advantage since one could learn from the Dutch experiences, the negative as well as the positive. In the Netherlands, it had become clear by the middle of the 1990's that the system of 'tolerated' distribution of cannabis through the coffee shops was not a successful strategy. The flood of foreign drug tourists resulted in an increase of the number of coffee shops as well as in their development into commercial enterprises that did not respect the tolerance criteria. Moreover, this resulted in an increase of nuisance in the major Dutch cities and municipalities at the boarders, an explosive growth of the illegal cannabis production and a spread of illegal selling points for the drug tourists. In fact, these evolutions resulted in a failure of the planned division of the markets. Learning from this Dutch experience, consensus grew in Belgium that introducing coffee shops were not an option.

2. The development of the Belgian drug policy: a bottom-up story

In the first half of the 1990's, the initiatives taken by the Belgian government were uncoordinated and unlinked. Every competent Minister 'discovered' the drug phenomenon and initiated isolated initiatives without any discussion with the other member of Government, let alone with members of other policy levels. Indeed, 24 (!) Ministers from the federal and regional government are competent with regard to the drug phenomenon. Despite this lack of coordination these initiatives were strongly appreciated by the work field. One cannot forget that at that time there was no Belgian drug policy and the politicians hardly had any experience with regard to the drug phenomenon.

This situation changed when in 1996 the Chamber of Representatives decided to establish a Parliamentary working group on drugs with the clear mission to inform itself about every (!) aspect of the drug phenomenon and, based upon this information, to give clear recommendations to the federal government. The parliamentary working group chose a brave working method: national and international experts, working in all the domains of the drug policy (epidemiology, prevention,

treatment, the social sector, repression) were asked to convey their analysis and their recommendations. The working group followed most of these recommendations. Throughout the different domains there was a striking consensus about the need for a multidisciplinary and coherent approach of the multi-dimensional drug phenomenon. The final report of the working group mirrored the needs and expectancies of the different domains in the work field and of the academic world. These would become the pillars of the Belgian drug policy.

It was recommended to develop an integrated and integral drug policy with horizontal (between the domains) and vertical (between the policy levels) policy coordination. Epidemiology, that was quasi nonexistent before that time in Belgium, would provide the facts and figures for the drug policy. Structural and person-orientated prevention should become the priority. For drug users experiencing problems, a wide variety and diversity of drug treatment services and of general treatment services (from low threshold to high-threshold) had to be established. As for highly problematic drug users, a harm reduction approach was opted for with the provision of substitution treatment aimed at the protection of the individual as well as society, in particular with regard to drug related crime and nuisance.

The working group proposed to limit repression to drug producers and drug traffickers striving for profit. The criminal justice system had to try, when possible, to divert problem drug users to drug treatment (based upon the philosophy of the last resort). Furthermore, priorities were set forth for the investigation and prosecution policy: the possession of a consumer quantity of cannabis by a non-problem drug user was to receive the lowest priority. The latter recommendation lead to the commentary by some observers that Belgian policy would resemble the Dutch policy (apart from the tolerated coffee shops). Despite these objections, the conclusions and recommendations of the working groups were quasi unanimously approved by the Chamber of Representatives. The foundations of the Belgian drug policy were laid and they were based upon a firm political basis.

3. The federal policy note on drugs (2001): a clear answer

The response from the federal government took more time than anticipated. The reason for this was the Dutroux-crisis in the summer of 1996 and the political attention it received in its aftermath. This crisis lead to the biggest reform of the police and of justice Belgium had ever seen (following a parliamentary enquiry committee).

In January of 2001 the Verhofstadt-Government approved the first federal policy note on drugs in the Belgian political history.

Since the federal note was for the most part a copy of the recommendations of the parliamentary working group on drugs, the political support for the recommendations of the parliamentary working group on drugs continued.

The starting point of the federal policy note was that drug use is a matter of public health. Therefore the federal Minister of Public Health is in charge of the integrated and integral drug policy and chairs the inter-ministerial conference uniting the 24 competent ministers in order to develop the necessary vertical policy coordination.

A General Cell on drugs was created, under the chairmanship of the national drug coordinator. This cell prepares the decisions of the inter-ministerial conference and guards the integrated character of the policy measures.

