FEDERAL RESEARCH PROGRAMME ON DRUGS

EVADRUG

An evaluation of the Belgian Drug Policy

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FINAL REPORT

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PREFACE

The growth of an evaluation culture in Belgian drug policy is one of fairly recent nature. This of course relates to the fact that a more detailed Belgian drug policy only saw the day of light in the second half of the 1990s. For the very first time in Belgian political history, a Parliamentary Working Group on Drugs examined a Belgian drug policy in detail. The recommendations of this Working Group called for a normalisation policy and an integrated, global approach to the drug problem. These recommendations, submitted in 1997, however, largely remained a dead letter partly due to the turbulent 1990s. This changed in the beginning of 2001, when the government introduced the Federal Drug Note. In this Federal Drug Note, the government responded to the concrete recommendations of the Parliamentary Working Group. In 2010, the Federal Drug Note was updated through the Joint Declaration of the Interministerial Conference on Drugs. This Joint Declaration continues to adhere to a global and integrated policy, as previously proposed in 2001 and by the Parliamentary Working Group in 1997.

This current study 'EVADRUG', as conducted between 2020 and 2021, presents a general evaluation of our Belgian drug policy, as defined by the Federal Drug Note of 2001 and the Joint Declaration of 2010.

Evaluating a drug policy provides some indications about the success but also the shortcomings of one's policy, and it contributes to transparency, accountability and a better planning of resources. It is no coincidence that the importance of systematically monitoring and evaluating (national) drug policy has been repeatedly stressed in several policy documents at international, European and national level. As a result, the past two decades spurred an increasing amount of countries to evaluate their national drug policy, mostly focusing on process evaluations verifying whether the objectives and actions described in one's drug policy have been implemented. These types of (process) evaluations are indispensable to policy evaluation and effective policy making, because they can indicate whether a policy action is fully or properly implemented, how the results of a policy are achieved, and what the limitations of a policy encounter.

The previous process evaluations of our Belgian drug policy date back more than ten years (De Ruyver et al., 2000; Interministerial Conference on Drugs, 2010). Such stresses the need and urgency for an updated general evaluation.

'EVADRUG' is the first study evaluating the general Belgian drug policy based on logic models.
In the first part of the report we elaborate on the process evaluation of the Belgian drug policy. We explore to what extent and how the objectives and actions of the Federal Drug Note (2001) and the Joint Declaration (2010) have been realised. We also verify whether the objectives and actions set in 2001 and 2010, are still in line with the current problems and needs.
In the second part of our report we not only conduct a process evaluation, but also an outcome evaluation of two specific interventions within our Belgian drug policy eg the drug treatment projects in detention and the CAO100.

'EVADRUG' was conducted by a multidisciplinary team of researchers from Ghent University, UCLouvain, KU Leuven and Trimbos Institute. The 'EVADRUG' research team would like to thank all those who gave us their time and valuable insights to write this report.

A first word of thanks goes to our respondents who have willingly shared their thoughts regarding the Belgian drug policy.

We would also like to thank the Belgian Science Policy Office for financing this important research, as well as the members of the steering committee for sharing their time, thoughts and valuable feedback. A special word of thanks goes to Aziz Naji, Ria D'haemers, Jean-Baptiste Andries, Anouck Billiet, Isabelle Demaret, Aurelien Mathieu, Michel Bruneau, Marc Vancoillie, Ronald Clavie, Pascale Hensgens, Shanah De Brabander, Niki Dheedene, Kurt Doms, Ann Duwael, Claude Gillard, Lies

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We hope that this 'EVADRUG' report sparks fresh ideas and an evidence-informed discussion about the future of our Belgian drug policy.

On behalf of the 'EVADRUG' research team,

Prof. dr. Charlotte Colman (coordinator EVADRUG)

Ghent, December 2021

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LIST OF ABBREVIATIONS

Abbreviation	English	Dutch	French
EMCDDA	European Monitoring Centre For Drugs and Drug Addiction	-	-
VAD	Flemish expertise centre for alcohol and other drugs	Vlaamse expertisecentrum Alcohol en andere Drugs	-
CLA100 (FR: CCT100; NL: CAO100)	Collective Labour Agreement 100	Collectieve arbeidsovereenkomst 100	Convention collective de travail 100
REITOX	European Information Network for drugs and drug addiction	-	Reseau Europeen d'Information sur les Drogues et les Toxicomanies
NFP	National Focal Point	-	-
MSOC/MASS	Medical Social shelter centre	Medisch-Sociaal Opvang Centrum	Maison d'Accueil Socio-Sanitaire
RIZIV/INAMI	National Institute for Disease and Disability Insurance	Rijksinstituut voor Ziekte- en Invaliditeitsverzekering	Institut National D'Assurance Maladie-Invalidite
VAZG	Flemish Care and Health Agency	Vlaams Agentschap Zorg en Gezondheid	-
CGG/SSM	Mental Health Centre	Centrum Geestelijk Gezondheidszorg	Services de santé mentale
COCOF	French Community Commission	Franse gemeenschapscommissie	Commission communautaire française
FR: COCOM/ NL: CGC	Joint Community Commission	Gemeenschappelijke Gemeenschapscommissie	Commission communautaire commune
FWB	Federation Wallonia-Brussels	Federatie Wallonië-Brussel	Fédération Wallonie Bruxelles
LOGO	Local Health consultation	LOkaal GezondheidsOverleg	-
VGC	Flemish Community Commission	Vlaamse Gemeenschapscommissie	Commission communautaire flamande
AViQ	Agency for Quality of life	-	Agence pour une Vie de Qualité
DSL	Dienststelle für ein Selbstbestimmtes Leben	-	-
VSPP	Permanent Secretariat for Prevention Policy	Vast Secretariaat voor het Preventiebeleid	Secrétariat permanent à la Politique de Prévention
BMCDDA	Belgian Monitoring Centre for Drugs and Drug Addiction	-	-
ESF	European Social Fund	-	-
BelPEP	Belgian Psychotropics Experts Platform	-	-
NL: FAGG/ FR: AFMPS	Federal Agency for medicines and health products	Federaal Agentschap voor Geneesmiddelen en Gezondheidsproducten	Agence fédérale des médicaments et des produits de santé
NL: FAVV; FR: AFSCA	Federal Agency for the Safety of the Food Chain	Federaal agentschap voor veiligheid van de voedselketen	Agence fédérale pour la sécurité de la chaîne alimentaire
NL: FOD; FR: SPF	Federal Public Service	Federale overheidsdienst	Service Publique fédérale
NL: WASO; FR: ETCS	Federal Public Service Employment, Labour and Social Dialogue	Werkgelegenheid, arbeid en sociaal overleg	Emploi, Travail et Concertation sociale
ASL	Arbeitsgemeinschaft für Suchtvoreugung und Lebensbewältigung	-	-
CLB	Centre for pupil guidance	Centrum voor leerlingenbegeleiding	-
FARES	Fund for respiratory diseases	-	Fonds des Affections Respiratoires
NL: NAR; FR:CNT	National Labour Council	Nationale Arbeidsraad	Conseil National du Travail
NRZV	National Council of Hospital Facilities		
VDAB	Flemish Service for Employment and Professional Training	Vlaamse Dienst voor Arbeidsbemiddeling en Beroepsopleiding	-
OCMW/CPAS	Public centre for social welfare	Openbaar centrum voor maatschappelijk welzijn	Centre public d'action sociale
CAW	Centre for General Welfare	Centrum Algemeen Welzijnswerk	-

IPhEB	Belgian Pharmaco-Epidemiological Institute	-	-
VVBV	Flemish Association of Addiction Treatment Centres	Vlaamse Vereniging van Behandelingscentra Verslaafdenzorg	-
IMC	Interministerial Conference	Interministeriële Conferentie	Conférence interministérielle
STRAP	Flemish Strategic Plan for Treatment and Service to Prisoners	Strategisch Plan Hulp- en dienstverlening aan gedetineerden	
CJS	Criminal Justice System	-	-
INCB	International Narcotics Control Board	-	-
ARQ	Annual Report Questionnaire	-	-
TDI	Treatment Demand Indicator	-	-
EWS	Early Warning System	-	-
HBSC	Health Behaviour in School-aged Children	-	-
ESPAD	European School Project on Alcohol and other Drugs	-	-
GDS	Global Drug Survey	-	-

CHAPTER 1

GENERAL INTRODUCTION

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1 GENERAL INTRODUCTION

1.1 Drug policy evaluation: State of the art

1.1.1 The increasing importance of drug policy evaluation research

Evaluating drug policy is indispensable for policy making as it advises policy makers at every stage of the policy cycle - ex ante, ex nunc, ex post - on the evidence base of their policy choices (EMCDDA, 2017a). These policy evaluations can focus on one or more of several criteria such as implementation, relevance, coherence and effectiveness, as well as vary in type, being either a process evaluation, an outcome evaluation or an impact evaluation. They can be conducted on different levels, being either a general evaluation of a national drug policy or a targeted evaluation of a specific key intervention[1] (EMCDDA, 2017a).

The importance of evaluating drug policy has been stressed at both the international (Sustainable Development Agenda 2030, UNGASS Outcome document 2016) and European level (EU Drugs Strategy 2020-2025, EU Drug Action Plan 2020-2025). The UNGASS 2016 outcome document is intended to improve the availability and quality of data in order to measure and evaluate (national) drug strategies. The EU Drug Strategy 2020-2025 and its related Action Plan identified 'research, innovation and foresight' as a cross-cutting theme, along with 'International cooperation', and 'Coordination, governance and implementation'. Strategic priority 10 of the EU Drug Strategy 2020-2025 elaborates on the objective "Building synergies to provide the EU and its Member States with the comprehensive research evidence base and foresight capacities necessary to enable a more effective, innovative and agile approach to the growing complexity of the drugs phenomenon, and to increase the preparedness of the EU and its Member States to respond to future challenges and crises". This action calls upon the European Commission, EU Member States and the EMCDDA, amongst others, to promote scientific evaluations of policies and interventions at national, European and international level.

Although the importance of monitoring and evaluating drug policy systematically has been stressed, general evaluation of national drug policy remains rather fragmentary. National drug policies often consist of various domains and a broad spectrum of programmes, processes, actors and stakeholders, which make them multi-layered and complex to evaluate (Home Office Government, 2017; van Laar & van Ooyen-Houben, 2009)

Nevertheless, over the past two decades, an increasing number of EU member states have evaluated their national drug policy (EMCDDA, 2017c). These evaluations, however, vary greatly in type and scope. **Most of them consist of process evaluations**, i.e. evaluations that focus on the degree of implementation and the operation of a drug strategy (EMCDDA, 2004). For instance, Luxembourg, Portugal and Croatia assessed the extent of implementation of their respective national drug strategies (Moreira et al., 2007; Trautmann & Braam, 2014; Trautmann et al., 2011), as part of measuring criterion effectiveness, and Ireland conducted a process evaluation through a rapid expert review of the national Drug Policy (Griffiths et al., 2016). The results of these process evaluations mostly revealed challenges and barriers to monitoring and evaluation (e.g. indicators to measure certain objectives), including a lack of baseline data impeding a more elaborate (outcome, impact or effect) evaluation. As a result, evaluations on outcome and impact of a drug strategy are scarce. This is mostly due to these methodological constraints including the absence of high-quality data and difficulties in determining

[1] Formative evaluations evaluate a policy (intervention) whilst it is still running (during development or implementation, often to improve the policy (intervention)). Summative evaluations evaluate after the policy (intervention) has been completed. A general evaluation is an overarching evaluation of a national policy. A targeted evaluation is an evaluation of (one or more) key intervention(s).

causality (Home Office Government, 2017; van Laar & van Ooyen-Houben, 2009). For example, the Netherlands aimed to review their national drug policy on implementation and outcome in 2009 using a theory-based evaluation (van Laar & van Ooyen-Houben, 2009). However, conclusions on effect could only be made in a limited number of sub areas because of the lack of data and/or monitoring. Likewise, the UK evaluated the effectiveness and value for money of national drug policy using a cost-benefit analysis (Drugs Strategy Research Group, 2013). But due to lack of data, the conclusions that could be drawn were very limited (Home Office Government, 2017).

Following the European drug strategy framework, our **Belgian drug policy is based on three pillars: (1) prevention; (2) treatment, risk reduction and reintegration; (3) enforcement** and two transversal themes namely **(1) integral and integrated policy; (2) epidemiology and evaluation**. Since the implementation assessment of the recommendations of the Parliamentary working group (1996-1997) in 2000 (De Ruyver et al., 2000), there has **not yet been a general evaluation of Belgian drug policy, despite a long list of new policy developments.** These are the Federal Drug Policy Note in 2001, the Cooperation Agreement of 2002, the operationalisation of the Cooperation Agreement and the establishment of the General Drugs Policy Cell and Interministerial Conference on Drugs in 2009, the Joint Declaration approved by the Interministerial Conference on January 25th 2010, the sixth state reform in 2014, which defederalised various domains within national drug policy, the Vision Note Addiction treatment in 2015, and the Framework Note on Integral Safety (2016-2019).

Hence, an update of the evaluation of 2000 is needed.

1.1.2 The fragmented nature of Belgian drug policy evaluation research

Similar to the situation at European level, Belgian drug policy evaluations remain fragmented. They have consisted ofroutine indicator monitoring and specific research projects (Reitox National Focal Point, 2019). The latter often consist of **targeted evaluation research** (e.g. an intervention of a specific part of the Belgian drug policy) or **evaluations of a specific criterion** (e.g. a public expenditure study).

For example, some of these studies focus on public expenditure: Drugs in Figures I, II and III (De Ruyver et al., 2004; De Ruyver, Pelc, et al., 2007; Vander Laenen et al., 2011), or the social cost of legal and illegal drugs, SOCOST (Lievens et al., 2016). Other research projects focus on a specific intervention. . Examples are n-EWS, the analysis of the early warning system in Belgium (Gelders, 2008), a study by De Ruyver et al. (De Ruyver, Macquet, et al., 2007) on the effects of alternative treatment for drug users or PROSPER (Vandevelde et al., 2016) which was a process and outcome study of prison-based registration points. Some research projects focus on a specific domain of the Belgian drug policy. Examples are SOCPREV (Pauwels et al., 2017) which evaluated social prevention of drug-related crime, and ALCOLAW (Van Havere et al., 2018) which evaluated the Belgian alcohol law. An overview of the evaluation projects financed by the Federal Science Policy, is shown in table 1. Many of these concluded that either the lack of, or inconsistencies with data monitoring limited the results of the evaluations.

Table 1 Overview of previous evaluation projects financed by the Federal Science Policy

Evaluation of Belgian drug policy	Evaluation of a specific part of Belgian drug policy	Evaluation of an intervention
• Drugs in figures I (2004), II (2007), III (2011) • Do's and don't's in an integral and integrated drug policy, DODONBEL (2009)	• The social prevention of drug-related crime, SOCPREV (2018) • The Law of 2009 concerning the selling and serving of alcohol to youths: from state of the art to assessment, ALCOLAW (2017)	• PRocess and Outcome Study of Prison-basEd Registration points PROSPER (2016) • Analysis and optimization of substitution treatments in Belgium, SUBANOP (2014) • The evaluation of Crisis and Case Management, ECCAM (2010) • Warning for dangerous drugs: analysis of the early warning system in Belgium, n-EWS (2008) • Monitor integrated (local) drug policy (2006) • Driving under the influence of psychoactive substances, ROPS (2006)

• Social costs of legal and illegal drugs in Belgium, SOCOST (2016)	• Consensus building on minimal quality standards for drug demand reduction in Belgium COMIQS.BE • Knowledge and application of evidence-based guidelines in addiction treatment (2006)	• Effectiveness and efficiency of drugs used for substitution, SUBST-OP (2005) • Meta-analysis of research into the efficacy and efficacy of the medicinal use of cannabis, (2004) • Case management in the addiction treatment and justice sector • Problematic drug use, (2004) • Meta-analysis of the impact of local drug nuisance projects METAN, (2004) • Research into the effectiveness of treatment programmes specifically for patients with a dual diagnosis, (2004) • Substitution treatment in Belgium: development of a model to evaluate the different types of facilities and patients, (2003) • Predictive value of an integrated vulnerability model based on a Dutch and French adaptation of the ASAM criteria in the choice of treatment for drug users, (2003) • Action-Research about the delivery of methadone in the public pharmacy in Belgium, (2004) • Drug Treatment court Gent, qualitative outcome evaluation, QUALECT (2014) • Effects of sentencing alternatives for drug users (2007)

None of these studies conducted an evaluation of overall national drug policy. There are, however, examples of studies which have provided insight into this topic. In 2000, De Ruyver et al. measured the extent of implementation of the recommendations of the parliamentary working group on drugs. The Joint Declaration of the Interministerial Conference Drugs also describes the state of affairs in 2010 to a certain extent. However, to date, we lack a theory-based and up-to-date general evaluation of Belgian drug policy.

1.1.3 A process evaluation of the overall Belgian drug policy

Although policy makers often focus on effect evaluations, process evaluations are an essential part of the evaluation process. Evaluation is more than judging whether something works or not (Frechtling, 2007). When a policy fails to achieve its goals, this might be because it has not been fully or correctly implemented, or has not reached the target population, or because the immediate expected outcomes have not occurred (Komro et al., 2016). To assess what has happened, a process evaluation is indispensable. A process evaluation helps us to understand how the results of a policy have been achieved, whether the policy was fully and properly implemented and what the limitations of a policy strategy are.

Previous evaluation studies aiming to study outcome and impact, at both European and national levels, have shown that attributing changes in the drug situation (e.g. in drug using trends, in psychosocial harm, in negative consequences) solely to a national drug policy response are nearly impossible. Reasons are diverse and numerous: the oblique nature of the relationships between drug market trends and policy responses, the hidden nature of drug use and related problems and mediating factors all hamper impact evaluations (Hughes & Stevens, 2007). Therefore, we opt to conduct a process evaluation of Belgian drug policy.

In this process evaluation we explore how Belgian drug policy works, how it was implemented and whether it is still in line with current problems and needs.

There are several reasons why we opted to conduct a process evaluation and not an effect evaluation:

1. First of all, the previous process evaluation of Belgian drug policy (on the extent of implementation) dates all the way back to 2000 (De Ruyver et al., 2000), updated to a only a very limited extent by the Joint Declaration of 2010.

2. The results of previous European and Belgian evaluation studies indicate the lack of high-quality data essential for an effect evaluation. Ideally, we should be able to ascertain what would have happened if the intervention had not taken place. Only then can the observed changes be attributed to the intervention, and we could speak of an 'effect'. However, an experimental design in which a 'treatment group' is compared to a 'control group' (minimum conditions according to the Maryland Scientific Methods Scale to measure effect) is not feasible on a large scale (an entire country). The absence of a baseline measurement, a control group or other possibilities to check for interfering variables prevent an thorough effect evaluation (Farrington et al., 2002). Previous Belgian research (including amongst others SOCPREV, PROSPER, MATREMI and SUPMAP) confirms that monitoring in Belgium remains too limited to make statements about effectiveness.
3. An effect evaluation requires measurable aims and objectives. These aims and objectives are not explicitly documented in the central policy documents of Belgian drug policy (as is illustrated more elaborately below).
4. Effect evaluations are extremely difficult for multicomponent policies like a national drug policy (Ritter et al., 2018; Sanderson, 2002). These policies are often too complex to disentangle direct and indirect effects, synergies and interactions. They therefore require an evaluation design that is equally complex, acknowledges differences between communities and assesses implementation as well as adaption over time (Komro et al., 2016). Even in relatively simple policy interventions, causal attributions are hard to establish (Sanderson, 2002), let alone complex, cross-cutting policy interventions like those in Belgian drug policy.

1.1.4 In-depth evaluations of some specific interventions

As well as a general process evaluation, we also conduct an outcome evaluation of two specific interventions within Belgian drug policy: The drug treatment projects in prison and the CAO100/CCT100. This targeted evaluation concentrates on the pillars of Belgian drug policy, and aims to gain a more in-depth view of (parts of) Belgian drug policy. Within the three pillars, two interventions have been selected, on which we conduct an evaluation reviewing outcome, besides its process and output.

Narrowing the scope of the evaluation (from a general evaluation to a targeted evaluation), allows for a more in-depth assessment of these two key interventions.

1.2 What do we evaluate?

When evaluating 'Belgian drug policy', it is imperative to define what is understood by this phrase. In this research, we use as reference points the two central, overarching policy documents of Belgian drug policy: the **Federal Drug Policy Note (2001) and the Joint Declaration of the Interministerial Conference on Drugs (2010)**.

These two documents are together often referred to as the Belgian drug policy, and often referred to as 'the Belgian drug policy' in international communication (Reitox National Focal Point, 2019). Therefore, they form the **basis of our evaluation framework** i.e. our theoretical basis

- The Federal Drug Policy Note is a long-term policy document that defines specific aims and action points for both illicit and licit substances, including alcohol, tobacco and psychoactive medicines (Reitox National Focal Point, 2019). It defines three central objectives: (1) to reduce the number of dependent drug users, (2) to reduce the physical and psychosocial damage caused by drug use, and (3) to reduce the negative impact of the drug phenomenon on society
- The Joint Declaration endorses the Federal Drug Policy Note, and can be considered an updated elaboration of Belgian drug policy.

Both policy documents rely heavily on the findings and recommendations of the **Parliamentary Working Group on Drugs (1996-1997),** as illustrated in chapter 3. As the parliamentary group had a different purpose (legislative power) from that of the Federal Drugs Note and the Joint Declaration (executive power), we rely on it only as a **context-providing** document which we consult whenever an action or objective is not clear:

- The Parliamentary Working Group on Drugs has defined the outlines of our current drug policy. It chose an integrated standardization policy with a bottom-up approach through three pillars: (1) prevention for non-users and people with problematic use; (2) treatment, risk reduction and reintegration for people with problematic use; (3) the repression of producers and traffickers. Further emphasis was put on two overarching axes: (1) a global and integrated approach and (2) evaluation, epidemiology and scientific research.

These documents are used to shape the theoretical basis for our evaluation framework. The emphasis on these documents does not mean we ignore other policy documents or legislation in this EVADRUG research. All policy documents and legislation with relevance to the Belgian drug policy are included when conducting our evaluation i.e. the measurement of the policy intentions. Although they are not included in the basis of the evaluation framework (the theoretical framework; WP1), they are part of the process evaluation (the measurement; WP2).

Hereafter, when we refer to 'the Belgian drug policy' in this report, we are actually refering to the two central policy documents of the Belgian drug policy: the Federal Drug Policy Note (2001) and the Joint Declaration of the Interministerial Conference onf Drugs (2010).

1.3 Central aims and research questions

To conduct a process evaluation of the Belgian drug policy and a targeted evaluation of specific interventions within it entails a **fourfold aim**:

1. To develop a framework suited for the evaluation of the Belgian drug policy
2. To conduct a general process evaluation of the Belgian drug policy
3. To conduct a targeted process, output and outcome evaluation of two interventions within the Belgian drug policy
4. To formulate recommendations for conducting (systematic) drug policy evaluations in Belgium

These aims are operationalised into the following **research questions**:

Table 2 Overview of the research questions

Work package 1: To develop a framework suited for the evaluation of the Belgian drug policy	What are the identified aims, action points, intended outputs and intended outcomes of the Belgian drug policy?	Part 1
	To what extent are the logic models of the pillars and transversal themes consistent and logical?	
Work package 2: To conduct a general process evaluation of the Belgian drug policy	To what extent and how have the actions set out in the Federal Drug Note (2001) and Joint Declaration (2010) been realised?	
	What barriers and facilitators have obstructed or facilitated the implementation of the actions set out in the Federal Drug Note (2001) and Joint Declaration (2010)?	

	To what extent are the objectives and actions set out in the Federal Drug Note (2001) and Joint Declaration (2010) in line with the current Belgian needs and problems?	
Work package 3: To conduct a targeted process, output and outcome evaluation of two interventions within the Belgian drug policy	What do we learn from the targeted process, output and outcome evaluation of two interventions within the Belgian drug policy?	Part 2
Work package 4: To formulate recommendations forto conducting (systematic) drug policy evaluations in Belgium	What recommendations can be made regarding methodology and evaluation of the Belgian drug policy?	Part 1

This research refers to drug policy as the approach to the overall drugs phenomenon, including legal substances, illegal substances or psychoactive medication, in accordance with the Federal Drug policy Note (2001) and the Joint Declaration (2010). This approach is supported by the focus on a (public) health approach to the drug phenomenon within (international) drug policy, rather than a criminal justice approach (De Ruyver, 2009).

1.4 Summary

Evaluating drug policy is indispensable for policy making as it can advise policy makers at every stage of the policy cycle on the evidence base of their policy choices (EMCDDA, 2017a). Despite recognition of the importance of systematic monitoring and evaluation, general evaluation of national drug policy remains rather fragmentary. Nonetheless, over the past two decades, an increasing number of EU member states have evaluated their national drug policy (EMCDDA, 2017c).

Since the implementation of the recommendations of the Parliamentary working group (1996-1997) in 2000 (De Ruyver et al., 2000), Belgium has not conducted a general evaluation of the Belgian drug policy, despite many new policy developments. An update of the evaluation of 2000 is therefore needed.

In this process evaluation we explore how the Belgian drug policy works, how it has been implemented and whether it is still in line with current problems and needs. To do this, we rely on the two central, overarching policy documents on Belgian drug policy as a reference point: the Federal Drug Policy Note (2001) and the Joint Declaration of the Interministerial Conference on Drugs (2010). Along with this general process evaluation, we also conduct an output and outcome evaluation of two specific interventions within the Belgian drug policy.

PART 1

GENERAL EVALUATION: A PROCESS EVALUATION OF THE BELGIAN DRUG POLICY

CHAPTER 2

METHODOLOGY

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2 METHODOLOGY

When complex policy interventions with multiple actors are evaluated, researchers often rely on an evaluation theory. These **theory-driven evaluations** describe the assumptions underlying a policy of how a policy causes intended or observed outcomes (Coryn et al., 2011). Afterwards, this theory is tested against empirical evidence.

Assessing a multi-faced and complex policy with various subjects, processes and actors, like our Belgian policy, requires a theory-driven approach of evaluating (Blamey & Mackenzie, 2007; van Laar & van Ooyen-Houben, 2009)A theory-driven approach allows researchers to identify **how** policy actions produce certain effects, rather than only focussing on the question **whether** there are specific effects. It helps the evaluation team to gain insight in the underlying logic and assumptions of a strategy, and guides the various stages of the evaluation (UNODC, 2017).

In this research, we rely on a pragmatic version of a policy theory, recommended by the EMCDDA (EMCDDA, 2017a): logic models.

This chapter starts with a general explanation of a theory-driven evaluation framework before explaining more in detailing the particular methods used in EVADRUG evaluation of the Belgian drug policy.

2.1 A theory-driven evaluation: an introduction

This policy evaluation relies heavily on the philosophy of **theory-driven evaluations**.

Theory-driven evaluations explicate the theory underlying a policy. This means that a theory-based evaluator perceives a policy as a theory that has to be tested against scientific evidence. Astbury and Leeuw (20illustrates it like this:

"*Interventions are always based on a hypothesis that postulates 'If we deliver a programme in this way or we manage services like so, then this will bring about some improved outcome'. Such conjectures are grounded on assumptions about what gives rise to poor performance, inappropriate behaviour and so on, and then move to speculate how changes may be made to these patterns.*" (pp 4)

A theory-driven evaluation, makes these assumptions explicit. This way, the policy theory can be properly tested against empirical evidence. If a policy does not deliver the desired results, a policy theory should be able to identify whether this can be attributed to a theory failure (flaws in underlying assumptions), an implementation failure or whether the context is not suited for the policy to work (Astbury & Leeuw, 2010; Coryn et al., 2011).

A theory-driven evaluation thus explains how a policy causes certain (intended) changes (Coryn et al., 2011).

Theory-driven evaluation therefore not only explains if a causal relationship exists between the policy and the observed outcomes, but also **how** the policy caused the observed outcomes and thus revealing what the underlying mechanisms are (what researchers describe as 'stepping out of the black box') (Coryn et al., 2011). After all, determining if a policy or program works, depends on how they were implemented, on how they are applied in practice and what outcomes were envisioned (Sridharan & Nakaima, 2012).

It is important to note that a policy theory is not necessarily (entirely) based on research evidence (Frechtling, 2007). It can be, but it might also be likely that policy theories are (partly) based on practitioner experience or other factors like values or availability of resources (Davies, 2004b). Therefore it is important that theory-driven evaluation assess not only the validity of the explanatory mechanisms behind the policy theory, but also the validity of the broader theory (Frechtling, 2007; Weiss, 2000).

2.1.1 The use of logic models

Considering the goals of the study, the resources and timing, we opt for a pragmatic approach of theory driven policy evaluation, i.e. getting insight in the policy logic by describing how the policy components fit together through **logic models**. This method is based on previous evaluation research (Astbury & Leeuw, 2010; Galla et al., 2006; Home Office Government, 2017; van Laar & van Ooyen-Houben, 2009) and is recommended by the EMCDDA in the context of evaluating a national drug strategy (EMCDDA, 2017c).

Logic models are a systematic and coherent description of the policy, making use of theoretical visualisations (Chen & Chen, 2005) that identify the aims, actions, resources, intended outputs and intended outcomes underpinning a certain policy, strategy or intervention (EMCDDA, 2017a). The logic models make the underlying assumptions explicit of how a policy, strategy or intervention aims to achieve its aims and accentuate the crucial elements in a policy, strategy or an intervention. Eventually, logic models help to identify what should be measured and what type of indicators need to be collected (Frechtling, 2007), thus structuring and guiding the evaluation (Peyton & Scicchitano, 2017). Logic models therefore provide the framework to test the extent to which these theoretical assumptions are supported by evidence.

Logic models are a pragmatic approach of theory-driven evaluations in the sense that they identify and describe how a policy fits together in a simple sequence, as is shown in figure 1. The policy theory is described in a linear model. It is pragmatic in the sense that it does not put as much emphasis on the explanatory account of how the policy works in terms of causal explanations (Astbury & Leeuw, 2010), which often results in comprehensive, ecological policy theory models (Coryn et al., 2011). Instead, it focuses on a logical depiction of how policy makers intent to achieve change.

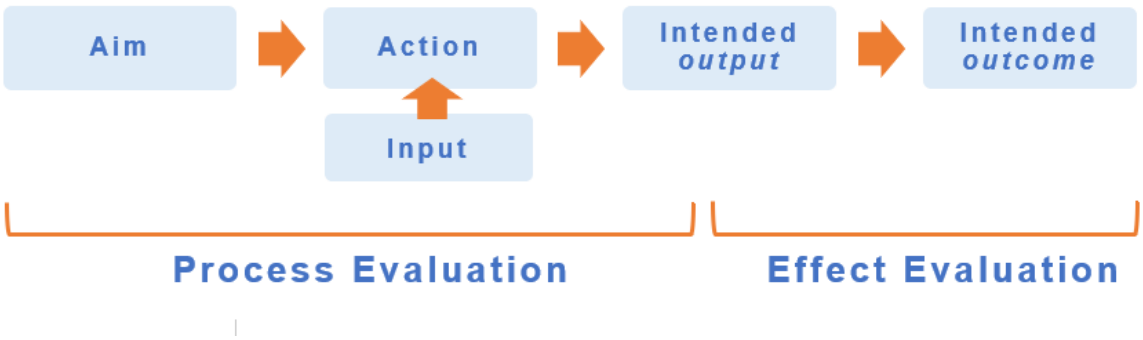

Figure 1 Visualization of a logic model, figure adapted from The Kellogg Foundation (2003)

Figure 1 shows what a logic model looks like. The policy theory is defined in the following concepts (Coryn et al., 2011; EUCPN Secretariat, 2013; Frechtling, 2007):

- Aim: this reflects the question 'What does the policy want to achieve?'.
- Action: this reflects the question 'What actions or interventions are put in place to achieve this aim?'. It is instrumental to the aim.
- Input: this reflects the question 'What (human, financial, organizational, and community) resources are needed to implement the actions?'.
- Intended output: this reflects the question 'What immediate outputs (services, products, collaborations) result from the implementation of these actions?'. The output indicates that an action has taken place.
- Intended outcome: this reflects the question 'What are the long-term results that occur directly or indirectly as a result of inputs, actions, and outputs?'. The intended outcome is an indication of the change that the policy intends to achieve.

We will illustrate the value of logic models with an example.

One of the policy actions in the Belgian drug policy intends *to prevent infectious diseases by providing access to needle and syringe exchange programmes* (Federal Drug Note, 2001). To evaluate this action, one could measure whether there was a decrease in the number of infectious diseases due to injecting drug use. However, this would not inform us on how this effect was achieved. To understand how providing access to needle and syringe exchange should lead a certain effect, a logic models can be created.

Using the logic model tool, figure 2 illustrates how policy makers intend to achieve the prevention of infectious diseases.

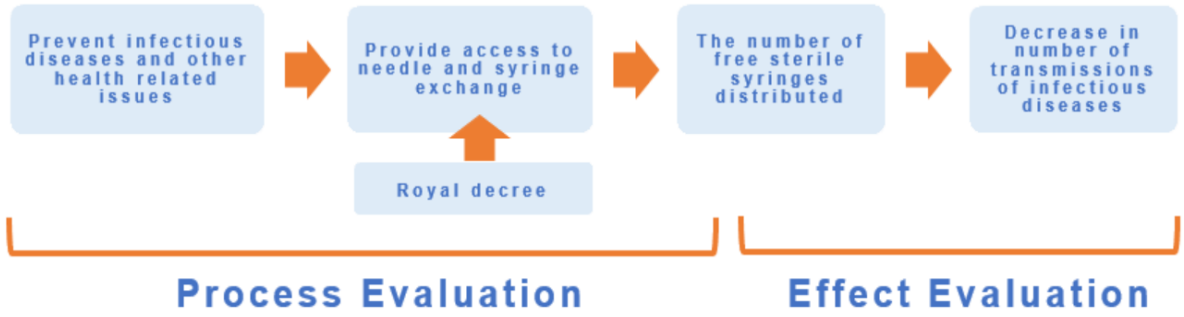

Figure 2 Example of a logic model visualization

Figure 2 **Example of a logic model visualization** clearly shows the different phases on how this policy action intends to generate impact:

- Aim: To prevent infectious diseases and other health related issues
- Action: To provide access to needle and syringe exchange programmes
- Input: The royal decree to provide legal basis for syringe exchange programs
- Intended output: The number of free sterile syringes that were distributed
- Intended outcome: A decrease in number of transmissions of infectious diseases

By making these underlying assumptions explicit, the logic model reveals the crucial elements of the action. In this example, it highlights the preconditions to be met in order to achieve impact (i.e. the Royal Decree and the distribution of free sterile syringes).

This not only supports the identification of the type of indicators that have to be collected (Frechtling, 2007), it also helps to assess the validity of the underlying logic: do the actions support the central objectives, do the intended outputs follow logically from the actions, and do the intended outcomes result logically from the outputs? In this way, logic models facilitate the detection of gaps, problems, and paradoxes in the policy theory.

Once the underlying logic of a model is assessed, data on the operation of the policy can be collected.

As noticed, a logic model solely focuses on intended consequences, not unintended. We address this further under ‘Limitations’.

2.2 EVADRUG method

Many member states face challenges when evaluating their national drug strategy. The evaluation refer for example to the lack of high-quality indicator monitoring, difficulties establishing conclusions about causality, including unintended consequences, etc. (Morell, 2018; van Laar & van Ooyen-Houben, 2009).

The evaluation team responsible for the evaluation of the Belgian drug policy faced these challenges too (cf. state of the art).

To meet this challenge, we combined different methods for data triangulation, as data triangulation intends to use multiple indicators and data sources to bring a more complete picture (Trautmann & Braam, 2014). Starting from the methodological insight of previous evaluation research, we chose a multi-methodological approach, i.e. combining quantitative and qualitative measures. As such, the weakness of one method could be overcome by the strength of another (Creswell & Clark, 2017).

Consequently, we used a range of research methods in the different work packages.

2.2.1 WP 1: Developing an evaluation framework

The first work package aimed to develop an evaluation framework to conduct a process evaluation of the Belgian drug policy. This first work package will answer the following research questions:

- What are the identified aims, action points, intended outputs and intended outcomes of the Belgian drug policy?
- To what extent are the logic models of the pillars and transversal themes consistent, coherent and logical?

We developed an evaluation framework based on a pragmatic approach of theory-driven evaluations, i.e. through logic models. For each pillar and transversal theme of the Belgian drug policy, a logic model was developed, constructed through a document analysis of the Belgian drug policy and stakeholder validation.

Figure 3 The three pillars and two transversal themes of the Belgian Drug Policy

2.2.1.1 Document analysis of central policy documents

To generate these five logic models, a thorough document analysis of the two central documents of the Belgian drug policy was conducted:

1. The Federal Drug Policy Note (2001)
2. The Joint Declaration of the Interministerial Conference Drugs (2010)

The Parliamentary Working Group on Drugs (1996-1997) was also analysed as a context-giving document, for reasons explained earlier (cf. supra).

The document analysis is a systematic method for reviewing documents (Bowen, 2009; Mackieson et al., 2019). It allows for a broad insight into the policy direction and context information of our Belgian drug policy, and is an often used method in drawing up logic models (Brousselle & Champagne, 2011; Home Office Government, 2017; van Laar & van Ooyen-Houben, 2009). As these policy documents are the official results of the political debate on the drug phenomenon and therefore have a high validity and trustworthiness (Mackieson et al., 2019). The aims, actions, outputs and outcomes outlined in these policy documents were the foundation for the logic models.

It became clear that the Federal Drug Note (2001) and the Joint Declaration of the Interministerial Conference Drugs (2010) did not have an explicit 'logic' written down, although both policy documents indicate that this 'logic' does exist. Therefore, we created this logic in retrospect. This has a few limitations, which we discuss further on in this chapter.

A. Coding of the three central documents

We started with coding the three central documents of our Belgian drug policy in Excel. All three policy documents were systematically checked for aims, actions, inputs, outputs and outcomes. If one of these elements was mentioned explicitly, it was written down word-for-word coded into the Excel structure. Sometimes, the policy documents implicitly referred to an aim/action/input/output/outcome. This was also coded in the Excel structure, but was highlighted with a notification of the aim/action/input/output/outcome being implicit. The coding of all three documents resulted in sixteen Excel files with word-for-word coding. In order to check for completeness and accuracy, the four-eye principle was applied. When discrepancies between both researchers occurred, they were discussed with the research teams and highlighted.

B. Thematic analysis with NVivo

After all, three policy documents were coded in Excel, we uploaded the data into NVivo. Using NVivo, we thematically analysed all the aims, actions, inputs, outputs and outcomes (Mackieson et al., 2019). Overarching themes were defined, through careful reading and rereading of the data (Fereday & Muir-Cochrane, 2006). The aims, actions, inputs, outputs and outcomes were then grouped, summarized and integrated in overarching themes (Clarke et al., 2015), remaining as close as possible to the original structure of the policy documents. This resulted in a coding tree with themes and sub-themes.

C. Reconstructing the logic models in Excel

As a last step, the coding tree in NVivo was reconstructed into five definitive logic models. These five logic models no longer described the actions in a word for word translation of the policy documents, but reformulated aims and actions to facilitate readability, and grouped parallel aims and actions into one. We did, however, used the same terminology used in the policy documents. This means that, when the policy documents for example used the terms 'addicts' or 'addiction' and further on spoke of 'problematic user' or 'problematic use', we used the same (thus both) terminology in the description of the logic model. As a consequence, when many different terms are used interchangeably in the description of the logic models, we were merely mirroring the policy documents.

The result of this exercise was an Excel file with five logic models on the three pillars and two transversal themes of the Belgian drug policy:

1. Prevention
2. Treatment, risk reduction and reintegration
3. Enforcement

4. Epidemiology, research and evaluation
5. Integral and integrated approach

2.2.1.2 Fill in the gaps through expert validation

Because the logic models were created in retrospect and solely based on the policy documents, there remained some gaps in the logic models (mostly with concerns to output and outcome). We therefore contacted experts involved in the drafting of the Federal Drug Note (2001) and/or the Joint Declaration (2010) to (1) fill in some of the gaps, and (2) to validate some of the existing findings. As both policy documents were drafted quite some time ago (the Joint Declaration already dated back ten years, the Federal Drug Note almost twenty years back), this was no obvious task.

We eventually contacted three key experts who could fill in some of the gaps in the pillars 'Prevention', 'Treatment, risk reduction and reintegration' and 'Integral and integrated approach'. Their additions were indicated in colour.

2.2.1.3 Visualising a summary of the logic models

Lastly, a visual summary was made for each logic model. This summary was drawn up for communication purposes only. The Excel file with the entire logic models was complicated and too elaborate to clearly communicate the policy intentions of the Belgian drug policy. In order to communicate and report properly on the 'policy theory', we established five summaries. These summaries provide a schematic overview of the bundled and key objectives, actions, outputs and outcomes.

The subsequent research steps, such as the critical appraisal and the measurement of policy intentions (extent of realisation), however, will based on the detailed Excel files.

2.2.1.4 Critical appraisal of the logic models

After a policy theory was drafted and before starting the process evaluation of the policy theory, it was essential to review its validity (Funnell & Rogers, 2011; Holliday, 2014; Mowbray et al., 2003; O'Donnell, 2008). A critical appraisal allows for exploring whether program failures are more likely to be attributable to a poor theory, or a poor implementation. A critical appraisal can thus identify plausibility gaps and allows to understand why a policy might not achieve its desired change (Funnell & Rogers, 2011). This critical appraisal will help to determine whether the policy has the potential to produce its intended outcomes, or not.

Therefore, after the logic models were drafted, we tested the internal validity of the five logic models in a critical appraisal. To do so, we relied on the internal validity (Funnell & Rogers, 2011) indicators mentioned in table 3. Funnell & Rogers describe internal validity as a critical appraisal to check "*whether the program theory hangs together in a way that makes sense and tells a clear, coherent, believable, and logical story about the outcomes the program is trying to achieve, why those outcomes are important, and how the program will contribute to the outcomes*" (pp. 296).

Table 3 Indicators for critical appraisal of the logic models

Internal validity (based on Funnell &	**Clarity of the description** of the objectives, the actions, the intended outputs and the intended outcomes: Is the logic of the different aims and actions with their corresponding outputs and outcomes clearly and with sufficient detail described?
	The outcomes chain as the central organizing principle for the policy theory: Does the logic model focus on the outcomes it wants to achieve, or does the logic model focus on what the policy does (activities).

Rogers, 2011)	**Demonstration of how desired outcomes relate to addressing the problem**: Can the intended outcomes be linked to the needs that gave rise to the policy?
	The strength and plausibility of **the logical argument:** Is the logic model logic in terms of coherence, sequencing, completeness?
	Articulation of **mechanisms for change** that underpin the choice of Outcomes: Does the logic model clearly identifies the assumed mechanisms for change that underpin its selection of outcomes and activities?

To measure these indicators, a desk review of the five logic models was undertaken (Funnell & Rogers, 2011). Each pillar was checked systematically against these five indicators. Findings were illustrated with examples and described per indicator.

- A first measure of internal validity is 'clarity of description'. It assesses whether the logic model describes how the policy works with enough detail.
- A second measure of internal validity is whether the logic model is built around the outcomes it wants to achieve. Are the outcomes central to the logic model, or are there other elements that are accentuated?
- A third measure of internal validity questions whether the logic model indicates how the outcomes address the problem(s) that the policy is to address. This means that we assess if and how the problem(s) that gave rise to the establishment of the policy, are linked to the intended outcomes.
- A fourth measure of internal validity is 'the strength of the logical argument'. This means that we measure the extent to which the logic model is 'logic' in terms of coherence, sequence and completeness.
- The last measure of internal validity is 'the articulation of the mechanisms for change'. This entails the question 'Does the logic model clearly identify the assumed mechanisms of change that underpin its selection of outcomes and activities'. Funnell et al. (2011) describe these mechanisms for change as the 'because' statements: if A happens, then it will result in B, because of C. 'C' is the mechanism for change in this case.

2.2.2 WP2: Conducting a process evaluation of the Belgian drug policy

The second work package aimed to conduct a process evaluation of the Belgian drug policy. This work package answered the following research questions:

- To what extent and how have the actions set out in the Federal Drug Note (2001) and Joint Declaration (2010) been realised?
- What barriers and facilitators obstructed or facilitated the implementation of the actions set out in the Federal Drug Note (2001) and Joint Declaration (2010)?
- To what extent are the objectives and actions set out in the Federal Drug Note (2001) and Joint Declaration (2010) in line with the current Belgian needs and problems?

To answer these research questions, we rely on a multi-method approach. The process evaluation of the Belgian drug policy, will be based on three methods: (1) a literature review to describe the previous developments in the Belgian drug policy, (2) a survey to measure the perception of implementation amongst practitioners and stakeholders, and (3) semi-structured interviews and a focus group with practitioners, civil servants, (scientific) experts and people with lived experiences to measure the implementation and relevance more in depth.

2.2.2.1 A document review to describe the previous developments in the Belgian drug policy

First, in order to measure to the extent to which the actions set out in the Federal Drug Note and the Joint Declaration are realised and how, we conducted a rapid document review of the websites, reports and other publications from various institutions with a role in the Belgian drug policy. We start from the existing websites, reports and other publications from various institutions (such as the General Drug Policy Cell, Belspo, VAD, Fedito, Sciensano, many different addiction care institutions, the public prosecutor's office, federal and local police, NGO's, etc.), scientific literature and the relevant documents (policy documents of the different regions, annual reports, legislation, etc.) that bundle information on the different components of the Belgian drug policy: prevention, harm reduction, treatment provision, enforcement, integrated and integral policy, epidemiology and research. This documentation is used to describe the developments within the different pillars of the Belgian drug policy. Most documentation is publicly available; a few documents were received from respondents who participated with the semi-structured interviews (cf. infra).

We described the major developments in the field for each objective of each pillar. We refrain from presenting a full inventory of all actions that have been realised in micro detail, because it is not feasible to do so. The Belgian drug policy field is fragmented among many different competences and many different policy levels (cf. infra). The follow-up of the realisations of the Federal Drug Note and the Joint Declaration was not centralised in one institution. Therefore, piecing together the puzzle in retrospect for all actions in all policy levels and domains, scattered over reports from different institutions, is not only virtually impossible, it is also not the core objective of this research. The document review thus rather seeks to summarise the key developments within the different objectives, as they feed into the overall performance of the pillars.

The result of this method is limited to an overview of the realisations within each objective, but does not reveal whether or not the realisations work as intended, whether they sufficiently meet the needs in the field, nor whether they are executed in a good way. Moreover, many of the realisations from the rapid document review are not necessarily a direct consequence of the Federal Drug Note or the Joint Declaration. We want to emphasise that the realisations in the different pillars and transversal themes, **were not necessarily implemented because they were listed by the Federal Drug Note and the Joint Declaration**. In many cases, the realisations were initiated by specific institutions or organisations, and were the effect of different policy processes than those put forward in the documents.

2.2.2.2 A survey to measure the perception of implementation

To address the research question 'to what extent and how have the actions set out in the Federal Drug Note (2001) and Joint Declaration (2010) been realised', we rely on a second method: an online survey amongst practitioners, administration and (scientific) experts working within one or more domains related to the drug policy. Following previous evaluation research (Kools et al., 2017; Purdy et al., 2018 ; Trautmann & Braam, 2014; Trautmann et al., 2011), the survey was used to get an explorative insight into the **perceived realisation** of the different actions defined by the Federal Drug Note and the Joint Declaration from a large number of stakeholders at all policy levels (federal, regions and communities, local level) and across the different policy domains (integral and integrated approach; epidemiology, research and evaluation; prevention; care, risk-reduction and re-integration; enforcement). The survey thus provides a first insight into how the work field evaluates the realisation of the policy intentions. The online survey was distributed amongst practitioners working within one or more domains related to the drug policy, therefore further deepening the first research question (To what extent and how have the actions set out in the Federal Drug Note (2001) and Joint Declaration (2010) been realised?).

A. Preparation, sampling and recruiting respondents

The target population of the survey are practitioners, administration and (scientific) experts working within one or more domains related to the drug policy, as they are key informants to get an overview on what the (perceived) level of realisation of the central actions of the Federal Drug Note and the Joint Declaration. To select respondents, we relied on a stratified sampling: a sampling method where researchers identify specific characteristic of their population (i.e. policy domain & policy level, both central characteristics that should (more or less) be evenly displayed amongst the survey sample), and then take an equal sample size of each group to ensure representation of all groups (Parsons, 2014; Smith & Dawber, 2019). Respondents could be included whenever they met the inclusion criteria (cf. table 4). Our sample was not intended to be representative, as it was our intention to get an explorative overview of the perceived realisation and was analysed in a qualitative way. Nevertheless, it was important to research enough respondents on each policy level, given the distribution of competences between the different policy levels (cf. infra 'Development of the Belgian Drug Policy').

Table 4 Inclusion criteria respondents online survey

Inclusion criteria online survey
• Practitioners, civil servants and/or (scientific) experts on a federal, regional, communal, provincial or local level • Practitioners, civil servants and/or (scientific) experts within one or more of the following policy domains: prevention, harm reduction, treatment provision, enforcement, integrated and integral policy, epidemiology and research • Practitioners, civil servants and/or (scientific) experts on a coordination level • One person per organisation (director or head of department), unless they have specific expertise related to a drug-related theme • Drug-specific as well as non-drug specific expertise

The survey was based on previous evaluation surveys (Kools et al., 2017; Purdy et al., 2018 ; Trautmann & Braam, 2014; Trautmann et al., 2011) and applied to the policy intentions formulated by the Federal Drug Nota and the Joint Declaration. The survey consisted a few background questions, and mainly focused on the level to which an action was perceived as (partially) realised or not. The survey was then translated to French and Dutch and input into Qualtrics. A pilot test was conducted amongst the research team and two external experts, before it was dispersed amongst the respondents.

B. Data collection and analysis

The online survey was dispersed amongst the pre-selected respondents between July and August 2020. Two weekly reminders were sent to the respondents who had not yet completed the survey. Often, the survey was completed by several people within an organisation/institution answer the survey. In that sense, the responses often represent the joint answer of an organisation or institution, rather than the answer of a single practitioner, civil servant or expert.

Within this two-month time period, we received 66 responses. Of those responses, 28 responses were French-speaking respondents, 38 responses were Dutch speaking respondents. As foreseen with the stratified sampling, respondents for all five pillars were more or less equally represented. Most respondents had expertise related to the pillars 'Treatment, risk reduction and re-integration' and 'Integral and integrated approach'. The least number of responses related to the pillar 'Epidemiology, research and evaluation'.

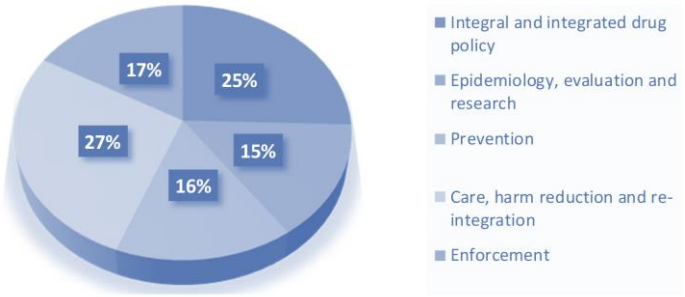

Figure 4 Expertise related to which pillar

Respondents from all policy domains, and all policy levels were reached. Lastly, the group of respondents comprised mostly of respondents who were at least aware of the Federal Drug Note and the Joint Declaration. Still, almost 20% of the respondents indicated not to be aware of the Federal Drug Note, nor of the Joint Declaration.

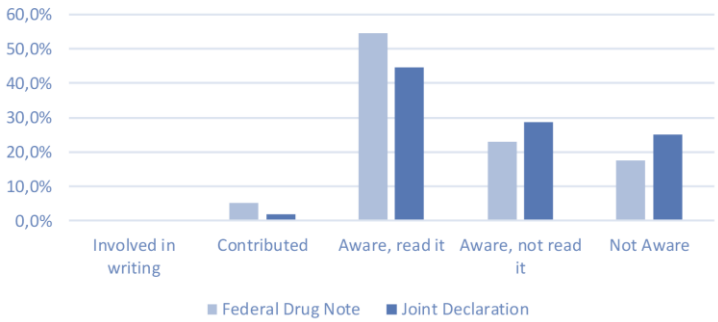

Figure 5 Knowledge of the Federal Drug Note and the Joint Declaration

After the survey was closed, the dataset was cleaned in and analysed through Excel. Rather than quantitatively, the survey was analysed in a qualitative way, looking for consistencies between policy levels and policy domains and the appraisal of the extent of realisation.

C. Ethical aspects

Respondents were presented with an informed consent form before completing the online survey. The informed consent explained the survey goal and format, and informed about the way the study findings would be analysed and processed. The informed consent further explained that participation was voluntary, that respondents could receive additional information upon request, and that any contact details will never be linked to the answers to the survey. During data analysis en processing, measures were put in place to ensure that participants' identities and personal information remained confidential.

D. Limitations

Lastly, it is important to consider the limitations of the survey when interpreting the results. The aim of the survey is to gain an explorative insight into the **perceived realisation** of the different actions. It is therefore not the intention to give a representative image of the extent to which the actions are actually realised. Respondents were encouraged to answer only those questions they were aware of, so the number of responses per action varied between 18 responses for the most answered action and zero response for the least answered action. In addition, the actions already date from 2001 and 2010, and since then, the drug field has evolved extensively (cf. infra). So, the respondents sometimes had to fall back on their recollection from actions realised several years ago. Finally, as was also highlighted in the

critical appraisal of the logic models, some actions are very broadly formulated and therefore difficult to appraise. This causes differences in interpretation among respondents: whereas for some respondents the actions are realised, this might not (fully) be the case for another respondent.

2.2.2.3 Semi-structured interviews to measure of the context of the realisations

To address the research questions relating to the barriers and facilitators within the Belgian drug policy and the extent to which the objectives and actions are still in line with the current Belgian needs and problems, we relied on semi-structured interviews with civil servants, practitioners and (scientific) experts that have an expertise in one or more domains related to the Belgian drug policy. These semi-structured interviews aimed to provide an explorative insight into the facilitators, barriers, bottlenecks, challenges and needs for the Belgian drug policy and aim to obtain and understand how Belgian drug policy is experienced by respondents. We examined how respondents shape the Belgian drug policy in daily practice, giving insight in how they translate “policy in the books” to “policy in practice”.

The focus group for the recommendations (cf. infra) also give some insight for the context or realisations, and are therefore sometimes used to further illustrate the findings.

A. Preparation, sampling and recruiting respondents

Our target population for this second research method is civil servants, practitioners and (scientific) experts that have an expertise in one or more domains related to the Belgian drug policy. To recruit respondents, we relied on purposive sampling, considering the inclusion criteria described in table 5. Respondents were thus chosen for their role in the implementation of the Belgian drug policy that enable detailed exploration of the operation of the Belgian drug policy in practice (Ritchie et al., 2013). The guidance committee was consulted to formulate potential respondents that fit the criteria. After each interview, respondents were also asked who we should ideally include in the evaluation, providing a form of snowball sampling too.

Table 5 Inclusion criteria respondents semi-structured interviews

Inclusion criteria semi-structured interviews
• Practitioners, civil servants and/or (scientific) experts on a federal, regional, communal, provincial or local level • Practitioners, civil servants and/or (scientific) experts within one or more of the following policy domains: prevention, harm reduction, treatment provision, enforcement, integrated and integral policy, epidemiology and research • Practitioners, civil servants and/or (scientific) experts with an institutional role • Drug-specific expertise

To enhance the consistency of the data collection, the researchers developed a topic list with central themes (Arthur & Nazroo, 2003) to guide the interviews. Also, the topic list ensured that the interview remained a focus on the central topic, as there were a lot of themes to discuss within each interview. The topic list is based on the topic lists of previous evaluations (Kools et al., 2017; Purdy et al., 2018 ; Trautmann & Braam, 2014; Trautmann et al., 2011), and adjusted to the policy intentions formulated by the Federal Drug Note and the Joint Declaration, as well as the research design of the evaluation. The topic list probes for how respondents evaluated the current objectives and realisations, and how they perceive the needs for a future Belgian drug policy. The topic list was then translated to Dutch and French, as all interviews took place in Dutch or in French. The topic list can be found in annex.

B. Data collection and analysis

The final sample consisted of 39 respondents representing the three pillars and two transversal themes of the Belgian drug policy. The interviews took place between November 2020 and March 2021, and

were conducted online due to the covid-19 confinement restrictions. Online interviews were conducted using MS Teams, and had the advantage that the respondents were more easily available to plan the interview. However, there were also some disadvantages to online interviewing, which included internet problems and malfunctions during the interview, challenges of communicating about the logic models from a shared computer screen, and the remoteness of online interviews which makes it difficult to establish a trustful environment. The eventual interviews lasted between 60 and 180 minutes.

All interviews were subsequently transcribed before they were coded and analysed through NVivo. The transcript was completely anonymised, as well as potentially identifying information, in accordance with the data management plan (Bancroft & Reid, 2016). The analysis consisted of a thematic analysis in a first step, and a more in-depth analysis in a second step. A thematic analysis systematically identifies, organises and gives insight into the patterns and main themes of the qualitative data (Braun & Clarke, 2012). This resulted in a coding three ordered per pillar and transversal theme. After a thematic analysis of the main themes, the main themes of coding tree established during the thematic analysis, was analysed more in-depth. Rather than analysing the data within the pillars, this analysis transcended the individual pillars and transversal themes and established the main reoccurring patterns throughout the data. These results are described elaborately in the report. The quotes, added to illustrate or further contextualise the results, were not translated to English to stay as closely as possible to what the respondent has said.

C. Ethical aspects

Respondents were presented with an informed consent form before the start of the interview. The informed consent explained the interview goal and format, and informed about the way the study findings would be analysed and processed. The informed consent further explained that participation was voluntary, that respondents could receive additional information upon request, and that all data would be anonymised. The respondents were asked to sign the informed consent, or acknowledge that they agree with the informed consent on tape. Respondents were also asked for consent to record the interview, again assuring confidentiality.

D. Limitations

It is important to note that semi-structured interviews are a qualitative method to gain an explorative and more in-depth insight into the Belgian drug policy. Therefore, this method does not give a representative view of all opinions in the (drug) field. The qualitative semi-structured interviews intended to report on recurrent perceptions, opinions and experiences that are prevalent in the drug field, to help explain why the realisation of certain objectives within the different pillars or transversal themes are hindered or facilitated, but also to record new barriers and bottlenecks, and to map what the field deems necessary for this pillar.

Additionally, it is important to consider that the Belgian drug policy covers a very broad field of topics, and therefore mainly identifies structural barriers, bottlenecks and facilitators, rather than on an organisational or individual level.

2.2.2.4 Focus groups with people with lived experiences

The representation of the various ‘voices’ within a drug policy, remains one of the challenges of an evidence-based drug policy (Lancaster et al., 2017). Engaging people from a particular community who share a lived experience (*peers*) – in this case with the use of drugs - in drug policy is essential as they are the people affected by drug policy (Lancaster et al., 2017; Ti et al., 2012). Within a drug policy, peers can leverage their personal knowledge and skills to collaborate and consult, ensuring that their priorities and needs are addressed (Ahmed & Palermo, 2010). Moreover, it reflects a broader trend towards inclusive democratic participation and pluralisation of knowledge (Gaventa & Cornwall, 2008). To equal

extent, these peers should be included in research evaluating this drug policy, although this is often not the case.

Engaging peers in research is a community-based approach. It refers a process of consulting and collaborating with members of a community who share a common lived experience, thereby using a bottom-up approach in order to better address the needs of the community (Ti et al., 2012). Ahmed et al. (2010) have shown that understanding the social and cultural characteristics identified by community members, "*improves research quality, ensures the research's relevance, addresses health disparities, and enhances the research's impact*" [OBJ], and are therefore consulted for both their perspective on the Belgian drug policy, as well as how their voice should be represented in the report.

The purpose of engaging peers in the EVADRUG research is therefore to actively process the experiences and perspective of people who use drugs with/on the Belgian drug policy in the EVADRUG research and to map out how people who use drugs and people in recovery evaluate the current drug policy. To do so, we originally planned to establish a Peer Advisory Board of people with lived experiences, to give input on the different stages of data collections and reporting. However, due to the covid-19 confinement restrictions, we were not able to organise meetings in person between March 2020 and May 2021. As a result, the PAB were downsized to a one-time focus group with people with lived experiences. These focus groups were organised in Brussels, Ghent and Antwerp.

A. Preparation, sampling and recruiting respondents

Our target population for this research method, are people who use drugs and people who identify themselves as in recovery, a target group we further refer to as people with lived experiences or experts by experience. We do not make a distinction between the use of legal and illegal substances, in accordance with the Federal Drug Note and the Joint Declaration that are both aimed at legal and illegal substances. Because we want to reach a diverse group of respondents and recruit as broadly as possible, we have not set any refined selection criteria that the respondents have to meet (Barbour, 2008). The more diverse the group of respondents, the better. This way, we aimed to bring together a heterogeneous group of people who use drugs or who identify themselves as being in recovery, in order to include different perspectives in the evaluation.

To recruit respondents, we relied on convenience sampling, counting on respondents that were available and willing to participate in one of the focus groups. Flyers were dispersed through several social media accounts, and through intermediate gatekeepers working with people who use drugs or people in recovery. With reaching a diverse group in mind, different intermediaries were involved, who interact with a diverse range of people who use drugs. With reaching out to these gatekeepers, we intended to reach a more diverse population (Hennink et al., 2020). In order to recruit participants from different cities, each focus group was organised in a different city. We selected large cities with a diverse population that were easily accessible by public transport: Ghent, Antwerp and Brussels.

Furthermore, to enhance the consistency of the data collection, the researchers developed a script with central themes that were to be discussed during the focus group (Arthur & Nazroo, 2003). Also, the script ensured that the focus group remained a focus on the central topic, as there were a lot of themes to discuss within each focus group. The script clarified the intent, the means of recruiting and the course of the focus group, including a timeline for each topic. The themes were deliberately kept very broad, so that the questions could not steer and a lot of room was left for the respondents' own interpretation. The script probed for how respondents evaluated the current Belgian drug policy. The script was then translated to Dutch and French, as the focus groups took place in Dutch or in French. The script has been added in annex.

B. Data collection and analysis

Three focus groups were organised in Ghent, Antwerp and Brussels and a total of 23 respondents were reached through the different focus groups. The duration of the focus groups varied between 1h15 and

1h35. The focus groups were deliberately limited to an hour and a half in order to keep the respondents' attention. Although the intention of the focus groups was to include respondents with different backgrounds of drug use, the majority of respondents appeared to have an history of addiction and other problems related to their drug use. Participants received a refund of their bus and train tickets, and a fee of 10 EUR for their participation in the focus group. Lunch was also provided to all participants during the focus group.

All focus groups were subsequently transcribed, before they were coded and analysed through NVivo. As with the semi-structured interviews, the analysis consisted of a thematic analysis in a first step, and a more in-depth analysis in a second step (cf. supra). A thick description of the results is detailed in the report. The quotes, added to illustrate or further contextualise the results, were not translated to English to stay as closely as possible to what the respondent has said.

C. Ethical aspects

In order to protect study participants from harm by the research, the research process or the researchers, several actions were put in place to ensure informed consent, self-determination, minimization of harm, anonymity, and confidentiality (Hennink et al., 2020). First of all, all respondents were presented with an informed consent form before the start of the interview. The informed consent explained the interview goal and format, and informed about the way the study findings would be analysed and processed. The informed consent further explained that participation was voluntary, that they had the right to refuse participation or withdraw from the research, that respondents could receive additional information upon request at any given time, and that all data would be anonymised and treated in a confidential way. The informed consent was translated into understandable language and handed out along with an information letter and contact details of the principle researcher. At the beginning of the focus group, the informed consent guidelines and guarantees were discussed in detail, and respondents were asked to verbally confirm whether they agreed or not, and to voice their questions, if they had any. Eventually, two participants have withdrawn from the focus groups.

Second, participation in the study was completely anonymous. The flyer gave a date and place where the focus group would take place, registration in advance was not required. Also, during the focus group, respondents were not required to leave their names or contact details. In this way, respondents remained completely anonymous and no personal data was gathered. The recordings of the focus groups were fully anonymised, treated and stored in a confidential way, in accordance with the data management plan.

Third, after the first focus group, a distress protocol was developed on how minimize potential risks to participants during the focus groups (Sim & Waterfield, 2019). This research applies a strength-based and empowering approach, where respondents are considered as experienced experts. Within this approach, respondents are given the agency to share their opinion and experience as an indispensable part of the evaluation. The focus group approach is focused around bringing about a feeling of empowerment, a sense of purpose and an opportunity to help the evaluation of the Belgian drug policy. Although there is little risk from participating in a focus group discussing how participants evaluate the Belgian drug policy, we do prepare a distress protocol to reduce the possible harms participants may experience (Draucker et al., 2009). This distress protocol described how we would deal with situation where stress related to emotional distress during or after data collection occurred. The protocol considered how to review, respond to and follow-up after the situation.

2.2.3 WP3: Recommendations

To address the last research question related to formulating recommendations, a focus group was conducted with ten key civil servants, practitioners and (scientific) experts that have an expertise in one or more domains related to the Belgian drug policy. During this focus group, six statements were

developed based on the research results, which were then discussed by the respondents. The aim of the focus group was to gain further insight into the future needs for the Belgian drug policy and receive input for the finetuning of the recommendations.

2.2.3.1 Focus group with stakeholders from practise and administration

A. Preparation, sampling and recruiting respondents

From the target population of the semi-structured interviews, ten key respondents were selected to participate in this final focus group. Respondents were chosen for their overview of Belgian drug policy, and their central information position already established by the semi-structured interviews. These ten respondents were then invited to participate to the focus group as a representative of a certain pillar.

As with the previous research methods the researchers developed a script with central themes that were to be discussed during the focus group, to enhance the consistency of the data collection (Arthur & Nazroo, 2003). Also, the script ensured that the focus group remained a focus on the central topic, as there were a lot of themes to discuss within each focus group. The script clarified the intent and the course of the focus group, including a timeline for each topic. The themes were deliberately kept very broad, so that the questions could not steer and a lot of room was left for the respondents' own interpretation. The script probed for how respondents evaluated the current Belgian drug policy. The script was then translated to Dutch and French, as the focus group took place both in Dutch or in French (simultaneous translation). The script has been added in annex.

B. Data collections and analysis

The focus group for the recommendations took place in June 2021, and took place online due to the covid-19 confinement restrictions. The focus group was conducted through Zoom, as this was to only tool available that offer means for simultaneous translation. The eventual focus group lasted 2 hours.

The focus groups were subsequently transcribed, coded and analysed through NVivo. The transcript was completely anonymised, as well as potentially identifying information, in accordance with the data management plan (Bancroft & Reid, 2016). The analysis consisted of a thematic analysis in a first step, and a more in-depth analysis in a second step, as was the case with the previous focus groups and the semi-structured interviews (cf. supra). The results of the focus group were incorporated within the sections of semi-structured interview results.

C. Ethical aspects

Respondents were presented with an informed consent form before the start of the focus group. The informed consent explained the interview goal and format, and informed about the way the study findings would be analysed and processed. The informed consent further explained that participation was voluntary, that respondents could receive additional information upon request, and that all data would be anonymised. The respondents were asked to sign the informed consent. Respondents were also asked for consent to record the interview, again assuring confidentiality.

2.3 Limitations

Theory-driven evaluations have many advantages. Whereas traditional evaluations often attempt to measure effectiveness through assessing the outcomes of a policy or program, theory-driven evaluations explain how these outcomes have been produced, by use of a detailed description on possible causes and contextual factors that lead to change. Scientist often refer to this type of evaluation as ‘opening the black box’ or ‘white box’ evaluations, opposing them to ‘black box evaluations’ with a sole focus on effects and outcomes (Astbury & Leeuw, 2010). Theory-driven evaluations can guide

evaluation by indicating what aspects should be measured and how, but they are also valuable in identifying why unsuccessful policies or programs are failing, or what makes a policy or program successful. Lastly, it can provide a framework to bring together lots of information, even from different evaluations to make improvements possible (Funnell & Rogers, 2011).

Nonetheless, there are a few limitations. One of the criticisms of theory-driven evaluations, is the inability of identifying unintended consequences or side effects that result from a certain policy (Coryn et al., 2011). Other scholars also highlight the oversimplification of reality when relying on a theory-driven evaluation. Lastly, there are some limitations with constructing logic models in retrospect, which was the case for the logic models of the Belgian drug policy.

2.3.1.1 Unintended consequences

Logic models focus on the desirable, intended outcomes. They therefore tend to be insensitive to unintended consequences and side effects (Bamberger et al., 2016; Morell, 2018). These unintended consequences were not anticipated in the policy and thus not reflected in the logic model. Nevertheless, it is important to include these unintended outcomes in an evaluation. Unintended consequences tell something about the design or implementation modalities that could affect efficiency and effectiveness and equitable access of certain target groups (Bamberger et al., 2016). Moreover, ignoring unintended consequences could affect specific groups, often the more vulnerable groups. This would mean that politically more powerful groups would get a disproportionate share of the policy benefits (Bamberger et al., 2016).

As these unintended consequences focus on the **outcomes** (and thus (long term) effects) of a policy, they are especially relevant for an effect evaluation. The focus on these unintended consequences is thus less relevant for the general process evaluation in this study. We are however aware of the possibility of unintended outputs due to implementation issues. Combining this with the recommendation of the Council of Europe that advises Member States to assess the intended **and unintended** effects of envisaged drug policy measures and their potential impact on human rights[2], Therefore, we included specific questions in the semi-structured interviews explore those possible unintended consequences, without attributing them explicitly and solely to a certain policy initiative.

2.3.1.2 Oversimplification due to the use of logic models

The great strength of logic models is that they offer a simplified view of the reality to emphasise the patterns that are important to the Belgian drug policy. Although this is the principal value of evaluating through logic models, it is also a pitfall. By highlighting the patterns that are important to the Belgian drug policy, other patterns are omitted (Morell, 2018). The logic models could depict the reality in an overly simplified manner, which fails to encompass the dynamic nature of real world complexity (Morell, 2018). A focus on the underlying assumptions and mechanisms could counter these oversimplified versions of policy theory (Astbury & Leeuw, 2010).

2.3.1.3 Constructing logic models in retrospect

Logic models should – in an ideal situation – be constructed in collaboration with the stakeholders. To clarify the policy theory, evaluators should check both policy documents, as well as checking and clarifying the policy theory in close cooperation with stakeholders. As the Belgian drug policy is more than twenty years old, the latter not feasible. Even if we found respondents involved in policy making at the time, it would be hard to extract the unbiased underlying assumptions of different actions from such

[2] Drug policy and human rights in Europe: a baseline study, Committee on Legal Affairs and Human Rights, Doc. 15086, 21 February 2020, http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-EN.asp?fileid=28282&lang=en

a long time ago. We therefore reconstructed the policy logic purely based on the policy documents. This poses a few limitations:

1. First of all, the documents did not have complete information on the different parts of the logic models (often outputs or outcomes were missing). Some aspects of the policy were simply not written down. This did not mean that these aspects were not defined at the time, but since it was not written down, we had no way of knowing. Therefore, there remain 'blank spots' in some of the logic models (often in outputs or outcomes), possibly about aspects that stakeholders could have elaborated on.
2. Second, we could not verify the logic models with the stakeholders to see whether the logic models were an accurate reflection of the policy logic at the time.

2.3.1.4 General evaluation does not allow for in-depth results and conclusion on sub-themes

This evaluation is focused on the entire drug policy, and thus deals with a wide range of topics related to the demand side and the supply side, but also on cross-cutting themes such as policy coordination, epidemiology, and research. As a result, the focus of this report is on the broadness of drug policy, rather than its depth. This contrasts with the two targeted evaluations, that give an in-depth insight into two a well-defined project (Drug treatment projects in prison; CLA100). Although various themes are discussed, they are not necessarily analysed in depth. After all, that would distract too much from the scope of the evaluation, which is to gain insight into the Belgian drug policy in its entirety. As a result, some results, conclusion and recommendations might come off as vague or lacking concrete information.

2.4 Overview of the EVADRUG project

Table 6 Overview of research aims, questions and methods

Aim	Research Question	Method
To develop a framework suited for the evaluation of the Belgian drug policy.	What are the identified aims, action points, intended outputs and intended outcomes of the Belgian drug policy?	• Document analysis of three central policy documents • Stakeholder validation
	To what extent are the logic models of the pillars and transversal themes consistent, coherent and logical?	
To conduct a general process evaluation of the Belgian drug policy.	To what extent and how have the actions set out in the Federal Drug Note (2001) and Joint Declaration (2010) been achieved?	• Rapid document review • Online survey • Semi-structured interviews • Focus groups with people with lived experiences
	What barriers and facilitators obstructed or facilitated the implementation of the actions set out in the Federal Drug Note (2001) and Joint Declaration (2010)?	
	To what extent are the objectives and actions set out in the Federal Drug Note (2001) and Joint Declaration (2010) in line with the current Belgian needs and problems?	

To conduct a targeted process, output and outcome evaluation of three interventions within the Belgian drug policy.	What do we learn from the targeted process, output and outcome evaluation of three interventions within the Belgian drug policy?	• Document review • Semi-structured interviews • Focus groups
To formulate recommendations to conduct (systematic) drug policy evaluations in Belgium.	Which recommendations could be raised regarding methodology and evaluation of the Belgian drug policy?	• Focus group with practitioners, civil servants and (scientific) experts

CHAPTER 3

THE DEVELOPMENT OF THE BELGIAN DRUG POLICY

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3 THE DEVELOPMENT OF THE BELGIAN DRUG POLICY

In this chapter, we summarise the development of the Belgian drug policy. To evaluate the Belgian drug policy, it is vital to understand its international and European background (Chen & Chen, 2005).

We start with outlining the international and European context in which the Belgian drug policy took place. After all, the drug phenomenon is an international phenomenon. The control strategy of the drug phenomenon should therefore not be limited to the borders of individual countries. It requires cooperation and coordination beyond borders. Based on these premises, we explore the international development concerning drug policy, before illustrating the developments of the Belgian drug policy over time.

3.1 The international context

3.1.1 Three UN conventions: the corner stone of the international drug policy

Long before the first United Nations (UN) convention was ratified, policy makers around the world recognised that the control of the drug phenomenon required a global approach (Ruyver et al., 2002). The internationalisation of the production, trafficking and distribution of different (plant-based) drugs, triggered several countries to collaborate on controlling the drug supply. In 1909, thirteen states took initiative to regulate (rather than prohibit) the control on a pressing narcotics problem at the time: opium (Stewart, 1989). This resulted in the International Opium Convention at The Hague, aimed at restricting the production and distribution of several plant-based drugs. Production, distribution and possession of these narcotic drugs became limited to their use for medical and scientific purposes (Fijnaut & De Ruyver, 2015). In the following years, several international treaties were established under the auspices of the League of Nations (later the United Nations) to further restrict the production, import and export of narcotic drugs (opium, cocaine and cannabis) and to strengthen international supervision on drug trafficking (Bewley-Taylor, 2002; Stewart, 1989). These treaties were regulatory rather than strictly prohibitive in nature and did not inquire states to prohibit drug consumption nor did the treaties require the member states to impose criminal sanctions on production (Jelsma, 2011; McAllister, 2002). The focus remained predominantly on illicit trafficking, with regulations for supplying narcotic drugs in the necessary quantities for medical or scientific use and with government licenses for trade and control services in accordance with the treaties (Lande, 1962).

These treaties eventually became the predecessors of the three UN conventions that still form the legal framework for an international system of drug control today (Bewley-Taylor, 2002). In what follows, we present a brief overview of the three central UN conventions that still define the current international drug policy framework: (1) the Single Convention on Narcotic Drugs and (2) the Convention on Psychotropic Substances that regulate the legal production and distribution of controlled substances and prohibit all other substances, and (3) the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

3.1.1.1 The Single Convention on Narcotic Drugs (1961)

In 1961, the previous international collaborations were consolidated in the Single Convention on Narcotic Drugs. This convention replaced the previous international agreements, and streamlined the (complex and sometimes overlapping) oversight mechanisms at the time (Stewart, 1989).

The Single Convention on Narcotic Drugs solidified a prohibition-based international drug control system on narcotic substances. The Convention was aimed at plant-grown, raw material of natural narcotic drugs (Sinha, 2001). It limited the cultivation, production, distribution, trade, possession and use of these

narcotic substances strictly to medical and scientific purposes. Specific attention was given to opium, heroin, cocaine and cannabis.

The Convention categorised more than 100 substances into four schedules, with their level of control depending on the level of perceived dependence creating properties and risks to public health (Bewley-Taylor, 2002). Schedule I contains the narcotic substances that are subject to all the measures under the Convention. They included, amongst others, raw organic materials and their derivatives (Sinha, 2001). Cannabis was categorized under this schedule (and under schedule IV), on the same level as opium and coca. Schedule II and III contain, amongst others, codeine-based narcotic substances, and were subject to less strict controls than the other two Schedules (Jelsma, 2011). Schedule II contains substances used for medical purposes that have less dangerous properties, schedule III lists the exemptions. Schedule IV comprises mostly of codeine-based manufactured drugs (Sinha, 2001). These substances can be allowed in strictly necessary quantities for scientific and medical purposes, but are considered particularly dangerous with a therapeutic value. These four lists of drugs and preparations are placed under the control of the Convention.

The Convention prohibited and penalised the supply side of narcotic drugs explicitly in art. 4 and 36. Art. 4 limits the production, manufacture, export, import, distribution of, trade in, use and possession of drugs to **scientific and medical purposes**. Art. 36 explicitly **penalised** the "*cultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation and exportation of drugs*."[3] The focus on the **demand side** was limited, with only art. 38 '*treatment of drug addicts'* stating that special attention had to be given to treatment, care and rehabilitation.

The Convention further established the International Narcotic Control Board (INCB), a multilateral authority that supervises the implementation of the Convention. The implementation of the Convention provisions, however, remained under the domestic power of the states (Ruyver et al., 2002), which means that the Convention are not self-executing, and can only apply indirect control to signing parties (Bewley-Taylor, 2002). Consequently, the INCB does not have the power to enforce the implementation of the Convention.

The Convention applies indirect control and relies on the states to implement them in their domestic legislation (Bewley-Taylor, 2002).

In 1972, the Convention was amended by the 1972 Protocol which streamlined the Convention with the Convention on Psychotropic Substances (1971). At the initiative of the US, the Protocol specifically expanded the role of the INCB in the control of illicit drug trafficking in general (Sinha, 2001), but also gave (a little) more attention to the demand side, in line with the (limited) measures for the demand side in the Convention on Psychotropic Substances (1971).

The prohibitionist character of the Convention is clear: control measures were implemented to provide narcotic drugs for medical and scientific purposes, while explicitly prohibiting illicit supply. The 1961 Convention was initially signed by 76 countries. It was not until 20 August 1969 that the Belgian government ratified the document.

3.1.1.2 The Convention on Psychotropic Substances (1971)

In 1971, a Convention very similar to the Single Convention on Narcotic Drugs (1961) was established in response to the significant increase of (psychotropic) drug use and harms caused by psychotropic substances (Sinha, 2001). The Convention on Psychotropic Substances (1971) was largely based on

[3] United Nations. (1961). The Single Convention on Narcotic Drugs, New York, 1961 as amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs, 1961, Geneva, 1972. http://www.incb.org/e/conv/1961/articles.htm.

the Single Convention on Narcotic Drugs of 1961, although it included less strict control measures due to lobbying activities of the multinational pharmaceutical industry (McAllister, 2002).

Similar to the Single Convention on Narcotic Drugs of 1961, the psychotropic substances were distributed into four schedules. The first schedule had the tightest control measures (the use of substances included in this schedule was limited to medical or scientific purposes), whereas the fourth schedule was the least restricting (the use and possession of substances in this schedule was permitted in specific cases, like for industrial purposes). The psychotropic substances in the four schedules consisted of – amongst others – amphetamines, barbiturates, benzodiazepines and psychedelics, however, their derivatives were not included in the schedules. This meant that all the substances had to be named in the schedule, which posed an impossible task as there are new substances being created every day (Sinha, 2001). The classification depended on the level of perceived dependence creating characteristics, the risks for public health and the therapeutic value of the substance.

Penal provision in art. 22 instructed states to "*treat as a punishable offence, when committed intentionally, any action contrary to a law or regulation adopted in pursuance of its obligations under this Convention, and shall ensure that serious offences shall be liable to adequate punishment, particularly by imprisonment or other penalty of deprivation of liberty*".. The Convention also added that states may provide measures of treatment, education, after-care, rehabilitation and social reintegration as an alternative to or additional to the penalty. This paragraph was later added in the Single Convention with the 1972 Protocol (cf. supra).

With regards to the focus on the demand side, art. 20 stated "*Parties shall take all practicable measures for the prevention of abuse of psychotropic substances and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved*"[4], which was an improvement to the Convention of 1961 which merely mentioned that attention had to be paid to the abuse of drugs.

As with the Single Convention, the Convention on Psychotropic Drugs applies indirect control and relies on the states to implement them in their domestic legislation (Bewley-Taylor, 2002).

Overall, the 1971 Convention was not as strict as the Single Convention of 1961. Both Conventions limited the use of narcotic drugs and psychotropic substances to medical, scientific and pharmaceutical purposes and strictly controlled these substances for other purposes. (Jelsma, 2011).

As Belgium was an important producer of benzodiazepine (and thus had economic interest in substances that were strictly regulated under the 1971 Convention), the Belgian government stalled the ratification of the 1971 Conventions until 1992[5] (Fijnaut & De Ruyver, 2014).

3.1.1.3 The Convention Against Illicit Trafficking in Narcotics and Psychotropic Substances (1988)

To handle the growing problem of international illicit drug trafficking, the United Nations established a third Convention in 1988, the Convention Against Illicit Trafficking in Narcotics and Psychotropic Substances. This Conventions was to deal with the increasing trafficking of illicit drugs in the seventies and eighties.

The aim of the Convention was therefore to combat international illicit drug trafficking more effectively. Penal provisions in art. 3 require states to establish as a **criminal offence** the '*production, manufacture, extraction, preparation, offering, offering for sale, distribution, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation or exportation of any narcotic drug or any*

[4] United Nations. (1971). The Convention on Psychotropic Substances, Vienna, 1971. http://www.incb.org/e/conv/1971/artciles.htm.
[5] Wet van 25 juni 1992. BS 21 maart 1996.

psychotropic substance' as well as "***possession***, ***purchase*** *or* ***cultivation*** *of narcotic drugs or psychotropic substances* ***for personal consumption***"[6]. Contrary to the previous Conventions, the demand side was explicitly criminalized in 1988. The international community declared in this way their intention to stop illicit drug trafficking through criminalization of not only the supply side, but also the demand side. As with the previous Conventions, these crimes should be punishable by adequate punishment like imprisonment, however states could provide alternatives to imprisonment in appropriate cases of a minor nature. Lastly, in an annex to the Conventions, two tables were added that listed forbidden precursor substances, frequently used in the illicit production of narcotic drugs or psychotropic substances.

The development and evolution of the three UN Conventions form the international legal framework for addressing the (illicit) drug phenomenon. It clearly indicates the international discourse of a prohibition-based, punitive approach to the drug phenomenon. The emphasis mostly remains on controlling the supply side, although the 1988 Convention not only criminalised the production, distribution and transportation of narcotic drugs and psychotropic substances, but also the possession and purchase of these substances. It is against this backdrop, that the Belgian drug policy has been developed. As the UN Conventions are not self-executing, there is room for the states to interpret the measures of the Conventions (Ruyver et al., 2002).

After 1988, a series of non-binding multilateral declarations (e.g. the 2009 Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem, the Joint Ministerial Statement of the 2014 high-level review by the Commission on Narcotic Drugs of the implementation by Member States of the Political Declaration and Plan of Action6 and the outcome document of the thirtieth special session of the General Assembly, entitled "Our joint commitment to effectively addressing and countering the world drug problem"[7]) further shaped the international landscape.

3.2 The European Context

Since the 1980, the European community systematically established measures to combat international drug trafficking and to increase cross-border cooperation within a European context. Milestones are the development of the Schengen Agreement, the Maastricht and Amsterdam treaty, as well as the many European drug strategies and action plans of the EU (Ruyver et al., 2002).

3.2.1 Convention implementing the Schengen Agreement (1990)

The Convention implementing the Schengen Agreement of 14 June 1985 on the gradual abolition of checks at common borders, is the first European document with relevance for the Belgian drug policy. This agreement goes beyond the drug phenomenon and regulates the abolishment of the checks at the common borders of the member states to facilitate the transport and movement of goods and persons at those borders. 'A free movement of persons' however also raised concerns on organized crime (among which drug trafficking) now being able to move freely across borders.

Relevant in the context of the European Drug Policy, is chapter 6 'Narcotic Drugs' of the third title 'Police and Security'. Here, all parties state that they would "*examine common problems relating to combating crime involving narcotic drugs*"[8]. Especially relevant is art. 71 that state that "*The Contracting Parties*

[6] United Nations. (1988). The Convention Against Illicit Trafficking in Narcotics and Psychotropic Substances

[7] United Nations Office on Drugs and Crime (2019). Ministerial declaration on strengthening our actions at the national, regional and international level to accelerate the implementation of our joint commitments to address and counter the world drug problem. Retrieved August 29, 2020 from https://www.unodc.org/documents/commissions/CND/2019/Ministerial_Declaration.pdf

[8] Schengen Convention of 1990, art. 70.

*undertake as regards the **direct or indirect sale** of narcotic drugs and psychotropic substances of whatever type, including cannabis, and the **possession** of such products and **substances for sale or export**, to adopt in accordance with the existing United Nations Conventions, all necessary measures to prevent and punish the illicit trafficking in narcotic drugs and psychotropic substances*." The article continues to require penal and administrative measures on the supply side. For the demand side, the Agreement states to "*prevent and combat the negative effects arising from the illicit demand".*

Art. 76 further stipulates that parties should adopt appropriate measures to combat narcotic drugs and psychotropic substances that are in the territory of another party are regulated more strictly. This measure was a direct result from the fear for enhancing drug tourism between liberal and stricter policies. The tension between France and the Netherlands prompted this measure: the negative cross border effects of the (more lenient) approach in the Netherlands of which countries like France suffered (e.g. with French drug runners causing trouble in Rotterdam, or with French drug tourist at the Dutch borders (Fijnaut & De Ruyver, 2014).

3.2.2 1992 Maastricht Treaty and 1997 Amsterdam Treaty

Two other treaties with relevance for the European drug policy, are the Maastricht Treaty[9] (also known as the Treaty on the European Union) of 1992 and the Amsterdam Treaty of 1997.

The Maastricht Treaty establishes the European Community in 1992. In art. K.1 it marks 'combating drug addiction' as a matter of common interest between the member states, next to judicial cooperation in criminal matters, police cooperation in preventing and combating unlawful trafficking and serious international crime.

The Amsterdam Treaty in turn amended several measures from the Treaty of Maastricht. This Treaty eventually established several measures with relevance to the drug phenomenon. First of all, art. 29 stated that a high level of safety should be ensured by preventing and combating crime, in particular illicit drug trafficking[10]. This entailed a need for closer cooperation between police, customs and judiciary actors and even an approximation of regulations on criminal matters (Ruyver et al., 2002). Furthermore, the Treaty mentions "*The Community shall complement the Member States' action in reducing drugs-related health damage, including information and prevention*". More concrete, it states that "*Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education.*" This article forms a judicial basis for harm reduction strategies in member states (Ruyver et al., 2002).

In line with the Schengen Agreement, criminal sanctions are required for the supply side, however on the demand side prevention and counteracting should be prioritized (Ruyver et al., 2002). The EU therefore went a step further compared to the UN Conventions by actively considering the demand side as an important pillar of drug policy.

3.2.3 A European drug policy: Strategies and Action Plans

Shortly after the Convention implementing the Schengen Agreement of 14 June 1985 in 1990, a first European Drug Policy plan was adopted at the Rome European Council in 1990. This plan clearly stated what the EU wanted to achieve concerning drug policy and how EU member states could work together in this area. It mentioned amongst others the feasibility of a European Drugs Monitoring Centre, laying

[9] Treaty on European Union, Counsil of European Communities, 1992 (https://europa.eu/european-union/sites/europaeu/files/docs/body/treaty_on_european_union_en.pdf)

[10] Amsterdam Treatty, amending the Treaty of the European Union, (https://www.europarl.europa.eu/topics/treaty/pdf/amst-en.pdf)

the foundation of the European Monitoring Centre for drugs and drug addiction (EMCDDA). Actions are structured around the following policy domains: inter-member state coordination, demand reduction, suppression of illicit trafficking and international cooperation. There was a limited amount of actions compared to the strategies of the following year, however, it was the first time that the EU addressed the drug phenomenon on this level.

In 1993, the 'Reseau Europeen d'Information sur les Drogues et les Toxicomanies (REITOX)' was established, and in 1995 the European Monitoring Centre for drugs and drug addiction (EMCDDA) was created. Both organizations collect and disseminate information on the drug phenomenon in the EU, and are used to inform the EU drug debate.

Between 1990 and 1999, the EU drafted three Action Plans. The first Drug Strategy however, was only established in 2000. After 2000, three more Drug Strategies have been developed, each with corresponding action plans. All Drug Strategies and Action Plans from 2000 onwards, were evaluated before establishing the next Strategy (EMCDDA, 2019).

3.2.3.1 European Drug Action Plan 1995-1999

The European Drug Action Plan 1995-1999 was established, choosinga similar approach as in 1990 (Maastricht Treaty). This involvedprioritising an integrated and comprehensive response to the drug phenomenon, meaning that the EU would focus both on demand reduction, combatting illicit trafficking and international cooperation. The need for coordination was stressed both at EU and member state level.[11] The European Drug Action Plan 1995-1999 was not evaluated.

3.2.3.2 European Drug Strategy 2000-2004

Building on the previous Drug Action Plan, The European Drug Strategy of 2000-2004 was developed, this time considering the new possibilities the Amsterdam Treaty had created. Making full use of the expertise of the EMCDDA and of Europol, The EU suggested a balanced, multidisciplinary and integrated approach. The actions were structured around four main policy domains and cross-cutting themes: demand reduction, supply reduction, international cooperation and information and evaluation. The latter domain, Evaluation, was new compared to the previous years: "*The EU Strategy has to be based on a regular assessment of the nature and magnitude of drugs phenomenon and its consequences as well as on knowledge acquired from research and lessons derived from past programmes. The present strategy itself must also be evaluated"*[12]

This strategy was evaluated mid-term in 2002, and was subjected to a final evaluation in 2004. The final evaluation indicated that most actions were (in a stage of being) implemented and progress was made looking at the overall targets of the EU. However, the overall drug use and the availability of drugs seemed to not have changed, based on the available data at the time. Recommendations stressed amongst others the importance of clearly defining the objectives, selecting clear indicators to measure these objectives and the need to clearly define deadlines and responsibilities[13].

[11] European Union Action Plan to combat drugs (1995-1999)
[12] European Union Action Plan to combat Drugs (2000-2004)
[13] EU Drugs Strategy (2005-2012); communication from the Commission to the Council and the European Parliament on the results of the final evaluation of the EU Drugs Strategy and Action Plan on Drugs (2000-2004)

3.2.3.3 European Drug Strategy 2005-2012

The European Council adopted a new EU drugs strategy 2005–2012 in December 2004[14]. This time, the Strategy covered a period of eight years. The Strategy had two main aims:

1. Complementing Member States in their actions to prevent and reduce drug use, dependence and drug-related harms to health and society in order to contribute to a high level of health protection, well-being and social cohesion;
2. Ensuring a high level of security for the general public by acting against drugs production, cross-border trafficking in drugs and diversion of precursors on the one hand, and by focusing on prevention of drug-related crime on the other hand. Both should be carried out in cooperation and should be embedded in a joint approach.

Similar to the previous years, an integrated, multidisciplinary and balanced approach was put forward in which the demand side, as well as the supply side were emphasised. The cross-cutting themes of the Drug Strategy were international cooperation and research; coordination; and information and evaluation.

The Strategy resulted in two action plans, each one covering a period of four years. Each year, the European Commission reported on the extent of implementation of the actions, which in turn fed the evaluation of the first Action Plan in 2008 and the second Action Plan in 2012. Based on the evaluation of the first Action Plan, the Action Plan 2009-2012 was drafted. This Action Plan was eventually evaluated together with the entire Strategy of 2005-2012 in 2012 by an external party, RAND Europe, in line with the requirements of an evaluation mentioned in the Action Plan 2009-2012 (Action 72). The final evaluation noted that the Strategy was logical and coherent. The Action Plans were very elaborate, leaving to little room for specific focus and priorities within of the Strategy and Action Plans. There are some clear successes at the demand side, among which the wide scope of the demand side, evidence for the positive impact of harm reduction measures. There is however also a need for broader policy framework of addiction and licit drugs (Culley et al., 2012). For supply reduction, there seemed to be indicators that show some positive results (e.g. successful joint operations), however the available evidence could not attribute the change to the Strategy or its Action Plans. These limitations for measuring effectiveness of the supply reduction initiatives remain eminent (Culley et al., 2012). Positive results were found for the themes ‘coordination’, ‘international improvement’ and ‘research and evaluation’, although there remains room for improvement (e.g. on holding the balance between supply and demand reduction in the Horizontal Drugs Group, disparities in quality and availability of data) (Culley et al., 2012).

3.2.3.4 European Drug Strategy 2013-2020

In June 2013, a new European Drug Strategy was adopted, after taking into account the RAND Europe evaluation of 2012. Similar to the previous Drug Strategy, it covered a period of eight years, with an action plan established every four years. The Drug Strategy is very clear with regards to the overall aim of the EU: “*The Strategy aims to contribute to a reduction in **drug demand and drug supply** within the EU, as well as a **reduction as regards the health and social risks and harms** caused by drugs through a strategic approach that supports and complements national policies, that provides a framework for **coordinated and joint actions** and that forms the basis and political framework for EU external cooperation in this field. This will be achieved through an **integrated, balanced and evidence-based** approach*.”[15]. The strategy is, like the previous Strategies, structured around two policy domains, demand reduction and supply reduction, and three cross-cutting themes: coordination; international cooperation and research, information, monitoring and evaluation. Learning from the previous

[14] EU Drugs Strategy (2005-2012)
[15] EU Drugs Strategy (2013-20)

evaluations, criteria were established for the actions of the Action Plans. Actions had to be evidence-based, scientifically sound, cost-effective, and realistic and measurable. They should be measurable with an indication of the responsibilities, and have a clear EU relevance and added value.