The drug phenomenon is considered to be a permanent social reality and thus the drug policy is aimed at rational risk-control. Next to this starting point, the recommendations of the parliamentary working group on drugs regarding epidemiology, prevention, treatment and repression are taken over. The federal note is in accordance with the EU drug policy and respects the UN Drug Treaties. For ten years now, the diverse components of the federal note are being implemented.

At *epidemiological level*, the early warning system was implemented, at first for ATS and later on for new synthetic drugs and psychotropic substances. The evaluation research was stimulated which contributed to the development of an evidence based policy. Nonetheless, we have to admit that for epidemiology Belgium remains a weak partner within the EU, as becomes abundantly clear in the annual reports of the EMCDDA.

At *prevention level* (which is strictly speaking the competence of the Communities): although the number of prevention workers has increased, prevention is still far from achieving its priorities. Public expenditure research demonstrates that the means for prevention represent but a fraction of the means for treatment and repression.

At *treatment level*, the most pressing needs were answered. Through pilot projects, the capacity of crisis centers and for double-diagnoses patients increased. Treatment circuits were installed to counter shopping in treatment and especially to optimize the use of the diverse treatment offer. Ten years after the consensus conference, a legal framework was established for substitution treatment (following a law on needle-exchange). The funding for drug treatment increased (more treatment centers and focus on drug-using parents and minors).

The criminal policy regarding drugs was provided with a clear framework. This policy is anchored through an adaptation of the Drug Law and a number of Ministerial Circulars. The starting points formulated by the parliamentary working group on drugs were maintained to the full: the criminal response is primarily aimed at drug production and drug trade. Problem drug users who come in contact with the criminal justice system because of drug related crime, need to be promptly diverted to (drug) treatment making use of the existing legal provisions on the different levels of the criminal justice system (prosecution, sentencing and execution of sentence). The possession of less

than three grams of cannabis or one female cannabis plant has the lowest prosecution priority except in the case of nuisance, the presence of minors or when there are indications of problem drug use.

Prioritizing drug production and trade proved to be a necessity since the Netherlands increased the pressure on the professional cannabis cultivators and the synthetic drug laboratories over the past ten years, leading Dutch organizers to shift their activities to Germany and in particular to Belgium.

The cooperation between the criminal justice system and treatment services increased these past years, not in the least because of the success of the pilot-projects "Test care" and the "Drug treatment court", both installed in the judicial district of Ghent. The criminal justice system in particular is willing to extend these projects to all judicial districts. The problem however is the limited capacity of drug treatment services and the differences in geographical spread of drug treatment. Some Belgian regions lack the necessary capacity to even respond to the treatment demands from the criminal justice clients and the limited number of regions that do have sufficient treatment capacity cannot adhere to all the treatment requests.

4. The long road to an integral and integrated policy: state of the affair in Belgium

Belgium has clearly chosen for an integral and integrated drug policy (as described above).

To what extent has this approach been implemented at present? The structures to develop and monitor an integral and integrated drug policy are present, both at federal and at local level.

Evaluation research has indicated that local steering groups or committees on drugs, under the supervision of a local drug coordinator, can be considered as good practices. These coordination structures, including all the domains and actors, enable cooperation that increases the efficiency of the interventions in the domains involved. The surplus value of developing a policy at the local level is that the policy is based upon the drug phenomena as it most frequently manifests.

Furthermore, evaluation research has indicated that the pilot projects on the cooperation between the criminal justice system and treatment services (described above) can be labeled as good practices as well. However, the planned and desired generalization of these projects faces capacity and financial obstacles.

Research regarding the cooperation between the criminal justice system and treatment has demonstrated that better results can be obtained when several life domains are included and improved (such as housing and employment). For problem drug users, this involves the homeless sector, social housing and social economy and general social services all of which lack sufficient funds. It is clear that the success of a drug policy is determined by the financial means it can use. The

public expenditure studies conducted in Belgium clearly demonstrate an increase in the financial means over the past decades. Nonetheless it is also clear that the public expenditure in Belgium is still far from the level of expenditure in Sweden and in the Netherlands.

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