A mid-term assessment of the Strategy and the first Action Plan was conducted in 2016, informing the development of the new Drug Action Plan. This evaluation concluded that most of the actions were implemented. The least progress was made in the area of international cooperation and demand reduction. One of the main recommendations was that the new action plan should update the existing Action Plan, rather than drafting a complete new Action Plan (Balbirnie et al., 2016). A new Action Plan (2017-2020) was adopted in July 2017. The EU Drug Strategy and the second EU Drug Action Plan 2017-2020 were consequently evaluated in 2020[16]. The main findings were that the evolving threat picture and the context in which the Strategy was developed, changed considerably since 2013. As such, thestrategy as well as the Action Plan lost relevance. Also, both policy documents have proven to be consistent with European sectoral legislation and policy at international level, although the coherence between the major domain of Health and Security have been weakening due to "*the dynamic developments in the drugs situation since 2013*" (p. 38) such as. the criminal patterns of OCGs, and new ways of drug consumption. The evaluation further stated that both plans were only partially effective in achieving a reduction in supply and demand. Both policy plans were more effective in achieving the objective in the cross-cutting themes. Lastly, the mid-term evaluation found that both policy plans did have added value indicating that national or other EU initiatives would not have achieved the objective that these policy documents did.

3.2.3.5 EU Drug Strategy and Action Plan on Drugs 2021-2025

Considering the results of the previous evaluation, the new EU drug strategy[17] was approved on 18th of December 2020. It aims to "*protect and improve the well-being of society and of the individual, to protect and promote public health, to offer a high level of security and well-being for the general public and to increase health literacy. The Strategy takes an evidence-based, integrated, balanced and multidisciplinary approach to the drugs phenomenon at national, EU and international level. It also incorporates a gender equality and health equity perspective*". It introduces, next to the previously known pillars 'Drug supply reduction/enhanced security' and 'Drug demand reduction', a third pillar 'drug-related harms'. The cross-cutting themes remain the same as the previous EU Drug Strategy: (1) International cooperation, (2) Research, innovation and foresight; and (3) Coordination, governance and implementation.

[16] Commission Staff Working Document Evaluation of the EU Drugs Strategy 2013-2020 and EU Action Plan on Drugs 2017-2020
[17] EU Drugs Strategy 2021-2025, 13932/20

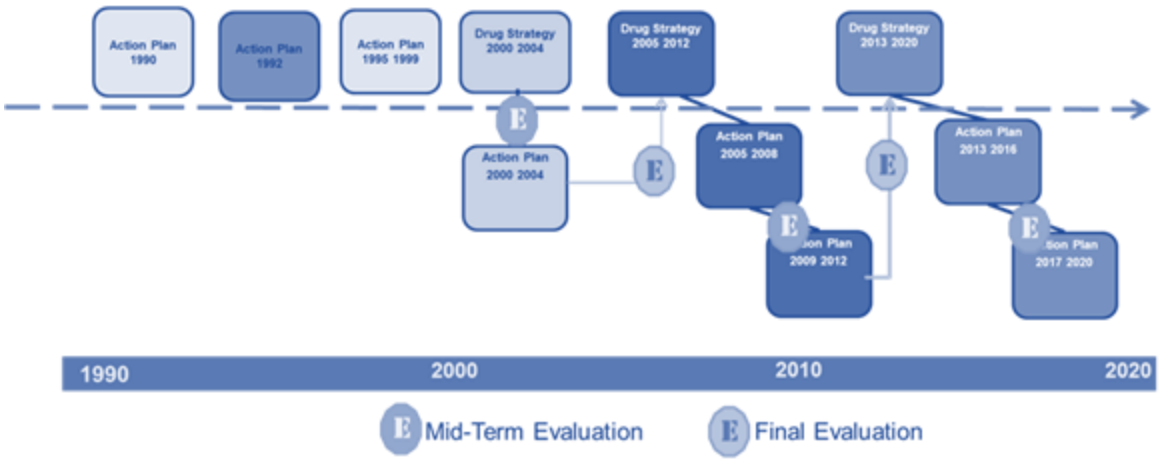

Figure 6 Timeline of the EU Strategies, Action Plans and Evaluations until 2020 (EMCDDA)

3.3 The Belgian drug policy

The first legislate initiative regarding drug could be found with with the establishment of the Drug Law in 1921. However, it was not until 1996 that the first steps to an integral an integrated policy were taken with the Parliamentary Working Group on Drugs. This eventually was the catalysator to the development of the Belgian drug policy.

3.3.1 First legislative initiatives in 1921

In 1921, Carton de Wiart initiated the establishment of the Belgian Drug Law[18]. The drug problem was, however, not prominent at the time (Fijnaut & De Ruyver, 2014).After WWI there were some concerns about soldiers selling their pharmaceutical supplies of cocaine and morphine , but eventually this turned out to be a temporal phenomenon. Some excesses however occurred in the medical context, which explains why the Drug Law of 1921 was primarily aimed at substances like sedatives[19]. The Drug Law comes shortly after the 'prohibition' of alcohol in 1918 and the Alcohol Laws of Vandervelde in 1919, banning strong liquors from publicly accessible places as well as restricting and taxing the sale of strong liquors to private individuals (Casselman, 2019). Fearing a displacement from of alcohol use to the use of narcotic substances, policymakers at the time pushed for a similar legislation for narcotic substances (Fijnaut & De Ruyver, 2014). The Drug law also fulfilled the international obligations under the International Opium Convention of the Hague of 1912 at the time[20].

The Drug Law of 1921 is a framework law. This means that there are Royal Decrees giving substance to the law. The Drug Law of 1921 should therefore be read together with these Royal Decrees. With this Drug Law, there are two groups of substances regulated. The first group consists of 'toxins, disinfectants and antiseptics', the second group are 'sedatives and narcotics. In 1975, psychotropic substances would be added and in 2003, precursors would complement the list of substances ('the substances which may

[18] Wet van 24 februari 1921 betreffende het verhandelen van gifstoffen, slaapmiddelen en verdovende middelen. BS 6 maart 1921. This Royal Decree was repealed by the 'Koninklijk besluit van 6 september 2017 houdende de regeling van verdovende middelen, psychotrope stoffen. BS 26 september 2017'
[19] Memorie van toelichting bij het Wetsontwerp betreffende het verhandelen van de giftstoffen, slaapmiddelen en verdovende middelen, ontsmettingsstoffen en antiseptica, Parlementaire Stukken Kamer 1920-21, nr. 41.
[20] Ibid

be used for the illicit manufacture of narcotic drugs and psychotropic substances'[21]). The aim of the 1921 Drug Law was to combat drug trafficking.

3.3.2 Developments between 1921-1990 are limited to legislative initiatives

It is not until 1930 that the Drug Law of 1921 is operationalised by a Royal Decree[22]. This Royal Decree stipulates in article 11 that "*no one may import, export, manufacture, possess, sell or offer for sale, deliver or acquire narcotic drugs, whether in return for payment or free of charge, unless he has obtained prior authorization from our Minister, who has public health in his attributions".* It did not aim to criminalize the consumption of drugs at that time, but it did make the possession of narcotic drugs illegal (Guillain, 2003).

Furthermore, up until the 1970's, the legislative and policy initiatives concerning the drug phenomenon remained limited (e.g. penalisation of LSD) (Brosens, 1976). This changed in 1975, when not only the international context (Single Convention on Narcotic Drugs and Convention on Psychotropic Substances were established), but also a fear for an escalation of drug use in Belgium, urges policy makers to take more repressive action against the drug phenomenon (Vander Laenen & Dhont, 2004) (Fijnaut & De Ruyver, 2014; Tieberghien, 2015).

Led by Alfons Vranckx, a conservative counter-movement of the socially critical movement(s) at the end of the 1960s started up reactions against drugs and crime on multiple fronts (Fijnaut & De Ruyver, 2014). On a legislative level, a bill was introduced in 1971 which eventually resulted in the 1975 Law[23] to change the Drug Law of 1921. This law tightened the legislation at the time in many ways: it amongst others introduced a few new offences like drug use in group, it extended the scope of the law to psychotropic substances (in accordance with the 1971 UN Convention), it introduced the concept of 'dependence', it increased penalties for drug offences and added new aggravating circumstances, it introduced an exemption or reduction of sentence for people who could give relevant information, and added an article on (the extended) suspension and probation for drug users[24].

At that moment, there was no political nor a social consensus on the distinction between cannabis and heroin or cocaine in Belgium. All these substances remained categorised in the same group, as was the case in the UN conventions (Fijnaut & De Ruyver, 2014).

The changes made in 1975 clearly followed the international prohibitive discourse and had found inspiration in the 'War on drugs' framework of the United States (Fijnaut & De Ruyver, 2014; Vander Laenen & Dhont, 2004). On the other hand, it showed the intention to rehabilitate drug users which could be regarded as a first step towards a policy oriented approach towards both the supply and demand side.

3.3.3 The Belgian Drug Policy: a late bloomer

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[21] Wet van 3 mei 2003 tot wijziging van de wet van 24 februari 1921 betreffende het verhandelen van de giftstoffen, slaapmiddelen en verdovende middelen, ontsmettingsstoffen en antiseptica, BS 2 juni 2003

[22] Koninklijk Besluit van 31 december 1930 houdende regeling van de slaapmiddelen en de verdovende middelen en betreffende risicobeperking en therapeutisch advies, BS 10 januari 1931

[23] Wet van 9 juli 1975 tot wijziging van de wet van 24 februari 1921 betreffende het verhandelen van giftstoffen, slaapmiddelen en verdovende middelen, ontsmettingsstoffen of antiseptica, BS 26 juli 1975

[24] Wetsontwerp tot wijziging van de wet van 24 februari 1921 betreffende het verhandelen van de giftstoffen, slaapmiddelen en verdovende middelen, ontsmettingsstoffen of antiseptica, Parl. St. Kamer, 1974-75, 20 juni 1975, nr.608/2, 4

During the late 1980 and early 1990 some of the major cities in Belgian were confronted with an increase in crime rates and public nuisance. The high crime rates in combination with the outbreak of infectious diseases, were attributed to an increase in problematic drug use and became a source of fear in various neighbourhoods (De Ruyver et al., 2012). At the same time, the confidence of citizens in justice is also being dented by incidents such as the raids of the Bende van Nijvel and the perceived laxity of the justice system towards these incidents (Vander Laenen & Dhont, 2004). Some right winged parties used these feelings of insecurity and distrust to their advantage to win the elections of 1991, which was later marked as 'black Sunday'. This led to an increased focus onof 'security' as the central policy issue of the 1990s. As a result, addressing the 'drug problem' became a key item in the Belgian policy.

Several measures were taken to tackle the drug phenomenon. First of all, security and prevention contracts were drawn up in the major cities. These contracts insured financing local projects that tackled crime and public nuisance(Fijnaut & De Ruyver, 2014; Tieberghien, 2015). Second, the minister of Justice dispersed a circular letter together with the five General Prosecutors on the 5th of May 1993, which instructed Public Prosecutors to respond to violations of the Drug Law, regardless of type of drugs, indicating a stricter approach towards drug users (Guillain, 2003). It also made a distinction between occasional users, habitual users and drug dealers (Fijnaut & De Ruyver, 2014). Yet, the first timethat the entire federal government was involved in implementing a drug-related policy initiative, was the Ten Points plan of 1995. The plan aimed at the reduction of public health and crime dangers and the further tackling of drug trafficking. It started from four key principles: (1) the expansion and diversification of the treatment offer, (2) prevention, (3) gaining a better understanding of the drug phenomenon and (4) reducing drug supply[25]. Ten action points were prioritised, among which the introduction of MSOC/MASS as low-threshold treatment initiatives, syringe exchange projects and drug policy in penitentiary institutions[26].

Several policy initiatives were introduced although they were not aligned with one another, and were perceived uncoordinated and unlinked (De Ruyver et al., 2012). Different policy levels (federal, regional local) and domains (justice, internal affairs, public health, social affairs, federal urban policy, welfare) were involved in the drug policy, but coherency was lacking leading to some measures even counterbalancing each other (De Ruyver et al., 2012).

Eventually, a parliamentary working group was created by the Chamber of Representatives in 1996 to address the drug problem in its entirety and to formulate clear recommendations for the Federal government.

3.3.3.1 Parliamentary Working Group on Drugs (1996-1997)

The working method of the Parliamentary Working Party was quite unique in the parliamentary history of Belgium (Fijnhaut & De Ruyver, 2014): Central in de Parliamentary Working Group on Drugs was the bottom-up approach, in which experts from each relevant sector were asked for a state of affairs and recommendations for a future drug policy. This resulted in a status quo on the drug phenomenon in Belgium and clear recommendations on how the Federal government should approach the phenomenon in the future. Most of these recommendations were followed by the working group, and lead to a consensus on a multidisciplinary and coherent approach to the multi-dimensional drug phenomenon (De Ruyver et al., 2012).

The Parliamentary Working Group on Drugs stated that a prohibitionist policy no longer guaranteed to master the drug phenomenon. An anti-prohibitionist policy on the other hand (in the form of decriminalisation) could – according to the working group - lead to an explosion in supply. They therefore proposed a **normalisation policy, a third way between a prohibitionist and anti-prohibitionist policy**. This approach was based on the historical reality that drug use is of all times and societies.

[25] Federaal Actieplan 'Toxicomanie-drugs' (1995)
[26] Ibid.

Within this approach, it is essential that the boundaries are determined within which the use of resources is acceptable to society. To achieve this, the working group started from three premises: **First** of all, there should be a **permanent balance** between setting the standard on the one hand and the necessity of a flexible and adequate adaptation of the policy to an evolving, multi-dimensional, social phenomenon on the other hand[27]. A **second premise** is the vertical and horizontal policy coordination and alignment. The vertical policy alignment must take place between the federal and community levels, between the community and provincial levels, between the federal and local levels and between the provincial and local levels. Horizontal alignment involves interdepartmental consultation, intersectoral consultation platforms and cooperation with other policy domains. **Third**, the Belgian drug policy must be integrated within the European drug policy.

The working group identified six priorities:

1. The main priority is to discourage and reduce the use of drugs, both legal and illegal, and to slow down the number of people who start using drugs. The development of a **prevention** policy is essential for this priority.
2. The second priority is to **protect society and its members** affected by the drug phenomenon.
3. A third priority aims to increase efforts to **strengthen repressive policies** against organised drug trafficking and criminal organisations linked to drug trafficking.
4. Fourth, an **adaptation of the criminal policy** regarding drug user(s) is necessary. The imprisonment of drug users who have not committed a drug-related offence should be avoided.
5. Fifth, a **penitentiary policy** should be developed that, on the one hand, prevents people getting imprisoned for drug use and, on the other hand, provides for the possibility of substitution treatment for the drug addicts[28].
6. Lastly, **evaluation** is indispensable for an integrated and integral drug policy.

As such, the working group centralised the **ultimum remedium approach**, in which priority was given to prevention, followed by treatment to people who misuse drugs and repression should only be used as a last resort and for people involved in drug supply for profit. For the first time, a distinction was made between the approach towards cannabis and the approach towards other illegal drugs. Cannabis would get the lowest prosecution priority, honouring the principles the normalisation policy (showing boundaries of what is acceptable).

The orientations set out by the working group eventually presented the foundation of today's drug policy. Shortly after the Parliamentary Working Group had finished its report, the House of Representatives filed a motion to request the implementation of the recommendations on a federal level.

3.3.3.2 The Federal Drug Note 2001

The political crisis dealing with the aftermath of the Dutroux case, slowed down the consolidation of the recommendations of the Parliamentary Working Group on Drugs. Only a limited number of action points were implemented in the period between 1997 and 2000. One of the action points that did get implemented, was the new circular letter of the Board of Prosecutors General[29] on prosecution policy regarding the possession and retailing of illicit drugs. This circular letter clarified that the possession of small quantities of cannabis for personal use had the lowest prosecution priority, and would only be registered by a simplified police report. What was considered as ‘small quantities’ was not further defined, resulting in differences in prosecution across judicial districts (Fijnaut & De Ruyver, 2014).

[27] Parliamentary Working Group on Drugs, 1996-1997
[28] Terminology of the Parliamentary Working Group of Drugs is used here.
[29] COL 5/98 van 8 mei 1998

An evaluation of the implementation of the Parliamentary Working Group on Drugs (De Ruyver et al., 2000) in 2000 confirmed that most of the recommendations had remained a dead letter. Parts of this report were later used to review to extent of implementation.

Finally, in 2001, the Federal government established the Federal Drug Note as an answer to the recommendations of the Parliament.

The Note comprises of two main parts: a review of the state of implementation of the recommendations of the Parliamentary Working Group on Drugs, and several actions points that implement a number of unrealised recommendations. The Federal Drug Note focuses on the (legal and illegal) psychoactive substances, including tobacco. Gambling addictions are not covered, nor is the medical use of cannabis. Central in the policy document, is the premise that the drug problem is essentially a public health matter. Therefore, it prioritises a normalization policy with attention for both the supply and the demand side. The Federal Drug Note has three central objectives:

1. to reduce the number of dependent drug users;
2. to reduce the physical and psychosocial damage related to drug use;
3. to reduce the negative impact of the drug phenomenon on society;

Policy makers intent to achieve these three objectives through three pillars and two transversal themes. The pillars consist of (1) Prevention for people of (problematic) drug use (2) Treatment, risk reduction and reintegration of problematic drug use (3) Repression towards production and trafficking. In order to meet these goals, collaboration and coordination between the different policy levels and policy domains is necessary, as well as the development of epidemiological and evaluation tools.

Figure 7 Three pillars and two transversal themes of the Belgian Drug Policy

The specific aims and actions from the Federal Drug Note are discussed in detail per pillar/transversal theme in the following chapters (cf. chapter 4-8).

3.3.3.3 The Joint Declaration of the Interministerial Conference Drugs 2010

After the endorsement of the Note, a variety of measures were taken at different policy levels. One of the most significant measures was the signing of the Cooperation Agreement between the Federal State, the Communities, the Joint Community Commission, the French Community Commission and the Regions for a global and integrated drug policy in September 2002. The agreement gave the Federal Minister of Public Health the mandate to coordinate the implementation of the Agreement. This Agreement established an Interministerial Conference Drugs (now: Public Health) and a General Drug Policy Cell, that unites all authorities involved in the drug policy.

On 25 January 2010, the Inter-Ministerial Conference on Drugs approved a joint declaration, basically an update of the Federal Drug Note of 2001 (De Ruyver et al., 2012).

This Joint Declaration sums up the state of affairs since the Federal Drug Note in 2001. The last chapter of the Declaration then indicates the direction the Belgian drug policy should take. In many ways, the Joint Declaration is a confirmation of the previous commitments: an integral and integrated drug policy, based on three pillars and strengthened by two transversal themes. The principles and objectives are essentially the same, but less detailed.

The specific aims and actions points are discussed in detail per pillar/transversal theme in the following chapters (cf. chapter 4-8).

3.3.3.4 The current organisation of the Belgian drug field

Although the Joint Declaration of the Interministerial Conference Drugs of 2010 was the last overarching drug policy plan of Belgium[30], the drug field has changed since. Most notably, the Sixth State Reform changed some competences even further. Many competences concerning 'Prevention' and 'Treatment' were defederalized from the Federal government to the regions and communities.

The Sixth state reform, initiated in 2011 by the Butterfly Agreement[31], defederalised several competences concerning healthcare to the Communities, specifically within the domains of care for the disabled, hospitals, institutions for the elderly, rehabilitation, mental health care, health prevention, the organisation of primary health care, some aspects of the health care professions and specialised drug treatment (Hannes, 2014; Vander Laenen, 2016). The transfer of competences was accompanied by a major shift of financial and other (such as personnel) resources (Pas, 2014), which concerned partial financial autonomy of the Regions.

After the formal transfer of competences in 2014, a transitional period started during which the federal institutions (in this case RIZIV/INAMI) continued to ensure the financing of the health care providers, while the federated entities already had budgetary responsibility. On 1 January 2019, that transitional period ended, and the regions and communities became fully responsible for implementing and managing the transferred competences (Rossignol et al., 2019).

A. Impact of the Sixth State Reform on the Prevention field

Since the state reform of 1980, preventive health policy has been the competence of the communities through the so-called 'person-related matters. There were still a few exceptions, especially in practise (e.g. tobacco cessation) (Hannes, 2014; Vlaamse Regering, 2013). As of 2014, these 'person-related matters' were further expanded. The federated entities received the full competence to take prevention initiatives, and the resources for prevention that were previously deployed federally, were transferred to the federated entities, as was the case with the Fund for combating addictions. Although prevention competences have become a purely regional competence, in institutional terms they are often part of other competences and may therefore also depend on the governmental level to which the latter belong. Prevention, for example, belongs to the competence 'health', but also to other competences that are managed both at the federal level and at the level of federated entities (Sholokova, 2021). In that sense is a 'health in all policies' approach encouraged, a cross-sectoral approach to public policy that systematically considers the health consequences of decisions, seeks synergies and avoids adverse health effects in order to improve public health and health equity" (World Health Organisation, 2013).

[30] As explained in the Introduction, there are more recent policy documents that refer to the drug phenomenon, such as the Framework Note on Integral Security. None of these policy documents are overarching all policy levels and domains like the Joint Declaration did.
[31] Vlinderakkoord 11 oktober 2011 (https://www.dekamer.be/FLWB/PDF/53/1964/53K1964016.pdf)

In this section, we describe the consequences for the federated entities specifically regarding 'Prevention'.

a. The Flemish government

To guide the transfer of these competences from the Federal to Flemish government, a green paper was drafted (Vlaamse Regering, 2013). This green paper consisted of an analysis of which competences would be transferred, and the possible policy options for Flanders. The defederalised competences were later given shape by means of concept notes, policy declarations and decrees (cf. infra).

The legal basis for the Flemish prevention policy is the decree of 21 November 2003 on the preventive health care policy, in which the fundamental policy instruments are written down[32]. For example, initiatives must be scientifically underpinned and can be taken both within healthcare and within the facet policy. The decree also regulates the accreditation of the locoregional health consultation (LOGO's), partner organisations, organisations with field operations and individual care takers. The decree also regulates the fundamental policy instruments, for example, that a health conference should be convened to develop (a proposal of) a health objective. These health objectives are then operationalised into strategic and action plans. The most recent Strategic Plan is the health plan endorsed in 2018 'De Vlaming leeft gezonder in 2025'.

The prevention competences are managed and directed by the Flemish Agency for Care and Health (VAZG) (Rossignol et al., 2019), in line with the health goals defined in the strategic plan (Sholokhova, 2021). In order to achieve these objectives, VAZG works together with local government services (local health consultations (further: Logo's), partner organisations with expertise in the field of prevention and partner organisations with field operations. As figure 8 explains, the Flemish Government and VAZG regulate and support care and health initiatives and set the health objectives. The partner organisations (e.g. VAD, Free Clinic, etc.) are the experts who develop strategies and methods. The LOGO's are regional disseminators who mobilise and coach their network. Lastly, there are organisation with field operations (e.g. Spuitenruil, De Sleutel, CGG prevention work Tobacco, Alcohol and Drugs) who carry out and implement the prevention methods and initiatives, or who coach during their implementation (Vlaamse Logo's, 2015).

Figure 8 Organisation of prevention in Flanders (Vlaamse logo's, 2015)

So, specifically for drug prevention, the prevention field unites the following actors (Moernaut, 2019):

1) **Expertise centres** like the 'Flemish centre of expertise on alcohol, illegal drugs, psychoactive medication, gambling and gaming' (further: VAD), and 'Flemish institute for a healthier life' for tobacco prevention: The expertise centres are partner organisation of the Flemish government to develop a prevention policy towards tobacco, alcohol and other drugs.
2) **Organisations with field operations** like CGG prevention work Tobacco, Alcohol and Drugs and De Sleutel: Eleven Centers of Mental Health with prevention work are responsible for the regional implementation of Flemish prevention methodologies and informs, supports and coaches intermediaries and organisations in different social settings (education, health, welfare, leisure and culture, labour, local authorities,).
3) **Logo's**: The fifteen Logo's are geographically defined networks in Flanders and Brussels. They participate in the implementation of the Flemish preventive health policy and the realisation of

[32] Decreet van 21 november 2003 betreffende het preventieve gezondheidsbeleid

the Flemish health objectives by disseminating validated prevention methods, and guiding local government in developing a local preventive health policy.

4) **Local and intermunicipal prevention workers**: The employment of local and intermunicipal prevention workers differs across municipalities. Some work within the municipalities, other are seconded to non-profit organizations (e.g. street work, non-specialised care provision). Sometimes, these prevention workers are financed entirely by the municipality. They are often given a limited task on drug prevention (they have to combine it with other municipal tasks or health themes), although some larger cities have a prevention coordinator to coordinate all initiatives on drugs (Moernaut, 2019). In 2019 a new Flemish Decree concerning intermunicipal prevention was implemented. This decree introduced cofinancing between the Flemish government and (at least) two municipalities of prevention workers on one of the health themes from the Strategic Plan 'De Vlaming leeft gezonder in 2025'.

Most of these prevention workers work together with 'intermediaries' (Rosiers et al., 2018). Intermediaries are in a position where they have direct contact with a target group, and apply various prevention methods (Moernaut, 2019).

For the prevention of local security problems (e.g. drug-related crime), the federal government also finances municipalities through the Strategic Prevention and Security contracts. These prevention workers purely focus on the prevention of drug-related crime (Federale Overheidsdienst Binnenlandse Zaken, 2020).

b. Brussels Capital Region

Since the Sixth state reform, each federated entity is responsible for its own prevention policy. In the Brussels-Capital Region, the prevention competences are divided between three institutions, depending on the community for which they are intended: the French-speaking Community Commission (further: COCOF), the Flemish Community Commission (further: VGC) and the Common Community Commission (further: COCOM/CGC) (Sholokhova, 2021). After the state reform, the Fédération Wallonie Bruxelles (further: FWB) has delegated most of the competences for Brussels to COCOF and COCOM/GGC.

For the Dutch-speaking Brussels population, the VGC falls back on the department Local Health Consultation (LOGO) as a platform for the various government departments and organisations involved in health promotion. At the VGC, the department Local Health Consultation (LOGO) serves as a platform for the various government departments and organisations involved in health promotion. The service is in charge of achieving the Flemish health objectives in Brussels (Sholokhova, 2021).

For the French-speaking population of Brussels, prevention is regulated by the COCOF decree of 1 April 2016. For the implementation of this decree, a health promotion plan ("Plan de la Promotion de la Santé") was approved for a period of five years (Sholokhova, 2021).

COCOM/GGC develops its prevention and health promotion policy within the framework of the Brussels Health Plan (Sholokhova, 2021).

In Brussels, a public utility institution with autonomous management was implemented for the joint management of defederalised matters (Rossignol et al., 2019). This organisation in charge of health, disability and family matters, is called 'Iriscare'.

c. Walloon region and Federation Wallonia Brussels

After the transfer of a number of health competences from the federal government to the Regions and Communities, the French-speaking entities have changed the internal distribution of their competences: the Fédération Wallonie Bruxelles (further: FWB) has delegated most of its competences the Commission Communautaire française (further: COCOF) and the Commission Communautaire

Commune (further: COCOM) for Brussels and to the Walloon Region. In Wallonia, it is the Agence pour une Vie de Qualité (further: AViQ) which is the Public Interest Organisation (OIP) in charge of health, disability and family matters.

The 6th state reform led to the transfer of competences in the field of social and health action from the Federal government to the FWB (cf."Saint-Quentin" agreements) and then to the Regions (see table below). A joint project for the organisation of health, personal assistance and family allowances (cf."Sainte-Emilie" agreements) was consolidated in 2014, by the framework cooperation agreement of 27 February 2014, between the French Community, the Walloon Region and COCOF. For the addiction sector, the addiction fund (including the Tobacco Fund) was regionalised (Walloon Region). The health promotion decree adopted by the Walloon Parliament in May 2019 has led to the development of a 'Walloon prevention and health promotion plan for 2030', which includes a chapter devoted to drug prevention entitled 'Prevention of the addictive use of alcohol and other psychoactive substances, cannabis, heroin and psychotropic drugs'.

Table 7 Division of competences between the French-speaking entities for Prevention

French-speaking regions and communities	Competences relating to prevention
Walloon Region	X
Wallonia Brussels Federation	X (Only for the part related to education)
French Community Commission (COCOF)	X

For prevention in Wallonia/FWB, the orientation has been not to develop a specific "substance-related" prevention plan, but rather to consider substance-related prevention in other, more generic prevention policies. Therefore, there is a chapter on drug prevention in the (generic) health promotion plan**.**

d. Ostbelgien

After the sixth state reform, Ostbelgien decided to set up a hybrid governance model in order to implement and manage the new competences in the health sector. This meant that the government manages and develops health prevention and promotion, rehabilitation, financing of hospital infrastructure and residential care centres and day-care centres, while the Dienststelle für ein Selbstbestimmtes Leben (DSL) provides assistance to individuals (Rossignol et al., 2019).

B. Impact of the Sixth State Reform on the drug treatment field

a. The Flemish government

Before the sixth state reform, Flanders was already responsible for the Centres for Mental Health Care (NL: CGG) and preventive health care. From 1 July 2014 onwards, Flanders became additionally responsible for psychiatric care homes, sheltered housing initiatives and mental healthcare consultation platforms for the domain of mental health. Within the domain of rehabilitation, a diversity of rehabilitation facilities (functional, psychosocial, ambulatory, etc.), as well as the categorical addiction treatment (previously recognised and financed by the RIZIV/INAMI) had been transferred to Flanders. Also, the Fund to combat addiction (NL: Fonds ter bestrijding van de verslavingen) became a Flemish competence. Lastly, parts of non-specialized community treatment (NL: Eerstelijnszorg) were transferred the Flemish government (Vander Laenen 2016). To guide the transfer of these competences from the Federal to Flemish government, a green paper was drafted (Vlaamse Regering, 2013). This green paper consisted of an analysis of which competences would be transferred, and the possible policy options for Flanders.

Concerning the financial 'shift' to the regions, Flanders established the so-called "Takeover decree" (Takeover decree of 6 July 2018 and according implementation decree an annexes). This decree assures the continuity and financing of psychiatric care homes, sheltered housing initiatives, rehabilitation facilities, rehabilitation hospitals and multidisciplinary palliative care guidance services,

that were previously financed by RIZIV/INAMI, as of January 2019. The “Takeover decree” largely takes over the current financing of these sectors, in anticipation of its integration in the Flemish social protection system (Agentschap Zorg & Gezondheid, 2019).

With regards to the organization of the specialized addiction treatment field, specialized addiction treatment has been integrated in the mental health care networks in 2014. Flanders further developed its vision centred around recovery in all its dimensions (Vander Laenen, 2016; Vander Laenen et al., 2020; Vander Laenen et al., 2019). A crucial for this, was the Flemish Concept Note on Addiction Treatment, which was established in 2016 and aimed to improve the health, quality of life, and recovery of all those with an addiction problem by integrating the current 'categorically-oriented' addiction treatment into the broader mental health care system. This was formalized with the Flemish Decree Mental Health Care of 5 April 2019, which includes all existing regulations of the mental health sectors. The decree addresses, among other things, stigma, experts by experience (in policy and in healthcare), the context of the person with a mental health problem, the recognition, programming and composition of mental health networks and levels of care. The further development through implementation decrees is yet to follow. Nevertheless, at the Flemish level, defederalisation has led to a policy framework that is committed to a broad interpretation of recovery, not just focused on clinical recovery (Vander Laenen et al., 2020; Vander Laenen et al., 2019). Nevertheless, the inclusion of specialized addiction treatment in the mental health care is not without risk. For example, there may be less attention to people with drug problems. Indeed, with the current trend toward specialisation in psychiatric hospitals, it appears that target groups other than people with drug problems are often chosen (Vander Laenen et al., 2020; Vander Laenen et al., 2019). To complicate the matter further, the competences relating to (psychiatric) hospitals for people with drug problems have remained at the Federal level. On top of that, practitioners state that after the defederalisation of specialised drug treatment, the Flemish Community did not sufficiently take the necessary investments (Vander Laenen et al., 2020).

b. The Walloon region, the Wallonia Brussels Federation, Brussels Capital region and the French-speaking community

A number of "health" competences (the organisation of the first line of help and care, prevention, the addiction fund, mental health institutions, hospital infrastructures, and certain revalidation agreements formerly under the responsibility of the INAMI) have been transferred from the State to the Regions and Communities. The French-speaking entities have also changed the internal distribution of their competences: the FWB (FR: Fédération Wallonie Bruxelles; NL: Federatie Wallonië Brussel) has delegated most of its competences to COCOF (FR: Commission Communautaire française) and COCOM (FR: Commission Communautaire Commune; NL: Gemeeschappelijke Gemeenschapscommissie) for Brussels and to the Regions. In Wallonia, it is the AViQ (FR: Agence pour une Vie de Qualité) which is the Public Interest Organisation (OIP) in charge of health, disability and family matters. In Brussels, the ‘OIP’ it is called ‘Iriscare’.

The 6th reform of the state led to the transfer of competences in the field of social and health action from the Federal government to the FWB (cf."Saint-Quentin" agreements) and then to the Regions (see table below). A joint project for the organisation of health, personal assistance and family allowances (cf."Sainte-Emilie" agreements) was consolidated in 2014, by the framework cooperation agreement of 27 February 2014, between the French Community, the Walloon Region and COCOF. For the addiction sector, the addiction fund (including the Tobacco Fund) was regionalised (Walloon Region). The health promotion decree adopted by the Walloon Parliament in May 2019 has led to the development of a 'Walloon prevention and health promotion plan for 2030', which includes a chapter devoted to drug prevention entitled 'Prevention of the addictive use of alcohol and other psychoactive substances, cannabis, heroin and psychotropic drugs'. In high school (FR: Ecole secondaire), there are programmes to combat addiction, in the form of medical and psychological support, during school time as part of the pact for excellence (Wallonie-Brussels Federation).

Table 8 Division of competences between the French-speaking entities for Treatment

French-speaking regions and communities	Competences relating to Treatment, risk reduction and reintegration
Walloon Region	X
Wallonia Brussels Federation	
French Community Commission (COCOF)	X

c. Ostbelgien

In order to implement and manage the new competences in health care and treatment to persons, the German-speaking Community has decided to set up a hybrid governance model, whereby the government takes care of matters relating to health (health prevention and promotion, rehabilitation, financing of the hospital infrastructure and residential care centres and day-care centres), and the public utility institution "Dienststelle für ein Selbstbestimmtes Leben" with assistance to persons (Rossignol et al., 2019).

C. Impact of the Sixth State Reform on the Enforcement field

The Sixth state reform, initiated in 2011 by the Butterfly Agreement[33], defederalised some competences concerning Justice to the communities (Vandenbruwaene, 2014). From 2015, the communities participated in the criminal and security policy for the matters within their competence, received a right of injunction, became fully competent to issue regulation on the organization, operation and method of mission of the houses of justice, and were granted competences in connection with juvenile delinquency law. Cooperation agreements were concluded between the Federal State, the communities and the regions on the houses of justice[34] and the criminal justice & security policy[35].

In Flanders, this mainly resulted in two decrees: The Decree of 26 April 2019 on the Houses of Justice and the Judicial Frontline Assistance[36], and the Decree of 15 February 2019 on Juvenile Delinquency[37].

3.3.3.5 Public expenditure of the Belgian drug policy

Lastly, we describe the results of the public expenditure inventory of the Belgian drug policy. This monitoring identifies the direct expenditure of public administrations of the Federal Government, the Communities and the Regions.

Public expenditure has been measured four times in the past. The first three times, public expenditure was measured through three scientific research projects, funded by the Drug Program of the Federal Science Policy: Drugs in figures I, II and III (De Ruyver, Pelc, et al., 2007; Vander Laenen et al., 2011). In 2012, a protocol agreement was established where all signatories have committed themselves to communicate the direct public expenditure related to illicit drugs, alcohol, tobacco and psychoactive medication each year. The most recent meeting of public expenditure dates from 2014-2015, and describes the following expenditure:

The expenses of the different governments were measured for prevention, treatment, harm reduction, security and a category of 'others.

[33] Vlinderakkoord 11 oktober 2011 (https://www.dekamer.be/FLWB/PDF/53/1964/53K1964016.pdf)
[34] Samenwerkingsakkoord van 17 december 2013 tussen de Federale Staat, de Vlaamse Gemeenschap, de Franse Gemeenschap en de Duitstalige Gemeenschap, met betrekking tot de uitoefening van de opdrachten van de Justitiehuizen
[35] Samenwerkingsakkoord van 7 januari 2014 tussen de Federale Staat, de Gemeenschappen en de Gewesten betreffende het strafrechtelijk beleid en het veiligheidsbeleid
[36] Decreet van 26 april 2019 houdende de justitiehuizen en de juridische eerstelijnsbijstand (Publicatie: 17-06-2019)
[37] Decreet van 15 februari 2019 betreffende het jeugddelinquentierecht (Publicatie: 26-04-2019)

For psychoactive substances, the public expenditure of 2014-2015 showed that the largest share of expenditure goes to the treatment sector (59.4%). Safety represents more than 39% of expenditure, prevention represents 1.24% of expenditure and the harm reduction budget represents 0.38%. Compared to the Drugs in Figures studies (ref), the safety pillar gains in importance and the treatment pillar decreases in importance (-9% compared to 2013). In the 2013 monitoring, the security pillar still represents about 29% of expenditure, in 2014 it already represents more than 39% of drug policy expenditure. In this regard, the measurement does emphasise that the functioning of the judiciary requires much more resources compared to the resources needed to needed to carry out prevention.

As in the Drugs In Figures (Vander Laenen et al., 2011) measurement, most expenses are related to alcohol (57%). This is followed by the expenses related to illegal drugs (33,4%), non-specified expenses (5.6%) and expenses related to tobacco (1.35%).

The report concludes with the fact that the public expenditure is highly intertwined and sometimes overlapping. For example, treatment centres that mostly rely on federal financing, can sometimes receive global budgets for initiatives related to prevention, treatment and risk reduction. Furthermore, it remains remarkable that prevention, which is presented as the cornerstone of Belgian drug policy, receives only a little over 1% of the funds allocated to it. Finally, public expenditure also shows that different regions have different emphases on drug policy. For example, the report describes differences in online treatment (proportionally more the case in Flanders), but also in harm reduction initiatives (proportionally more the case in Wallonia).

3.3.4 Timeline of the Belgian Drug Policy

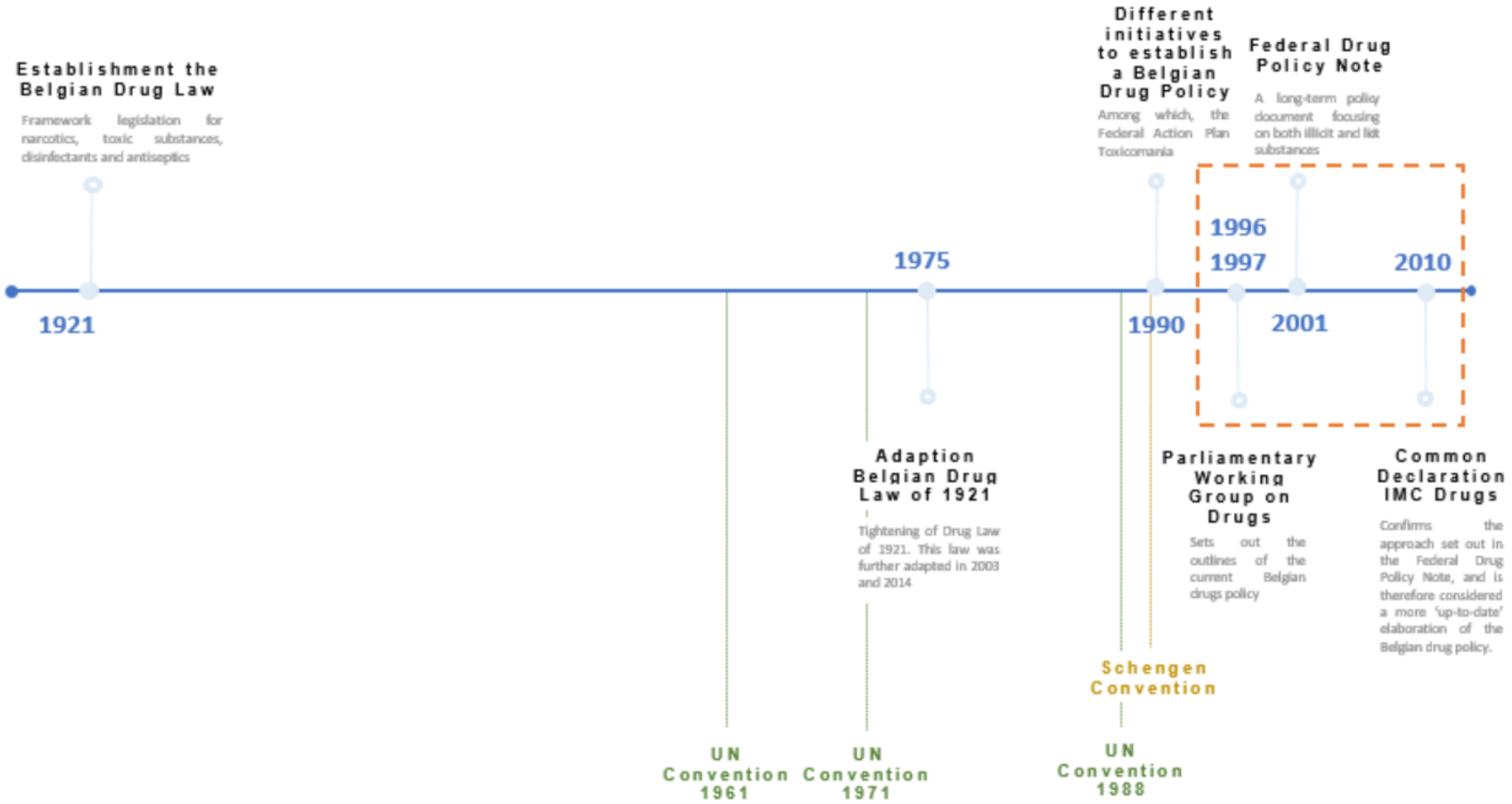

Figure 9 Timeline of the Belgian Drug Policy

3.4 Conclusion

The drug phenomenon is a phenomenon shaped by both national and international trends (Babor et al., 2010). Not only the globalisation of drug production and drug trade, but also the globalisation of drugs use has challenged policy makers for a global approach to the drug issue.

On an international level, the three UN conventions play a central role in the prohibition-based drug control approach. For a long time, supply control was emphasised and less attention was paid to the demand side. This changed in 1988, when the possession of narcotic and psychotropic substances was penalized. Since then, the UN Conventions obliged member states to criminalize not only the supply side, but also the demand side. Furthermore, on the level of the EU, the drug issue was addressed as an area of shared competence between the EU Member States and the European Institutions. The EU and their member states have been committed to a Drug Strategy and respective Drug Action Plans since 1995, centralizing two policy domains, demand reduction and supply reduction, and three cross-cutting themes, coordination; international cooperation and research, information, monitoring and evaluation.

The Belgian drug policy relies on this international and European framework. The Belgian drug policy repeatedly refers to the international legislative context as the framework in which Belgian policy has been further developed. Consequently, it has implemented the international obligations in its national policy and legislation. Nevertheless, the Belgian drug policy remained a late bloomer compared to other countries with regard to the development of its drug policy. It was not until 1996 with the Parliamentary Working Group on Drugs that a spark was ignited to address the drug issue with a clear policy approach. The late development in the Belgian drug policy enabled the Parliamentary Working Group on Drugs to learn from the experiences of neighbouring countries (De Ruyver et al., 2012). The recommendations of the Parliamentary Working Group on Drugs eventually resulted in the establishment of the Federal Drug Note in 2001, and the Joint Declaration in 2010. Both policy documents centralised a Public Health as the main approach for the drug issue, and highlighted a normalization policy with attention for both the supply and the demand side. This is pursued through a policy based on three pillars:

1. Prevention for non-user(s) and non-problematic user(s);
2. Treatment, risk reduction and (re)integration for problem users;
3. Repression for drug production and drug trade.

These three pillars are accompanied by two transversal themes:

A. An increased cooperation between the various policy areas concerned; and
B. the development of an epidemiological and evaluation toolbox.

Since 2010, the (drug) policy field has changed extensively, amongst other because of the Sixth State Reform. The Sixth state reform defederalised several competences especially concerning healthcare to the Communities, specifically within the domains of care for the disabled, hospitals, institutions for the elderly, rehabilitation, mental health care, health prevention, the organisation of primary health care, some aspects of the health care professions and specialised drug treatment (Hannes, 2014; Vander Laenen, 2016). The regions and communities subsequently further developed their (addiction) policies. However up till today, an updated and overarching, integral and integrated drug policy plan is lacking.

CHAPTER 4

PILLAR 1: PREVENTION

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4 PILLAR 1: PREVENTION

This chapter evaluates the pillar 'Prevention' of the Belgian drug policy.

The pillar 'Prevention' was – like the other pillars - given its current form based on the report of the Parliamentary Working Group on Drugs in 1997. The Parliamentary Working Group on Drugs gave a detailed overview of the drug prevention field in 1997. The report described that there were different ways of classification for prevention at the time. The standard, medical classification of types of prevention, was the division between primary prevention, secondary prevention, tertiary prevention. Primary prevention aimed at potential drug users and intents to prevent problems related to drug use, whereas secondary prevention focused on early detection of problems related to drug use, and tertiary prevention tried to reduce the harms related to problematic drugs use (p. 1014 Parliamentary Working Group on Drugs). The report described that Belgium still primarily relied on primary prevention, especially focusing on education (e.g. programs to train and stimulate social skills among teenagers, an informative approach aimed at increasing knowledge and warning teenagers). The recommendations of the Parliamentary Working Group on Drugs endorsed the importance of primary prevention and encouraged the – at the time - recent shift towards younger aged groups (instead of secondary school, also primary school). At the same time, the report stressed the difficulties to distinguish between the pillar prevention and the pillar treatment, especially for prevention initiatives aimed at reducing risks associated with drug use (the so-called harm reduction approach) (p. 964). The indicated budget figures described in the report therefore related to both pillars. The report further stated that the fourth State reform (1993) and the consequent division of competences between the federal level and the communities lead to a fragmentation of the prevention field: Both on the federal level, the level of the communities, the provincial level and local level, drug prevention workers were active.

On the level of Flanders, five bottlenecks were described: (1) the prevention sector was overburdened (which resulted in a sprawl of prevention projects that lacked a solid foundation, expert staff, structure, coordination and experienced an extreme performance pressure) (2) limited resources for the prevention sector, (3) a predominant focus on prevention of the use of illegal drugs (resulting in the focus on youth as main target group; adults remaining out of reach), (4) problems with evaluation (lack of data, difficulties with measuring effect) and (5) lack of coordination (a proliferation of plans, but no global policy, lack of stability and continuity of initiatives, confusion about division of competences, lack of coordination structures).

On the level of the French speaking Community, described five very similar bottlenecks: (1) specific problems with the new coordination levels, (2) the absence of intercommunity coordination at the political, administrative and operational level, (3) limited resources for the prevention sector, (4) lack of attention for alcohol in the prevention policy (5) lack of proper evaluation.

On the level of the German-speaking Community, four bottlenecks were described: (1) the discontinuation of the Intercommunal CCI Commission has led to problems with cooperation with other policy levels, (2) lack of resources for the prevention of drug-related crime on non-urban level (e.g. provinces) and for (3) police (policy units concerned with (drug-related crime) prevention) and (4) lack of coordination between the federal measures and the coordination bodies working in the field and the communities.

Furthermore, the Parliamentary Working Group raised some additional bottlenecks. First of all, at the time, there was no reference frame for the prevention of drug addiction[38]. The various preventive

[38] We adopt the same terminology as used in the policy documents. This has two consequences. First, the policy documents often use certain concepts interchangeably (e.g. 'addicts' or 'addiction' with 'problematic user' or 'problematic use'). We know these concepts do not have the same meaning. However, since the description of the logic model is a representation of these policy documents, we adopt the terminology as used in the policy documents. Second, some of the concepts used in the policy

initiatives were very diverse and the report described a lack of coherence regarding the various prevention initiatives, actions taken and job/task descriptions. Second, prevention did not seem a priority compared to the safety and treatment dimension (budgetary, but also for coordination). Lastly, the need for more research was emphasised.

The conclusions of the report further described that the development of harm reduction interventions (specifically: needle exchange projects and substitution programs), were still hindered by existing legislation, but also described psychoactive medicine and smart drugs as a problem.

Lastly, the report of the Parliamentary Working Group on Drugs repeatedly stressed that the division between legal and illegal drugs in prevention strategies are irrelevant in terms of public health repercussions, and that the pillar prevention should therefore be aimed at both legal (alcohol, psychoactive medicine, tobacco) and illegal drugs (p. 961).

Subsequently, the Working Group advised to introduce a pillar 'Prevention' in addition to the pillars focussing on 'Treatment, risk reduction and re-integration' and 'Enforcement'. This pillar should – according to the Working Group - ideally aim at preventing substance use. Since complete abstinence (as an objective) was not deemed feasible, objectives like raising the age of onset of use, reducing drunk driving, delaying or controlling the use of legal and illegal substance and reducing substance abuse were emphasised (p. 1015). The Working Group thus prioritized the discouragement (Dutch: *ontrading*, French: *dissuation*) and reduction of both legal and illegal drug use, together with slowing down the number of new drug users by means of prevention of a personal and structural nature. The Federal Drug Note (2001) took on board these recommendations and introduced a pillar 'Prevention', in addition to the pillars 'Treatment, risk reduction and re-integration' and 'Enforcement'. This approach was confirmed in 2010 with the Joint Declaration of the Interministerial Conference Drugs. In this policy document too, 'Prevention' was considered as one of the three central pillars.

This chapter discusses the pillar 'Prevention and the different related actions stressed in the Federal Drug Policy Note (2001) and the Joint Declaration of the Interministerial Conference Drugs (2010). We first explain the logic model of the pillar 'Prevention, i.e. how the actions identified in the pillar 'Prevention' intend to achieve change. Subsequently, we conduct a critical analysis of the logic model. This way, discrepancies, inconsistencies and omissions in the policy's theory are raised and discussed. Next, we present the results of the process evaluation, i.e. whether the actions have been implemented the way it was intended and whether the aims and actions are still relevant to the current issues and needs within the Belgian drug field.

4.1 What were the policy intention? A logic model of the pillar 'Prevention'

In this section, we address the first research question 'What are the identified aims, action points, intended outputs and intended outcomes of the Belgian drug policy?'. To do so, we rely on logic models as an evaluation framework, as explained in the methodological chapter (cf. supra). Logic models are a systematic and coherent description of a policy that identify the objectives, actions, resources, intended outputs and intended outcomes underpinning a certain policy (EMCDDA, 2017a). The logic models make the underlying assumptions of how a policy aims to achieve change, explicit. Logic models identify and describe how a policy fits together in a simple sequence. The policy's theory is described in a logical, linear depiction of how policy makers intend to achieve change.

To establish a logic model for the pillar 'Prevention', we did a document analysis of the two central and overarching policy documents of the Belgian drug policy: The Federal Drug Note of 2001 and the Joint Declaration of the Interministerial Conference of Drugs of 2010. We extracted the aims, the actions, the

documents (and therefore also in the description of the logic models) are considered vague and/or stigmatizing language. We discuss the two problems with these concepts further on in the chapter.

inputs, the intended outputs and the intended outcomes (where possible) verbatim from these documents, and rearranged them in a logical sequence (shown by *Figure 10. Summary of the logic model on 'Prevention'*).

We additionally analysed the report of the Parliamentary Working Group on Drugs (1997) to further contextualize these aims and actions (where actions were unclear). The logic model on 'Prevention' shown by *Figure 10. Summary of the logic model on 'Prevention'*, thus describes how the aims and actions under 'Prevention' – according to the Belgian drug policy - contribute to the central aims of the Belgian drug policy.

Since the description of the logic model is a representation of the central policy documents, we adopt the terminology mentioned in the policy documents to describe the actions, inputs, intended outputs and intended outcomes. That means that sometimes stigmatising language is used, or old names of institutions that have since changed names are used. For the latter, we added the current name between brackets.

4.1.1 Seven main objectives and corresponding actions:

It is important to emphasise that a lot of the objectives and actions in the pillar 'Prevention' were introduced by the Federal Drug Note of 2001. This document was established at the level of the Federal Government. The Federal Drug Note stressed in this case that: "*The policy document currently only binds the federal government*. (…) *The Federal Government asks the Communities to continue their efforts in the field of prevention and recognizes the autonomous competence of the Communities in this matter*." (p. 37). This explains the predominant focus on the federal level for the logic models for 'Prevention'.

The Federal Drug Note of 2001 and the Joint Declaration of the Interministerial Conference of Drugs of 2010 identify seven main objectives within the pillar 'Prevention':

- To implement strategic measures specifically targeted at psychoactive drugs
- To discourage (Dutch: *ontraden*, French: *dissuader*) driving under the influence of legal or illegal drugs
- To prevent the use of tobacco and alcohol (In the logic model: '*Tobacco and alcohol prevention policy*')
- To develop a prevention policy
- To apply a policy of dissuasion towards (non-)users of legal and illegal drugs
- To develop social prevention at work
- To prevent drug-related nuisances

4.1.1.1 Objective 1: Actions aimed at implementing strategic measures specifically targeted at psychoactive drugs

A first group of actions under the objective 'to implement strategic measures specifically targeted at psychoactive drugs' is aimed at **alerting the population of the dangers of psychoactive medication**. A first action mentioned in the policy documents, is that the Minister for Public Health will review the registration of benzodiazepines and amphetamines together with the European partners, in the light of their therapeutic added value. A second action in this group, promises to add additional warnings to the packaging and leaflets of benzodiazepines, again in consultation with the European partners. Next, the Health Council will organize a consensus conference on the prescription of benzodiazepines in collaboration with universities, doctors and pharmacists. In addition, a prevention campaign will be developed to alert the general population to the dangers of benzodiazepine (e.g. risks in traffic).

A second group of actions is aimed at **preventive and repressive counselling and at monitoring of the prescribing behaviour of physicians for dependency causing medication**. A first action describes that the prescribing behaviour of the physicians will be supervised and followed up in a

preventive and representative way through the Local Quality Councils (Dutch: *Lokale Kwaliteitskringen*, FR: *Groupes d'évaluation médicale*) and the Provincial Medical Committees. The policy documents describe that the Provincial Medical Committees may, in exceptional circumstances, revoke a physician's visum or refer him or her to the Order of Physicians and even to the Justice Department. Another action plans to investigate what role Farmanet can play in the influence of the prescription behaviour of physicians. More specifically it will be investigated whether an extension of Farmanet to the non-refundable medication would be appropriate. The policy documents describe that a confrontation with the data from Farmanet (compared to the prescription behaviour of fellow physicians) is often sufficient to modify prescription behaviour of an individual physician. The role of the Pharmaceutical Inspection is also emphasised.

A third group of actions intends **to limit the influence of the pharmaceutical industry on the prescription behaviour of doctors**. First of all, one actions mentions to limit the advertising of medication to objective, scientific information. Additionally, the independent doctor's visits, organized by the Belgian Centre for Pharmacotherapeutic Information, will be maintained. Third, the expertise promotion packages of the Belgian Centre for Pharmacotherapeutic Information, which can be used by the Local Quality Councils, will be disseminated more widely. Also, the distribution of samples of benzodiazepines (amongst physicians) will be significantly reduced. These samples were already prohibited for amphetamines and other narcotics.

Apart from these three groups of actions, there some **other actions mentioned that are not bundled** together. A first action intends to further develop the concept of double and numbered prescriptions, at the initiative of the Federal Consultation Platform "Safety Physicians", chaired by the VSPP[39][40]. Subsequently, the Federal Government will implement a nationwide system of double and numbered prescriptions for narcotics to prevent that these prescription books are stolen. Lastly, the policy documents mention to organize consultation moments with organizations representing physicians, pharmacists' unions and the pharmaceutical industry on the above-mentioned actions.

The Minister of Public Health is responsible for the implementation of this objective. She consults with the Minister of Social Affairs, the Minister of Economy and the Minister of Internal Affairs.

4.1.1.2 Objective 2: Actions aimed at discouraging driving under the influence of legal or illegal drugs

The first action under this objective introduces drug testing for drivers. Driving under the influence of illegal drugs and medication was made punishable by the Law of 16 March 1999 and the subsequent Royal Decree of 4 June 1999[41]. A second action therefore mentions that the Minister of Justice (in consultations with the Minister of Mobility and Transport) draws up circulars and guidelines for police services and prosecution actors for the following actions: (1) An awareness-raising or information campaign (organized by the Belgian Institute for Road Safety (now Vias)) informing drivers about the law on driving under influence, (2) an annual evaluation of the law of 16 March 1999 (to do so, a registration tool will be developed), (3) blood and/or urine test after a standardized test battery, for which police officers will be trained properly (recognition of the signs of sobriety with maximum reliability), (4) implementation of clear limits, and (5) the development of an offer of meaningful, alternative punishments.

[39] Permanent Secretariat for Prevention Policy (VSPP) is the central service of the Ministry of the Interior, which is responsible for supporting local prevention initiatives and prevention policy in Belgium.
[40] Some of these actions are clearly outdated. However, since the description of the logic model is an accurate representation of the Federal Drugs Note (2001) and the Joint Declaration of the Interministerial Conference on Drugs (2010), we list all actions mentioned in the policy documents, even if we know they are outdated.
[41] Royal Decree on blood testing for the purpose of determining the level of substances other than alcohol which affect driving ability (BS: 8 June 1999)

Another list of actions is specifically aimed at driving under the influence of medication. The Federal Government will, where necessary in consultation with the European partners, (1) apply a warning sign on the packaging of this medication (e.g. a sticker with an icon of a car in a red prohibition circle, which can be applied by the dispensing pharmacist while explaining the dangers of drink-driving to the customer), (2) make sure that the package leaflet is adapted, and (3) raise the awareness for prescribing physicians.

The Minister of Justice is responsible for the implementation of this objective. He consults with the Minister of Mobility. The Minister of Public Health is responsible for the packaging of medication. The Minister of Internal Affairs is responsible for training police officers.

The Minister of Public Health is responsible for the implementation of this objective. She negotiates with the regional governments (who have very broad competences in this matter). She consults with the Minister of Internal Affairs and the Minister of Economy.

4.1.1.3 Objective 3: Actions aimed at preventing the use of tobacco and alcohol

The **first group** of actions under this objective, is aimed at **reducing tobacco consumption**. There were already some legislative initiatives for the advertising of tobacco products, for public transport and in the hotel and catering industry. These legislative initiatives will be complemented with awareness-raising and information campaigns. Another action is regularly repeating the inspection actions of the Food Inspection in the hotel and catering industry on the smoke ventilation systems and the no smoking zones. As part of an integrated control action, tobacco regulations will also be checked again in autumn 2001. Furthermore, this group mentions actions concerning smoking behaviour at schools: (1) Each school community should develop a binding and written smoking policy that can be included in the general school regulations (the policy documents mention that a total smoking ban offers the most effective protection against passive smoking), (2) the exemplary role of teachers is emphasised. Two other actions in this group are the exploration of a ban on addiction increasing additives to cigarettes, and the elaboration of an anti-tobacco policy in a policy document of the Minister of Public Health.

The **second group** of actions under this objective, concern the **use of alcohol**. In a first action, the federal government asks the communities to make sufficient room in the school curriculum to teach adolescents how to deal with alcohol. Second, a prevention offer will be provided for families and in the work place. Third, the federal government will implement the recommendations of the European Alcohol Action Plan 2000-2005, insofar as they are compatible with tradition, culture and public opinion in Belgium. Fourth, the problem of alcohol addiction will be given adequate attention in the development of regional care circuits and in the definition of regional treatment needs (cf. pillar 'Treatment, risk reduction and re-integration). Fifth, action mentions that the Federal Government will ask Belgian alcohol producers to take a position on the 'The Geneva Partnership on Alcohol: Towards a Global Charter', charter that was developed by the international alcohol producers, in collaboration with scientists and policy makers. Sixth, the Minister of Public Health will, in consultation with the communities, examine whether the advertising regulations concerning alcohol should be adapted to the new mixed drinks (the so-called 'alcopops'), often promoted among young people. Lastly, the decree law of 14 November 1939 on the restraining of intoxication and the law of 15 July 1960 on the moral protection of youth will receive more attention from the competent inspection services (especially for underage drinking and serving alcohol to drunk people).

4.1.1.4 Objective 4: Actions aimed at developing a prevention policy

The policy documents introducing this objective, start again with the emphasis that vision of the communities must be the starting point of any prevention policy. The Federal government, however, asks the communities to plan the following actions.

The first group of actions concerns the **development of an integrated school prevention policy**. The communities are asked to structurally integrate prevention initiatives in the training of teachers, and to

dedicate time in the school curriculum for 'life skills' (e.g. through the "Life Keys" education package). At the time of the Federal Drug Note (2001), it is mentioned this was already the case for Flanders. The federal government further emphasises the importance of drug prevention activities throughout the all school curriculum, from primary to higher education (e.g. prevention of alcohol and drug abuse for young people in higher education).

A second group of actions, mentions that the **existing prevention initiatives at the different levels (local, supralocal) should be further developed (and, where necessary, coordinated with one another)**. These prevention initiatives should be scientifically founded and evaluated according to the evaluation criteria of the European Monitoring Centre for Drugs and Drug Addiction. Next to primary prevention, secondary and tertiary prevention towards both legal and illegal drugs should be expanded. Targeted prevention at the neighbourhood level or at the local level (in which there is cooperation between educational institutions, health care, social services, justice, leisure organizations, employers and trade unions) is recommended. Also, the federal government will further stimulate the municipalities to develop a local policy. Additionally, the Federal government will establish framework agreements between the federal government and the communities and regions concerning an integrated prevention policy, if necessary. The General Drug Policy Cell and the Belgian Monitoring Centre for Drugs and Drug Addiction (BMCDDA)[42] are the ideal forum for this.

Furthermore, the Federal government emphasises the existence of the European Action Plan 2000-2004 to the Communities (as they have the competence for Education), which promotes the development of an academic course on 'Treatment for drug addicts. Additionally, health professionals (nurses, doctors, social workers, etc.) should increasingly be trained on substance use problems during their basic courses.

Lastly, the federal government will pay special attention to the problem of illegal dance parties (the clandestine raves). The federal government will assess the size of the problem and charge the Drug Policy Unit with the development of a concrete action plan.

The Minister of Internal Affairs is responsible (at federal level) for the implementation of this objective. He consults with the Minister of Public Health.

4.1.1.5 Objective 5: Actions aimed at applying a policy of dissuasion towards (non-) users of legal and illegal drugs

This objective was mentioned in the Joint Declaration and shows a lot of overlap with the actions under the objective 'develop a prevention policy'. The objective lists six sub-objectives: (1) Prevent young people and young adults from starting smoking, drinking alcohol or taking illegal drugs, (2) postpone the onset of the intended use, (3) promote responsible behaviour through education of skills in making choices, including risk reduction policies, (4) encourage early intervention of the problem, (5) provide psychosocial and medical assistance, and (6) pursuing a healthy living environment (meaning: a smoke-free environment, a maximum alcohol limit in traffic, giving clear messages adapted to the target group, both legal and illegal drugs).

After the list of sub-objectives, the actions were listed. A first action under this objective mentions to improve the impact of existing preventive actions by promoting networking and consultation at local, regional, community and international level. A second action intents to train (professional or non-professional) adults who are in close contact with different areas of young people's lives. Third, prevention methods for the different products (or product groups) are integrated as one theme. Next, smoke stop counselling will be expanded. The same goes for early detection and early intervention. Also, initiatives will systematically pay attention to specific target groups (e.g. people living in poverty,

[42] The establishment of the General Drug Policy Cell, as well as the Belgian Monitoring Centre for Drugs and Drug Addiction will be discussed in the pillars 'Integral and integrated approach' and 'Epidemiology, research and evaluation' respectively.

ethnic cultural minorities, prisoners) and to gender differences. Another action says to implement risk reduction initiatives aimed at reducing the transmission of diseases (like HIV, hepatitis C) and at empowering users with regard to their health. The objective mentions three target groups for these actions: the general population, families, parents of drug users (not limited to these three, indicated by '...'), and refers to the role of (health) care workers and social workers in close contact with youth, local governments, and families as having a key role in health prevention.

Lastly, the demarcation of tasks and responsibilities, making optimal use of the existing capacity and investing in validated registration, monitoring and process and impact evaluations, are emphasised.

The objective did not specify who would be responsible for its implementation.

4.1.1.6 Objective 6: Actions aimed at social prevention at work

In the area of alcohol and drug policy at work, the policy documents mention that the Minister of Work wants to focus his policy on two areas. On the one hand, the focus will be on extending the obligation to implement an alcohol and drug policy to civil servants (the current collective bargaining agreement (Dutch: *collectieve arbeidsovereenkomst*, French: *CCT*)is only applicable to the private sector). On the other hand, the focus will be on providing guidance to employers, employees and prevention experts on the alcohol and drug policy at work, and on ensuring the compliance with the CAO/CCT 100.

The latter is ensured by a list of actions. A first action will distribute the national labour council (Dutch: *Nationale Arbeidsraad*; French: Conseil national du travail) brochure: "A preventive alcohol and drug policy in the company. Working in consultation on prevention". A second action will realise a brochure on the good practices in the field of prevention (practical approach). A third action comprises of a poster campaign. Next, information sessions will be held for members of the hierarchical line about the new collective bargaining agreement and the drafting of a prevention policy at work. Additionally, the National Training Centre will organise a study afternoon on alcohol and drugs at work in the spring of 2010. Lastly, explicit attention will be paid to problematic alcohol and drug use in the European Social Fund (ESF) project 'psychosocial risks'.

The objective did not specify who would be responsible for its implementation.

4.1.1.7 Objective 7: Actions aimed at preventing drug-related public nuisances

There are seven actions concerning ‘the prevention of drug-related public nuisances. First of all, the policy documents mention that the police services and prevention sector make clear agreements in permanent dialogues so that an incompatible policy is avoided. Second, social nuisances, crime, and drug-related phenomena are systematically mapped and analysed at local and supralocal level. Third, structural monitoring and evaluation of the agreements and commitments made public administration and police services are implemented. Fourth, the flow of grants for the operations and projects developed to combat to drug problems, will be structurally identified and screened. Fifth, the policy reports mention to support public administration and police services in preventing, identifying and reducing drug-related social nuisance, crime and insecurity phenomena by concluding agreements with one another. Sixth, the development of a local integrated drug policy[43] by public administration and police is promoted, through the supervision of (supra)local projects, providing good methods and practices, stimulating (supra)local partnerships and offering advice and measures on horizontal and vertical policy coordination. Lastly, the further development of the preventive and treatment dimension for drug tourism is emphasised.

The objective did not specify who would be responsible for its implementation.

[43] Other actions regarding local drug policies (drug- and security plans) are mentioned in the pillar ‘Integral and integrated approach’.

4.1.2 Inputs

The inputs displayed in *Figure 10. Summary of the logic model on 'Prevention'*, show the human, financial, organizational, and community resources that are needed to implement the actions under the pillar 'Prevention'. The inputs are not always clearly defined in the policy documents. Therefore, not every action was allocated a specific input.

For the first objective, namely **the actions aimed at implementing strategic measures specifically targeted at psychoactive drugs**: *"20 million BEF will be included in the budget of the Minister of Public Health"* (p.43).

For the second objective, namely **the actions aimed at discouraging driving under the influence of legal or illegal drugs**, there is no detail on the budget that will be allocated. The policy documents merely mention that: *"The budget for the actions concerning psychoactive medication are included in the budget of the Minister of Social Affairs (see also objective 'implementing strategic measures specifically targeted at psychoactive drugs')"* (p. 44).

For the third objective, **the actions aimed at preventing the use of tobacco and alcohol,** a budget will be freed up*: "The Minister of Public Health will release funds from his budget to take measures against tobacco advertising, in consultation with the Communities"* (p. 46).

For the fourth objective, namely **the actions aimed at developing a prevention policy**, it is said that: *"At the federal level, this action point does not create additional budgetary costs"* (p.47). In addition, the policy documents mention that the Minister of Internal Affairs should distribute the resources earmarked for prevention and local coordination from the part "Drugs" of the global plan.

For the fifth objective, namely **the actions aimed at applying a policy of dissuasion towards (non) users of drugs**, there is no mention of budget. The same counts for the sixth objective, **the actions aimed at namely social prevention at work,** and the last objective concerning '**preventing drug-related nuisances**. There are no budget allocations or other inputs mentioned in the policy documents.

4.1.3 Intended outputs

The outputs displayed in *Figure 10. Summary of the logic model on 'Prevention'*, show the immediate outputs (deliverables) that result from the implementation of the actions under the pillar 'Prevention'. Like inputs, intended outputs are not always clearly defined. Some outputs were not explicitly mentioned, but could be deduced from other parts of the text. These outputs are indicated in grey. For the pillar, we see that most outputs were not explicitly defined. Sometimes, there was no output defined at all. In these **cases, we left the space blank.**

4.1.3.1 Outputs for objective 1: To implement strategic measures specifically targeted at psychoactive drugs

For the first objective, **implementing strategic measures specifically targeted at psychoactive drugs,** the outputs are diverse. A first group of actions under this objective is aimed at **alerting the general population of the dangers of psychoactive medication.** Outputs of this group are: Initiatives to review registration of benzodiazepines and amphetamines in consultation with European partners, a consensus conference on the prescription of benzodiazepines together with an end report, and a campaign on the dangers of benzodiazepines.

A second group of actions is aimed at **preventive and repressive counselling and monitoring of the prescribing behaviour of physicians for dependency causing medicine**. The outputs from these actions are: the supervision of the Local Quality Councils and the Provincial Medical Committees, the sanctions by the Provincial Medical Committees to revoke a physician's license, the referrals of physicians to the medical association or even to criminal justice, the expansion of Farmanet to include

non-refundable medication, and the situation in which doctors are confronted with the Pharmanet figures for prescription (of psychoactive medication).

A third group of actions intends to **limit the influence of the pharmaceutical industry on the prescription behaviour of doctors**. The outputs of these actions consist of: measures to limit the advertising of medication to scientific information, the independent doctor's visits organized by the Belgian Centre for Pharmacotherapeutic Information, the expertise promotion packages of the Belgian Centre for Pharmacotherapeutic Information, and reduced to no distribution of samples of benzodiazepines (amongst physicians).

The other actions under this objective define the following outputs: a draft note of double and numbered prescriptions, the creation of a national double and numbered prescription system for narcotics, and lastly, various consultations between representative organisations of doctors, pharmacists' unions and the pharmaceutical industry and the Federal government.

4.1.3.2 Outputs for objective 2: To discourage driving under the influence of legal or illegal drugs

For the second objective, **discouraging driving under the influence of legal or illegal drugs,** there are several outputs. The first group of outputs comprises of drug tests in traffic, ministerial circulars and guidelines for police services and prosecution actors on the new legislation, an information campaign to inform the general population about the new legislation, an annual evaluation and registration system, blood and/or urine tests following a standardized test battery, trainings for police officers to recognize drivers under the influence of drugs, clear limits for drug tests, and an development of alternative punishments.

The second group of outputs (for driving under the influence of psychoactive medication), are a warning sign on the packaging of this medication, an adapted package leaflet (including a warning), and initiatives that raise the awareness to people who use this medication.

4.1.3.3 Outputs for objective 3: To prevent the use of tobacco and alcohol

For the third objective, **the actions aimed at preventing the use of tobacco and alcohol**, the policy documents describe the many outputs.

For tobacco, the outputs are: An information campaign towards drivers on the existing legislation, the inspection actions of the Food Inspection in the hotel and catering industry on the smoke ventilation systems and the no smoking zones, an integrated control action that will control the tobacco regulations, a binding and written smoking policy in the general school regulations, a ban on addiction increasing additives to cigarettes, a policy document on the anti-tobacco policy of the Minister of Public Health.

For alcohol, the outputs are: a course on ‘how to deal with alcohol’ in the school curriculum, a prevention offer for families and in the work place, the implementation of the recommendations of the European Alcohol Action Plan 2000-2005 in national legislation, adequate attention to alcohol addiction in the development of regional care circuits, a clear position on the ‘The Geneva Partnership on Alcohol: Towards a Global Charter’, adaptation in the advertising regulations concerning alcohol to the new mixed drinks (the so-called ‘alcopops’), and lastly, an increased number of inspections to control for underage drinking and in the catering sector.

4.1.3.4 Outputs for objective 4: To develop a prevention policy

For the fourth objective**, developing a prevention policy**, outputs are divided over different groups**.**

The first group of outputs concerns the actions related to the **development of an integrated school prevention policy.** These consist of initiatives that structurally integrate prevention in the training of teachers, and the attentions for 'life skills' in the school curriculum.

The second group of actions, emphasizing that the **existing prevention initiatives at the different levels (local, supralocal) should be further developed (and, where necessary, coordinated with one another)**, list the following outputs: scientifically founded prevention initiatives, evaluation of prevention initiatives according to the evaluation criteria of the EMCDDA, the expansion of secondary and tertiary prevention (towards both legal and illegal drugs), initiatives for targeted prevention at the neighbourhood level or at the local level, local prevention policies for municipalities, and. framework agreements between the federal government and the communities and regions. Lastly, these outputs are mentioned too for the fourth objective: the development of an academic course on 'Treatment for drug addicts', training on substance use problems during the basic courses of health professionals, and assessment of the scope of the problem of 'rave parties' and a concrete action plan on the latter phenomenon by the General Drug policy Cell.

4.1.3.5 Outputs for objective 5: To apply a policy of dissuasion towards (non) users of drugs

For the fifth objective**, applying a policy of dissuasion towards (non) users of drugs,** the outputs are clear, but implied (not explicitly defined). First of all, the creation of networks and consultations concerning prevention at different levels (local, supralocal) are implied as an output. Other implied outputs are: training for (non) professional adults in close contact with young people, integrated methods for the different products (or product groups), the expansion of smoke stop guidance and early detection and intervention, initiatives for targeting specific groups and gender differences, risk reduction initiatives, the clear demarcation of tasks and responsibilities between prevention actors, optimal use of the existing capacity, and lastly, a validated registration and monitoring system, as well as process and impact evaluations.

4.1.3.6 Outputs for objective 6: Social prevention at work

For the sixth objective**, social prevention at work**, there are two general outputs formulated: (1) the obligation to implement an alcohol and drug policy to civil servants, and (2) providing guidance for the implementation of an alcohol and drug policy at work for employers. The latter generates some more outputs: the dispersion of a brochure on "A preventive alcohol and drug policy in the company. Working in consultation on prevention", the creation of a brochure on the good practices in the field of prevention at work, a poster campaign, information sessions about the new collective bargaining agreement and the drafting of a prevention policy at work, a study afternoon on alcohol and drugs at work in the spring of 2010, attention to problematic alcohol and drug use in the European Social Fund (ESF) project 'psychosocial risks'.

4.1.3.7 Outputs for objective 7: To prevent drug-related nuisances

Finally, for the seventh objective, **preventing drug-related nuisances**, the following outputs are implied: Clear agreements in permanent dialogue between the police and prevention sector; an overview of drug-related public nuisance at local and supralocal level; the structural monitoring and evaluation of the agreements and commitments between public administration and police services; an overview of the flow of grants for projects developed to combat drug problems; agreements between public administration and police. Another (quite elaborate) output is 'the supervision of (supra)local projects, providing good methods and practices; stimulating (supra)local partnerships and offering advice on horizontal and vertical policy coordination'. Lastly, 'a preventive and treatment dimension for the approach towards drug tourism' is implied as an output.

4.1.4 Intended outcomes

The summary depictured in *Figure 10. Summary of the logic model on 'Prevention'*, shows the outcomes of the actions under the pillar 'Prevention'. These outcomes demonstrate the mid- and long-term effect(s) the policy makers sought to achieve by implementing the actions above. The policy documents not often mention a clear outcome. Some outcomes were not explicitly mentioned, but could be deduced from other parts of the text. These outcomes again are indicated in grey. Sometimes, there was no outcome defined at all. In these cases, we left the space blank. Outcomes were only clearly defined by the policy documents for a minority of the actions mentioned above.

For the first objective, **the actions aimed at implementing strategic measures specifically targeted at psychoactive drugs,** the following outcomes are explicitly mentioned: changes in prescription behaviour of doctors for addictive medicine, the reduction of the impact of pharmaceutical industry on the prescription of psychoactive drugs, reduce the stealing of prescription booklets. There is also one outcome implied: 'better information on (the dangers of) benzodiazepines. One outcome was added during the expert validation: 'Evidence-based listing of benzodiazepines and amphetamines.

For the second objective, **the actions aimed at discouraging driving under the influence of legal or illegal drugs,** the following outcomes are explicitly mentioned: driving under the influence of legal or illegal drugs is discouraged, drivers are informed about legislation of driving under the influence of drugs, increased traffic safety, and a reduction in the use of psychoactive drugs when driving a vehicle. One outcome is implied: standardization of drug tests and better identification of signs of a person being under the influence of drugs.

For the third objective, **the actions aimed at preventing the use of tobacco and alcohol**, there are several explicit outcomes: Both the supply and the use of tobacco is regulated, amelioration of smoking behaviour in schools, reduction of passive smoking, and promotion of a tobacco free life. There is also one outcome implied: Changes in youth's attitudes towards alcohol. Two outcomes were added during the expert validation: Improving the regional treatment offer for alcohol addiction, and the alignment of BE policies with EU and international policies and recommendations.

For the fourth objective**, the actions aimed at developing a prevention policy** there is one explicit outcome: The local prevention policy is being expanded. Implicit outcomes are: Prevention is part of the school curriculum, and international comparison of prevention initiatives is possible. Two outcomes were added during the expert validation: Better understanding of the problem of illegal dance parties, and tackling the problem of illegal dance parties.

For the fifth objective**, the actions aimed at applying a policy of dissuasion towards (non) users of drugs,** there is one explicit outcome: the avoidance and, where possible, the reduction of health damage. Other, implicit outcomes are: Improvement of the impact of existing prevention actions, a reduction of the transmission of diseases (HIV, Hep C), and users are informed about existing practices and assume responsibility regarding their health.

For the sixth objective**, the actions aimed at social prevention at work**, there is only one implicit outcome: Every employer has an alcohol and drug policy at work.

Finally, for the seventh objective, **preventing drug-related nuisances**, the explicit outcomes are the prevention, identification and reduction of drug-related social nuisances, crime and insecurity phenomena; existing financing channels are transparent, and a clear distinction of prevention activities of the police and the psycho-medico-social sector exists.

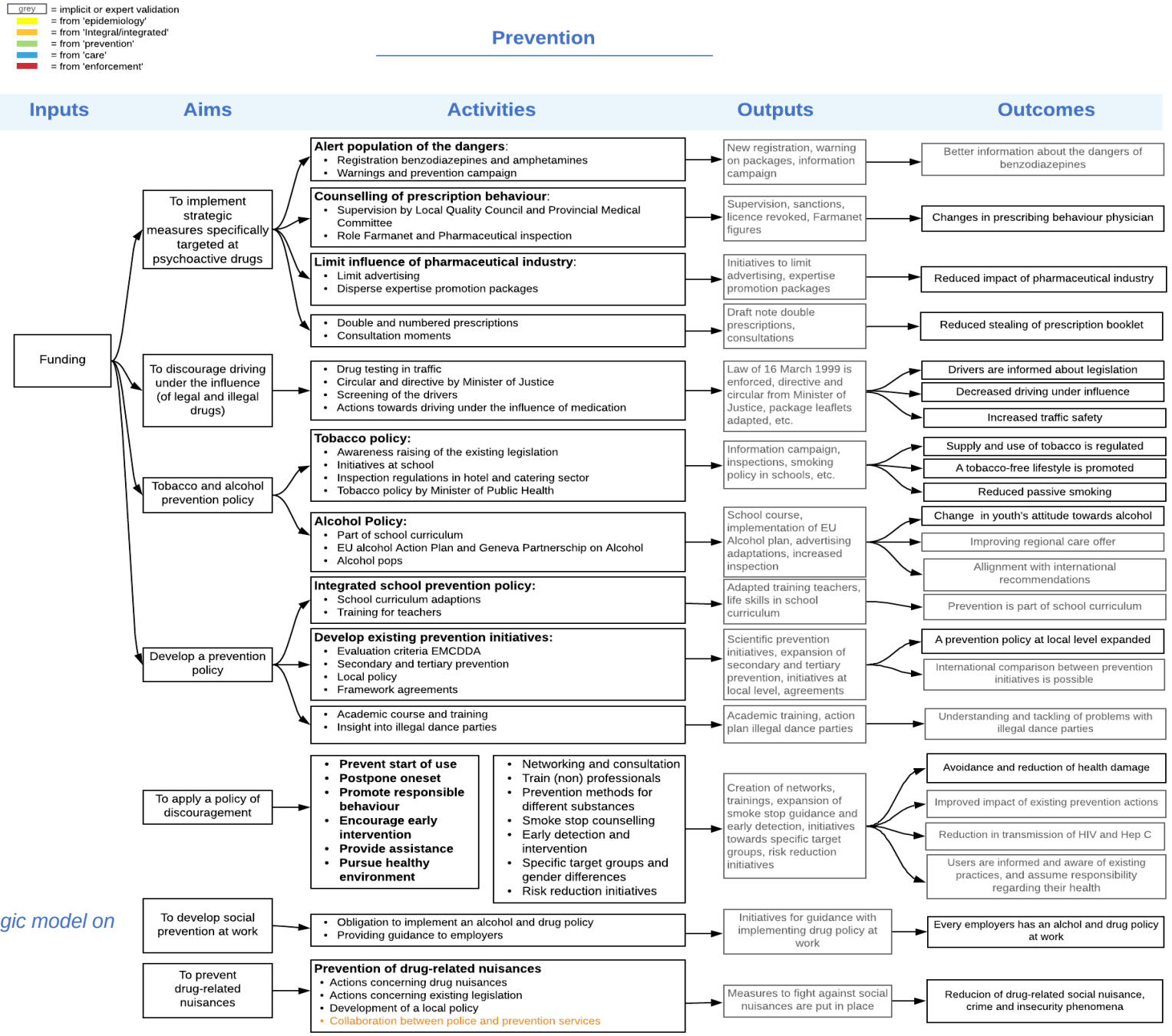

Figure 10. Summary of the logic model on 'Prevention'

4.2 Critical appraisal of the logic models

In this section, we address the research question 'To what extent are the logic models of the pillars and transversal themes consistent, coherent and logical?'. This critical appraisal of the policy theory is a first step of the process evaluation, in the sense that it allows us to control whether possible policy issues are attributable to a poor policy theory or not.

Building further on the document analysis of the central policy documents, we critically analyse the logic models, relying on indicators of internal validity (Funnell & Rogers, 2011). This way, discrepancies, inconsistencies and omissions in the policy's theory are raised and discussed.

The internal validity of the policy theory shows to what extent the policy theory is clear, realistic and logical about what the policy wants to achieve, and how the policy wants to achieve these outcomes (Funnell). In this section, we assess this internal validity based on five indicators: Clarity of description, the outcome chain, demonstration of how the outcomes are related to the problem, the logical argument of the policy theory, and the articulation of mechanisms for change.

Summary of 'Critical appraisal of the logic models'

A critical appraisal of the policy logic found that:

- ⇨ The pillar 'Prevention' is generally **explicit on its objectives and central actions, but often remains vague about the concrete intended outputs and outcomes**. This is illustrated by the lack of explicit outputs for most of the actions, and even outcomes for at least half of the listed actions.
- ⇨ The pillar 'Prevention' is not explicitly based on a (recent) situation analysis.
- ⇨ The pillar 'Prevention' **does not distinguish between short-term, medium-term and long-term outcomes,** although starting points for this distinction are present.
- ⇨ The pillar 'Prevention' is **focuses on both legal and illegal substances,** however remains vague about actions aimed at alcohol. Also, youth is often defined as a target group for prevention, while prevention initiatives towards adults (or other target groups) remain scarce.
- ⇨ The pillar 'Prevention' is **barely explicit about the processes through which change is achieved,** although the Parliamentary Working Group on drugs clearly shows some starting points. The main focus of the policy documents remain on the policy design.

4.2.1 Clarity of description

A first measure of internal validity is 'clarity of description'. It assesses whether the logic model describes how the policy works with enough detail.

The pillar 'Prevention' describes many different objectives and actions. Nevertheless, a substantial part of these actions remains vague. Moreover, there are a lot of uncertainties about output and outcome, as will be shown in this section.

First of all, there are some issues with the problem description. For this problem description, both the Federal Drug Note and the Joint Declaration rely on the report of the Parliamentary Working Group on Drugs. However, the Parliamentary Working Group on Drugs **could not outline a clear picture of the drug problem in Belgium in 1997**. The available data on drug users in health care, the prison system, and the general population were unclear and scarce, particularly with regard to illegal drugs (The Parliamentary Working Group on Drugs, p. 415 and p. 957). Given a lack of data about the prevalence

of drug use and the related problems, the problem description was limited to the prevailing good practices and bottlenecks in the prevention sector at the time. Additionally, the question can be raised as **to what extent this problem description of the late nineties is still relevant** for the central drug policy documents in 2001 and 2010. The Federal Drug Note provides an update on the 'state of affairs' described in the report of the Parliamentary Working Group on Drugs. Although this focuses mostly on the extent of implementation of the recommendations of the report, it also describes (very marginal) the number of smokers and the use of alcohol in Belgium (p. 18). This indicates that the Federal Drug Note did address an up-to-date problem. The 2010 Joint Declaration however (which was established almost 13 years after the Parliamentary Working Group on Drugs) only lists the accomplishments per authority and policy level at the time. There is almost no referral to the drug use in Belgium at the time (with the exception of some limited data on Flanders). For its problem description, it still seems to rely on the report of the Parliamentary Working Group on Drugs. Based on the policy documents, it is therefore unsure whether the actions of the Joint Declaration address the relevant problems in the prevention sector at the time.

Second, although the pillar 'Prevention' is **- in general - explicit about its objectives and actions, it often remains vague about the intended outputs and outcomes**. A little more than half of objectives and actions are described with sufficient detail or more or less in a SMART[44] way. A good example is the actions of the objective 'To support social prevention at work', where a very concrete list of actions is described. However, there are several examples of objectives and actions missing detail, especially for the actions mentioned under the objective 'develop a prevention policy' and 'apply a policy of discouragement towards (non-)users of legal and illegal drugs'. It is no coincidence that both objectives fully fall within the competence of the communities and regions. **The actions of both the Federal Drug Note and the Joint Declaration relating to competences of the communities and the regions, systematically tend to be vague or less detailed, as if they were formulated as broad as possible so that the various visions could still be included in one policy document.** Some of the actions under the latter give insufficient detail on what the actions does precisely. For example, 'the existing prevention initiatives should be further developed' does not specify how they should develop, in what direction or with what purpose. These unclear actions raise more questions than they clarify, and does not give any direction for implementation whatsoever. Other actions are formulated in such a non-binding way, one could argue whether they are actions at all, e.g. 'Federal Government will ask Belgian alcohol producers to take a position on the 'The Geneva Partnership on Alcohol: Towards a Global Charter'. There is even confusion on the objective 'develop a prevention policy' itself, because several actions under this objective are formulated in such generic terms, they could be mistaken for (sub)objectives, e.g. 'next to primary prevention, secondary and tertiary prevention should be expanded'. Moreover, the Federal Drug Note refers to both 'primary, secondary and tertiary prevention' and 'targeted prevention', without further explanation. Lastly, it is not always clear which specific action is related to which specific objective (this is especially the case for 'apply a policy of discouragement towards (non) users of legal and illegal drugs'). The objectives merely list a number of subobjectives, after which a number of actions are listed. No links are established between both.

Additionally, there is no clarity on who is responsible for the implementation of the objectives 'To apply a policy of discouragement', 'Social prevention at work' and 'to prevent drug-related nuisance', all three objectives introduced by the Joint Declaration. If no one is given an explicit responsibility, who should feel addressed?

In contrast to the general clarity of the objectives and actions, the policy documents are much less clear about the outputs and outcomes. The direct output of the actions is often implied, rather than specified (which can be seen by the many grey boxes in *Figure 10. Summary of the logic model on 'Prevention'*). For example, the action 'investing in validated registration, monitoring and process and impact evaluations' implies the set-up of a registration system which could allow for evaluation, however does not explicitly says so. Vague or implied outputs could raise difficulties for implementation. The same

[44] Specific, measurable, achievable, realistic (or relevant) and time-bound (cf. infra)

counts for the outcomes. Similar to the outputs, some outcomes are implicit rather than explicit, for example for the actions under the objective 'social prevention at work' (not a single outcome is explicitly defined). Moreover, outcomes are sometimes not mentioned at all, for example for the actions related to 'development of a prevention and treatment dimension with regards to drug tourism'. One could logically reason that the outcome here would be 'a reduction in drug tourism' or 'a decrease in drug-related nuisance', however, this is not explicitly mentioned in the pillar. This is problematic, because outcomes are the changes a policy maker wants to achieve, and when this is omitted, the relevance of the actions altogether could be questioned. And finally, the outcomes that are defined, are often not specific enough. The outcome 'the local prevention policy is being expanded' does not clarify to what extent, over what time sloth or for which cities.

The same analysis relates to input: only for a few actions, an explicit budget is defined. This does not mean that there was no budget allocated, it merely means that based on the policy documents, no clear budget was agreed upon at the time. Other inputs (like legislation, capacity, etc.) than budget allocations were not mentioned. The Federal Note mentions prevention as the highest priority, yet the means allocated to this pillar are unclear.

4.2.2 The outcome chains

A second assessment of the logic model's internal validity is whether it is built around the outcomes it wants to achieve. Are the outcomes central to the logic model, or are there other elements that are accentuated?

A first observation, and most importantly, is that **the outcomes are not systematically defined per action or per group of actions**. Half of the actions do not have a (clear) outcome, which suggests that the pillar 'prevention' is not built around the outcomes it wants to achieve. The lack of clear outcomes leads the reader to logically deduce the intended outcomes, which makes it difficult to properly understand the 'mechanisms of change' underlying the logic model.

Second, the policy documents **do not distinguish between medium-term and long-term outcomes.** Although a minority of the outcomes imply a difference in type of outcomes, a distinction is not made explicit. For example, the objective 'to discourage driving under the influence of legal or illegal drugs' describes 'increased traffic safety' and 'a reduction of the use of psychoactive drugs when driving a vehicle' as outcomes. The objective thus mentions medium-term outcomes (a reduction of the use of psychoactive drugs when driving a vehicle), and long-term outcomes (increased traffic safety), however the policy documents do not define it this way. These distinctions should be made explicit, because they indicate how change is achieved. Changes like 'drivers are informed about the legislation of driving under influence' are described as an end-point of the drug policy. Although these outcomes are essential to understand the policy logic, they do not illustrate the long-term changes the policy makers want to achieve. These long-term changes should be made explicit, all the more, because these long-term outcomes explain how the actions contribute to the three central outcomes of the Belgian drug policy[45].

In general, we can conclude that the logic model on 'Prevention' seems to emphasise the aims and the objectives, and to a lesser extent the outputs and outcomes. The pillar 'Prevention' is therefore more centred around what the policy will do (and already does), rather than what it wants to achieve.

4.2.3 The demonstration of how the outcomes are related to the problem

A third measure of internal validity questions whether the logic model indicates how the outcomes address the problem(s) that the policy aims to address. This means that we assess if and how the problem(s) leading to the establishment of the policy, are linked to the intended outcomes.

[45] Defined by the Federal Drug Note (2001) as: (1) a reductions of the number of dependent drug users, (2) a reductions of the physical and psychosocial damage caused by drug use, and (3) a reductions of the negative impact of the drug phenomenon on society.

The problem description of the Parliamentary Working Group on Drugs is limited to a description of how the Belgian prevention field looked like after the fourth State reform (1993). A clear overview of the problems is dispersed over the different interviews with experts, as described in the introduction. Throughout the different interviews, **eight main trends** could be deduced. A first trend was that **prevention in Belgium primarily focussed on primary prevention**, especially focusing on education (e.g. programs to train and stimulate social skills among teenagers). A second trend could be found in the **difficulties to distinguish between the pillar prevention and the pillar treatment**, particularly for prevention initiatives aimed at reducing risks associated with drug use (the so-called harm reduction approach). A third trend described the **sprawl of prevention projects that lacked a solid foundation, expert staff, structure, coordination and experienced an extreme performance pressure** in the prevention sector due to an increased demand for prevention. The **limited resources** were mentioned too in this context. A fourth trend addressed the **predominant focus on prevention of the use of illegal drugs**, whereas there were clearly problems with alcohol too. For example, the report highlighted the **overuse of psychoactive substances** among the Belgian population (among young people and young adults). These behaviours were said to be linked to an overproduction of these substances in Belgium and to the prescription behaviour of physicians, which in turn led to an increase in the number of dependent users. Fifth, **problems with evaluation and the lack of coordination** were described. A sixth trend established a **link between prevention and crime**: *The link between hard drug use and crime is real, and certain forms of acquisitive crime (street crime, breaking and entering into cars and homes, shoplifting, pickpocketing) can only be tackled in depth if the heroin problem, in particular, can be significantly reduced*" (PWG, p.664). The Parliamentary Working Group on Drugs states that this is often linked with extreme poverty, and then illustrates that drugs are both a crime problem, health problem, a problem of well-being and treatment. A seventh trend described the phenomenon of '**smart drugs'** (misrepresentations of the nature, composition and effects). Lastly, the influence of legal and illegal **drug use on driving behaviour** was clarified. In the recommendations, a clear difference was made between structural prevention (combat poverty, focus on urbanisation, community development), and person-centred prevention (health promotion and education).

The objectives and actions described in the pillar 'Prevention' **address to a large extent these problems described in the Parliamentary Working Group**. Almost all trends are dealt with in the policy documents, although there are some remarks. First of all, although the main focus on primary prevention was defined as a problem in the report of the Parliamentary Working Group, only one (vague) action in the policy documents addresses this: The Federal Drug Note intends to expand secondary and tertiary prevention (yet, without clarifying how this will be done). On the other hand, harm reduction (towards injecting drugs use) is addressed by the pillar 'Treatment, risk reduction and reintegration' (cf. infra). Similarly, the difficulties to distinguish between the pillar prevention and the pillar treatment, particularly for prevention initiatives aimed at reducing risks associated with drug use, are only marginally addressed in the pillar 'Prevention'. Policy makers made the deliberate choice to discuss harm reduction in the pillar 'Treatment, risk reduction and re-integration'.

Second, some of the problems described under 'Prevention' are addressed in other pillars. For example, the problem of coordination, and the problems concerning evaluation were addressed by the pillars 'Integral and integrated approach' and 'Epidemiology, research and evaluation' respectively.

Also, although problems with 'smart drugs' were identified in the Parliamentary Working Group, no actions were taken to address this problem. Similarly, there is no difference in structural prevention and person-centred prevention in the policy documents. Moreover, there are no objectives aimed at structural prevention at all.

4.2.4 The strength of the logical argument of the policy theory

A fourth assessment of internal validity is 'the strength of the logical argument'. This means that we measure the extent to which the logic model is 'logic' in terms of coherence, sequence and completeness.

The logic model on 'Prevention' is mostly logical. In general, the actions follow logically from the central objectives, the intended outputs (when they are defined) follow logically from the actions, and the intended outcomes result logically from the intended outputs (Culley et al., 2012). Objectives and actions are aimed both at legal substances (alcohol, tobacco and psychoactive drugs) and illegal substances. Also, there is consistency between the two policy documents: both the Federal Drug Note and the Joint Declaration, mention similar priorities (with the Federal Drug Note being more elaborate and concrete than the Joint Declaration).

There are a few exceptions to the logical policy theory. First of all, because not every action has a clear, explicit output and outcome, it is not possible to control for the 'logic' of these actions. They are simply incomplete. The same can be concluded for the lack of a concrete budget allocation for most actions that require a certain input.

Second, the pillar 'Prevention' is not always consistent in terminology. An example is the use of several synonyms for psychoactive medicine (dependence causing medicine, narcotics, medication, pharmaceuticals, etc.). The inconsistency in terminology is confusing as to whether these actions are referring to the same substances. On other concepts, the pillar 'Prevention' is mostly consistent.

Apart from these observations, there are some other inconsistencies in the logic model on 'Prevention'. A first inconsistency can be found with the actions to prevent the use of alcohol. The logic model on prevention defines actions for all substances, however, the actions related to 'alcohol' are shrouded in vagueness. Whereas the actions for psychoactive medicine and tobacco are clearly defined and concrete, actions the prevent the use of alcohol are very general (e.g. 'a prevention offer will be provided for families and in the work place' ⇨ What prevention initiatives? Aimed at what?), are non-binding (e.g. 'the Federal Government will ask Belgian alcohol producers to take a position on the 'The Geneva Partnership on Alcohol: Towards a Global Charter''⇨ What should happen after a position is taken?), or remain vague on the actual implementation (e.g. 'the federal government will implement the recommendations of the European Alcohol Action Plan 2000-2005, insofar as they are compatible with tradition, culture and public opinion in Belgium').

Also, some actions focus on the prevention of drug-related crime in a way that seemingly contradicts with the key principle of a public health perspective towards the drug phenomenon. For example, for the objective 'to prevent drug-related nuisance', one of the few actions where the local policy is given a central role, the main focus of the actions is on the collaboration between public administration and the police (all the actions were introduced by the Joint Declaration). Only two actions (from the Federal Drug Note) highlight the role of prevention and care workers.

Lastly, youth is predominantly defined as a target population for prevention initiatives. Whenever a specific target population is defined, young people are mentioned. This contrasts with other target populations, which are barely subject of the policy documents (once, family is mentioned, and under 'social prevention at work' the professional context is mentioned).

We can conclude that globally, the pillar 'Prevention' is logical, but some inconsistencies remain.

4.2.5 The articulation of mechanisms for change

The last assessment of internal validity is 'the articulation of the mechanisms for change'. This entails the question 'Does the logic model clearly identify the assumed mechanisms of change that underpin its selection of outcomes and activities'. Funnell et al. (2011) describe these mechanisms for change as the 'because' statements: if A happens, then it will result in B, because of C. 'C' is the mechanism for change in this case.

In this area we can be brief. Almost none of the actions explicitly mention the mechanisms for change that lead to their outcome. This means that whereas for most actions a sequence of 'if-then' statements can be made; these sequences are often not accompanied with a 'because'. Therefore, these

'mechanisms for change' are almost completely absent from the logic model. Nevertheless, there are (a limited number of) reference points. Additionally, for some actions this 'because' can be found in the report of the Parliamentary Working Group on Drugs. Although this is not one of the central policy documents (cf. supra), it does help to uncover the mechanisms for change for some parts of the logic model. There are several links in the Parliamentary Working Group that explain mechanisms of change, especially for prevention towards young people:

> Prevention towards youth in schools is aimed at discouragement. It mainly consists of teaching personal and social skills, increasing social resilience and learning to deal with conflicts. Social skills include communication, conflict management and negotiation. Personal skills include building self-confidence, dealing with feelings and setting goals. These skills should not only be taught once, but should also be maintained and integrated (p. 967). It is emphasised that campaigns based on fear, untruths, and repression are ineffective.
>
> Within drug prevention, other strategies for influencing young people are the project 'Youth Advisors' that was developed within the Youth Advice Centres. The approach is based on the observation that young people who fulfil a key function in the peer-group can have an influence on the way the group deals with substance use. It is the intention that these young people would fulfil a linking function between the youth counselling services and the youth group to which they belong (p.986).

For person oriented primary prevention, the Parliamentary Working Group on Drugs describes:

> Three models are described. The first model is the knowledge attitude model. This model assumes that extensive information about drugs and the effects of drug use will lead to a negative attitude. The negative attitude would then lead to a negative perception of drug use. The method evolved from an approach based on warning against use - the so-called dissuasive approach - to a more objective transfer of information. A second model is the affective model. This assumes that if an individual study his/her own values, he/she will decide not to use drugs. This model concentrates efforts on value clarification and on learning to make decisions for oneself. A final model is that the social competence model assumes that a shortage of personal and social skills can be observed in people who take drugs and in those who continue to use drugs. As a rule, the approach starts from a broader perspective of health promotion, and the objectives include a responsible attitude towards all drugs (p. 962).

This illustrates that the Parliamentary Working Group on Drugs clearly explains mechanisms of change (at least for some actions). However, the translation of these 'mechanisms for change' is not reflected the policy documents (and thus the logic models).

4.2.6 Conclusion of the policy intentions

The mapping of the policy intentions through logic models, and the critical appraisal of these logic models reveal something about the shape of Belgian drug policy, but also what was emphasised for the pillar 'Prevention' by policy makers in 2001 and 2010.

In terms of shape of the Belgian drug policy, we see first of all see that the policy documents were often explicit about the objectives and actions, and thus about what the policymakers intent to undertake. Yet, the actions of both the Federal Drug Note and the Joint Declaration relating to competences of the communities and the regions, systematically tend to be vague or less detailed, as if they were formulated as broad as possible so that the various visions could still be included in one policy document. The downside if this, is that these unclear actions do not give any guidance for implementation, nor as to how to measure them. These actions are therefore difficult to implement as intended by the policy makers, as the 'intention' is not clear in the first place.

Second, although most actions and objectives were more or less clearly defined (with the exception of the actions concerning the competences of the regions and communities), the policy documents were

less explicit about the expected changes that an action could bring about. Vague or implied outputs and outcomes cannot show how the objectives and actions are related to the intended changes in practice. This might produce problems with accountability. If it is not clear what change a certain action has to produce, then why is the action introduced? It also hinders the monitoring and evaluation of the policy plans. If it is not clear what change an action should bring about, how can we measure whether this change has occurred at all?

Third, whenever the outcomes are defined, there is no differentiation between short-term, medium-term and long-term outcomes. This makes it seem as if the short-term outcomes are the final destination of the drug policy, which they are not.

In terms of what the policy makers implicitly or explicitly emphasised, the critical analysis showed that policy makers intended to focus on the prevention of (non-problematic) drug use. Youth was predominantly defined as a target population for prevention initiatives. Although most objectives and actions were described with sufficient detail, some were defined in very broad way or in a non-binding way. These unclarities were especially apparent with the objectives ‘to prevent the use of alcohol’ and ‘to develop a prevention policy’. For the former, the actions were general, vague and non-binding actions. This suggests that although policy makers wanted ‘to prevent the use of alcohol’, they did not perceive the objective as a priority requiring concrete and decisive action. Indeed, the objective is shrouded in 'options', 'possibilities', and 'action insofar as they are compatible with Belgian culture'. For the latter objective, it seems that policy makers tried to define the vision as broad as possible, as to leave a margin for implementation for the regions and communities. However, the result is that the overarching drug policy plan does not provide a concrete vision for the central objectives of the Prevention pillar. Lastly, the objective on the prevention of drug-related crime, seemingly contradicts with the key principle of a public health perspective towards prevention. Nevertheless, it is one of the few objectives where the local policy is given a central role.

4.1 Have the policy intentions been realised: a measurement

In this chapter, we describe whether the policy intentions, summarised in the logic models, were actually realised. We discuss the results in two steps. First of all, we examine to what extent and how the policy intentions were realised. Second, we measure how the realisation of the policy intentions is perceived, discussing the facilitators, barriers, bottlenecks, challenges and needs, by different stakeholders and experts in drug policy.

To examine to what extent and how the policy intentions were realised, the analysis consists of two parts. First, we examine which objectives were implemented, based on a document review. Second, we describe the results of the online survey, to report on the perceived realisation of the different actions defined by the Federal Drug Note and the Joint Declaration. Both parts will be summarised in the section 'realisation of the policy intentions. To measure how the realisation of the policy intentions is perceived by different stakeholders and experts in drug policy, we rely on semi-structured interviews. The results are discussed in the section 'Providing context to the stage of realisation'.

4.1.1 Realisation of the policy intentions

In this section, we map the extent to which the policy intentions, summarised in the logic models, are actually realised. We map this out in two ways[46].

We start with an analysis **of the main developments** in the field within the various objectives of the 'Prevention' pillar. We do this through a **rapid document review** of the websites, reports and other publications from various institutions with a role in the Belgian drug policy. In this section, we describe the major developments in the field for each objective. We refrain from presenting a full inventory of all actions that have been realised in micro detail, because it is not feasible to do so. The Belgian drug policy field is fragmented among many different competences and many different policy levels (cf. infra and supra). The follow-up of the realisations of the Federal Drug Note and the Joint Declaration was not centralised in one institution. Therefore, piecing together the puzzle in retrospect for all actions in all policy levels and domains, scattered over reports from different institutions, is not only virtually impossible, it is also not the core objective of this research. This section rather seeks to summarise the key developments within the different objectives, as they feed into the overall performance in the pillar 'Prevention'.

We therefore opted to list some of the major developments within the various objectives. We have mapped out these developments with a rapid document review, using the websites, reports and other publications from various institutions, such as the General Drug Policy Cell, Belspo, VAD, Fedito, Sciensano, many different addiction care institutions, the public prosecutor's office, federal and local police, NGO's, etc.

The result of this section is limited to an overview of the realisations within each objective, but does not reveal whether or not the realisations work as intended, whether they sufficiently meet the needs in the field, nor whether they are executed in a good way. Moreover, many of the realisations from the rapid document review are not necessarily a consequence of the Federal Drug Note or the Joint Declaration. Often, realisations fit as if coincidentally into the framework outlined by the Federal Drug Note and the Joint Declaration, but were no direct implementations of the two policy documents.

Second, we map the **perceived realisation** through **an online survey** amongst practitioners working within one or more domains related to the drug policy. The survey gained an explorative insight into the perceived realisation of the different actions defined by the Federal Drug Note and the Joint Declaration

[46] For a more elaborate description of the methods used in this project, we refer to Chapter 2 'Methodology'.

from a large number of experts at all policy levels (federal, regions and communities, local level) and across the different policy domains (integral and integrated approach; epidemiology, research and evaluation; prevention; care, risk-reduction and re-integration; enforcement)[47]. The survey thus provides a first insight into how the work field evaluates the realisation of the policy intentions. The online survey was distributed amongst practitioners working within one or more domains related to the drug policy.

Twelve respondents completed the section on 'Prevention'. The respondents were experts who represent different domains (mostly from specialised drug treatment, prevention and mental healthcare) and policy levels (mostly the local, Flemish and Walloon region, and the federal level). There were no respondents representing COCOM. The survey respondents also had a long experience in the drug field (with the exception of one, all respondents were working in the drug field for longer than 10 years).

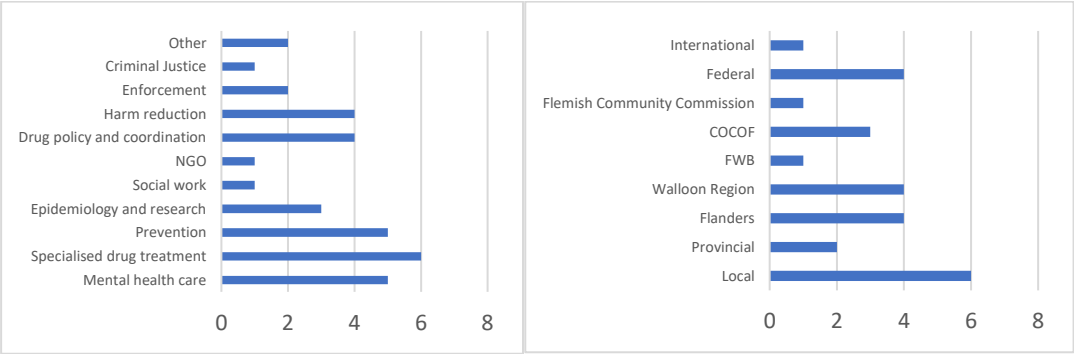

Figure 11 Domains and policy levels that respondents of the pillar 'Prevention' represent

Lastly, it is important to consider the limitations of the survey when interpreting the results. The aim of the survey is to gain an explorative insight into the **perceived realisation** of the different actions. It is therefore not the intention to give a representative image of the extent to which the actions are actually realised. Respondents were encouraged to answer only those questions they were aware of, so the number of responses per action varied between 10 responses for the most answered action ('To extent the obligation of an alcohol and drug policy to a public employer '), and 1 response for the least answered action ('Role of Farmanet and Pharmaceutical Inspection'). In addition, the actions already date from 2001 and 2010, and since then, the prevention field has evolved extensively (cf. supra). So, the respondents sometimes had to fall back on their recollection from actions realised several years ago. Finally, as was also highlighted in the critical appraisal of the logic models, some actions are very broadly formulated or difficult to measure. This causes differences in interpretation among respondents.

4.1.1.1 Results of the 'extent of realisation'

First, we will present a summary of the results before we will elaborate on the realisations of each objective more in detail.

Summary of the 'extent of realisation'

With regards to the extent of realisation, we found that:

- ⇨ The document review revealed that there is no structural follow-up of the implementation of the Federal Drug Note and Joint Declaration, nor of other developments in the drug prevention field. We had to puzzle the overview of realisations in retrospect, which resulted in a very fragmented and anecdotical picture.

[47] For more information about the methodology, we refer to chapter 2 'Methodology'

- ⇨ There have been many developments in the prevention field, both actions that were intended by the Federal Drug Note and the Joint Declaration, as well as realisations and developments within the drug prevention field that were not foreseen by the policy documents. Most realisations are situated amongst the objectives 'to implement strategic measures specifically targeted at psychoactive drugs', 'to discourage driving under the influence of legal and illegal drugs' and 'tobacco policy'. The developments for the objectives 'to prevent drug-related nuisance' and 'alcohol policy' are much more modest. Most additional actions, not foreseen in the Federal Drug Note and the Joint Declaration, are situated with the objectives 'to develop a prevention policy', 'to apply a policy of discouragement' and 'a tobacco policy', and to a lesser extent for the other objectives. It seems that practice, but also individual policy makers and sometimes even an individual region, are further fuelling the pillar 'Prevention', even without an overarching and crosscutting drug plan giving direction.
- ⇨ There are a lot of discrepancies in the level of perceived realisation. This is in about half the cases explained by regional or policy-level differences (after the Sixth State Reform, Prevention was almost completely defederalized). However, there are some discrepancies that cannot be explained by regional or policy-level differences. These discrepancies could be due to differences in interpretation, the fact that some actions are non-quantifiable or measurable because they are described in a vague way, or the lack of overview on the different prevention realisations in the prevention field amongst practitioners, civil servants and (scientific) experts.
- ⇨ Comparing the results of the document review with the survey, shows that although the document review identifies certain actions as realised, survey respondents indicate them as partially or even not realised. This indicates that actions may be implemented, but they do not necessarily operate in the best possible way.

A. Realisations of the objective 'To implement strategic measures specifically targeted at psychoactive drugs'

a. Extent of realisation: a document review

There is no centralised overview of the realisations for the objective 'to implement strategic measures specifically targeted at psychoactive drugs. The information on the various achievements of the objective is spread over many publications, report and websites by different institutions and organisations. The description of the developments in this section, mainly relies on the documentation on BelPEP, presentations during conferences and the information on the VAD website and materials. Some publications provide a better overview than others. For example, a publication by the VAD gives a complete overview of the prevention initiatives available in Flanders for psychoactive medication and BelPEP describes several initiatives taken at the federal level. As a result of this fragmentation, this section presents an anecdotal overview of the achievements within the objective that is not a complete representation of the field.

The document review reveals that many actions intended by the Federal Drug Note and the Joint Declaration for the objective 'To implement strategic measures specifically targeted at psychoactive drugs' were realised. At the federal level for example, there have been a number of advices and guidelines to guide prescription behaviour of psychoactive medicines. For instance, in 2002 and 2011, the Supreme Health Council issued an advisory report on sedatives and hypnotics (advisory report 7600) and on the impact of psychopharmaceuticals on health, particularly with regard to the

elderly (advisory report 8571). In 2018, a guideline on the management of sleep disorders and insomnia in adults in primary care was developed by the Working Group Development of Primary Care Guidelines (WOREL) of EBPracticeNet (Van Tomme, 2017). Over the years, a number of consensus conferences have also been organised, aimed at evaluating medical practice regarding psychoactive medication in a particular sector and formulating recommendations. For example, in 2006 and 2007, there have been consensus conferences on the use of antidepressants, organised by RIZIV/INAMI. Furthermore, in support of general practitioners and other care and health professionals, efforts were also made to promote knowledge, skills (e.g. with regard to biopsychosocial consultations, motivational interviewing, etc.) and cooperative relations between the various partners and health professionals (BelPEP).

Additionally, with regard to the population at large, various awareness-raising campaigns took place at a federal level, that focused for example on general information (2002-2003), personal interaction between healthcare provider and patient (2005-2006, 2009-2010, 2013-2014), or on the online resource book for general practitioners and pharmacists (2018) (Van Tomme, 2017).

There are also several examples of awareness raising, monitoring, guidance and support for psychoactive medication in Flanders. For example, fact sheets of the VAD inform about the use of psychoactive drugs in Flanders (De Donder, 2020b), FAQ about psychoactive medication are bundled in the DrugLijn folders, and different brochures inform about the use of psychoactive medication with or without a focus on a specific target group or specific medication (e.g. the use of psychoactive drugs in traffic, the use of psychoactive drugs amongst the elderly, the use pain medication, ...). An overview of the different educational, preventive and curative materials on psychoactive medication is available through a VAD publication (Seys, 2017). It bundles the informative materials to use in counselling patients and clients, but also methods to set up prevention activities, and is addressed to intermediaries, prevention workers, counsellors and other professionals (such as general practitioners, pharmacists) (Seys, 2017). For example, Domus Medica materials, such as the online health guide and the file cards for general practitioners are highlighted there, along with VAD screening and assessment tools and the algorithms for the appropriate use of psychoactive medication in the context of fall prevention (Seys, 2017).

In Brussels and Wallonia, authorities have set regional, pluriannual plans for prevention. However, while Brussels has a specific drug plan including prevention actions, Wallonia is relying on a generic health promotion and prevention plan. In Brussels, the topic of misuse of psychoactive medicine is not specifically mentioned in the plans, although a few associations are having annual training programmes and material about this topic (InforDrogues, 2021). In Wallonia, the Horizon 2030 health promotion plan includes a specific action for supporting continuing education activities on the over-consumption of benzodiazepines and painkillers. In Wallonia, the operational program of the prevention and health promotion plan for Wallonia, Horizon 2030, highlights a specific action related to the use of psychoactive medicine: support for continuing education activities on the over-consumption of benzodiazepines and painkillers.

Although several intended actions were realised, some intended actions were not (fully) realised. For example, the double and numbered prescriptions were never realised. Instead electronic prescriptions were introduced in 2017, which served a similar purpose: to prevent prescription fraud. An example of an action that was not fully realised, is related to the role of Farmanet for non-refundable medicine. Farmanet provides data to doctors and dentists to inform them about their prescribing behaviour and the prescription behaviour of the group of prescribers to which they belong (e.g. doctors of a certain speciality) (RIZIV, 2020). This was not extended to non-refundable medicine. Another example of an action that was not fully realised, are the independent doctor visits by Farmaka. These visits informed general practitioners about which medicines are best (not) prescribed based solely on scientific evidence. They were organised for a long time, but were no longer subsidised in 2018, and the project was discontinued.

However, **there have been several additional realisations within this objective, that were not foreseen by the Federal Drug Note and the Joint Declaration**. For example, the Belgian

Psychotropics Experts Platform (BelPEP) was established. BelPEP was created in 2013, in response to the high use of psychoactive medication in Belgium (Belgian Psychotropics Experts Platform BelPEP, 2014)[48]. BelPEP aims to achieve a more appropriate use of psychostimulants, benzodiazepines, antidepressants and antipsychotics. The platform wants to increase knowledge about psychopharmaceutic substances and promote the use of biopsychosocial consultation methods, as well as strengthen cooperation between (and among) general practitioners and other health care professions (Van Tomme, 2017). A coordination committee and three working groups developed action plans for the target group of young people, adults and the elderly. Initiatives were then planned in the areas of awareness-raising, and the drafting and implementation of guidelines and recommendations for professionals. Examples include: an update of the antidepressant guidelines for general practitioners, a benzodiazepine awareness campaign for pharmacists, hospital directors and general practitioners, to promote the appropriate use of benzodiazepines and provide training through the Local Quality Council, and a pilot project to develop and implement a needs-based care program for the diagnosis and treatment of children and young people with ADHD (Algemene Cel Drugs, 2019). Another example of additional realisation at a federal level, are prevention initiatives targeting the sale and production of psychoactive medication. For instance, the federal government, in cooperation with the FAGG, has sought to reduce the packaging of psychoactive medications.

Additionally, there is attention to psychoactive medicine in the prevention policy of the regions. For example, in Flanders, the 'De Vlaming leeft gezonder in 2025' policy document highlights psychoactive medication as an accompanying theme that can deepen and broaden the health goals. The policy document for instance refers to the project on psychopharmaceuticals in residential care centres as an action to improve health in care and welfare facilities.

From the document review it is clear that **most of the actions** mentioned by the Federal Drug Note and the Joint Declaration **were addressed**. Most actions were (at least partially) realised. However**, many other realisations have taken place** besides the actions intended by the Federal Drug Note and the Joint Declaration, and this at all policy levels. It therefore seems **that practice, but also policy makers at individual policy domains** and are **further fuelling the objective, without an overarching crosscutting drug plan** giving direction.

b. Perceived realisation: a survey amongst experts

First of all, we see that most actions are only answered by a few respondents. Although we reached 12 experts in prevention, many of the actions within this objective are only answered by one or two experts. This suggests that, **even amongst experts, there is little visibility of realisation of all these actions**.

Second, most survey respondents indicate that **the actions of the objective** 'implement strategic measures specifically targeted at psychoactive drugs' are **only partially realised**. As the survey gives an indication of how the realisation of the actions are perceived, the results suggest that experts consider that most actions weren't fully realised as was intended.

In general, there is **a consensus about the extent of realisation** of the actions under 'counselling of prescription behaviour' and 'Limit the influence of the pharmaceutical industry', and the last group of actions. The survey responses for the actions aimed at 'alerting the population of the dangers of psychoactive medication' and 'revoke a visa or refer to justice' and 'consultation between the government, physician organisations, pharmacist union and the industry' are more diverse, although there are no large discrepancies. For the consensus conference, there is a discrepancy: the Flemish respondents indicate it was both fully, partially and not realised. This could indicate that not all experts

[48] Belgian Psychotropics Experts Platform BelPEP: Globale visienota en actieplan van de 3 werkgroepen (December 2014), te raadplegen via: ; Actieplan Psychofarmaca 2019-2021 (December 2018)

are aware of the organisation of consensus conferences, or it could indicate that there is still room for improvement.

The survey responses thus demonstrate that there is a **relative consensus on the perceived level of realisation** of the objective 'implement strategic measures specifically targeted at psychoactive drugs', with the exception of **some differences in appreciation within a region.**

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **a number of (minor) discrepancies between the actual realisation and the perceived realisation**. Although the document review identifies certain actions as realised, survey respondents indicate them as partially or even not realised. For example, there have been several awareness raising campaigns, both by the federal government and the regions, yet still, some of the experts mention this action has only been partially realised. Another example are the actions within 'counselling of prescription behaviour'. Although these actions were implemented, the experts indicate that this is still only partially realised.

These discrepancies could indicate two things. First, could mean that **practitioners** are not always aware of the existence of these initiatives, and that **they lack an overview of the concrete developments** within the objective 'To implement strategic measures targeted at psychoactive drugs. Second, it could suggest that, **although the actions are implemented** (cf. document review), the actions **do not necessarily operate in the best possible way** and improvement is needed according to the experts (cf. survey).

B. Realisations the objective 'To discourage driving under the influence of legal and illegal drugs'

a. Extent of realisation: a document review

There is no centralised overview of the realisations for the objective 'to discourage driving under the influence of legal and illegal drugs. The information on the various achievements of the objective is spread over many publications, report and websites by different institutions and organisations. The description of the developments in this section, mainly relies on the documentation of VIAS, presentations during conferences and the information on the VAD website and materials. Some publications provide a better overview than others. For example, a publication by the VAD gives a complete overview of the prevention initiatives available in Flanders for psychoactive medication and BelPEP describes several initiatives taken at the federal level. As a result of this fragmentation, this section presents an anecdotal overview of the achievements within the objective that is not a complete representation of the field.

The document review reveals that almost all the actions intended by the Federal Drug Note and the Joint Declaration for the objective 'to discourage driving under the influence of legal and illegal drugs' were realised. For example, the legislations regarding driving under influence of alcohol or other drugs, has evolved. The Articles 61bis §2 and 63 §1 of the Road Traffic Act[49] (added in 2009 by the Law introducing saliva tests on drugs in traffic[50]), introduce a standardized checklist of external signs for police to check whether someone is driving under influence. In case of suspicion of driving under the influence of drugs or medicines, the police can take a saliva test. Police carry out regular control actions to enforce the legislation. Recent figures from the Framework Note Integral Security and year report of the Federal Police however show that the number of man hours spent on drugs and

[49] Wet van 16 maart 1968 betreffende de politie over het wegverkeer (BS 27/03/1968)
[50] Wet van 31 juli 2009 tot invoering van speekseltesten op drugs in het verkeer (BS 15/09/2009)

alcohol controls show a downward trend in the period 2016-2018. According to the evaluation, this decrease is most likely due to the sharp decrease in capacity at the Federal Road Police from 2016 to 2018. The report emphasised, however, that the effectiveness of alcohol checks is increased by the use of sampling devices. In addition, the saliva tests for drug controls that have replaced blood sampling since 1 April 2019 are less time-consuming (and therefore more effective) for staff in the field.

Another example of a fully realised action, are the several awareness campaigns towards the general public, of which the most well-known are the BOB campaigns. The campaign 'Don't do drugs and drive' highlighted in 2019 the dangers of driving under the influence of illegal drugs (Leblud et al., 2019). The awareness towards doctors regarding psychoactive medication, has been discussed in the previous section. In general, VIAS notes that the current measures against driving under influence are mainly aimed at alcohol use and hardly at drug and medicine use. Yet, there are measures that can reduce the use of drugs and medicines in traffic. In the case of illegal drugs, most measures concentrate on the domain of enforcement/legislation, and in the case of medicines, mainly on awareness and education in health care (Leblud et al., 2019).

In summary, the theme of 'driving under influence' is mainly dealt with under the heading of road safety, with the main emphasis on driving under influence of alcohol (2015 VIAS institute[51] report).

Only one of the intended actions was not fully realised: the annual evaluation of the application of the legislation concerning driving under influence. There are a few reports on driving under influence (e.g. last VIAS report on 'Traffic security', the VIAS 'road safety dossier: drugs in traffic'), but none of the reports evaluate the application of the legislation, nor has this research found evidence of a registration system.

Additionally, **there have been some additional realisations within this objective, that were not foreseen by the Federal Drug Note and the Joint Declaration**. For example, in Wallonia, the proposition of the Walloon Road Safety Agency (FR: Agence Wallonne de Sécurité Routière) to citizens to share their opinion on the subject of road safety, through a questionnaire. The results of this consultation served as a basis for the establishment of a road safety action plan based on 10 priority measures. These measures include the promotion of the use of educational sanctions as an alternative to prosecution or as a probationary measure (particularly in the case of driving under the influence), and the strengthening of prevention of driving under the influence of alcohol (4 enforcement measures have been identified).

From the document review it is clear that **all the actions** mentioned by the Federal Drug Note and the Joint Declaration **were (at least partially) realised**. There have been **a few additional realisations, especially in the regions,** apart from the actions intended by the Federal Drug Note and the Joint Declaration. These additional actions remain limited.

b. Perceived realisation: a survey amongst experts

First of all, most actions mentioned in the survey are only answered by a few respondents. Although we reached 12 experts in prevention, many of the actions within this objective are only answered by one or two experts. This suggests that, **even amongst experts, there is little visibility of realisation of all these intended actions**.

Second, most survey respondents indicate that **the actions of the objective** 'to discourage driving under the influence of legal and illegal drugs' are **only partially realised**. Most of the actions within this

[51] At the time VIAS was called the 'Belgian institute for Traffick Security (NL: Belgisch instituut voor Verkeersveiligheid; FR: Institut Belge de sécurité routière)

objective have partially or fully been realized, according the survey respondents. Only the 'offer of alternative punishment for driving under influence' is only partially to not realised, respondents indicate.

In general, **there is a large consensus among the respondents** about the level of realisation. There are no significant discrepancies in the responses, except for the action concerning 'Clear limits to the standardised test battery'. Variations between the answers categories appear between the different policy levels: Flemish and Walloon respondents indicate that this action is fully realised, whereas a Brussels respondent indicates that it is not realised. For the actions 'to evaluate legislations annually' and 'a registrations system to evaluate the legislation', there is only one French-speaking respondent from the Walloon and Brussels region who filled in the question, and the respondents indicates that it is not realised. **This suggests that there is little visibility of these actions in the field**.

The survey responses thus demonstrate that there is a **relative consensus on the perceived level of realisation** of the objective 'to discourage driving under the influence of legal and illegal drugs', with the exception of **some regional differences** and **some lesser known actions**.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **only a small difference in the actual and perceived realisation.** Whereas the document review found that almost all the actions were implemented, the perceived realisation by practitioners often indicated that the actions were only partially realised. This indicates that, **although the actions are implemented** (cf. document review), the actions **do not necessarily operate in the best possible way** and improvement is needed according to the experts (cf. survey).

C. Realisations objective 'Tobacco and alcohol policy'

a. Extent of realisation: a document review

There is **no centralised overview of the realisations** for the objective 'tobacco and alcohol policy'. The information on the various achievements of the objective is spread over many publications, report and websites by different institutions and organisations. The description of the developments in this section, mainly relies on the documentation and annual reports of Healthy Life (NL: Gezond Leven), the Federal Agency for the Safety of the Food Chain (NL: FAVV; FR: AFSCA), the website of the Fédération Wallonie-Bruxelles, the Federal Public Service on Public Health (NL: FOD Volksgezondheid; FR: SPF Santé Publique), and on policy documents from the regions, like 'De Vlaming leeft gezonder in 2025', 'Horizon 2030' or the 2018-2022 health promotion strategic plan of the French-speaking government of Brussels. As a result of this fragmentation, this section presents an **anecdotal overview of the achievements** within the objective that is not a complete representation of the field.

The document review reveals that **almost all the actions** intended by the Federal Drug Note and the Joint Declaration for the objective **'tobacco policy' were realised.** For example, it is clear that the federal government closely monitors compliance with the tobacco legislation: the inspections service of the Federal Public Service of Public Health regularly checks the application of the smoking ban in public places as mentioned in the year reports (FAVV, 2020). The Federal Agency for the Safety of the Food Chain (NL: FAVV; FR: AFSCA) controls catering establishments where food is served. For example, the year reports of 2019 and 2018 show almost 9000 controls for the application of the smoking ban each year, a slight decrease compared to 2017 (+- 10000) and 2016 (+- 11500). Additionally, the Federal Public Service Employment, Labour and Social Dialogue carries (NL: FOD WASO; FR: SPF ETCS) out inspections in the workplace.

Another example of an action that was implemented, is the fact that, in Flanders and in the French-speaking community, smoking is prohibited in all primary and secondary schools.

A last example we give in this overview, is the implementation of the action 'to develop an anti-tobacco policy'. The Thematic Meeting Drugs of the IMC Public Health agreed in October 2015 that a global tobacco policy was urgently needed. One of the aims was to bring the number of adults who smoke on a daily basis below the 17% mark by 2018. The Federal Minister of Health and Social Affairs proposed a federal tobacco plan in March 2016, which was subsequently approved by the Council of Ministers. Among other things, this plan aimed to reduce supply and demand and ensure better protection against passive smoking. The report of the General Drug Policy Cell (Algemene Cel Drugs, 2019) further described the intention to develop, in agreement with the regions, an integrated inter-federal strategy with the aim of reducing tobacco consumption within the Cell Health Policy Drugs (which is a part of the General Unit on Drug Policy). In this context, the new system for the reimbursement of smoking cessation benefits in Flanders was proposed and implemented (with the website: Vlaanderenstoptmetroken.be), as well as a tobacco control campaign for smoke-free environments in hospitals, other residential structures or in prisons in the Walloon region. However, the report goes on to say that in the view of the Cell Health Policy Drugs, it was no longer opportune to develop a common policy, although Flanders emphasises the cross-jurisdictional cooperation for future preventive policies.

Only one of the intended actions for 'tobacco policy' was not fully realised: to examine the possibility of banning addictive additives in cigarettes.

Additionally, **there have been many additional realisations within this objective, that were not foreseen by the Federal Drug Note and the Joint Declaration**. For example, both in Flanders and Wallonia, a prohibition was implemented for smoking in the car when children (in Flanders children under 16[52], in Wallonia minors[53]) are present (FAVV, 2020; Gezond Leven, 2020). In 2019, this was also embedded in federal legislation[54]. Another example is that in 2019, the age limit to buy tobacco was raised to 18[55]. The regions and communities have also continued to develop policies that address smoking. For example, in 2015, the Flemish action plan on tobacco, alcohol and drugs 2009-2015 ended, and during the health conference in 2016 a new strategic plan "de Vlaming leeft gezonder in 2025" was proposed (cf. infra). This plan is setting-oriented, instead of thematic. Health promotion (with this inclusion of tobacco) is the overarching goal for all health professionals. An example of the Walloon Region, is the 'No Tobacco Plan' of 2004 and the Walloon Prevention and Health Promotion Plan (FR: Plan Prévention et Promotion de la Santé en Wallonie, Horizon 2030). The theme of tobacco is also developed in "the Walloon strategic plan for the prevention and management of tobacco use/plan 2018-2030". This system is part of the continuity of the Walloon Tobacco-Free Plan. In Wallonia, the strategy was to include drug prevention into a generic health promotion and prevention plan instead of having a specific drug plan. While Brussels has set specific prevention plans on the topic, Wallonia has decided, so far, that problematic drug-use was always linked to other health and social issues. Therefore, prevention of problematic drug-use, including tobacco and alcohol, is part of more generic health promotion plans and plans for the prevention of several types of unhealthy behaviours. That priority is further detailed in a reference plan for action, although it remains limited to tobacco. This plan stipulates several objectives, specifically related to tobacco (not to other substances):

[52] Decreet van 21 december 2018 houdende de luchtkwaliteit in het binnenmilieu van voertuigen, BS, 30 januari 2019
[53] Waals decreet van 31 januari 2019 betreffende de kwaliteit van de binnenlucht, BS, 12 maart 2019
[54] Wet van 8 juli 2019 tot wijziging van de wet van 22 december 2009 betreffende een algemene regeling voor rookvrije gesloten plaatsen toegankelijk voor het publiek en ter bescherming van werknemers tegen tabaksrook, teneinde een rookverbod in te voeren in gesloten personenvoertuigen in de aanwezigheid van kinderen jonger dan 16 jaar, BS, 8 augustus 2019
[55] Wet van 12 juli 2019 tot wijziging van de wet van 24 januari 1977 betreffende de bescherming van de gezondheid van gebruikers op het stuk van de voedingsmiddelen en andere producten, wat betreft de verkoop van tabak en soortgelijke producten aan minderjarigen, BS, 8 augustus 2019

- to reduce the initiation of vaping by at least 2% on young people (11-24y)
- to contribute stopping smoking by at least 2% on young and adults
- to limit the exposure of the population to passive smoking

In contrast, the **document review** reveals that **most actions** intended by the Federal Drug Note and the Joint Declaration for the objective **'alcohol policy'** were **only partially addressed.** This is mostly due to the lack of an overarching alcohol policy plan. The document review informs about some of the intended actions, e.g. Flemish schools can indeed be assisted by VAD to develop an alcohol policy (VAD, 2020), there are programmes to combat addiction, in the form of medical and psychological support, during school time in high school in the French-speaking community, Belgium endorsed the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020 (Eurocare, 2016), and alcohol treatment is indeed provided by many ambulant and residential facilities in Flanders (De Maeyer et al., 2017), Brussels and Wallonia. Still, there remains **a lack of an overarching alcohol policy**. In 2008, the ministers responsible for public health signed a joint declaration on future alcohol policy in which the federal government, together with the Communities and Regions, defined a common policy line on alcohol. In June 2015, the Interministerial Conference on Public Health asked the General Drug Policy Cell to develop an alcohol policy. A working group on 'Alcohol' was established. This working group developed and proposed an action plan with measures to reduce the demand for alcohol. However, to implement the measures, no political agreement was found, despite the fact that the drug prevention field, the treatment sector and academic sector all supported the plan. Negotiations continued at ministerial level, however, the discussions came to a halt when the Drug Thematic Meeting of the IMC Public Health on 27 March 2017 ended without consensus (Algemene Cel Drugs, 2019). An important factor behind the lack of an alcohol plan is the clash between commercial and public health interests (Kramer et al., 2020). The recommendation of the World Health Organization (WHO) to develop an integrated alcohol policy has thus far not been fulfilled. Nevertheless, the work field is still asking for a comprehensive and integrated action plan (Algemene Cel Drugs, 2019; Fedito BXL et al., 2020; VAD, 2018).

Additional realisations within this objective**, that were not foreseen by the Federal Drug Note and the Joint Declaration**, are for example the many BELSPO studies regarding alcohol policy in Belgium: the BELSPO research, ALMOREGAL, for a better understanding of the Belgian alcohol marketing regulatory system (Decorte et al., 2019), and ALCOLAW, which evaluated the Belgium Alcohol Law of 2009 (Van Havere et al., 2018), and the ICarUS study for the development of an ICP for the integrated care of patients with alcohol dependence (Bekkering et al., 2016). Like with tobacco, the regions and communities have developed policies that address alcohol, for example the Flemish strategic plan "de Vlaming leeft gezonder in 2025", the 2018-2022 health promotion strategic plan of the French-speaking government of Brussels, the prevention and health promotion plan for Wallonia (Horizon 2030), and the Brussels health plan (2019-2025).

From the document review it is clear that there is **a significant difference between the realisations of the alcohol policy and the realisations of the tobacco policy**. The above developments clearly show several initiatives in support of a tobacco policy in Belgium. In contrast, the developments concerning an alcohol policy in Belgium are less pronounced. Many initiatives have been partially addressed, but an integrated alcohol policy has never been effectively implemented.
Moreover, there have been **many additional realisations for tobacco, especially in the regions,** apart from the actions intended by the Federal Drug Note and the Joint Declaration. This is less the case for alcohol.

b. Perceived realisation: a survey amongst experts

The survey responses for the actions aimed at a tobacco policy, **indicate that the actions** are **partially or fully realised, with consistent answers** throughout the all the regions. The only exception is the

smoking cessation counselling, which appears to be fully implemented in Flanders, but only partially according to a Walloon respondent. As this is a federated matter, discrepancies may occur. Only one action, 'an anti-tobacco policy', is partially to not realised according to the respondents.

With regards to the '**Alcohol policy', answers** are **much more diverse**. For all actions, except 'attention to alcohol addiction in care circuits', there are respondents indicating that the actions are fully, partially and not realised. These differences vary for some of the actions across policy level. For the actions 'Prevention for families and at work', 'attention to legislation by inspection services, for example control the minimum age' and 'the publicity for aclopops', Flemish respondents mention that the actions are fully to partially realised, whereas all Walloon respondents indicate that it is only partially realised, and one Brussels respondent believes the action is not realised. The discrepancies in the answers of the action 'To implement the European Alcohol Plan' are discrepancies purely amongst the Flemish respondents. Most of the Walloon and Brussels respondents indicate that the action is partially realised, only one Brussels respondent said that it is not realised.

The survey demonstrates that there is **disagreement about the level of realisation** of an 'Alcohol policy' among the respondents, a discrepancy that is not present for the actions of a tobacco policy. Not all discrepancies can be explained by differences between the different policy levels, which suggests that there is still some lack of clarity within the field.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **only a small difference in the actual and perceived realisation for the objective 'tobacco policy'.** Whereas the document review found that almost all the actions for 'tobacco policy' were implemented, the perceived realisation by practitioners often indicated that the actions were only partially realised. This indicates that, **although the actions are implemented** (cf. document review), the actions **do not necessarily operate in the best possible way** and improvement is needed according to the experts (cf. survey).

The **discrepancies** between the **actual and perceived realisation** is **much larger for the actions under the objective 'An alcohol policy'**. Whereas the document review indicates that the foreseen actions are nearly all partially realised, the survey depicts a more fragmented picture: for nearly every action there are respondents indicating the actions is fully and not realised. Thus, there are very many contradictory answers. These discrepancies could indicate two things. First, it could mean that experts are not always aware of the existence of these initiatives, and that **they lack an overview of the concrete developments**. Second, it could suggest that, **although the actions are implemented** (cf. document review), the actions **do not necessarily operate in the best possible way** and improvement is needed according to the experts (cf. survey).

D. Realisations objective 'Develop a prevention policy'

a. Extent of realisation: a document review

There is **no centralised overview** of the realisations for the objective 'to develop a prevention policy'. The information on the various achievements of the objective is spread over many publications, report and websites by different institutions and organisations. The description of the developments in this section, mainly relies on the documentation of VAD, the websites of the "logo's" (cf. supra), and on policy documents from the regions, like 'De Vlaming leeft gezonder in 2025', 'Horizon 2030' or the 2018-2022 health promotion strategic plan of the French-speaking government of Brussels. As a result of this fragmentation, this section presents **an anecdotal overview of the achievements** within the objective that is not a complete representation of the field.

The document review reveals that **most actions** intended by the Federal Drug Note and the Joint Declaration for the **objective 'to develop a prevention policy' were only partially realised.** For example, regarding evidence-based prevention, the COMIQS.BE research project measured the feasibility, willingness and application of the European quality standards for prevention in Belgium. The study concluded that prevention standards generally have a low rate of application, often due to various practical and substantive reasons (Autrique et al.).

As 'prevention' is a fully defederalized matter (cf. supra), we discuss some examples per region.

A first example for Flanders is the Strategic Plan 'De Vlaming leeft gezonder in 2025'. This Strategic Plan aims for a healthier life in terms of healthy eating, sedentary behaviour, physical exercise, tobacco and alcohol and drugs for the Flemish people in 2025. Whereas there used to be a thematic approach to prevention in Flanders, this Strategic Plan aims at a setting-oriented approach to prevention. Within this setting-oriented approach, prevention strategies are provided with matching thematic indicators. The Strategic Plan focuses on various life domains, on family, on leisure, on education, on work, on treatment and welfare, and on the neighbourhood (through the local government). The Strategic Plan also intends to encourage the other relevant policy areas of the various authorities to pursue a policy aimed at avoiding health risks, promoting healthy choices and a healthy lifestyle (at least) at the level of environmental interventions, agreements and regulations. The Strategic plan highlights several action points that the Federal Drug Note had foreseen, such as the importance of prevention at schools, as well as a major role for local government.

An example for the Walloon Region/FWB comes with the prevention and health promotion plan for Wallonia, Horizon 2030. The plan highlights several actions that the Federal Drug Note and Joint Declaration mention too. For example, it proposes to implement addiction prevention in schools as well as several prevention projects. Furthermore, the plan refers to the training of professionals (amongst others in the education sector) relating to prevention, health promotion and risk reduction. Another example is the emphasis on evaluation and an inventory of field practices regarding prevention.

For an example for Brussels, we refer to the Global Security and Prevention Plan 2017-2020, which highlights the educational setting, amongst other themes, with awareness raising, particularly towards young people, by setting up an education module on risk reduction and vigilance with regard to the supply of psychotropic drugs, and by supporting school health promotion programs.

An example for Ostbelgien, is provided by the Arbeitsgemeinschaft für Suchtvoreugung und Lebensbewältigung (further: ASL). It takes on the bulk of drug prevention in Ostbelgien. It focuses on prevention towards individuals and groups, but also towards the wider system (ASL, 2020). They have three main settings where they intervene with prevention initiatives: school, family and local governments. At school, ASL for example provides drug prevention through the KoPS-Projekt (information on rights, obligations, safe use, etc. in cooperation with the police), 'Klettern statt Kiffen' (a challenge to push limits without stimulants), counselling sessions at the RSI, the 'Nicht wegsehen bei Drogen' campaign, interactive prevention activities while children are waiting for Kaleido, and awareness-raising actions (ASL, 2020).

Two of the intended actions were not realised: the inventory of the scientific evaluation of prevention projects at national level, and the actions related to inventarising and drafting a concrete action plan towards drug use at clandestine rave parties.

Additionally, **there have been many additional realisations within this objective** that were not foreseen by the Federal Drug Note and the Joint Declaration, **especially within the regions**. For example, in Flanders, the Strategic Plan 'De Vlaming leeft gezonder in 2025' has a more elaborate approach towards prevention compared to the Federal Drug Note and the Joint Declaration. The Strategic Plan focuses on four prevention strategies: Education (informing and sensitising the target group and/or the immediate surroundings, and the intermediaries; reinforcing the skills of the target group and/or the immediate surroundings and increasing the expertise of the intermediaries),

Environmental intervention (physical, spatial, material and social environment), Policy through agreements and rules (agreements and rules within a setting, like school regulations or internal regulations), Care and guidance (including a caring environment, early detection and early prevention).

The evolution of the Flemish prevention field is also described by the Ginger report of VAD. It concludes that the prevention field in Flanders shows a clear evolution over the last ten years. Whereas ten years ago the bulk of prevention activities were carried out in the settings of health, education and government, settings such as welfare and the general population are now more prominent. Also, within the settings, there is a diversification of sub-settings. For example, in the education setting, secondary school still receives the most attention, but higher education is also given more attention. In the leisure setting, youth work remains the most important partner, but the nightlife and sport settings have become much more manifest (Rosiers et al., 2018). Nevertheless, the report also emphasises that this additional prevention development in new settings is not accompanied by an increase in the (funding for) prevention workers, which means that some settings used to be reached more often in the past, are now less well covered (Rosiers et al., 2018). Also, although the prevention activity 'consultation' is still important, the importance of consult and advise has increased, which emphasises the role of the Flemish prevention workers more strongly from an expert point of view (Rosiers et al., 2018).

Another example of additional developments, can be found in Brussels, where the Global Security and Prevention Plan 2017-2020 intends to improve knowledge of the products in circulation by strengthening the project for the analysis of psychotropic products (drug testing). The plan also mentions a measure concerning the strengthening and networking of Brussels research teams in the field of drugs (qualitative and quantitative research).

From the document review it is clear that **the actions mentioned by the Federal Drug Note** and the **Joint Declaration were partially or not realised**. Nevertheless, a lot has happened in the prevention field. As 'prevention' is a fully defederalized matter, prevention policy has further developed at the level of the regions. There are **numerous additional realisations in the regions** that were not foreseen in the Federal Drug Note and the Joint Declaration. These additional realisations were often guided by specific, regional or domain-specific policy plans. Thus, the regions are **further fuelling the objective, without an overarching, cross-cutting drug plan** giving direction.

b. Perceived realisation: a survey amongst experts

Most action within this objective are only partially to not realised, respondents indicate. However, as this objective concerns federated competences (cf. supra), the results of Flemish, Brussels' and Walloon respondents are discussed separately in this section.

According to the **Flemish survey respondents**, most actions are **only partially or not realised**. None of the Flemish respondents could indicate whether there is prevention training in the education of teachers, or whether the problems with 'rave parties' were inventoried. The action concerning the educational package for 'Life skills' is fully realised, only one respondent indicates the action is partially realised. The actions concerning 'evidence-based prevention initiatives', 'local prevention policy', and 'extent expertise on substances in education of health workers' are partially realised. Most respondents indicate that the actions 'expand the existing prevention initiatives in all policy levels', 'Establish an academic course on addiction treatment', 'a concrete action plan towards rave parties', and 'inventory scientific research on drug prevention projects' are not realised, although for the latter, there is one respondent that indicates that this is fully realised. For the other two actions, Flemish respondents indicate that the action is both partially to not realised. **In general, most answers for these actions are relatively consistent.**

According to the majority of the Walloon and Brussels, **most action are partially realised** (e.g. harmonise prevention initiatives; negotiate framework agreements between policy levels; extent

expertise on substances in education of health workers; concrete actions plan towards rave parties) **or not realised** (e.g. life skills; develop evidence-based prevention initiatives; Stimulating local prevention policy). For certain actions (e.g. Implement prevention training in education of teachers; Expand the existing prevention initiatives in all policy levels, establish an academic course on addiction treatment; A concrete action plan towards rave parties) there is a **discrepancy** between the answers. None of the respondents could indicate whether the action 'to organise and record the scientific evaluation of prevention projects' was realised.

The survey demonstrates **relative consistency in the answers** within the regions. Most respondents in either region, indicate that the actions are partially to not realised. Not all discrepancies can be explained by differences between the different policy levels, which suggests that there is still some lack of clarity and/or overview on 'what's out there' within the field.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **small differences in the actual and perceived realisation.** Whereas the document review found that most actions were partially implemented, the perceived realisation by practitioners often indicated that the actions were often partially or not realised. This indicates that, **although the actions are implemented** (cf. document review), the actions **do not necessarily operate in the best possible way** and improvement is needed according to the experts (cf. survey).

E. Realisations objective 'To apply a policy of discouragement'

This objective has a lot of overlap with the previous objective. Consequently, both objectives can be seen as complementary, and so can the developments. In this section, we elaborate on the different sub-objectives mentioned under the objective 'To apply a policy of discouragement': (1) Prevent young people and young adults from starting smoking, drinking alcohol or taking illegal drugs, (2) postpone the onset of the intended use, (3) promote responsible behaviour through education of skills in making choices, including risk reduction policies, (4) encourage early intervention of the problem, (5) provide psychosocial and medical assistance, and (6) pursuing a healthy living environment (meaning: a smoke-free environment, a maximum alcohol limit in traffic, giving clear messages adapted to the target group, both for legal and illegal drugs).

a. Extent of realisation: a document review

There is no centralised overview of the realisations for the objective 'to apply a policy of discouragement'. The information on the various achievements of the objective is spread over many publications, report and websites by different institutions and organisations. The description of the developments in this section, mainly relies on the documentation of VAD, the websites of the "logo's" (cf. supra), and on policy documents from the regions, like 'De Vlaming leeft gezonder in 2025', 'Horizon 2030' or the 2018-2022 health promotion strategic plan of the French-speaking government of Brussels. As a result of this fragmentation, this section presents **an anecdotal overview of the achievements** within the objective that is not a complete representation of the field.

The document review reveals that **all the actions** intended by the Federal Drug Note and the Joint Declaration for the objective **'to apply a policy of discouragement' were partially realised.** As 'prevention' is a fully defederalized matter (cf. supra), we discuss some examples per region.

A first example for Flanders can again be found in the Strategic Plan 'De Vlaming leeft gezonder in 2025'. The plan prioritises the settings of 'Family', 'Leisure', and 'Education' to target young people to promote a healthy lifestyle. Both the prevention of the use of tobacco, alcohol and drug use, the pursuit

of a healthy living environment, as well as the promotion of responsible behaviour and risk reduction are especially addressed in these settings. There are many examples prevention initiatives in Flanders within these settings: Quality Nights and Safe 'n Sound of VAD, campaigns like 'Binnen roken is nooit OK' from the institutions 'Kom op tegen Kanker' and 'Vlaams Instituut Gezond Leven', the interactive coaching initiative 'Als kleine kinderen groot worden' of VAD, the Sportivo's in the sports setting, obligated drug policy in schools in which school can be assisted by the pupil survey of VAD, educational packages on gaming, gambling, etc. (such as "YouBet" and "Vlucht naar Avatar" by VAD), ... The Strategic Plan further prioritises the provision of psychosocial assistance by providing prevention within care and welfare facilities. Here again, there are already a few examples of prevention initiatives within this setting: Smoking cessation counselling by tobacco consultants, BackPAC used by centre for pupil guidance (NL: CLB) and youth care, policies for psychoactive medication in residential care homes, … The Stategic Plan also confirms the importance of early detection and intervention, and emphasise it as prevention strategy in different settings. The importance of early detection was also highlighted in the concept note of the Flemish government on addiction treatment in 2016. The concept note emphasises the continuum of prevention, early detection and early intervention, various forms of treatment (cure and care), harm reduction, social integration, monitoring and security policy for an addiction policy. The concept note also states that the aim is to strengthen early detection and early intervention. The concept note highlights in particular the role of non-specific care (e.g. general practitioners, CAW and streetworkers) as central point for early detection and early treatment. In the context of early detection, we also mention the use of screening tools like me-ASSIST, SEM-J, AUDIT-C, adapted and brought under the attention of the prevention field by VAD. There are many institutions providing early detection and early intervention in Flanders, for example the regional CGG prevention work Tobacco, Alcohol and Drugs, the various 'Drugpunten', etc.

An example for the Walloon Region/FWB comes with the prevention and health promotion plan, Horizon 2030, which focuses on the promotion and support of health-promoting behaviour in relation to alcohol and tobacco consumption. it includes contributing to the reduction of tobacco use by discouraging people from starting to use tobacco, particularly young people. There are many examples prevention initiatives within these settings, but also examples that refer to responsible behaviour, and early intervention: e.g. Réseau Drogues Risquer Moins, a project for the dissemination of information from harm reduction in festive settings, or specialised services for school drop-outs. While Brussels has set specific prevention plans on the topic, Wallonia has decided, so far, that problematic drug-use was always linked to other health and social issues. Therefore, prevention of problematic drug-use, including tobacco and alcohol, is part of more generic health promotion plans and plans for the prevention of several types of unhealthy behaviours. That priority is, however, further detailed in a reference plan for action. This document stipulates several specific objectives, specifically related to tobacco (not to other substances):

- to reduce the initiation of vaping by at least 2% on young people (11-24y)
- to contribute stopping smoking by at least 2% on young and adults
- to limit the exposure of the population to passive smoking

Actions suggested to develop these objectives are based on professional's sensitization and training, and the development of networking and "intersectionality" in support of general health policies. Despite these specifications, no particular strategy or concrete action is mentioned. The operationalization of these actions and objectives is devolved to the FARES ("Fonds des Affections Respiratoires") that provides information and training material. Therefore, it can be considered that the Walloon Region has transferred its responsibilities to an actor outside the public institutions[56]

[56] Plan Prévention et Promotion de la Santé en Wallonie, Partie 1: Définition des priorités en santé (http://sante.wallonie.be/sites/default/files/plan-pr%C3%A9vention-janvier%202017-final-2.pdf)

Despite the many existing prevention initiatives, previous research has reported on the underfunding of the sector, especially compared to the other domains of treatment and enforcement (Lievens et al., 2016). This is not only the case in Flanders, but throughout the entire country.

As mentioned in the previous chapter, there have been many **additional realisations within this objective,** that were not foreseen by the Federal Drug Note and the Joint Declaration. For examples, we refer to the previous section 'Develop a prevention policy' (cf. supra).

From the document review it is clear that **all the actions** mentioned by the Federal Drug Note and the Joint Declaration **were at least partially addressed**. There have been **additional realisations, especially in the regions,** apart from the actions intended by the Federal Drug Note and the Joint Declaration.

b. Perceived realisation: a survey amongst experts

There seem to be some discrepancies in the realisation of the actions within 'to apply a policy of discouragement' according to the survey respondents. These differences appear both between regions (Flemish vs. Brussels and Wallonia), as well as within regions (Wallonia).

According to the Flemish survey respondents, all the actions of this objective are partially to fully realised. There is one exception. For the actions on real detection and early intervention, the Flemish answers vary between all categories. For this action, respondents disagree on whether or not the actions is properly realised. Again, it is noticeable that for two actions only one Flemish respondent answered: integrate prevention methods for different products, and coach adults who work with young people. This suggests that there is little visibility of these actions in the field.

For the action 'to implement risk reduction initiatives', Walloon and Brussels respondents agreed on a partial realisation (one respondent indicating it is fully realised). For all the others actions, however, answers of Walloon and Brussels respondents vary across partially and not realised. For these actions, there thus seem to be some discrepancies in the answers of Walloon and Brussels respondents. This could be explained by the lack of overview on all prevention initiatives (cf. supra), or by the fact that some actions are formulated in such a broad matter, that it can be interpreted in different ways (cf. supra). It could also mean that, although there are initiatives implementing the actions, there are still there is still room for improvement.

The survey demonstrates that there is **a general consensus about the level of realisation** of the actions within the objective 'To apply a policy of discouragement'. There are **a few exceptions** both within the Flemish answers, as well as amongst Walloon and Brussels respondents. These discrepancies cannot be explained by differences between the different policy levels, which suggests that there is still some lack of clarity within the field on the several developments in the prevention field, or that there is still need for improvement for some of the actions.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **only a small difference in the actual and perceived realisation.** Whereas the document review found that almost all the actions were partially implemented, the perceived realisation by practitioners often show similar answers, with a few exceptions where sometimes Flemish, sometimes Brussels and sometimes Walloon respondents indicate that an action was not realised. This suggests that, **although the actions are implemented** (cf. document review), the actions **do not necessarily operate in the best possible way** and improvement is needed according to the experts (cf. survey).

F. Realisations objective 'To develop social prevention at work'

This chapter is discussed more elaborately in the targeted evaluation 'CAO100/CCT100'. In this section, we summarise the main developments.

a. Extent of realisation: a document review

There is no centralised overview of the realisations for the objective 'to develop social prevention at work'. The information on the various achievements of the objective is spread over several publications, report and websites by different institutions and organisations. The description of the developments in this section, mainly relies on the documentation of VAD, Belspo research and information of FOD WASO/SPF ETCS. As a result of this fragmentation, this section presents an anecdotal overview of the achievements within the objective that is not a complete representation of the field.

The document review reveals that **almost all the actions** intended by the Federal Drug Note and the Joint Declaration for the objective **'to develop social prevention at work' were realised.** The developments within the objective 'to develop social prevention at work' are mostly related to the CAO100/CTT100. The obligation to have a drug and alcohol policy, meant that (private) companies were obliged to include a policy statement in the work regulations with regard to the implemented drug policy (of CAO100/CTT100). The implementation of the CAO100/CCT100 was indeed accompanied by an information campaign where the NAR/CNT provided and distributed a brochure widely together with a practical manual, information sessions were held, both by employers, prevention experts, and at the level of the organization itself. The expansion of the CAO100/CCT100 to the public sector and subsidized education personnel was not achieved.

Additionally, **there have been some additional realisations within this objective, that were not foreseen by the Federal Drug Note and the Joint Declaration**. For example, there have been two BELSPO research projects regarding this theme: UPTODATE 1 on attitudes and experience of occupational physicians concerning work-related alcohol and drug use of employees, and UPTODATE 2, an implementation research that measures prevalence and guidelines for screening and early detection. Also, the recent PREVPED study explored performance enhancing drugs in the work setting (amongst the use of these substances in other settings).

An example in Flanders, is the 3 million euros that were released in 2016 for health coaches specifically for small businesses. These coaches helped companies in a 20-hour process to start a preventive health policy in the company. One of those topics for a health policy is alcohol and drugs[57].

In Wallonia, the Horizon 2030 plan mentions to support institutional prevention initiatives and to provide an individualized response (related to risk reduction and/or the management of problematic situations), especially in the company environment.

From the document review it is clear that **all the actions** mentioned by the Federal Drug Note and the Joint Declaration **were (at least partially) realised**. There have been **a few additional realisations,** apart from the actions intended by the Federal Drug Note and the Joint Declaration.

b. Perceived realisation: a survey amongst experts

The survey respondents indicate that most actions are partially to fully realized, which indicates a general consensus on the level of realisation. There is one exception: Extending the obligation for employers to have an alcohol and drug policy to the public employer, for which the answers vary across

[57] Schriftelijke vraag nr. 23 (22 juli 2019), aan Jo Vandeurzen, Vlaams minister van welzijn, volksgezondheid en gezin

all categories. This discrepancy is especially noticeable in Flanders, where answers vary between the categories 'fully realised' and 'not realised'.

The survey demonstrates that there **is a general consensus about the level of realisation** of the actions within the objective 'to develop social prevention at work' amongst the respondents.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **coherency in the actual and perceived realisation.** The findings from the document review are backed up by the survey respondents. This seems to suggest that there is **a relatively good overview on the realisations related to the CAO100/CCT100** in the field.

G. Realisations the objective 'To prevent drug-related nuisance'

a. Extent of realisation: a document review

There is no centralised overview of the realisations for the objective 'to prevent drug-related nuisance'. The information on the various achievements of the objective is spread over many publications, reports and websites by different institutions and organisations. The description of the developments in this section, mainly relies on the documentation of the federal police and the Security and Prevention Directorate-General of the Federal Public Service for Home Affairs. This section therefore presents an anecdotal overview of the achievements within the objective that is not a complete representation of the field.

The document review reveals that **only a few actions** intended by the Federal Drug Note and the Joint Declaration for the objective **'to prevent drug-related nuisance' were (partially) realised.** The prevention projects aimed at drug-related nuisance are often financed by the strategic prevention and security plans (previously the prevention and security contracts) of FOD Internal Affairs. 57% of the projects funded by the strategic prevention and security plans, address drug-related nuisance (Federale Overheidsdienst Binnenlandse Zaken, 2020). The Ginger report of 2018 indicates that in Flanders, the intersectoral collaboration is most pronounced within the setting police and criminal justice, confirming the action on collaboration (Rosiers et al., 2018).

The SOCPREV research developed an evaluation and registration handbook for the prevention of drug-related crime (Pauwels et al., 2017). In Flanders, SOCPREV identified five projects that were directly aimed, among other things, reducing drug-related nuisances. The problem analysis of the projects mentioned drug-related nuisances as a problem to be tackled, but rarely as a priority objective. The primary target group of these five projects is vulnerable problem users with multiple problems (homelessness, psychiatric comorbidity or other problems) who sometimes cause drug-related nuisances (Pauwels et al., 2017). Currently, a follow-up project is currently ongoing to advance the practical implementation of the toolbox (SOCPREV bis).

None of the other actions, has - to our knowledge - been structurally addressed. For example, respondents clarified that there are several examples of dialogue between the police and prevention sectors, yet, this is ad hoc, voluntary or project-wise. Another example is the 'Security Monitor' at the level of the local police zones. This is a population survey on different safety topics (e.g. sense of insecurity, neighbourhood problems, prevention, …) (Federale Politie, 2018) and thus gives some insight into drug-related crime and related security phenomena, but does not systematically map them.

From the document review, it is clear that **most actions** envisioned by the Federal Drug Note and the Joint Declaration **were not realised**.

b. Perceived realisation: a survey amongst experts

First of all, as with some previous objectives, there are some actions where there are only one or two respondents who answered. This suggests that there is little visibility of these actions in the field, but could also due to local differences.

None of the Flemish respondents knew whether there is structural control and evaluation of the implementation agreements, or whether there are structural initiatives to inventory and check the funding. This suggests that there is little visibility of these developments in the Flemish field. The delineation of tasks between the police and the healthcare sector is partially realised according to Flemish respondents (with the exception of one respondent), whereas this is not realised according the Walloon and Brussels respondents. Respondents emphasise opposite for the actions 'enter into agreements and commitments to support local governments' and 'a prevention and treatment dimension for drug tourism': All Flemish respondent indicate that this is not realised, whereas Walloon and Brussels respondents indicate this is partially realised. Lastly, the discrepancy in answers for the action 'develop a local integrated drug policy' can be fully attributed to discrepancies in the answers of Flemish respondents. These discrepancies show two things. Discrepancies between the regions, suggest differences in realisations between the regions. Differences within the regions on the other hand, indicate that there is no sufficient overview on the realisations within this objective, and could indicate local differences.

The survey thus demonstrates **some regional differences in perceived realisation**, **as well as** discrepancies in the answers **within the regions**. The latter could indicate that there is no sufficient overview on the realisations within this objective, local differences or that there is still need for improvement for some of the actions.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **only a small difference in the actual and perceived realisation.** Whereas the document review found that only a few actions were implemented, the perceived realisation by practitioners often indicated that the actions were partially realised or not realised. This indicates that, **although we could not find many realisations during the document review,** there must be several (perhaps more local) actions **that fit within the objective**.

4.1.1.2 Conclusion of the extent of realisation

First of all, the document review reveals that there is no structural follow-up of the implementation of the Federal Drug Note and Joint Declaration, nor of other developments in the drug prevention field. This is the case at the federal level, the communities and the regions. There are many annual reports that list the developments in drug prevention on specific parts of the drug prevention policy, yet there is a lack of centralisation and overview. All of these reports and publications help to get a grasp of specific realisations within the drug prevention field, however, it paints a very fragmented and anecdotical picture. As a result, this fragmentation is reflected in this evaluation too.

Second, the document review shows that there have been many developments in the prevention field, both actions that were intended by the Federal Drug Note and the Joint Declaration, as well as other developments within the drug prevention field. This is especially the case for the objectives 'to implement

strategic measures specifically targeted at psychoactive drugs', 'to discourage driving under the influence of legal and illegal drugs' and 'tobacco policy'. The developments for the objectives 'to prevent drug-related nuisance' and 'alcohol policy' are much more modest. It is also noteworthy that for various objectives a lot of additional actions have been realised, which were not foreseen in the Federal Drug Note and the Joint Declaration. This is specifically the case for the objectives 'to develop a prevention policy', 'to apply a policy of discouragement' and 'a tobacco policy', and to a lesser extent for the other objectives. Nevertheless, none of the additional actions directly contradict the general framework set out by the Federal Drug Note and the Joint Declaration. It seems that practice, but also individual policy makers and sometimes an individual region, are further fuelling the pillar 'Prevention', without an overarching and crosscutting drug plan giving direction.

Nevertheless, it is important to emphasise that the realisations in the pillar 'Prevention' do not necessarily directly result from the Federal Drug Note and the Joint Declaration. In many cases, the realisations were initiated by specific institutions or organisations, and fit within the broader framework of de Federal Drug Note and the Joint Declaration by chance. As mentioned before, there was no structural follow-up of the implementation of the Federal Drug Note or Joint Declaration. Additionally, this overview does not paint a picture on the performance nor of the difficulties that were encountered with the realisation of the objectives.

Third, the survey learns that there are a lot of discrepancies in the level of perceived realisation. This is in about half the cases explained by regional or policy-level differences, for example when actions are (partially) realised in one region, but not (or only partially) realised in another region. However, there are some discrepancies that cannot be explained by regional or policy-level differences. In these cases, one explanation is that some actions are formulated very broad, so respondents could have interpreted the action in a different way. Depending on how the action is interpreted by the respondent, replies may vary. Another explanation might be that some actions are not quantifiable or measurable, so what is 'fully realised' for one respondent, might only be 'partially realised' for another respondent because this is not specified clearly. However, some actions were very clear, and still discrepancies remained. This suggests that even amongst experts, there is no overview of the different realisations in the prevention field.

And lastly, when we compare the results of the document review with the survey, we learn that although the document review identifies certain actions as realised, survey respondents indicate them as partially or even not realised. This might indicate for example that actions may be implemented, but they are not widely known, or don't necessarily operate in the best possible way.

4.1.2 Providing context to the stage of realisation: interviews and a focus group with stakeholders

A third method used in the EVADRUG evaluation, are semi-structured interviews and a focus group with civil servants and practitioners that have an expertise in one or more domains related to the Belgian drug policy. These semi-structured interviews aim to provide an explorative insight into the facilitators, barriers, bottlenecks, challenges and needs for the Belgian drug policy. The semi-structured interviews were conducted amongst 39 civil servants and practitioners at all policy levels (federal, regions and communities) and across the different policy domains (Integral and integrated approach; Epidemiology, research and evaluation; Prevention; Treatment, risk-reduction and reintegration; Enforcement).

This section summarises their views on the realisation of the objectives across the pillar 'Prevention'. The interviews and the focus group are aimed at obtaining and understanding how Belgian drug policy is experienced by respondents. We examined how they shape the Belgian drug policy in daily practice, giving insight in how they translate "policy in practice", as opposed to "policy in the books".

It is important to note that semi-structured interviews are a qualitative method to gain an explorative and more in-depth insight into the Belgian drug policy. Therefore, this method does not give a representative

view of all opinions in the field. The qualitative semi-structured interviews intended to report on recurrent perceptions, opinions and experiences that are prevalent in the drug field, to help explain why the realisation of certain objectives within the pillar of 'Prevention' is hindered or facilitated, but also to record new barriers and bottlenecks, and to map what the field deems necessary for this pillar. Additionally, it is important to consider that the Belgian drug policy covers a very broad field of topics. Because of that, we were not able to describe every bottleneck in detail. In this section, each topic is touched upon briefly.

In this section, we describe the results of the semi-structured interviews for the pillar 'Prevention'. First, we will present a summary of the results before we will elaborate on the facilitators and barriers more in detail.

Summary of 'providing context to the stage of realisation'

The semi-structured interviews and the focus group with practitioners, civil servants and experts gave insight in how the Belgian drug policy is shaped in daily practice, and how "policy in the books" is translated to "policy in practice". With regards to the context to the stage of realisation, practitioners and civil servants perceived that:

- ⇨ Given the small resources, the existing prevention initiatives still manage to have a clear impact with the current prevention offer.
- ⇨ Nevertheless, there is a structural underfinancing of the prevention pillar, resulting is a less efficient prevention offer and play into the hand of further fragmentation. The current budgets do not allow for structural, long-term prevention and often mean a quality reduction or scaling back prevention in certain target groups. It also does not allow, for example, a greater commitment to early intervention.
- ⇨ Several respondents refer to a good cooperation with both other prevention partners or with other partners (e.g. law enforcement). However, these cooperation initiatives are mostly situated at the local level, initiated by organisations or prevention partners themselves. They are informal and tied to the voluntary initiative of a particular network, organisation or individual.
- ⇨ Respondents describe a narrow vision on prevention as a means to discourage drug use amongst (particularly) Flemish policy makers and law enforcement partners, which in turn hinders cooperation and that practice and politics are increasingly diverging.
- ⇨ There are several problems related to the lack of a coherent alcohol policy, for example with the age limit, and publicity.
- ⇨ Furthermore, respondents refer to specific challenges like the current division of competences complicates policy development and alignment, the ever-changing drug field to which prevention initiatives have to adapt, and to bring drug prevention to the attention of local authorities within a setting-oriented prevention field.
- ⇨ Finally, respondents seem to be less aware of unintended (positive or negative) consequences and only refer to tobacco policies in this context.

4.1.2.1 Facilitators with regard to the realisation of the 'Prevention'- pillar's objectives

We asked our respondents what they identified as a facilitator in the realisation of the prevention objectives defined by the Federal Drug Note and the Joint Declaration. Three facilitators were recognised:

- The general consensus on the impact of tobacco on health,

- Additional financial input for (specific) prevention initiatives
- The advantage of a small community like Ostbelgien for cooperation in the prevention field.

In this section, these facilitators are briefly explained.

A. The general consensus on the impact of tobacco on health facilitates a non-smoking policy

Some respondents pointed to the general consensus, both in the general public as well as amongst policy makers, on the harmful impact of smoking on health, as a facilitator to further develop an anti-tobacco policy. According to the respondents, this (national and international) political consensus facilitates a structural prevention policy, limiting both supply and demand, which is more successful in achieving the central outcomes: a decreased number of people who smoke and a reduction of passive smoking.

> "*C'est peut-être un peu bateau ce que je vais dire, mais autant sur le tabac, il y a maintenant un relatif consensus politique sur le fait qu'il faut lutter presque par tous les moyens contre le tabac parce que tout le monde sait que c'est nocif et qu'il y a probablement un soutien important, au sein de la population pour les mesures anti-tabac*" (FR_3)

Respondents stress that the general public is aware of the harmful health effects of (passive) smoking, which increases the support for the development of a non-smoking policy. Even more, respondents describe that after the implementation of further restrictions in the non-smoking policy (e.g. the introduction of a smoking ban in closed public places, or in the car), the support for a non-smoking policy increased even further.

> "*het pejoratief dat ik mag roken bestaat nog altijd als ik bereid ben om daar veel voor te betalen en als ik daar anderen niet mee schaad. De werkomgeving is rookvrij, het café is rookvrij, ik mag niet roken in mijn wagen als er kinderen bij zijn. Dus men heeft daar toch duidelijk regelgeving en een fiscaliteit opgeplakt, die maakt dat ik nog wel mag roken maar ik ga alleen nog maar mezelf daar mee schaden*." (NL_9)

One respondent in particular describes which elements facilitate this consensus. First of all, the respondent emphasises the international and European regulatory frameworks as facilitators in the advancement of a Belgian tobacco policy framework. For example, the respondent refers to the WHO Framework Convention on tobacco of 2005, and the European directives on tobacco of 2014. The international framework creates a number of obligations for Belgium and can therefore be used to denounce a lack of action in Belgium. In that respect, the international pressure provides an impulse for the development of a Belgian anti-smoking policy.

> *'Il y a au niveau du tabac, une convention cadre de l'OMS qui en fait un traité international qui a officiellement force de loi. La Belgique l'a ratifié en 2006… Mais je pense qu'au niveau du tabac, l'international a fortement joué. (…) Ça, eu cet aspect porteur. Et puis, il y a eu un domino assez rapide de pays qui ont adopté cette interdiction… Quand est ce que la Belgique va interdire de fumer dans l'Horeca? Pourquoi est ce que c'est pas encore le cas? (..) On ne se serait jamais posé la question de la vente à distance de tabac ou de cigarettes électroniques en Belgique en 2016, si on n'avait pas dû mettre en œuvre la directive. Et donc, il y a vraiment ce jeu international qui a eu énormément d'impact' (FR_3)*

Second, the respondent mentions that the different NGOs with interests in an anti-tobacco policy find each other across language borders when it comes to the tobacco debate. According to the respondent, this shows that the tobacco debate as a national rather than a regional issue.

> *Les ONG ont toujours travaillé de manière nationale. Je vous ai parlé de la Coalition nationale. (...) Ce sont des gens qui, dans d'autres contextes, n'ont peut être pas tendance à se parler, mais qui, dans le contexte du tabac, fonctionnent relativement bien ensemble* (…) C*et aspect*

là démontre que c'est une vraie problématique nationale, peut-être aussi parce que c'est une vraie problématique internationale'. (FR_3)

Yet, this general political consensus on the development of a non-smoking policy, is quite recent, the respondent emphasises. Ten years ago, there was an opposition that strongly opposed restrictions on smoking in public places, and predicting the "economic death" of the catering sector with the introduction of a smoking ban. However, the experiences of other countries dealing with these restrictions, such as Ireland and Italy, played a role in convincing policy makers otherwise.

'Ce consensus politique s'est construit. Il n'existait pas il y a vingt ans, donc au moment de l'interdiction de fumer dans l'Horeca. Le grand débat, c'était :"si on interdit de fumer dans l'Horeca, on va tuer économiquement le secteur et tous les cafés vont devoir fermer". Ce n'est pas ce qui a été observé. Mais on a aussi pu utiliser les expériences des premiers pays qui interdisaient pour dire "regardez, en Irlande, le nombre de cafés n'a pas diminué et ce ne sera pas différent en Belgique"'. (FR_3)

Eventually, by introducing further restrictions on smoking in public places, the political consensus grew over the years.

'Donc de 2006 à 2011, (…) Il y avait encore pas mal de tensions au niveau politique. Mais on voit que maintenant, 15 ans plus tard, le consensus s'est construit' (FR_3)

Respondents often refer to this consensus on tobacco opposite to the absence of a consensus in the alcohol debate (cf. infra).

B. **Additional financial input for (specific) prevention initiatives**

Throughout the interviews of both Flemish, Walloon and Brussels respondents, the limited financial resources were consistently brought up. For this reason, financial injections within the framework of specific prevention initiative were often pointed out as facilitators.

For example, Flemish respondents referred to implementation initiatives relating to CAO/CCT100 within this context. With the obligation for employers of private firms to develop an alcohol and drug policy at work, extra budget was allocated for prevention workers in mental healthcare to provide guidance for such an alcohol and drug policy. Employers also effectively called on these prevention workers, which, according to our respondents, facilitated the implementation of the measure. This way, the extra financial input was highlighted as an indispensable facilitator to structurally implement the prevention initiative.

"*Op een bepaald moment met die CAO, toen dat kwam, is er vanuit de Vlaamse overheid gezegd geweest van 'o ja, maar nee, dat is wel heel erg belangrijk, we gaan extra middelen via een projectfinanciering toevoegen aan de CGG'. (…) Maar door de extra middelen, kwam daar een extra preventiewerker... En dan zie je hoeveel meer werk dat er verzet geweest is. Het is daardoor dat heel wat bedrijven konden daarrond werken*." (NL_4)

Another example given by two respondents, emphasise that at the local level, the financial incentive of the Strategic Security and Prevention Plan (further: PSSP) financed by the minister of Internal Affairs, is an extra source of funding for prevention projects at a local level, and is therefore perceived as a facilitator. One respondent mentions that it enables certain cities to further develop and coordinate prevention, that would otherwise not have been possible, for example for the 'gardien de paix'.

'En fait, le PSSP nous permet d'avoir un montant au niveau de la ville, au niveau de la prévention et alors au niveau du plan de prévention, on répartit les différents budgets en fonction des activités qu'on souhaite mettre en place d'une année à l'autre (…) Ce sont des subsides supplémentaires. C'est une équipe (…) de quatre personnes. On n'a pas ça partout, donc ça permet effectivement de développer et de coordonner au mieux certaines initiatives' (FR_11)

C. **A good collaboration between the prevention partners and/or enforcement partners on a local level**

Several respondents refer to a good cooperation between prevention partners or between prevention partners and other actors like the treatment sector or law enforcement. Respondents, however, consistently describe these cooperations as local initiatives, often initiated by organisations or prevention partners themselves.

A first example is given by some Walloon respondents. They refer to the drug addiction network of Liège as a network with proactive networking activity and a good collaboration between the different prevention partners. This in turn facilitates prevention initiatives, since there is already a good basis for cooperation. However, this positive view on cooperation is specifically defined in Liège. As each addiction network has its own projects and mechanisms, this is not necessarily the case in the other regions.

> *'Ce que je peux dire de manière générale, en termes de prévention, c'est qu'au niveau de Liège, on a quand même pas mal de structures, pas mal de partenaires, mais qu'on a des plateformes qui nous permettent d'être en contact très régulièrement'*. (FR_11)

Similarly, and again in Liège, the cooperation between prevention partners and law enforcement is highlighted, for example to provide alcohol training is schools or awareness raising in the nightlife scene.

Another example was given by a respondent of the German-speaking community, who refers to the advantage of small communities where 'everybody knows everybody'. After all, contact between the actors is much easier when they know each other. Especially in the cooperation with police and criminal justice, the respondent stresses this. The cooperation between the local actors happens on their own initiative and is not structurally embedded.

> *Wij zijn een heel kleine gemeenschap hier, dus ik ken die mensen. Ik ken de politiemensen bijvoorbeeld die naar drugs kijken, ik ken die mensen, die politieagenten die voor iedere gemeente verantwoordelijk is bijvoorbeeld, en daar zijn de contacten een beetje laagdrempeliger, zal ik zeggen. Want je belt die even op om te zeggen van, ja, ik hebben deze problemen met die en die, kan ik die even naar jullie toesturen? (NL_21)*

An example of a good collaboration between prevention partners, enforcement partners and local government in Flanders, was given in the context of drug policy at festivals. One respondent highlight that describe that the different partners found a way to cooperate at festivals to support a policy aimed at prevention and harm reduction, although this cooperation was not without difficulty.

4.1.2.2 Barriers and bottlenecks

We asked our respondents what they identified as a barrier or a bottleneck in the prevention today. In this section we list all barriers and bottlenecks in general and related to a specific objective.

A. **General barriers and bottlenecks**

a. A narrow view on prevention amongst policy makers and law enforcement partners

Both Flemish and Walloon respondents mentioned **a narrow focus on discouragement in prevention, especially amongst partners in the police and criminal justice field**, as well as **amongst policy makers**. Respondents from the prevention field describe that they are often confronted with the view of policy makers and law enforcement actors that prevention workers should discourage people from (ever) using drugs, for example by warning them about the harmful consequences of drug use. This narrow focus of prevention does not acknowledge the importance of a harm reduction approaches and safe use messages, which are an indispensable part of the prevention field too. These conflicting views on prevention complicate the cooperation between law enforcement and the prevention sector, and

therefore pose a challenge when these actors have to work together, for example when developing a prevention policy for the festivals.

> "*maar wat ik dus in de praktijk heel sterk voel en vooral voelt ge dat als je met politie en parket samenwerkt is dat zij, uhm...eigenlijk geen goed beeld hebben van preventie. Dat zij verwachten dat preventie doet wat zij willen dat het doet, namelijk dat niemand aan de drugs geraakt, want dat is eigenlijk, ja, dat is een stuk van hun doelstelling. (…) Dus wat dat je voelt, is dat dat, het accent binnen het preventiebeleid door te veel actoren nog altijd wordt gelegd op het ontradende, en daardoor voel je dat het uitrollen van een breed preventiebeleid in de praktijk dat dat heel vaak, dat dat gewoon heel veel energie kost. Ik ga u één voorbeeld geven, (…) om het drugbeleid op één festival recht te trekken van een zero tolerance festivalbeleid (…), om dat recht te trekken naar een evenwichtig drugbeleid, dat heeft mij 3 jaar gekost, voor één festival.*" (NL_15)

> *''Parce qu'à ce moment-là, l'argument qu'on nous renvoyait, c'était que tant qu'on n'avait pas affaire à de la toxicomanie, il fallait faire de la prévention. Et donc décourager l'usage. (FR_8)*

Indeed, when respondents from law enforcement were asked about prevention, most of them referred to the importance of discouragement of drug use. Some of the respondents within law enforcement also mentioned the difference in vision between healthcare professionals and law enforcement agencies in their view of prevention:

> "*Maar ik vind wel dat de sociale keten ook dat idee zou moeten hebben dat ontraden nog altijd beter is dan tolereren. En dat is [de] grote vrees bij justitie dat die straathoekwerkers en al die sociale assistenten en (…) mensen die met die druggebruikers werken, dat die allemaal zeggen van, ja, waarom kunnen we dat niet tolereren? Ja, dan loopt het dus scheef hé. Want dan… Zij staan daar te zeggen van, ja, het moet getolereerd worden. Wij zeggen van, nee, ontraad dat dat alstublieft, want als je het niet ontraadt, komen ze ten slotte bij [justitie] terecht*" (NL_20)

Respondents describe that prevention workers are not only confronted with this narrow vision on prevention in the cooperation with law enforcement, they are also confronted with this narrow vision on prevention in cooperation with the Flemish government. They explain that harm reduction initiatives, like drug testing, continue to clash with those narrow views on prevention, in spite of the elaborate evidence based proving the effect of these initiatives. More and more, respondents notice a rift between the between the direction taken by prevention partners in the work field and the government's prevention policy.

> *"Waarbij dat je toch nog altijd voelt vanuit Vlaamse overheid vanuit beleidsmakers, vanuit ministers van gezondheid, dat ze blijven hameren op dat, op dat hele enge preventie idee, van we moeten zorgen dat mensen niet aan, niet met middelen beginnen en dus in de praktijk voel ik dat dat dus steeds verder uit mekaar begint te komen" (NL_15)*

After all, the respondents indicate that the harm reduction approach is indispensable within prevention. Respondents emphasise that especially within the setting of nightlife and sports, the 'safe use' approach seems to be catching on, as the ever-increasing number of participants in campaigns demonstrates. Also, internationally, more and more evidence is emerging that the approach works, and these methods are increasingly being applied (e.g. at EU level).

While actors in Flanders may complain about the narrow view of authorities on drug prevention, Walloon actors are not facing such restrictive approach, but instead, may struggle to make authorities acknowledge the specificity of problematic drug use.

Respondents indicate that harm reduction is often classified under prevention, and also used as a last resort. Yet, respondents from the health care sector emphasise, harm reduction initiatives are no longer solely aimed only at people with problematic drug use, but also at people with a recreational use.

> *Dans ce cas-là, faire de la réduction des risques, c'était faciliter l'usage. On avait l'impression que la réduction des risques, finalement, c'était de la prévention tertiaire de la toxicomanie. Et ça ne*

pouvait être vu que comme ça, une sorte de soins palliatifs, quand il y n'a plus rien d'autre à faire. Donc, c'était déjà un point où on était en tension' (FR_8)

Respondents thus mention that this narrow view on prevention amongst both law enforcement partners and the governments slows down cooperation between prevention partners and even prevents the further development and implementation of certain prevention strategies (mainly harm reduction).

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On all policy levels:
  - Consultation and cooperation between the various partners in a prevention policy (prevention, treatment, police, criminal justice, local government, etc.), as is the case, for example, with local drug consultations organised in some municipalities.
  - Addressing addiction problems in a continuum of care in which prevention, early intervention and harm reduction are structurally built in and financed, and in which the link with treatment is further expanded.
- On the level of Flanders: Address addiction in a continuum where harm reduction is given a structural place alongside prevention and early intervention.

b. Limited prevention budgets produce a number of additional bottlenecks

The majority of the respondents, across all pillar, stress that the prevention sector is under-financed. The respondents describe that, although many policy documents recognise and highlight the important role of prevention, this is rarely effectively represented in a budget. The limited budgets are felt in all regions, and within all sub domains of prevention. The limited prevention budgets are of course a bottleneck in themselves, but some respondents subsequently link other bottlenecks with this lack of sufficient financing:

1. A demand-driven prevention approach, instead of a proactive approach
2. Internal competition between health themes and prioritizing one setting over another
3. Lack of technological development

The **first bottleneck** that most (Flemish and German-speaking) respondents emphasised, is that with the current capacity they can hardly meet the demand for prevention in the field. Prevention initiatives therefore often work in a reactive way, for example when there is a specific demand in the field or when an incident has occurred.

> *"Ik wil maar zeggen, de capaciteit die nu op het veld is, is nog altijd te weinig om op een, euhm…Als ge een evaluatie zou doen, is er nog altijd te weinig volk preventief aan de slag om volledig effectief te kunnen zijn. Zie, we zijn nog altijd bezig op vraag en minder proactief bezig." (NL_4)*

> *"Uiteindelijk is er een crisis rond iets, bijvoorbeeld de crisis rond de Kompass club in Gent, en dan zie je dat daar duidelijk wordt dat de organisatie zowel op stadsniveau, als op niveau van de club, als op niveau van de intermediairs die daar rondhangen of tussenhangen, dat dat eigenlijk nog niet goed genoeg was." (NL_15)*

Several respondents indicate that because of the lack of capacity, prevention does not always live up to its potential. Prevention workers are not always capable to meet the demand (in time), or the quality of implementation must be compromised to meet demand. These respondents stress that this is a huge bottleneck in practice.

Related to this bottleneck, is the remark raised by a respondent from Ostbelgien. The respondent mentions that, although there is a good relation between the government and the healthcare sector in

Ostbelgien, they feel that the government does not fully understand the workload inherent to prevention, and thus the capacity that is required to meet it.

A **second bottleneck** that some Flemish respondents associated with the limited prevention budgets, is the unintentional competition between settings or, in Flanders, even within health themes. When only a limited budget is available, there is no room to build a comprehensive prevention offer in every setting or sector. So, as the quote demonstrates, creates a kind of competition among prevention workers from different settings to get the available capacity to work within their setting in order to meet the demand. Moreover, when efforts are made to promote prevention in a specific sector or setting, the demand for prevention in that sector or setting also increases. As a result, in both examples, the capacity for another setting, which also has a demand for prevention, may be compromised.

> "*En op een gegeven moment krijg je dus competitie tussen [de] setting (…) uitgaan, en pakweg onderwijs, of pakweg jeugdwerk, of pakweg gevangenissen of een andere setting. Want ik wil natuurlijk dat mensen in het veld zoveel mogelijk naar clubs gaan, naar festivals gaan en zorgen dat daar de boel veilig draait, maar diezelfde preventiewerkers moeten ook in de gevangenis werken of die moeten ook in onderwijs werken, of ook in arbeid, (…) Dus krijg je bijna competitie tussen settings en sectoren.*" (NL_15)

The unintended competition is not only apparent between the different settings and sectors of drug prevention, but also between different health themes. With the prevention plan 'De Vlaming leeft gezonder in 2025', the thematic approach to prevention was integrated into for a setting-oriented approach that brought together different health goals of different health topics (cf. supra). Flemish respondents fear that within this policy approach, the different health themes will have to compete with each other in a local prevention policy. The respondents stress that that this is a concern, rather than a bottleneck, because the policy plan is of fairly recent date. A similar concern for the struggle to make authorities acknowledge the specificity of problematic drug use in Wallonia was expressed by a Walloon respondent.

> *Dat gemeenten kunnen inzetten of keuzes maken voor meerdere thema's. Dus daar zijn we onzeker of dat specifieke alcohol en drugs zal blijven. En da's wel een jammere evolutie. (NL_4)*
>
> *Hoe gaat dat in de toekomst verder evolueren? Blijven de gemeenten dan rond drugs, of gaan ze dan ook rond andere gezondheidsthema's willen werken? (NL_19)*
>
> *On essaie de sensibiliser nos responsables politiques régionaux à l'importance de ce sujet [...] il pourrait y avoir effectivement, en tout cas du côté politique wallon, un plus grand investissement dans un lieu de concertation afin de faire évoluer le contexte wallon lui-même en fonction de ses réalités qui ne sont pas toujours les mêmes que celles de Bruxelles ou de la Flandre. [...] Je pense à un exemple, le SPF Santé a interpellé les nouveaux cabinets chez nous au printemps [...] pour nommer un représentant à cette cellule générale politique drogue et ce n'est toujours pas le cas [...] il y a peu de d'investissements, en tout cas au niveau de la Wallonie, pour parler de ce que je connais, dans cet espace de concertation et d'élaboration d'une politique globale. (Fr_10)*

Especially since municipalities working on drug prevention invest substantially in staff, some respondents fear that the topic of drugs will be pushed into the background in a local prevention policy. One respondent even mention that the current covid-19 circumstances becomes another competitive prevention theme, the impact of which will not be known until later.

And lastly, a **third bottleneck** mentioned by Flemish respondents, is that, since the budgets are limited, the technological options to expand prevention online, for example, remain limited. Some Flemish respondents note that the Flemish government urges to focus on (online) innovation. However, developing online modules, e-learning and apps, are often very expensive. This leaves little room for improvement within the current budget. One Walloon respondent mentions a lack of continuity in funding

of prevention initiatives as barrier. Projects that do not have structural funding are thus only extended for a few months, or at best for a year, which creates a lot of uncertainty.

> *'Alors il y a aussi une précarité au niveau des subsides ou parfois, on prolonge les plans de 6 mois ou d'un an, et de manière générale, l'annualité quand ce sont des subventions facultatives ou la non poursuite des plans ou la réécriture totale des plans qui parfois se chevauchent. Ou alors il y a des trous de quelques mois et il y a une incertitude totale au niveau des équipes de terrain. Ça ne facilite rien'.* (FR_15)

Despite the limited resources for prevention, most respondents emphasise that the existing prevention initiatives still manage to have a clear impact with the current prevention offer, and present a coherent vision in practice. Both Walloon, Flemish and Brussels respondents emphasise that sensibilisation campaigns conducted, for example the BOB campaigns or the 'Te Gek' campaigns, have contributed to a change in perception within the general public, for example breaking the taboo surrounding mental health, or promoting responsible driving. Prevention initiatives aimed at skills training, but also risk reduction campaigns are highlighted too by respondents and described as effective. Respondents also often highlight the willingness for broader implementation.

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On all policy levels:
  - Invest in prevention to allow a long term prevention policy. Respondents stress a long-term, policy-based prevention approach that is not led by incidents and "firefighting." At the local level, this need is most evident. A good locally developed prevention policy is essential for this. Some respondents indicate that this can be extended to a policy-oriented prevention approach in various settings too. For example by focusing on regulation, among other things, as has happened, for example, with the CAO/CCT100 in the setting 'work'.
  - Attention to the quality of prevention initiatives. To continue to develop quality standards of what is good prevention, and to provide support and coaching within this context.
- On the level of Flanders: Make the necessary investments to develop structural and sustainable approach to prevention, that has sufficient capacity to meet prevention demand in all settings, and that provides flexibility to also proactively engage in prevention.

c. Different network structures

Another barrier mentioned by some Flemish respondents, is that there are many different ways that networks are organized. Healthcare actors participate in different networks, but depending on the topic, those networks are organized differently. Also, the fact that networks are occasionally adapted or rearranged over the years causes confusion in the field. The repeated consolidation and elaboration of the collaboration within each (new) network, is time consuming and can create a certain frustration for some respondents. Flemish respondents demand stability in these frameworks, so that the focus can once again be on the client.

> "*Hoe baken je de regio af. Zijn dat de eerstelijnszones? Zijn dat de zorgregio's? Zijn dat nu de netwerken van artikel 107? Ja, ze maken daar ook allemaal andere regio's, waarom het moeilijk wordt."* (NL_10)

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On the level of Flanders: Clear, stable and long-term commitment to network structures that are aligned with one another.

d. The underutilization of early intervention in Flanders

A forth bottleneck mentioned by some Flemish respondents, is that early intervention has a lot more potential than what is currently being achieved in Flanders. Early intervention is not systematically implemented, nor does it have a structural status. As a result, the use of early intervention depends heavily on the initiative of local governments. And here again, respondents mentions that the competition with other health themes is a barrier, especially because requires sufficient capacity:

> "*Dus (…) vanuit Vlaanderen [wordt een] vrij lage subsidie [gegeven] en de vraag is dat, gemeenten hetzelfde bedrag er tegenover zelf inleggen. En we zien bij de nieuwe initiatieven dat de gemeenten niet hoger gaan dat het subsidiebedrag dat ze krijgen. Waar dat je dan tot relatief lage bedragen komt, waar je dan maar een parttime kunt aanwerven. Terwijl dat de gemeenten die rond drugs werken, die investeren substantieel in personeel. (…) Omdat je, ja, als je investeert in vroeginterventie en preventie dat, daar heb je mankracht voor nodig he*." (NL_19)

One respondent even emphasises, that the dependency on the commitment of local government, is exactly what prevents a structural implementation of early intervention, because it does not guarantee stability across elections, for example. The lack of structural implementation of early intervention is a shame according to respondents, because there are still many underutilized opportunities for early intervention, both towards youth and adults. Especially in the work sector, traffic, and within the hospitals, the momentum can be better used to engage in early intervention.

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On the level of Flanders: Address addiction in a continuum where early intervention is given a structural place alongside prevention and harm reduction.

e. Other bottlenecks and barriers

Lastly, there are some barriers that were only mentioned by one respondent. We have grouped those barriers in this section.

One Flemish respondent mentioned the disappearance of the policy level of the provinces as a barrier in the prevention pillar. The respondent describes that the distance between Flanders and local governments remains great.

Another barrier mentioned by just one respondent, is the fact that, in Flanders, the focus of prevention organisations have often been intermediaries, and not often enough the target group itself.

> *"Het was een, ja, altijd een pijnpunt geweest in Vlaanderen dat alle preventie-organismen laten we zeggen, zich enkel richten op intermediairs, en dat er maar weinig gebeurde naar de doelgroep zelf". (NL_19)*

B. Barriers and bottlenecks related to 'An integral and integrated alcohol plan'

The **absence of an integral and integrated alcohol plan**, is clearly an important bottleneck for nearly all respondents involved in this study. Almost every respondent mentions the failed attempts in developing an alcohol plan at some point during the interview. They unanimously stress the need for an

integral an integrated alcohol policy plan. First of all, respondents lists the most recurrent problems about the current alcohol policy. In this way, the want to show why there is such a need for a policy plan on alcohol. These issues have been explored more in depth by previous Belspo studies (Decorte et al., 2019; Kramer et al., 2020; Van Havere et al., 2018).

First of all, some respondents mention the age limits of alcohol. The division between alcohol and wine from the age of 16 and liquors from the age of 18 *an sich* is clear. However, for the diverse offer of mixed drinks, Martini, *vin cuits* and premixed drinks the distinction is less straightforward, especially in practice. Additionally, some respondents refer to the current evidence-base that show the impact of alcohol use on health, especially for young people. Based on this evidence-base, respondents refer to the problems with the current age limit of 16 for alcohol use. One respondent indicates that this is a sensitive political issue. The respondent clarifies that there are many options to ameliorate the age limit for alcohol, however, none of the options have ever been implemented by policy makers.

> *'Clairement, le plus simple en termes de mise en œuvre, c'est d'avoir un seul âge pour toutes les boissons alcoolisées. Moi… C'est quelque chose qui est refusé politiquement ou qui a été refusé politiquement jusqu'à présent…. L'autre option, c'est si, on garde 16 et 18 ans. Comment est-ce… Comment simplifier la, le… La séparation entre ce qui peut être vendu aux 16 ans et ce qui peut être vendu aux 18 ans et donc, heu…Voilà y a toute une série d'options possibles, mais aucune n'a jamais. Aucune n'a jamais abouti jusqu'ici'.* (FR_3)

Second, some respondents mention to the autoregulation on publicity for alcohol as a problem. They describe the persistent policy choice for a autoregulatory framework in spite of international studies showing its ineffectiveness.

> *'le concept même d'autorégulation ne fonctionnait pas. Donc, il y a toute une série d'études internationales qui le montrent. Et notre expérience aussi a toujours été que ça ne fonctionne pas bien et que, finalement, les producteurs d'alcool sont assez libres en matière en matière de publicité'* (FR_3)

Furthermore, the respondent clarifies that the advertising ethics panel, which is comprised of advertisers and civil society representatives, seem to make far fewer judgements about violations than experts and the department of Public Health do. The self-regulatory ethical commission often concludes an advertising campaign to be in line with the covenant, when FOD/SPF Public Health judges differently. Moreover, the respondent clarifies that a verdict on a problematic advertising campaign violating the covenant often comes after the advertising campaign has already been running for several weeks. Moreover,

> *'Le jury d'éthique publicitaire qui regroupe des publicitaires et des gens dits de la société civile. Heu, et donc ce qui…Notre expérience c'est que très souvent, quand le SPF considère qu'il y a un problème avec une publicité qu'il porte plainte. Le jury d'éthique publicitaire a une vision différente et laisse passer la publicité….l'autre aspect, c'est que si une publicité pose problème le temps de porter plainte, le temps que le jury d'éthique publicitaire prenne une décision. Même si c'est très rapide, il y a toujours au moins une ou deux semaines. On sait qu'une campagne publicitaire, ça dure rarement plus que deux ou trois semaines, donc même en cas de décision négative du jury. Ils peuvent aller en appel, donc ça prend un peu de temps et donc souvent, la campagne est presque, peu déjà être terminée, au moment de la décision, et donc, même si la décision est négative, le producteur ne risque pas grand-chose'* (FR_3)

Also, violations on the agreements for publicity for alcohol rarely results in financial penalties, although they should, the respondent emphasises.

Third, Flemish respondents problematize current availability of alcohol, for example in petrol station, and the current lack of a regulated price-policy (e.g. very low prices for alcohol).

Some respondents also point to the weight of alcohol industry lobbies as a barrier to the development of an alcohol plan

> *'Il y a une vraie industrie de l'alcool en Belgique, avec notamment les brasseries et le secteur Horeca qui est derrière. L'alcool occupe en Belgique des dizaines de milliers d'emplois, directement ou indirectement'* (FR_3)

The lack of binding legislation at international level is seen as a barrier for some respondent

> *'Au niveau de l'alcool, Il y a une stratégie de l'OMS, mais c'est juste un document de bonnes intentions…ça n'a aucune force légale ni contraignante pour les États… Et au niveau européen, il n'y a strictement rien non plus en termes de législation contraignante'* (FR_3)

Lastly, some respondents stress that the general public is not aware of the harmful impact of alcohol on health. The same counts for policy makers. Many respondents often oppose this to the perception of tobacco, where the general public is very aware of the harmful impact on health. Alcohol is still generally perceived as 'not so harmful'. Even more, positive health outcomes attributed to alcohol are often highlighted, for example that a glass of red wine reduces cardiac risks.

> *'Au niveau alcool, je pense que la perception personnelle des politiciens, comme la perception de la population vis à vis du produit, est fondamentalement différente. Qui connait, les risques sanitaires liés à l'alcool? Qui sait que la consommation d'alcool renforce par exemple fortement les risques de cancer du sein? Je pense que ce sont des informations qui ne sont pas connues ni partagées à grande échelle'* (FR_3)

Although practitioners in Belgium have been asking for years for a structural alcohol policy, very little has been done in recent years, respondents emphasise. Many respondents criticize the fact that, despite the scientific evidence for certain measures and the need in the field, no structural initiatives are implemented.

> "*Maar het brede alcohol beleidsplan waar de sector al jarenlang vraagt, ja, dat is er door vorige ministers eigenlijk nooit gekomen hé, en de reden daar is om zich niet maatschappelijk willen verbranden zeker*" (NL_19)

Respondents describe that there have been good policy intentions in the past (e.g. the amendments to the Covenant for the self-regulation of publicity in 2013[58]), but that they are often shrouded in vagueness and almost never entail strict regulation. Policy initiatives rely on the goodwill of the alcohol industry and often leave room for interpretation.

> "*Elle rendait les choses un peu plus strictes, mais on reste dans une convention, où la plupart des dispositions restent fort sujet à interprétation."* (FR_3)

According to the respondents, a barrier for the implementation of an alcohol plan, is the fragmentation of the competences across the different policy levels and domains. The fragmentation an sich is not a problem, but it complicates reaching a consensus (more players at the table). Respondents stress that, for the alcohol policy to be effective, measure should be taken on all policy levels: on a federal level to impose regulations for the supply, and on a regional level to pursue a comprehensive prevention policy for the demand; However, to achieve that, a consensus on the desired approach must be established. And that is exactly where the shoe pinches. In the past, a lack of consensus between the many different policy actors has prevented an integral and integrated alcohol plan.

> «*On est arrivé, après beaucoup de travail, à quelque chose de concerté. Et puis on a eu 2 ou 3 ministres sur les 22 qui ont mis leur veto. Et le plan alcool n'est jamais passé."* (FR_1)

Also, according to the respondents, the debate is further complicated by the fact that the majority of the population still drinks alcohol (usually not in a problematic way), and therefore politicians might encounter resistance when restrictive measures are implemented. In addition, respondents mention that there are large economic interest in the alcohol industry in Belgium, with thousands of jobs in the breweries and the hotel and catering sector. This economic interest is particularly higher for the alcohol

[58] Covenant on Advertising and Marketing of Alcoholic Beverages, adapted on 25th of April 2013

industry, compared to other sectors, for example the tobacco sector. Many respondents thus refer to the influence of the alcohol lobby on this debate, to explain why it is so hard to reach a consensus.

> «*Mais il y a aussi une question de perception de la population et du politicien, qui est finalement un homme ou une femme comme un autre, et qui a ses propres idées, propres perceptions. Souvent, quand l'alcool devient un problème, c'est plus la question des nuisances ou de jeunes qui terminent dans le coma ou blessés à l'hôpital, ce genre de choses, mais assez peu par le prisme de la santé publique en tant que tel* » (FR_3)

<u>In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:</u>

- <u>On an all policy levels</u>: An integral and integrated alcohol plan with clear, result-driven objectives. The alcohol plan should at least address the following items:
  - Legislation to limit the supply, with attention to price increases, increased age limit, and restrictions to publicity
  - Widespread dissemination and sensibilization of the risks of alcohol use
  - Attention to specific settings, for example the sports, or target groups, for example young people
  - Simplifying the legislation regarding age limits for alcoholic beverages
  - A concerted plan for tobacco and alcohol, with clear indicators and intended outcomes

C. Barriers and bottlenecks related to the objective 'To prevent drug-related nuisance'

A second bottleneck related to the objectives, refers to the prevention of drug-related nuisance, specifically the initiatives funded within the strategic prevention and security plans. One respondent highlighted that the concept of drug-related nuisance is problematic, and that there is a lack of overview on prevention initiatives on the federal level. These issues have also been explored in depth by the SOCPREV study (Pauwels et al., 2017).

First of all, one respondent noted that there is some conceptual unclarity in the field about the concept of drug-related nuisance. The term 'drug-related nuisance' explained as "*nuisance created by drug use*", is often used within the context of the umbrella concepts 'drug-related crime' and 'nuisance'.

Related to the definition problem, is the confusion in the distinction between prevention of the communities and prevention funded by the federal government. Prevention is a regional competence (cf. supra), and only the prevention of security phenomena (amongst which drug-related nuisance) is still funded by the federal level (Internal Affairs). According to several respondents, this distinction is not always the case in practice and causes much confusion.

> *"Maar die nog niet te goed zijn doorgesijpeld, (…) omdat [federaal] dus ook nog een aantal zaken rond primaire preventie dus sensibilisering in scholen financieren. Terwijl dat dat eigenlijk niet meer voor ons, allee, dat is iets dat de regio's voor bevoegd zijn." (NL_19)*

> *'Je sais que pour Bruxelles, les compétences sécurité et prévention ont été données à la Région. En plus, c'est une spécificité bruxelloise. Ça complexifie encore les choses. Les Communes ne s'y retrouvent pas totalement entre les missions. En fait, c'est parfois difficile. Je pense notamment aux MASS. La difficulté est de savoir quelle mission est subsidiée par quels types de sources de financement. La réduction des risques, est-ce que ce serait la diminution des nuisances ?' (FR_15)*

A Walloon respondent even refers to this delineation as a barrier. For so me prevention workers, the financing though the strategic prevention and security plans are seen as an additional source for financing prevention (cf. facilitators). For them, the clear delineation between the prevention from a

health perspective and the prevention of drug-related nuisance thus limits the number of projects where they can appeal for funding.

> *'Le subside du PSSP ne permettent pas, en tout cas, de rémunérer à la fois des travailleurs et de mener les différentes activités'* (FR_11)

Underlying this perceived barrier, of course, is the fact that the financing of the prevention sector is inadequate from a health perspective (cf. previous barriers). This example, however, acknowledges that the division between regular prevention initiatives and prevention initiatives targeting drug-related crime is unclear.

Another result of this fragmentation is that no one has a clear overview of what prevention initiatives exist. One respondent specifically criticised the lack of coordination, for example across communities and regions.

> *"[Dat] gelijkt bijna de omgekeerd wereld, want ja die persoon, die vzw heeft eigenlijk meer continuïteit en meer overzicht over wat er gebeurt op gebied van drugspreventie in Limburg dan wat federaal [heeft]." (NL_19)*

> *'Je pense que le service est un peu vidé de son personnel, tout doucement. Et donc, je ne sais pas si ils sont encore capables de mettre de la réelle coordination et du partage d'expériences entre les Communes'*. (FR_15)

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On all policy levels:
  - A clear delineation is made between the roles of the different partners: logo's, mental health care prevention workers, (inter-)municipal prevention workers, and the prevention workers funded within the strategic prevention and safety plans. There is a need for clear definitions, with a clear division of tasks.

D. Barriers and bottlenecks related to the objective 'Development of a prevention policy'

a. Difficulties with a prevention policy in schools

Some Walloon and Brussels respondents mentioned difficulties with prevention in schools. The respondents refer to practical problems, for example that the schools have difficulties to make time available outside of specific hours for awareness-raising sessions. They also refer to difficulties to demonstrate the need and the importance for prevention. This is mentioned by both Walloon respondents, but also by respondents from Ostbelgien. They for example mention, some schools deny that drugs are used in their schools, and that drug prevention is therefore not necessary. Providing drug prevention in a school that claims that "no drugs are used", is perceived by these schools as painting a bad image. Prevention workers are thus confronted with difficulties to illustrate the importance of prevention.

> *Et certaines écoles sont plus réticentes que d'autres. Il y a des écoles qui ont dit dès le départ, qu'il n'y a pas de drogues chez eux. Alors que ce n'est pas la question… (*FR_11)

Lastly, one Walloon respondent mentions that there is confusion within schools as to what risk reduction is, and that prevention workers are therefore (sometimes) confronted with resistance to apply risk reduction initiatives in schools. The following respondent for example clarifies that, faced with a class that has already used drugs, it would be more appropriate to do risk reduction than prevention. However, this may meet with resistance within the schools. The respondent further explains how schools have a lot of autonomy to decide whether prevention is needed, which is problematic when school managers

deny that there is a drug problem. This example shows how the wider public (or in this example schools) are not always well informed about the two different angles towards prevention (harm reduction and (primary) prevention), which makes it hard to organise.

> *' S'ils font de la prévention dans les écoles et qu'ils se retrouvent avec une classe où la moitié des élèves consomme, une partie de leurs actions, ce serait de la réduction des risques. Mais, à l'époque, c'était sous le titre Prévention… Et en milieu festif, on a toujours dit ce n'est pas l'endroit pour faire de la prévention de l'usage. Ce n'est pas au moment de l'usage qu'on fait de la prévention de l'usage… Beaucoup d'acteurs de prévention font ce qu'on appelle de la prévention et de la réduction des risques' (FR_8).*

4.1.2.3 Challenges

We asked our respondents what they identified as a challenge. In this section we list the challenges the respondents identified.

A. The current division of competences as a challenge to align policy

The division of competences is relatively clear with regards to prevention, especially compared to treatment: The regions are fully competent for prevention initiatives (cf. supra). However, as the previous examples of the alcohol policy and the prevention of drug-related nuisance have shown, there is still some interdependency. This interdependency poses a challenge, especially for aligning policy approaches and dealing with disparities between the regions. This is illustrated with the following quote:

> *«[Pour] la plate-forme, pour favoriser un usage adéquat des psychotropes en Belgique, on a identifié toutes les mesures possibles qu'on pourrait mettre en place. Et on se rend compte que toutes les mesures ne sont pas de notre compétence. (…) On peut aller en parler et se concerter avec les entités fédérées ou les autres niveaux de pouvoir. Mais c'est toujours à eux de décider si ils mettent ça comme une priorité ou pas. (…) On a fait des entretiens bilatéraux avec chaque niveau de pouvoir. Et donc, on voit bien qu'il y a des choses qui sont mis en place en Flandre, mais pas en Wallonie, on voit les disparités. Et on voit parfois des thématiques qui sont une priorité depuis des années en Flandre et qui ne le sont pas en Wallonie, et vice versa »*

Sometimes, the division of competences is not only a challenge, it also becomes a barrier. Some Flemish respondents mention that regional policy makers hesitate to take in a setting under federal competences. One respondent gave the example of a hesitation about investing in drug prevention in hospitals, because hospitals are a federal competence. However, the federal government is no longer competent to take prevention initiatives. As a result of this hesitation, prevention opportunities in the federal setting are postponed, while there are many prevention opportunities in those settings too. In this example, the current division of competences is no longer a challenge, but a real barrier that stands in the way of the implementation of prevention initiatives.

B. Evolution in the ever-changing drug prevention field

The first challenge that respondents identified, is a structural one. The prevention field is often confronted with new trends in the ever-changing drug field. Prevention has an important role to play in these thematic and drug-specific trends, however, sometimes, it is challenging to keep developing effective prevention methods. This is illustrated by respondents with the example of laughing gas (nitrous oxide), or (in the past) with gaming. Here it is also important to distinguish between a situation that is problematic and one that is not. After all, prevention always starts from a health perspective.

In connection with the methodological challenge, it also remains a challenge to involve hard-to-reach target groups in prevention. Especially for people with greater vulnerability, such as people with a migration background and people in prison. A respondent from Ostbelgien additionally mentions that it

is a challenge for the German-speaking community to reach out to the south, who are not equally well reached by prevention compared to the north.

> "*Sommige scholen kunnen we beter bereiken, andere scholen minder. In het noorden hebben we veel meer aanspraak in de scholen. Dat zie ik, daar ben ik meestal in iedere school, ieder jaar. In het Zuiden is dat minder. Die zeggen, ja, daar moet je toch niet zo veel over alcohol prat n(…). Ja, en dat is zo een beetje die, euh, ja, die feeling voor het thema toch een beetje anders. Een beetje meer taboe. Daar moeten ze gewoon niet over praten*." (NL_21)

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On the level of Flanders: Attention to the prevention of gambling, gaming, the use of psychoactive medication and the use of performance enhancing drugs.

C. **Integration of the thematic perspective to a setting-oriented perspective in the Flemish prevention field**

One of the challenges mentioned by all Flemish respondents, is the recent orientation of the Flemish prevention policy from a thematic perspective to setting-oriented perspective. This challenge has already been touched upon under the bottleneck of the unintended competition due to limited prevention budgets, but will be discussed here as a challenge. The advantage according to respondents, is that the prevention offer will be adapted to the needs of the local level, but respondents also fear that local governments will not choose drugs as a health topic because of budget limitations, and that the already existing differences between municipalities in the provision of specific drug prevention will only increase. The respondents however also stress that this is a concern, but that time will tell if that is effectively the case, because the policy plan is of fairly recent date. The challenge with this integration of the thematic perspective in the drug prevention field, is to get a local government committed to drug prevention

Yet, respondents also emphasise expertise as a challenge in this context. When prevention workers are assigned to multiple topics, there is less opportunity for depth and development of expertise. This is another challenge with the setting-oriented approach.

> *Met de intergemeentelijke preventiewerkers, waar vroeger inderdaad zij bezig waren op één thema. En dat is een zorg die we nu zeker hebben naar de toekomst. Die mensen moeten op verschillende thema's werken. Dat is niet altijd haalbaar. Ja, wij geloven dat het, uhm, dat het heel belangrijk is, dat je specifieke expertise nodig hebt, om thematisch advies te kunnen geven of daarrond aan de slag te zijn. Je kan niet rond al die thema's evenveel expert zijn. Je moet keuzes maken*. (NL_4)

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On all policy levels: The importance of the **evidence-base**, not only in the development and application of evidence-based methodologies, but also in making evidence-based policy choices.
- On the level of Flanders: A specifically thematic approach remains essential in prevention.

4.1.2.4 (Perceived) unintended consequences of the objectives

When respondents were asked to identify possible positive or negative unintended consequences of initiatives, the answers remained limited. For the pillar Prevention, one positive unintended

consequence was identified: the decrease in people smoking inside in private spaces. The anti-tobacco policy intends to reduce the number of people who use tobacco, and to reduce passive smoking in enclosed public spaces. Gradually, various initiatives were taken to ban smoking at work, in the train, eventually in all enclosed public spaces, and recently even in the car. The respondent additionally points out that, although there is no legislation banning smoking in private spaces, recent evidence shows that that fewer and fewer people are smoking indoors when they have the opportunity to smoke outside or out the window. The respondent identifies that as a positive unintended consequence of the restriction of smoking in public areas, which seems to have extended into the private sphere too.

> "*Et donc, il y avait des données, début des années 2010, qui montraient que le nombre de personnes qui fumaient à l'intérieur, chez elles, avait aussi diminué et qu'il y avait de plus en plus de gens qui vont fumer sur le balcon ou à la fenêtre ou dans leur jardin, et certainement les gens avec enfants, donc ça a aussi eu un impact sur la consommation de tabac dans la sphère privée, même si en fait c'est une disposition de règlement*." (FR_3)

4.1.2.5 Conclusion of the context to the stage of realisation

The semi-structured interviews and the focus group with practitioners, civil servants and experts gave insight in how the Belgian drug policy is shaped in daily practice, and how "policy in the books" is translated to "policy in practice". The results show that there are limits to the "policy in the books" intention for an evidence-based drug policy. First of all, many respondents emphasise that, given the small resources, the existing prevention initiatives still manage to have a clear impact with the current prevention offer. Nevertheless, many barriers and bottlenecks remain.

First of all, nearly all respondents refer to the structural underfinancing of the prevention pillar, especially compared to the other pillars. The current budgets do not allow for structural, long-term prevention and often mean a quality reduction or scaling back prevention in certain target groups. It also does not allow, for example, a greater commitment to early intervention. Respondents furthermore mention to try to make up for those financial shortfalls with other funding, for example through the funding from the Internal Affairs with the Strategic Prevention and Security Plans. This alternative source of funding is however aimed at drug-related nuisance initiatives, and further blurs the differences between prevention from a health perspective and prevention of drug-related crime. As a result, the prevention landscape – an already fragmented landscape – is fragmented even further.

Another observation within the Prevention pillar, is that several respondents refer to a good cooperation. However, in a further analysis of these collaborations, these cooperation initiatives are mostly situated at the local level. When respondents refer to cooperation between the different prevention partners, or cooperation with other actors like law enforcement, they often describe local cooperation initiatives initiated by organisations or prevention partners themselves. They are informal and tied to the voluntary initiative of a particular network, organisation or individual. The cooperation is therefore also site-specific, so that it happens in one place and not in another. There are very few mechanisms that formalize and support cooperation.

Additionally, several respondents refer to the fact that a narrow vision on prevention as discouraging drug use amongst (particularly) Flemish policy makers and law enforcement partners. As a result, respondents describe not only how cooperation is hindered, but also that the prevention field on the one hand, and policy on the other hand grow further and further apart. The evolution of harm reduction in practice, has not (yet) translated into policy.

Furthermore, several respondents emphasise problems related to the lack of a coherent alcohol policy, for example with the age limit, and publicity. They describe how the general public is not aware of how harmful alcohol is. The lack of structural measures concerning the age limit, publicity or alcohol supply, do not contradict this message. Stand-alone prevention initiatives trying to change this perception, are

a losing battle, respondents describe. Respondents voice the need for structural support and an integral approach. Respondents often refer to tobacco policy in that context.

Throughout all these barriers, several themes were discussed as challenging, but not necessarily posing as a barrier. The current division of competences complicates policy development and alignment, is a first recurring challenge. Another challenge is the ever-changing drug field, to which prevention initiatives have to adapt. Lastly, several respondents emphasise the challenge to bring drug prevention to the attention of local authorities within a setting-oriented prevention field.

Finally, respondents seem to be less aware of unintended (positive or negative) consequences and only refer to tobacco policies in this context. By thoughtfully restricting smoking in public places, people also smoke less in private places. The restriction of smoking in public places seeming also led to a reduction in private places too.

4.2 Lessons learned

The pillar 'Prevention is the first pillar of the Belgian drug policy, after 'Treatment, risk reduction and re-integration' and 'Enforcement'. This chapter has evaluated the pillar 'Prevention' of the Belgian drug policy. These are the lessons learned.

POLICY INTENTIONS:

A critical appraisal of the policy logic found that:

- ⇨ The pillar 'Prevention' is generally **explicit on its objectives and central actions, but often remains vague about the concrete intended outputs and outcomes**. This is illustrated by the lack of explicit outputs for most of the actions, and even outcomes for at least half of the listed actions.
- ⇨ The pillar 'Prevention' is not explicitly based on a (recent) situation analysis.
- ⇨ The pillar 'Prevention' **does not distinguish between short-term, medium-term and long-term outcomes,** although starting points for this distinction are present.
- ⇨ The pillar 'Prevention' is **focuses on both legal and illegal substances,** however remains vague about actions aimed at alcohol. Also, youth is often defined as a target group for prevention, while prevention initiatives towards adults (or other target groups) remain scarce.
- ⇨ The pillar 'Prevention' is **barely explicit about the processes through which change is achieved,** although the Parliamentary Working Group on drugs clearly shows some starting points. Its main focus of the policy documents remain on the policy design.

MEASUREMENT OF POLICY INTENTIONS:

With regards to the **extent of realisation**, we found that:

- ⇨ The document review revealed that there is no structural follow-up of the implementation of the Federal Drug Note and Joint Declaration, nor of other developments in the drug prevention field. We had to puzzle the overview of realisations in retrospect, which resulted in a very fragmented and anecdotical picture.
- ⇨ There have been many developments in the prevention field, both actions that were intended by the Federal Drug Note and the Joint Declaration, as well as realisations and developments within the drug prevention field that were not foreseen by the policy documents. Most realisations are situated amongst the objectives 'to implement strategic measures specifically targeted at psychoactive drugs', 'to discourage driving under the influence of legal and illegal drugs' and 'tobacco policy'. The developments for the objectives 'to prevent drug-related nuisance' and 'alcohol policy' are much more modest. Most additional actions, not foreseen in the Federal Drug Note and the Joint Declaration, are situated with the objectives 'to develop

a prevention policy', 'to apply a policy of discouragement' and 'a tobacco policy', and to a lesser extent for the other objectives. It seems that practice, but also individual policy makers and sometimes even an individual region, are further fuelling the pillar 'Prevention', even without an overarching and crosscutting drug plan giving direction.

- ⇨ There are a lot of discrepancies in the level of perceived realisation. This is in about half the cases explained by regional or policy-level differences (after the Sixth State Reform, Prevention was almost completely defederalized). However, there are some discrepancies that cannot be explained by regional or policy-level differences. These discrepancies could be due to differences in interpretation, the fact that some actions are non-quantifiable or measurable because they are described in a vague way, or the lack of overview on the different prevention realisations in the prevention field amongst practitioners, civil servants and (scientific) experts.
- ⇨ Comparing the results of the document review with the survey, shows that although the document review identifies certain actions as realised, survey respondents indicate them as partially or even not realised. This indicates that actions may be implemented, but they do not necessarily operate in the best possible way.

With regards to the **context to the stage of realisation**, practitioners, civil servants and (scientific) experts perceived that:

- ⇨ Given the small resources, the existing prevention initiatives still manage to have a clear impact with the current prevention offer.
- ⇨ Nevertheless, there is a structural underfinancing of the prevention pillar, resulting is a less efficient prevention offer and play into the hand of further fragmentation. The current budgets do not allow for structural, long-term prevention and often mean a quality reduction or scaling back prevention in certain target groups. It also does not allow, for example, a greater commitment to early intervention.
- ⇨ Several respondents refer to a good cooperation with both other prevention partners or with other partners (e.g. law enforcement). However, these cooperation initiatives are mostly situated at the local level, initiated by organisations or prevention partners themselves. They are informal and tied to the voluntary initiative of a particular network, organisation or individual.
- ⇨ Respondents describe a narrow vision on prevention as a means to discourage drug use amongst (particularly) Flemish policy makers and law enforcement partners, which in turn hinders cooperation and that practice and politics are increasingly diverging.
- ⇨ There are several problems related to the lack of a coherent alcohol policy, for example with the age limit, and publicity.
- ⇨ Furthermore, respondents refer to specific challenges like the current division of competences complicates policy development and alignment, the ever-changing drug field to which prevention initiatives have to adapt, and to bring drug prevention to the attention of local authorities within a setting-oriented prevention field.
- ⇨ Finally, respondents seem to be less aware of unintended (positive or negative) consequences and only refer to tobacco policies in this context.

CHAPTER 5

PILLAR 2: TREATMENT, RISK REDUCTION AND REINTEGRATION

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5 PILLAR 2: 'TREATMENT, RISK REDUCTION, AND REINTEGRATION[59]'

This chapter evaluates the pillar 'Treatment, risk reduction and reintegration' of the Belgian drug policy.

The pillar 'Treatment, risk reduction and reintegration' was – like the other pillars - is based on the report of the Parliamentary Working Group on Drugs in 1997. The Parliamentary Working Group on Drugs describes what the landscape of care and treatment of 'addicts'[60] looked like with a lot of detail. Belgium had a wide range of facilities at the various levels of treatment (from general, community-based to specialised residential treatment). At the time, the sectors of Homeless Care (Dutch: *Thuislozenzorg*, French: Soins aux sans Abris), Judicial Welfare, and the OCMW/CPAS reported an increase in clients who use drugs. Several causes were described. First of all, the report described that among the most disadvantaged groups the use of alcohol has clearly been replaced by the use of illegal drugs. Additionally, a large group of "non-treatable" drug users had been transferred to the General Welfare, due to the pressure for abstinence within specialised drug services. More and more problematic drug users seemed to drop out from specialised drug services, and increasingly turned to the outpatient centres (especially General Welfare Centres and Homeless Care). Another trend described that the distribution of drug treatment, both geographically and across the various treatment levels, was fairly uneven. Although this was described as the result of coincidental circumstances rather than political choices (at least for the geographical dispersion), it posed a significant problem. The report further emphasised that especially non-specialised community treatment had been understaffed for a long time. This was the result of a minimal funding policy for this type of care. As a consequence, the non-specialized community treatment and crisis shelter faced serious capacity problems, which impacted the quality of care. Another trend at the time, was the concern about the containment of HIV infections. The danger of transmission of HIV and AIDS and certain types of hepatitis, together with the problems arising from certain forms of drug-related crime (e.g. acquisitive crime like street crime, breaking and entering into cars and homes, shoplifting, pickpocketing), stimulated risk reduction initiatives, such as syringe exchange projects and methadone treatments (both as detox medication, and as maintenance therapy). These initiatives allowed for the limitation of harmful consequences of excessive rug use. Problems with the legal framework for substitution treatment and syringe exchange projects complicated a widespread implementation though. The report further described a significant increase in the number of patients/drug users in the general practitioners' offices (especially for substitution treatment). The increase of heroin use across the country, confronted general practitioners everywhere with the problem of heroin 'addicts. The need for additional training was highlighted. Lastly, the problem of disparate funding of the different types of institutions and facilities was put forward.

Subsequently, the Working Group advised to introduce a pillar 'Treatment, risk reduction and reintegration' in addition to the pillars focussing on 'Prevention' and 'Enforcement'. The priority of this pillar is – according to the Working Group - the protection of society and its members who are confronted with the drug phenomenon. Drug 'addicts', despite their drug use, should be given the help they need to live in a humane way (p. 992). The Federal Drug Note (2001) took on board these recommendations and introduced a pillar 'Treatment, risk reduction and re-integration, in addition to the pillars 'Prevention'' and 'Enforcement'. This approach was confirmed in 2010 with the Joint Declaration of the Interministerial

[59] Care (Dutch: *Zorgverlening*; French: *Assistance*/*Soins*), Risk reduction (Dutch: *Risicobeperking*, French: *Réduction des risques*) and Reintegration

[60] We adopt the same terminology as used in the policy documents. This has two consequences. First, the policy documents often use certain concepts interchangeably (e.g. 'addiction' with 'substance use treatment'). We know these concepts do not have the same meaning. However, since the description of the logic model is a representation of these policy documents, we adopt the terminology as used in the policy documents. Second, some of the concepts used in the policy documents (and therefore also in the description of the logic models) are considered vague (e.g. problematic use) and/or stigmatizing language e.g. addicts). We discuss the two problems with these concepts further on in the chapter.

Conference Drugs. Both policy documents emphasised public health approach that integrates other dimensions such as well-being and social integration.

Based on these observations, this chapter discusses the pillar 'Treatment, Risk reduction, and Reintegration' and the different actions emphasised in the Federal Drug Policy Note (2001) and in the Joint Declaration of the Interministerial Conference Drugs (2010). We first explain the policy logic behind the pillar 'Treatment, Risk reduction, and Reintegration', i.e. how actions under the pillar 'Treatment, Risk reduction, and Reintegration' intend to achieve their goal. Then, we conduct a critical appraisal of the policy logic. Possible discrepancies, inconsistencies, and omissions in the policy's framework are raised and discussed.

5.1 What were the policy intentions? A logic model of the pillar 'Treatment, Risk reduction, and Reintegration'

In this section, we address the first research question 'What are the identified aims, action points, intended outputs and intended outcomes of the Belgian drug policy?'. To do so, we rely on logic models as an evaluation framework, as explained in the methodological chapter (cf. supra). Logic models are a systematic and coherent description of a policy that identify the objectives, actions, resources, intended outputs and intended outcomes underpinning a certain policy (EMCDDA, 2017a). The logic models make the underlying assumptions of how a policy aims to achieve change, explicit. Logic models identify and describe how a policy fits together in a simple sequence. The policy's theory is described in a logical, linear depiction of how policy makers intend to achieve change.

To establish a logic model for the pillar 'Treatment, Risk reduction, and Reintegration', we did a document analysis of the two central and overarching policy documents of the Belgian drug policy: The Federal Drug Note of 2001 and the Joint Declaration of the Interministerial Conference Drugs of 2010. We extracted the aims, the actions, the inputs, the intended outputs and the intended outcomes (where possible) verbatim from these documents, and rearranged them in a logical sequence (shown by *Figure 12. Summary of the logic model for 'Treatment, risk reduction and reintegration'*).

We additionally analysed the report of the Parliamentary Working Group on Drugs (1997) to further contextualize these aims and actions (where actions were unclear). The logic model on 'Treatment, Risk reduction, and Reintegration' shown by *Figure 12. Summary of the logic model for 'Treatment, risk reduction and reintegration'* thus describes how the aims and actions under 'Treatment, Risk reduction, and Reintegration' – according to the Belgian drug policy - contribute to the central aims of the Belgian drug policy.

Since the description of the logic model is a representation of the central policy documents, we adopt the terminology mentioned in the policy documents to describe the actions, inputs, intended outputs and intended outcomes. That means that sometimes stigmatising language is used, or old names of institutions that have since changed names are used. For the latter, we added the current name between brackets.

5.1.1 Thirteen main objectives and many corresponding actions

The Federal Drug Note of 2001 and the Joint Declaration of the Interministerial Conference of Drugs of 2010 identify thirteen main objectives within the pillar 'Treatment, Risk reduction, and Reintegration':

1. To create a comprehensive and integrated treatment offer
2. To fund each care circuit (Dutch: *zorgcircuits*; French: *circuit de soins*)

3. To introduce case management in addiction treatment (Dutch: *Verslavingszorg*, French: *Assistance aux toxicomanes*)
4. To create a treatment, offer for drugs users with a dual diagnosis
5. To organise an emergency and crisis response network for urgent requests for treatment
6. To organize initiatives towards the target group of minors
7. To organize aftercare for (delinquent) drug users
8. To further develop risk reduction
9. To support the MSOC/MASS
10. To develop a diverse range of treatment services that allows for cure, care and counselling.
11. To stimulate cooperation between the criminal justice system and the treatment sector
12. To stimulate evidence-based practices
13. To engage in the European drug policy

5.1.1.1 Objective 1: Actions aimed at creating a comprehensive and integrated treatment offer

This objective is introduced by the Federal Drug Note (and confirmed by the Joint Declaration). The actions within this objective are aimed at creating a framework to provide a more integrated, differentiated and comprehensive offer of treatment as an answer to for drug misuse and drug dependence (p. 42).

There are many different actions within this objective. The first, and most important action within this objective, is the development of an integrated legal framework that allows for the organisation of addiction treatment (Dutch: *verslavingszorg*; French: Assistance aux toxicomanes) in local networks, considering specific local needs for substance use treatment (Dutch: *drughulpverlening*; French: Assistance en matière de drogues). A second action is the inclusion of the institutions with a RIZIV/INAMI convention and those institutions providing treatment for drug addicts in psychiatric hospitals (or psychiatric departments of general hospitals) in this legal framework. Also related to these local networks, is the set-up of care circuits (Dutch: *zorgcircuits*; French: *circuit de soins*). A care circuit is described as the total treatment offer for a specific target group (in this case, addicts of a network. The policy documents emphasise that they want to improve addiction treatment both vertically (development and integration of the different categories of treatment related to dependency) and horizontally (establishment of agreements with the linked sectors) through the implementation of care circuits. The policy documents add that addiction treatment is further professionalised through uniform registration, quality control, adapting treatment offer to the demand, uniform diagnostics and assessment and evidence-based treatment techniques.

Other actions within this objective mention that local actors and services will be brought together in a 'Local Drugs Coordination Group' (LDC; Dutch: *Lokale Coördinatiegroep Drugs*; French: Groupe local de coordination drogues), These LDC will in turn connect with the consultation platforms for mental health care (Dutch: *Overlegplatformen voor geestelijke gezondheidszorg*; French:Plateforme de concertation de soins de santé et de santé mentale). The tasks of these LDC are: (1) to examine the regional need for treatment, (2) make an inventory of drug prevention and drug treatment in terms of regional treatment programmes and care circuits starting from the mental health care conceptual framework, (3) to detect missing functions and overlaps in the provision of treatment and fill in or eliminate them locally by means of consultation, (4) to develop a network for emergency and crisis treatment as soon as possible, and (5) to establish cooperation agreements between the criminal justice system and the emergency services on the basis of the guidelines of the Local Coordination Group' (with representatives of the criminal justice sector and the emergency services). Another related action is 'to invite the provincial prevention platforms in Flanders to participate actively in the Local Coordination Group'. Similarly, case managers from the criminal justice sector and representatives from other relevant organisations (justice, social sector, consumer associations, parents' associations, etc.) are invited to be part of the Local Coordination Group.

The other actions within this objective are adapting the care circuits specifically for young people, the recommendation to create a specific treatment pathway for certain patients with a dual diagnosis and the desire to increase the number of non-native (Dutch: *allochtoon*, French: *personnes d'origine étrangère*) treatment providers. Also, it is described that treatment facilities should make extra efforts to reach non-native drug users. Lastly, the policy documents highlight that sufficient attention should be given to cultural differences in the meaning of drug dependence during the training of treatment providers.

The Minister of Public Health and the Minister of Social Affairs are responsible for the implementation of this objective. They negotiate with the Regions and Communities (and through the communities with the provinces).

5.1.1.2 Objective 2: Actions aimed at funding each care circuit

This objective is introduced by the Federal Drug Note. The first action within this objective wants to develop the terms of reference of the treatment functions and treatment modules that have to be provided, based on the current local needs. The Minister of Social Affairs mentions the evaluation of the case load of the RIZIV/INAMI ambulant centres. This evaluation demands proper registration and an instrument to measure the work load. Furthermore, actions mention to solve the insurance problem of drug users on conditional release who are not covered by health insurance (especially for the people being treated in institutions with a RIZIV/INAMI convention (including de MSOC/MASS)[61].

The Joint Declaration adds one action to this objective: The relevant authorities should fully assume their financial responsibility, not only at the various policy levels but also in the context of an optimal vertical alignment of drug policies.

The Minister of Social Affairs is responsible for the implementation of this objective. He consults with the Minister of Public Health and the Minister of Social Integration.

5.1.1.3 Objective 3: Actions aimed at introducing case management in addiction treatment

This objective is introduced by the Federal Drug Note, and confirmed by the Joint Declaration. The policy document mentions the desirability of introducing case management to addresses the group of heavily dependent drug users, who were already enrolled in treatment several times, relapsed, and have had difficulties with reintegration. They also describe what case management should look like.

Two actions are formulated within this objective. First, the Federal Government will allocate funds from the budget of the Minister of Public Health to finance promising case management projects within the Local Drug Coordination Groups. The LDC can decide where to implement these addiction treatment case managers. These case managers should have sufficient experience in addiction treatment and be familiar with all relevant related areas. After all, they are not intended to fulfil the tasks of the already existing facilities. Second, the Joint Declaration mentions to stimulate case-management, especially for specific target groups[62]. The action explains that this method includes individualised treatment for better follow-up, strengthening the harmonisation of treatment provision and facilitating an integral approach to the above-mentioned problems (housing, employment).

The federal Minister of Public Health is responsible for the implementation of this objective. She consults with the Minister of Social Affairs and negotiates with the Regions and Communities.

[61] At the time of writing of the Federal Drug Note 2001, the financing of treatment centres is somewhat complex and spread over several levels.

[62] These target groups are not specified.

5.1.1.4 Objective 4: Actions aimed at creating a treatment offer for drugs users with a dual diagnosis

This objective is introduced by the Federal Drug Note. This group of actions is aimed at developing a sufficient treatment offer for the group of patients with psychiatric problems and with addiction problems. The policy documents describe that substance use and psychiatric disorder reinforce each other negatively.

The actions within this objective, first of all mention that the Federal government will evaluate the current experiments with dual diagnosis, and support them further. A second action explains to launch pilot projects in the form of separate intensive treatment units for patients with a dual diagnosis in general hospitals. Next, supervision and training of the staff will be improved on acute treatment of this group of patients. Additionally, one actions ensures that the federal government will give sufficient attentions to dual diagnosis in the development of regional care circuits and in the definition of treatment functions (cf. objective 1). A last action mentions the commitment to take necessary actions to fill the gaps in the organisation of the care circuit – if these gaps present themselves (cf. objective 1). Cross-trained teams (teams with expertise in both treatment methods for drug addicts and for psychiatric treatment) are deemed necessary in any case.

The federal Minister of Public Health is responsible for the implementation of this objective.

5.1.1.5 Objective 5: Actions aimed at organizing an emergency and crisis response network for urgent requests for treatment

This objective is introduced by the Federal Drug Note. This group of actions is aimed at developing an emergency and crisis response network. It refers to the urgent demand from the field for more crisis admissions capacity, especially for 'addicts', and highlights the existing pilot projects for crisis psychiatry.

A first action will evaluate the three pilot projects of crisis psychiatry in general hospitals Stuivenberg in Antwerp, Van Gogh in Charleroi and Brugmann in Brussels. These three projects will be evaluated to come to a uniform model for crisis psychiatry. A second action refers to the creation of a specific legal framework that will include standard norms, funding, and accreditation of emergency psychiatric units in general hospitals.

The federal Minister of Public Health is responsible for the implementation of this objective. She consults with the Minister of Social Affairs.

5.1.1.6 Objective 6: Actions aimed at organizing initiatives towards the target group of minors

This objective is introduced by the Federal Drug Note. This group of actions is aimed at developing specific measures for minors, because breaking a starting addiction process is easier than breaking a long-term addiction. It is emphasised that the federal government has very few competences towards minors. Yet, it is emphasised as an important part of the pillar 'Treatment, risk reduction and reintegration'.

A first action wants to enable the Youth Care Committee (Dutch: *Comité voor Bijzondere Jeugdzorg*) to play a significant role towards drug-using minors. The social service of the Youth Care Committee could provide the necessary treatment itself or could refer the youngster to an external treatment service. The diversion measure of youth judges and the prosecution can play an important role here too. It is emphasised that both parents, even if the parents are separated, should take part in the programme. Second, the Federal government emphasises the importance of parental services. Some parents of minor problematic drug users need information, coaching and a therapeutic offer. The Federal

Government therefore examines how resources can be made available for this action. In this context, the new modules in the specific RIZIV/INAMI agreements are being considered.

This objective is the sole competency of the Communities. In the General Drug Policy Cell[63], the Federal government is prepared to support the policy of the Communities. The Minister of Social Affairs is responsible for the new modules on parenting in the RIZIV/INAMI conventions.

5.1.1.7 Objective 7: Actions aimed at organizing aftercare for (delinquent) drug users

This objective is introduced by the Federal Drug Note. This group of actions is aimed at improving the social integration of former drug users. Drug users must be able to rely on better organised aftercare. After all, aftercare plays a unique role in terms of social integration (and consequently the prevention of relapse).

A first action mentions that the Federal government demands more attention for aftercare in the institutions it finances, and with this demand, the necessary funding will be allocated. A second action emphasises a better coordination between different initiatives to guide (former) addicts to the job market. These initiatives should come from the Communities as the professional training, job placement and welfare towards (former) addicts are within their competences. The welfare sector and the work sector will be asked to develop an action plan concerning the employment of (former) addicts (e.g. in collaboration with the OCMW/CPAS). The Houses of Justice and the forensic treatment services are suggested as possible partners. A third action highlights that the directive of the Minister of Justice (this action is introduced in the pillar 'Enforcement', cf. infra) tries to ensure that the execution of (old) sentences does not interfere with the reintegration process.

The Minister of Social Integration is responsible for the implementation of this objective. He negotiates with the communities and regions. He consults with the Minister of Social Affairs, the Minister of Employment and Labour, the Minister of Justice, the Minister of Public Health, the Minister of Internal Affairs and the Minister of Major Cities Policy (Dutch: *Grootstedenbeleid*; French: Politique des grandes villes).

5.1.1.8 Objective 8: Actions aimed at further developing risk reduction

This objective is introduced by the Federal Drug Note. This group of actions describes three risk reduction initiatives from the Federal Drug Note: (1) substitution treatment, (2) syringe exchange programs and (3) controlled heroin supply.

With regards to **substitution treatment**, the policy document highlights that these programs have proven to be effective to reduce opiate dependency, to increase social productivity, reduce risky behaviour, improve physical and psychological health, and establish better contact with treatment. In response, six actions were proposed. A first action says that the federal government will translate the conclusions (adapted by the Higher Council of Hygiene) of the Consensus Conference (Ghent, 8 October 1994) in binding legislation. A second action wants to introduce a policy based on scientific research and avoid double distribution, by implementing a uniform registration (central and anonymous). A third action highlights the investment in training and continued education of doctors. A fourth action wants to include doctors in a psycho-social support network so that patients can benefit from multidisciplinary support. A firth action mentions that penitentiary substitution treatment is given adequate attention in the new Directive concerning penitentiary drug policy (this action is introduced in the pillar 'Enforcement', cf. infra). The last action introduces the establishment of transregional agreements in the Euregions which, combined with the above measures, should make it possible to

[63] The establishment of the General Drug Policy Cell will be discussed in detail in the pillars 'Integral and integrated approach'.

counter methadone tourism. The federal Minister of Public Health, in consultation with the communities and regions, is responsible for these actions.

With regards to **syringe exchange** programs, the Federal Drug Note mentions the Royal Degree of 5 June 2000 (BS 7 July 2000) that stipulates that syringe exchange must go hand in hand with the provision of information on the correct use of equipment, the existence of serological tests and the availability of psychological, social, medical and legal care. In response, one action is mentioned: To support syringe exchange programs. The community governments are responsible for this domain. The federal Minister of Public Health signed the Royal Degree.

With regards to **controlled heroin supply**, the Federal Drugs Note describes that experiments with controlled heroin supply in other countries have shown a positive impact on the number of new HIV and hepatitis infections. In response, two actions are mentioned: (1) to evaluate the results of these experiments in other countries (e.g. Switzerland and the Netherlands), and (2) the General Drug Policy Cell can unite all active working groups on this matter. It is explicitly emphasised that the Federal government will not initiate or fund experiments of controlled heroin supply in Belgium. The federal Minister of Public Health is responsible for these actions.

5.1.1.9 Objective 9: Actions aimed at supporting the MSOC/MASS

The actions listed within this objective originate from the pillar 'Epidemiology, research and evaluation'. However, since the actions concern low-threshold treatment, we have reclassified them under the pillar 'Treatment, risk-reduction and reintegration'. Three actions are listed: (1) It is important that the MSOC/MASS integrate into the local network and that they have a clear position in the regional care circuits, (2) There is a need for clear cooperation agreements between the MSOC/MASS and other ambulatory and residential facilities, and (3) the Federal government will adjust its policy based on the evaluation study of the MSOC/MASS (a study by the Federal Scientific, Technical and Cultural Services (DWTC, now BELSPO)).

The Minister of Social Affairs is responsible for the implementation of this objective. He will consult with the Minister of Public Health and the Minister of Internal Affairs.

5.1.1.10 Objective 10: Actions aimed at developing a diverse range of treatment services that allows for cure, care and counselling.

This objective is introduced by the Joint Declaration. This group of actions describes very general actions aimed at developing a diverse range of treatment services that allows for cure, treatment and counselling. A first action describes the development and diversification of the treatment offer for problematic drug users, so that the offer allows for both care, cure and counselling. A balanced geographical distribution is indispensable and should be examined by considering an assessment of needs according to social, economic and cultural parameters of the territories. A second action intents to develop a specific treatment strategy for target groups who are not being reached by the existing treatment offer. A last action within this objective encourages the training of treatment providers. The objective did not specify who would be responsible for its implementation.

5.1.1.11 Objective 11: Actions aimed at stimulating cooperation between the criminal justice system and the treatment sector

This objective is introduced by the Joint Declaration, although most of its actions stem from the Federal Drug Note. This group of actions aims to enhance the cooperation between the criminal justice system and the treatment sector[64]. Only one action is described in the Joint Declaration: 'Pushing the

[64] The cooperation between criminal justice and the care sector is discussed in detail in the pillar 'Integral and integrated approach'. There, many more actions are described for this objective.

collaboration between criminal justice and treatment further, based on mutual respect for the - different - aims of each other and without neglecting the essential preconditions (e.g. an absolute respect for professional confidentiality)'. The objective did not specify who would be responsible for its implementation.

5.1.1.12 Objective 12: Actions aimed at stimulating evidence-based practices[65]

This objective is introduced by the Joint Declaration, although most of its actions come from the Federal Drug Note. The first action calls for evaluation research (especially impact and follow-up research) as a basis of the strategic choices concerning the treatment offer for substance use in terms of resources. The second action highlights that the Federal Services for Scientific, Technical and Cultural Affairs (now Federal Science Policy) will call for research on the organisation of addiction treatment. The third action mentions that the General Drug Policy Cell will be asked to follow up the results of international research on innovative treatment techniques. A last action intends to conduct an evaluation study of the MSOC/MASS.

The objective did not specify who would be responsible for its implementation.

5.1.1.13 Objective 13: Actions aimed at engaging in the European drug policy[66]

This objective is introduced by the Joint Declaration, although the first action stems from the Federal Drug Note. A first action mentions that the federal government, in consultation with other like-minded European countries, will advocate the renegotiation of the UN Conventions. Not only a realistic response to the use of cannabis, but also initiatives to reduce the damage caused by drug use (such as syringe exchange, controlled heroin substitution, on-site testing, drug consumption rooms, ...) are not yet explicitly provided for in the international treaties. A second action states that the various governments, represented in the General Drug Policy Cell, should be involved in EU policies, especially for cooperation in demand reduction and the development of the treatment offer. The objective did not specify who would be responsible for its implementation.

5.1.2 Inputs

The inputs displayed in *Figure 12. Summary of the logic model for 'Treatment, risk reduction and reintegration'*, show the human, financial, organizational, and community resources that are needed to implement the actions under the pillar 'Treatment, risk reduction and reintegration'. The inputs are not always clearly defined in the policy documents. Therefore, not every action was allocated a specific input.

For the first objective, the **actions aimed at creating a comprehensive and integrated treatment offer**, no budget was allocated: *"The Local Drug Coordination Groups will be created within the Mental Health Concertation Platforms and therefore do not generate additional costs"* (p 50, Federal Drug Note).

For the second objective, the **actions aimed at funding each care circuit,** the costs will depend on the work load: *"The costs depend on the evaluation of the workload of the day centres and outpatient centres"* (p 50, Federal Drug Note).

For the third objective, the **actions aimed at introducing case management in addiction treatment** "*30 Million BEF (743681.48 EUR) will be included in the budget of the Minister of Public Health to fund interesting local projects*" (p 51, Federal Drug Note).

[65] The stimulation of evidence-based practices is more elaborately discussed in the pillar 'Epidemiology, research and evaluation'.
[66] The engagement in European an international drug policy is also extensively discussed in the pillar 'Integral and integrated approach'.

For the fourth objective, the **actions aimed at creating a treatment offer for drugs users with a dual diagnosis,** the Federal Drug Note indicates that: *"The necessary investments will be discussed during budgetary control"* (p 52, Federal Drug Note). The same goes for the fifth objective, the **actions aimed at organizing an emergency and crisis response network for urgent requests for treatment .**

For sixth objective, the **actions aimed at organizing initiatives towards the target group of minors,** "*The Minister of Justice will assess the budgetary consequences of this measure"* (p 54, Federal Drug Note).

For the seventh objective, namely the **actions aimed at organizing aftercare for (delinquent) drug users,** the Minister of Social Integration will provide the means for the action plan on employment. The Federal government will further examine the possibilities of a budget within the 'drug plan' and the security contracts with the cities[67].

For the eighth objective, namely the **actions aimed at further developing risk reduction,** the policy document mentions that the Minister of Public Health already has a budget at his disposal for the substitution treatment actions. Syringe exchange programs are said to be the responsibility of the communities, so the Federal Drug Note does not define a budget: The actions on controlled heroin supply do not generate additional budgetary costs according to the policy note.

For the ninth objective, namely the **actions aimed at supporting the MSOC/MASS,** the allocation of a budget is postponed until the results of the evaluation study are announced.

For the tenth objective, namely the **actions aimed at developing a diverse range of treatment services that allows for cure, treatment and counselling,** does not mention any inputs. The same goes for the **action aimed at stimulating cooperation between the criminal justice system and the treatment sector,** the **actions aimed at engaging in the European drug policy, and the actions** aimed at stimulating evidence-based practices, can be called upon the Federal Science policy.

5.1.3 Intended outputs

The outputs displayed in *Figure 12. Summary of the logic model for 'Treatment, risk reduction and reintegration'*, show the immediate outputs (deliverables) that result from the implementation of the actions under the pillar 'Treatment, Risk reduction, and reintegration'. Like inputs, intended outputs are not always clearly defined. Some outputs were not mentioned, but could be deduced from other parts of the text. Such outputs are indicated in grey. Sometimes, there was no output defined at all. In these cases, we left the space blank. As the figure shows, most outputs were implied, rather than made explicit.

5.1.3.1 Outputs for objective 1: To create a comprehensive and integrated treatment offer

For the first objective the outputs are diverse. A first group of actions under this objective define the following outputs: (1) An integrated legal framework that allows for the organisation of addiction in local networks, (2) the inclusion of the institutions with a RIZIV/INAMI convention and institutions providing psychiatric treatment for drug addicts in this legal framework, (3) the local care circuits to improve addiction treatment both vertically and horizontally, (4) uniform registration, quality control, adapting the supply to demand, uniform diagnostics and evidence-based treatment techniques for addiction treatment.

The second group of actions concern the establishment of 'Local Drugs Coordination Groups'. This implies the following outputs: (1) a report on the regional need for treatment, (2) an inventory of the drug prevention and substance use treatment initiatives and their needs, (3) an overview of the missing

[67] The actions and objectives elaborating on these 'drug plans' on the local level, are explained in the pillar 'Integral and integrated approach', together with the security plans.

functions and overlaps in the provision of treatment, (4) a network for emergency and crisis treatment, (5) the establishment of cooperation agreements between the criminal justice sector and the emergency services based on the previous outputs, (6) the provincial prevention platforms in Flanders participate actively in the Local Coordination Groups, and (7) case managers from the criminal justice sector and representatives of other relevant organisations (justice, social sector, consumer associations, parents' associations, etc.) are part of the Local Coordination Groups.

The other actions within this objective, imply the last three outputs: (1) attention for young people in the care circuits, (2) a specific treatment pathway for certain patients with a dual diagnosis, (3) more non-native treatment providers, but also non-native clients, and (3) attention to cultural differences in the meaning of drug dependence during the training of treatment providers.

5.1.3.2 Outputs for objective 2: To fund each care circuit

This objective implies four intended outputs. None of the outputs are explicitly mentioned. A first output is the terms of reference of the treatment functions and treatment modules that have to be provided, based on the current local needs. A second output is the evaluation of the Minister of Social Affairs of the case load of the RIZIV/INAMI ambulant and day treatment centres. A third output is a registration system and an instrument to measure the work load of ambulant treatment. A last output is the initiatives that solve the insurance problem of drug users on conditional release who are not covered by health insurance (especially for the people being treated in a MSOC/MASS or an institution with a RIZIV/INAMI convention).

5.1.3.3 Outputs for objective 3: To introduce case management in addiction treatment

The third objective indicates the following two outputs: (1) funds from the budget of the Minister of Public Health to finance promising case management projects within the Local Drug Coordination Groups, (2) case-management, especially for specific target groups (like heavily addicted drug users with complex multiple problems), is implemented.

5.1.3.4 Outputs for objective 4: To create a treatment offer for drugs users with a dual diagnosis

This objective implies five intended outputs. Only the fifth output is explicitly mentioned, the others were implied. The outputs are: (1) the evaluation of the current experiments with dual diagnosis, (2) pilot projects in the form of separate intensive treatment units for patients with a dual diagnosis in general hospitals, (3) training sessions of the staff concerning acute treatment of patients with a dual diagnosis, (4) dual diagnosis is taken into account in the development of regional care circuits and the definition of treatment functions, and (5) cross-trained teams with expertise in both treatment methods for drug ‘addicts’ and psychiatric treatment.

5.1.3.5 Outputs for objective 5: To organise an emergency and crisis response network for urgent requests for treatment

The fifth objective mentions the following outputs (the first one being explicit, the second one implicit): (1) a uniform model for crisis psychiatry, based on an evaluation of the three pilot projects of crisis psychiatry in general hospitals, and (2) a specific legal framework that will include standard norms, funding, and accreditation of emergency psychiatric units in general hospitals.

5.1.3.6 Outputs for objective 6: To organize initiatives towards the target group of minors

This objective only lists implicit outputs: (1) The Youth Care Committee provides the necessary treatment for drug-using minors, or refers them to an external treatment service, (2) funding for parental services for parents of minors with a problematic drug use, for example through the new modules in the specific RIZIV/INAMI agreements, are being considered.

5.1.3.7 Outputs for objective 7: To organize aftercare for (delinquent) drug users

This objective implies four intended outputs. None of the outputs are explicitly mentioned. The outputs are: (1) The provision of aftercare in the institutions the Federal government finances, (2) coordination between different initiatives to guide (former) addicts to the job market, (3) actions plan concerning the employment of (former) addicts (e.g. in collaboration with the OCMW/CPAS), developed by the communities and (4) a directive of the Minister of Justice that ensures that the execution of (old) sentences does not interfere with the reintegration process.

5.1.3.8 Outputs for objective 8: To further develop risk reduction

The outputs of this objective, are structured into three groups. The first group of outputs concerns **substitution treatment**: (1) Legislation based on the conclusions of the Consensus Conference (Ghent, 8 October 1994), (2) a uniform registration system (central and anonymous), (3) training sessions and continued education for doctors, (4) doctors are part of a psycho-social support network so that patients can benefit from multidisciplinary support, (5) a new Directive concerning penitentiary drug policy addresses penitentiary substitution treatment (cf. Pillar 'Enforcement'), and (6) transregional agreements in the Euregions to counter methadone tourism.

The second group concerns **syringe exchange** programs, and implies just one output: initiatives to support syringe exchange programs.

The third group concerns **controlled heroin supply**. Two outputs are implied: (1) the evaluation of the results of controlled heroin supply experiments in other countries (e.g. Switzerland and the Netherlands), and (2) all active working groups on this matter, are united.

5.1.3.9 Outputs for objective 9: Support the MSOC/MASS

This objective only lists implicit outputs: (1) MSOC/MASS are integrated into the local network and have a clear position in the regional care circuits, (2) cooperation agreements between the MSOC/MASS and other ambulatory and residential facilities, and (3) an adapted federal policy based on the evaluation study of the MSOC/MASS (a study by the Federal Scientific, Technical and Cultural Services (now the Federal Science Policy)).

5.1.3.10 Outputs for objective 10: To develop a diverse range of treatment services that allows for cure, treatment and counselling.

This objective implies three intended outputs. None of the outputs are explicitly mentioned. The outputs are: (1) A diverse treatment offer for problematic drug users, with a balanced geographical distribution, (2) a specific treatment strategy for target groups who are not being reached by the existing treatment offer, and (3) training sessions for treatment providers.

5.1.3.11 Outputs for objective 11: To stimulate cooperation between the criminal justice system and the treatment sector

This objective only lists one implicit output: A collaboration between criminal justice and treatment based on mutual respect.

5.1.3.12 Outputs for objective 12: To stimulate evidence-based practices

This objective list four implicit outputs. The first output is that the strategic choices concerning the treatment offer is based on evaluations (especially impact and follow-up research). The second output is the research report(s) on the organisation of addiction treatment. The third output is an overview of the results of international research on innovative treatment techniques. A last output is an evaluation study of the MSOC/MASS.

5.1.3.13 Outputs for objective 13: To engage in the European drug policy

This objective lists the following outputs: (1) the renegotiation of the UN Conventions regarding a realistic response to the use of cannabis, but also initiatives to reduce the damage caused by drug use (such as syringe exchange, controlled heroin substitution, on-site testing, drug consumption rooms, ...), (2) the engagement in EU policies in the field of demand reduction and the development of the treatment offer.

5.1.4 Intended outcomes

The summary depictured in *Figure 12. Summary of the logic model for 'Treatment, risk reduction and reintegration'* shows the outcomes of the actions under the pillar 'Treatment, risk reduction and reintegration'. These outcomes demonstrate the mid- and long-term effect the policy makers sought to achieve by implementing the actions above. The policy documents often do not mention a clear outcome. Some outcomes were not explicitly mentioned, but could be deduced from other parts of the text. These outcomes are again indicated in grey. Sometimes, there was no outcome defined at all. In these cases, we left the space blank.

Regarding the outcomes for the first objective, **to create a comprehensive and integrated treatment offer**, the following outcomes are explicitly mentioned: (1) the organisation of treatment for drug addicts is done through regional networks, (2) addiction treatment is optimised an professionalized, (3) tailor-made treatment and continuity of treatment provision, (4) quantitative and qualitative strengthening of the treatment offer, (5) the facilitation of the referral of the target groups in terms of a more efficient treatment, and (6) the treatment offer of adults and minors is separated. There is also one outcome implied: (1) More non-native users in drug treatment, (2) increased social reintegration of non-native drug users. The expert validation added one outcome too: More evidence-based treatment.

The outcomes for the second objective, **to fund each care circuit**, the following outcomes are explicitly mentioned: (1) An integral and integrated treatment offer, (2) global financing of each local care circuit.

Regarding the outcomes for the third objective, **to introduce case management in addiction treatment**, the outcomes that are explicitly mentioned, relate to the client level, and to the level of the organisation. Outcomes on client level are: (1) decrease relapse, (2) tailor-made individual treatment and continuity of treatment provision, (3) increase social functioning of the client, (4) improved integral approach with emphasis on related problems such as housing and employment. Outcomes on organisation level are: (1) better coordination and cooperation within addiction treatment, and (2) an improved communication between different services (with consent of the client).

Regarding the outcomes for the fourth objective, **to create a treatment offer for drugs users with a dual diagnosis**, the explicit outcomes are formulated on a client level: Improvement of the general level of functioning, reduction of drug use and related problems, stabilisation of psychiatric disorders, risk

reduction and re-socialisation (housing, work and daily occupation). Regarding the outcomes for the fifth objective, **to organise an emergency and crisis response network for urgent requests for treatment** , the following outcomes are all implicit: (1) an increased capacity for crisis treatment, (2) integration of crisis treatment in the care circuits.

Regarding the outcomes for the sixth objective, **to organize initiatives towards the target group of minors**, there is one outcome implied: To interrupt a starting addiction.

Regarding the outcomes for the seventh objective, **to organize aftercare for (delinquent) drug users**, two outcomes are explicitly mentioned: (1) a better organized aftercare, (2) a job-orientated education and training programme that fits in seamlessly with the treatment provided, is the best guarantee of sustainable integration into society.

Regarding the outcomes for the eighth objective, **to further develop risk reduction**, the following outcomes are explicitly mentioned: (1) A policy based on scientific evidence, (2) promote access to substitution treatment, (3) avoid that substitution programmes are being turned into methadone service centres, and (4) counter drug tourism. One outcome was added through expert validation: improvement of substitution treatment.

Regarding the outcomes for the ninth objective, **to support the MSOC/MASS**, no explicit or implicit outcomes are mentioned.

Regarding the outcomes for the tenth objective, **to develop a diverse range of treatment services that allows for cure, treatment and counselling**, the following outcome is explicitly mentioned: A wide range of both drug-specific and general health and well-being services. There is one outcome implied: Improvement of the accessibility of psychosocial and medical assistance for target groups that have so far not been reached.

Regarding the outcomes for the eleventh objective, **to stimulate cooperation between the criminal justice system and the treatment sector**, no explicit or implicit outcomes are mentioned.

Regarding the outcomes for the twelfth objective, **to stimulate evidence-based practices**, the following outcomes are implied: Strategic choices on the provision of treatment are based on evaluation research, and insight into the organisation of addiction are and innovative treatment methods.

Regarding the outcomes for the thirteenth objective, **to engage in the European drug policy**, the following outcome is explicitly mentioned: alignment with the EU policies.

For the actions aimed at **creating a treatment offering for the dual diagnostic group, according to the document t**he different outcomes would contribute to provide appropriate, high-quality, ongoing and suitable treatment for drug users with a dual diagnosis

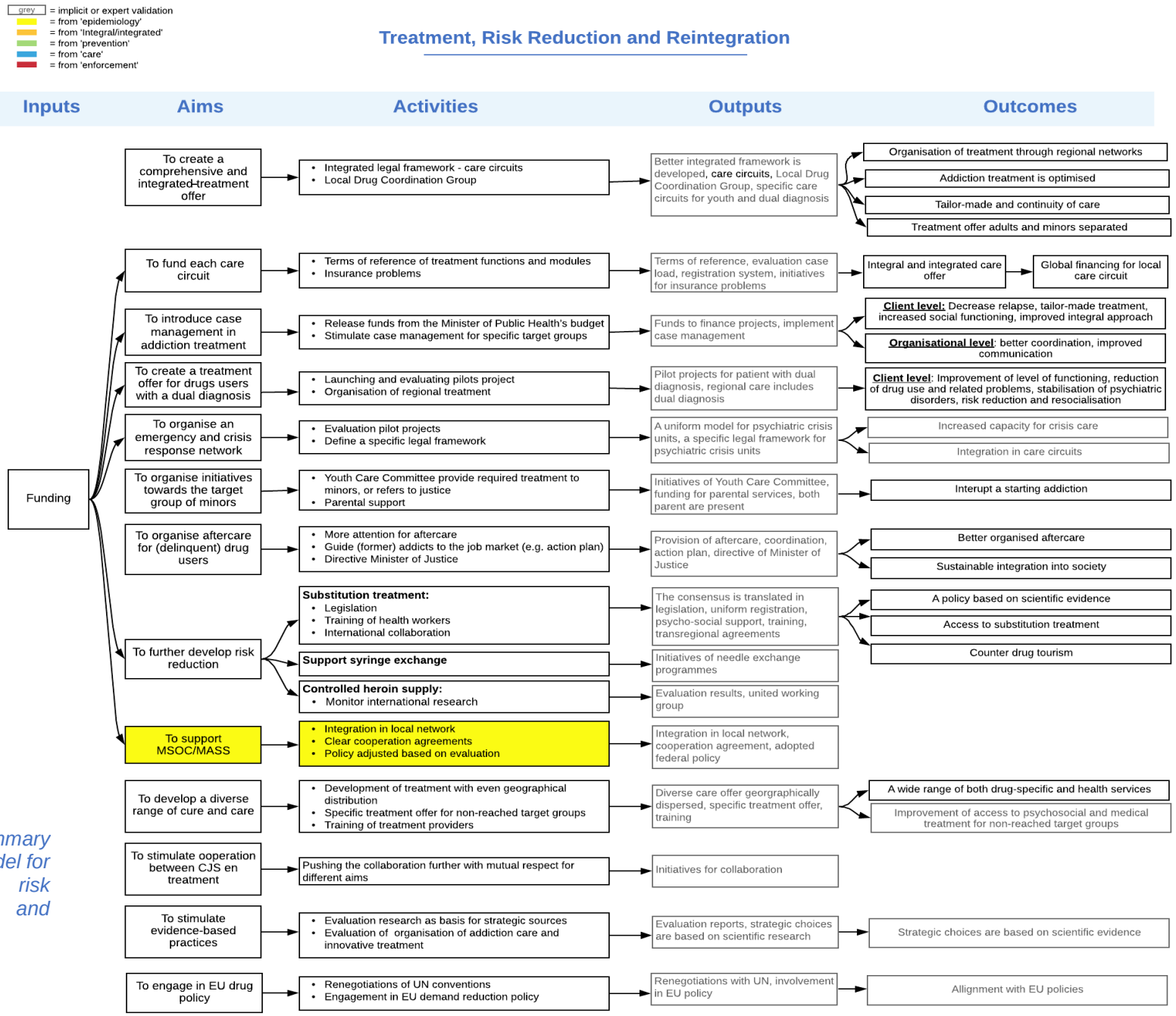

Figure 12. Summary of the logic model for 'Treatment, risk reduction and reintegration'

5.2 Critical appraisal of the logic models

In this section, we address the research question 'To what extent are the logic models of the pillars and transversal themes consistent, coherent and logical?'. This critical appraisal of the policy theory is a first step of the process evaluation, in the sense that it allow us to control whether possible policy issues are attributable to a poor policy theory or not.

Building further on the document analysis of the central policy documents, we critically analyse the logic models, relying on indicators of internal validity (Funnell & Rogers, 2011). This way, discrepancies, inconsistencies and omissions in the policy's theory are raised and discussed.

The internal validity of the policy theory shows to what extent the policy theory is clear, realistic and logical about what the policy wants to achieve, and how the policy wants to achieve these outcomes (Funnell). In this section, we assess this internal validity based on five indicators: Clarity of description, the outcome chain, demonstration of how the outcomes are related to the problem, the logical argument of the policy theory, and the articulation of mechanisms for change.

5.2.1 Clarity of description

A first measure of internal validity is 'clarity of description'. It assesses whether the logic model describes how the policy works with enough detail.

The pillar 'Treatment, risk reduction and re-integration' describes many different objectives and actions. Most of these objectives and actions are clearly described. This contrasts with the lack of clarification on the outputs and the outcomes, as will be shown in this section.

First of all, there is **a clear problem description**. Both the Federal Drug Note and the Joint Declaration rely on the report of the Parliamentary Working Group on Drugs for their problem description. The report of the Parliamentary Working Group on Drugs includes a thorough description of the treatment landscape in Belgium and the bottlenecks it encounters. It also elaborates on the people entering drug treatment, although this remains limited due to the lack of uniform registration (cf. infra, Pillar 'Epidemiology, research and evaluation'). Both the Federal Drug Note and the Joint Declaration refer to this well-developed problem description in the report, and build their policy objectives and actions around it.

However, the question can be raised as to what extent this problem description of the late nineties is still relevant for the central drug policy documents in 2001 and 2010. The Federal Drug Note provides an update on the report of the Parliamentary Working Group on Drugs in a first chapter. This chapter 'State of affairs' focuses mostly on the extent of implementation of the recommendations of the report, and adds only limited information on the treatment demand or the use of substances in the general population and/or specific target groups. However, the actions listed in the Federal Drug Note are often preceded by an introduction giving context on what problems the actions are trying to tackle. This indicates that the Federal Drug Note did address an (more or less) up-to-date problem. Although this problem description remains limited, it is much more informative than in the pillar 'Prevention'.

Contrary to the Federal Drug Note, the 2010 Joint Declaration only lists the accomplishments per authority and policy level at the time. It does not list the (evolution in) treatment demand, nor does it refer to the use of substances in the general population or specific target groups. So, despite being established almost 13 years later, it still seems to rely at least partially on the report of the Parliamentary Working Group on Drugs. Based on the policy documents, it is therefore unsure whether the actions of the Joint Declaration address the relevant problems in the prevention sector at the time.

Second, although the pillar 'Treatment, risk reduction and reintegration' is **- in general - explicit about its objectives and actions, it often remains vague about the intended outputs and outcomes**.

Almost all the objectives and actions are described with sufficient detail (a good example is the action 'Local actors and services will be brought together in a 'Local Drugs Coordination Group', after which the precise tasks of this committee are defined'). Lack of detail only appears in a few actions: almost all the actions mentioned in the Joint Declaration remain vague and are described in very general terms. For example, one action intents to 'to develop a specific treatment strategy for target groups who are not being reached by the existing treatment offer' without clarifying what 'target groups' it refer to. However, vague actions can also be found in the Federal Drug Note: The actions within the objective 'to organise initiatives towards the target group of minors' are also unclear. For example, the action 'the Federal government emphasises the importance of parental services' merely states that parental services are important, but does not define a clear approach as what is to be done about it. The lack of detail in the objective concerning minors is not surprising, given the fact that the competences towards minors at the time almost entirely belongs to the communities (the sixth state reform transferred more competences from the federal level to the regions and communities in 2014, cf. supra), and the Federal Drug Note was established by the Federal government. It is therefore surprising that one action does exactly the opposite, namely adding ample detail. The actions 'enable Youth Care Committees to play a significant role towards drug-using minors' adds 'it is emphasised that both parents, even if the parents are separated, should take part in the program'. Additionally, some actions are formulated in such a non-binding way, one could argue whether they are actions at all, e.g. 'the desire to increase the number of non-native treatment providers. And lastly, some actions refer to certain initiatives without explaining them. For example, for the actions 'the General Drug Policy Cell can unite all active working groups on this matter' it is not clear what is meant with 'active working groups', nor for what purpose the working group would be established.

In contrast to the clarity of the objectives and actions, the policy documents are much less clear about the outputs and outcomes. The direct output of the actions is almost always implied, rather than specified (which can be seen by the many grey boxes in *Figure 12. Summary of the logic model for 'Treatment, risk reduction and reintegration'*). For example, the action 'To conduct an evaluation of the MSOC/MASS' implies an evaluation report with policy recommendations from a specific actor as output, however does not explicitly mentions this. Vague or implied outputs could raise difficulties for implementation.

The same conclusion can be made for the outcomes. Similar to the outputs, some outcomes are implicit rather than explicit, for example for the actions under the objective 'to organise an emergency and crisis response network for urgent requests for treatment ', not a single outcome is explicitly defined, although they are implied. Interestingly, this is mainly the case for actions related to actions formulated by the Joint Declaration, and omissions are also more frequent in actions related to risk reduction initiatives. This again confirms that the Joint Declaration gives rather vague guidelines on how the Belgian drug policy should develop, but also indicates that policy makers did not explicitly state what changes they wanted to see with the introduction of risk reduction initiatives. Nevertheless, implied or omitted outcomes remains problematic, because they are the changes a policy maker wants to achieve, and when this is omitted, the relevance of the actions altogether could be questioned. Finally, the outcomes that are defined, are sometimes not specific enough. The outcome 'an increased capacity for crisis treatment' does not clarify how much 'increased' is or over what timing this should be realised.

The same analysis relates to input: only for one objective, an explicit budget is defined (case management). This does not mean that there was no budget allocated for the other objectives, but based on the policy documents, no clear budget was agreed upon at the time. Additionally, for the actions in the objective 'initiatives towards the target group of minors', the responsibility of the implementation is with the Communities and the Minister of Social Affairs, but the Minister of Justice will measure the budgetary consequences. At the very least, this needs to be clarified.

5.2.2 Outcomes chain

A second assessment of the logic model's internal validity is whether it is built around the outcomes it wants to achieve. Are the outcomes central to the logic model, or are there other elements that are accentuated?

A first observation is that **some of the actions** (although they remain a minority) **define outcomes both on a client level and on an organisational level**. For example, the introduction of case management in addiction differentiates between outcomes on a client level (decreased relapse, individual treatment, increased social functioning), and outcomes on an organisational level (better coordination, improved communication). Differentiating between a client-level outcome, organisation level outcomes and policy and societal level outcomes, adds to the complexity of the logic model, and therefore reveals more detail on how the action wants to achieve change. This can therefore be encouraged for the other actions.

A second observation is that, with the exception of one (objective 2), none of the outcomes indicate how the outcomes are related to one another. Most outcomes mentioned in the policy documents **do not distinguish between medium-term and long-term outcomes**. For example, the actions aimed at creating a comprehensive and integrated treatment offer mention the outcome 'the organisation of treatment for drug addicts is done through regional networks' and is listed next to 'tailor-made treatment and continuity of treatment provision'. The outcome mentions short-term outcomes (organisation of treatment through regional networks), and medium to long-term outcomes (continuity of treatment provision), however the policy documents do not (explicitly) say so. Another example of this, would be the outcome 'a job-oriented education and training program that fits in seamlessly with the treatment provided, is the best guarantee of sustainable integration into society'. When this distinction is not made, changes like 'the integration of crisis treatment in the care circuits', 'a better organized aftercare' and 'promote access to substitution treatment' are often described as an end-point of the drug policy. Although these outcomes are essential to understand the policy logic, they do not illustrate the long-term changes the policy makers want to achieve. These long-term changes should be made explicit, all the more, because these long-term outcomes explain how the actions contribute to the three central outcomes of the Belgian drug policy[68]. One objective already does this: The objective 'to fund each care circuit' describe actions that should lead to 'an integral an integrated treatment offer' as a medium-term outcome, but the long-term outcome is described as 'the global financing of each local care circuit'.

We can conclude that the pillar 'Treatment, risk reduction and reintegration' is concerned with the outcomes of the policy actions (to a greater extent than the pillar 'Prevention' for example), although there is still room for improvement.

5.2.3 The demonstration of how the outcomes are related to the problem

A third measure of internal validity questions whether the logic model indicates how the outcomes address the problem(s) that the policy is to address. This means that we assess if and how the problem(s) that gave rise to the establishment of the policy, are linked to the intended outcomes.

We previously established that both the Federal Drug Note and the Joint Declaration rely heavily on the Parliamentary Working Group on Drugs. The problem description of the Parliamentary Working Group is elaborate and thorough. The Federal Drug Note additionally illustrates a clear context to the actions it undertakes. The following overview illustrates how this problem description led to the actions and outcomes of the pillar 'Treatment, risk reduction and reintegration'.

[68] Defined by the Federal Drug Note (2001) as: (1) a reductions of the number of dependent drug users, (2) a reductions of the physical and psychosocial damage caused by drug use, and (3) a reductions of the negative impact of the drug phenomenon on society.

The Parliamentary Working Group on Drugs describes the following trends (cf. introduction). First, **low threshold treatment** described an increase in clients due to a group of "non-treatable" drug users that dropped out because of the pressure for abstinence within specialised drug services. This group increasingly turned to the outpatient centres (especially General Welfare Centres and Homeless Care). Related to this, was the fact that non-specialised community treatment had been understaffed for a long time. This was the result of a very **limited funding policy** for this type of care. As a result, the non-specialised community treatment and crisis shelter faced serious capacity problems, which impacted the quality of treatment. A second trend described the **uneven distribution of drug treatment**, both geographically and across the various treatment levels. Third, **risk reduction initiatives** were stimulated (both as detox medication and as maintenance therapy), but experienced problems with the legal framework for substitution treatment and syringe exchange projects. Fourth, the report described a significant increase in the number of **patients/drug users in the general practitioners' offices** (especially for substitution treatment). Lastly, the problem of **disparate funding** was emphasised.

Each of these problems were addressed by the Federal Drug Note with one or more objectives. Moreover, the Federal Drug Note even (marginally) elaborated on these problem descriptions, to illustrate how the actions were to tackle these problems (for example for 'case management in addiction treatment' or 'dual diagnosis'). The only clear difference was in 'risk reduction', where none of the actions differentiated between substitution treatment as detox medication or as maintenance therapy, which was clearly done in the Parliamentary Working Group. The actions in the Joint Declaration seemingly introduced two new objectives (evidence-based practices and engagement in the European Drug Policy) although the Parliamentary Working Group also elaborated on these themes under the pillars 'Integral and integrated approach' and 'Epidemiology, research and evaluation'.

In that sense, the pillar 'Treatment, risk reduction and reintegration' clearly addresses the problems that gave rise to the establishment of the policy.

5.2.4 The strength of the logical argument of the policy theory

A fourth assessment of internal validity is 'the strength of the logical argument'. This means that we measure the extent to which the logic model is 'logic' in terms of coherence, sequence and completeness.

The logic model on 'Treatment, risk reduction and reintegration' is mostly logical. In general, the actions follow logically from the central objectives, the intended outputs (when they are defined) follow logically from the actions, and the intended outcomes result logically from the intended outputs (Culley et al., 2012). Also, there is consistency between the two policy documents: both the Federal Drug Note and the Joint Declaration, mention similar priorities (with the Federal Drug Note being more elaborate and concrete than the Joint Declaration).

There are a few exceptions to the logical policy theory. First of all, because not every action has a clear, explicit output and outcome, it is not possible to control for the 'logic' of these actions. They are simply incomplete. The same can be concluded for the lack of a concrete budget allocation for most actions that require a certain input.

Second, the pillar 'Treatment, risk reduction and reintegration' is not consistent in terminology. The terms 'addicts', 'heavily dependent drug users', 'patients with addiction problems' and 'problematic drug users' are all used interchangeably to refer to people within addiction treatment. In a similar way, 'drug misuse', 'addiction', and 'dependence' are used interchangeably. The inconsistency in terminology leads to confusion, as it is not clear whether or not they refer to the same group of people. Moreover, stigmatizing language like 'addicts' and 'problematic drugs users' carries a notion of wilful misconduct, of which research has shown that it has negative consequences in the sense that it may influence judgments of admonishment, as well as the need for punishment (compared to treatment) (Ashford et al., 2019; Kelly & Westerhoff, 2010; Pivovarova & Stein, 2019).

Apart from these observations, there are some other inconsistencies in the logic model on 'Treatment, risk reduction and reintegration'. One of these inconsistencies concerns the consistency across substances. Most of the actions do not explicitly refer to a specific substance (more particularly, they refer to 'addiction' in general). This can be explained by the general premise of the Belgian drug policy to start from a public health perspective, where the distinction between the different substances is irrelevant. However, when a substance is defined, they mostly refer to 'drugs' and not 'substances' in general. For example, within the objective 'to create a comprehensive and integrated treatment offer' a multidisciplinary response is necessary for "*drug use that becomes problematic for the health*" (p. 42). Whether they mean legal or illegal drugs, remains unclear. The same examples can be found for 'to organize initiatives towards the target group of minors', 'introduce case management in addiction treatment', 'to organize aftercare for (delinquent) drugs users', and especially for the objective 'to further develop risk reduction'. All of these actions are aimed at opiates or intravenous drug use. Risk reduction in the Belgian drug policy (as introduced by the Federal Drug Note) does not address other substances (for example alcohol or synthetic drugs).

Another inconsistency can (again) be found with the risk reduction actions. All of these actions are aimed at persons with a problematic use. Other target group, who can also exhibit risky behaviour (like drunk driving, and binge drinking), are not addressed with the risk reduction actions in this pillar. Also, this is the only objective that explicitly refers to 'being evidence based' as an outcome. Moreover, its outcomes all refer to the organizational level (access, based on research and registration, etc.), none of the outcomes define outcomes related to individual or public health (although the Parliamentary Working Group clearly highlights the positive outcomes towards public health), as if those are the final changes the policy wants to achieve with risk reduction initiatives. It seems that the objective on 'Risk reduction' is unique in many ways, compared to the other objectives in this pillar.

We can conclude that globally, the pillar 'Treatment, risk reduction and reintegration' is logical, but some inconsistencies remain.

5.2.5 The articulation of mechanisms for change

The last assessment of internal validity is 'the articulation of the mechanisms for change'. This entails the question 'Does the logic model clearly identify the assumed mechanisms of change that underpin its selection of outcomes and activities'. Funnell et al. (2011) describe these mechanisms for change as the 'because' statements: if A happens, then it will result in B, because of C. 'C' is the mechanism for change in this case.

In this area we can be brief. Almost none of the actions explicitly mention the mechanisms for change that lead to their outcome. This means that whereas for most actions a sequence of 'if-then' statements can be made; these sequences are often not accompanied with a 'because'. Therefore, these 'mechanisms for change' are almost completely absent from the logic model.

For a quite some actions this 'because' can be found in the report of the Parliamentary Working Group on Drugs. Although this is not one of the central policy documents (cf. supra), it does help to uncover the mechanisms for change for some parts of the logic model. We found some (sometimes limited) explanations for mechanisms for change for some of the actions (e.g. substitution therapy, the MSOC/MASS, aftercare, CGG/CSM, etc.). We highlight two examples here:

Risk reduction: Substitution therapy. The role of methadone and other substitution medication is first and foremost an instrument to establish a connection to treatment . Not just the substitution medication, but also the psycho-social framing are essential (p. 983). This psycho-social framing could include support with the social and financial situation, additional education and retraining; the restoration of previous relationships and reintegration into a social network; the treatment of somatic conditions, etc. This psycho-social framing should be adapted to the needs if the patient (p. 985). This in turn leads to a decrease of risky behaviour, and a decrease of the use of other opiates. A decrease

in drug related crime is possible (depends on the quality of the substitution treatment, especially the guidance of multidisciplinary teams show promising results), as is an increase social productivity (increases with retention time).

Rehabilitation strives for the best possible reintegration into society. Housing, work, training, retraining are all aspects of the overall strategy to provide the patient with the best possible opportunities for reintegration into society in order to avoid the temptation to return to the drug environment as little as possible. For the same reason, aftercare is very important (p. 605).

Although starting points are clearly present, most of the 'underlying mechanisms' remain somewhat of a black box based on the policy documents.

5.2.6 Conclusion of the policy intentions

In terms of shape of the Belgian drug policy, we see first of all see that the policy documents were often explicit about the objectives and actions, and thus about what the policymakers intent to undertake. Objectives and actions are mostly defined, realistic and specifically formulated. There is one exception: the actions of the Joint Declaration remain vague and are formulated in a broad way that is hardly measurable. This again confirms that the Joint Declaration gives rather vague guidelines on how the Belgian drug policy should develop (cf. supra under 'Prevention'). The downside if this, is that these unclear actions do not give any guidance for implementation, nor as to how to measure them. These actions are therefore difficult to implement as intended by the policy makers, as the 'intention' is not clear in the first place.

Second, although most actions and objectives were more or less clearly defined (with the exception of the actions from the Joint Declaration), the policy documents were less explicit about the expected changes that an action could bring about. Outputs were often not explicitly mentioned, outcomes were only mentioned in about half of the cases. Policy makers were less explicit about the outcomes for the actions of the Joint Declaration. This is not surprising, as they were also vague about the actions in the first place. Remarkably however, outcomes were not defined or vaguely defined for the actions related to risk reduction initiatives too. Vague or implied outputs and outcomes cannot show how the objectives and actions are related to the intended changes in practice. This might produce problems with accountability. If it is not clear what change a certain action has to produce, then why is the action introduced? It also hinders the monitoring and evaluation of the policy plans. If it is not clear what change an action should bring about, how can we measure whether this change has occurred at all?

Third, whenever the outcomes are defined, there is no differentiation between short-term, medium-term and long-term outcomes. This makes it seem as if the short-term outcomes are the final destination of the drug policy, which they are not. Nevertheless, policy makers show more attention to clear outcomes for this pillar compared to, for example, the pillar 'Prevention' or 'Enforcement'. For example, outcomes are defined for more than half of the actions, and for some outcomes a distinction is even made between client-level and organisational-level outcomes. This adds to the complexity of the logic model and reveals more detail about how the action wants to achieve change.

In terms of what the policy makers implicitly or explicitly emphasised, the critical analysis showed consistency between the Federal Drug Note and the Joint Declaration. There are no contradictions between both policy documents and they show similar priorities. There are, however, a few inconsistencies in terminology to refer to people with addiction problems (various concepts are used to refer to the same thing), and the use of stigmatising language. Second, although the Federal Drug Note and Joint Declaration are aimed at both legal and illegal drugs, the actions for risk reduction all refer to intravenous drug use and the use of opiates, while in practice risk reductions addresses different substances. Furthermore, also for the objective on risk reduction, the main target group is people with an addiction problem; no other target groups are defined. Risk reduction thus seems to be very narrowly defined by the Federal Drug Note and Joint Declaration, with an explicit focus on the policy being

'evidence-based' although not explicit health outcomes are defined. The risk reduction objectives thus differs from the other objectives in different ways.

5.1 Have the policy intentions been realised: a measurement

In this chapter, we describe whether the policy intentions, summarised in the logic models, were actually realised. We discuss the results in two steps. First of all, we examine to what extent and how the policy intentions were realised. Second, we measure how the realisation of the policy intentions is perceived by different stakeholders and experts in drug policy, discussing the facilitators, barriers, bottlenecks, challenges and needs.

To examine to what extent and how the policy intentions were realised, the analysis consists of two parts. First, we examine which objectives were implemented, based on a document review. Second, we describe the results of the online survey, to report on the perceived realisation of the different actions defined by the Federal Drug Note and the Joint Declaration. Both parts will be summarised in the section 'realisation of the policy intentions. To measure how the realisation of the policy intentions is perceived by different stakeholders and experts in drug policy, we rely on semi-structured interviews. The results are discussed in the section 'Providing context to the stage of realisation'.

5.1.1 Realisation of the policy intentions

In this section, we map the extent to which the policy intentions, summarised in the logic models, are actually realised. We map this out in two ways[69].

First, we describe the major developments in the field for each objective stipulated in the 'Treatment, risk reduction and reintegration' pillar. We do this through a **rapid document review** of the websites, reports and other publications from various institutions with a role in the Belgian drug policy. We refrain from presenting a full inventory of all actions that have been realised in detail, because it is not feasible to do so. The Belgian drug policy field is fragmented among many different competences and many different policy levels (cf. infra and supra). The follow-up of the realisations of the Federal Drug Note and the Joint Declaration was not centralised in one institution. Therefore, piecing together the puzzle in retrospect for all actions in all policy levels and domains, scattered over reports from different institutions, is not only virtually impossible, it is also not the core objective of this research. This section rather seeks to summarise the key developments within the different objectives, as they feed into the overall performance in the pillar 'Treatment, risk reduction and reintegration'. We therefore opted to list some of the major developments within the various objectives. We have mapped out these developments with a rapid document review, using the websites, reports and other publications from various institutions, such as the General Drug Policy Cell, Belspo, VAD, Fedito, Sciensano, many different addiction care institutions, the public prosecutor's office, federal and local police, NGO's, etc.

Please note that the result of this section is also limited to an overview of the realisations within each objective, but does not reveal whether or not the realisations work as intended, whether they sufficiently meet the needs in the field, nor whether they are executed in a good way. Moreover, many of the realisations from the rapid document review are not necessarily a direct result of the Federal Drug Note or the Joint Declaration. Often, realisations fit as if coincidentally into the framework outlined by the Federal Drug Note and the Joint Declaration, but were no direct implementations of the two policy documents.

Second, we map the **perceived realisation** through **an online survey** amongst practitioners working within one or more domains related to the drug policy. The survey gained an explorative insight into the

[69] For a more elaborate description of the methods used in this project, we refer to Chapter 2 'Methodology'.

perceived realisation of the different actions defined by the Federal Drug Note and the Joint Declaration from a large number of experts at all policy levels (federal, regions and communities, local level) and across the different policy domains (integral and integrated approach; epidemiology, research and evaluation; prevention; care, risk-reduction and re-integration; enforcement)[70]. The survey thus provides a first insight into how the work field evaluates the realisation of the policy intentions. The online survey was distributed amongst practitioners working within one or more domains related to the drug policy.

Eighteen respondents completed the section on 'Treatment, risk reduction and re-integration'. The respondents represented different policy domains and policy levels as outlined in the figure below.

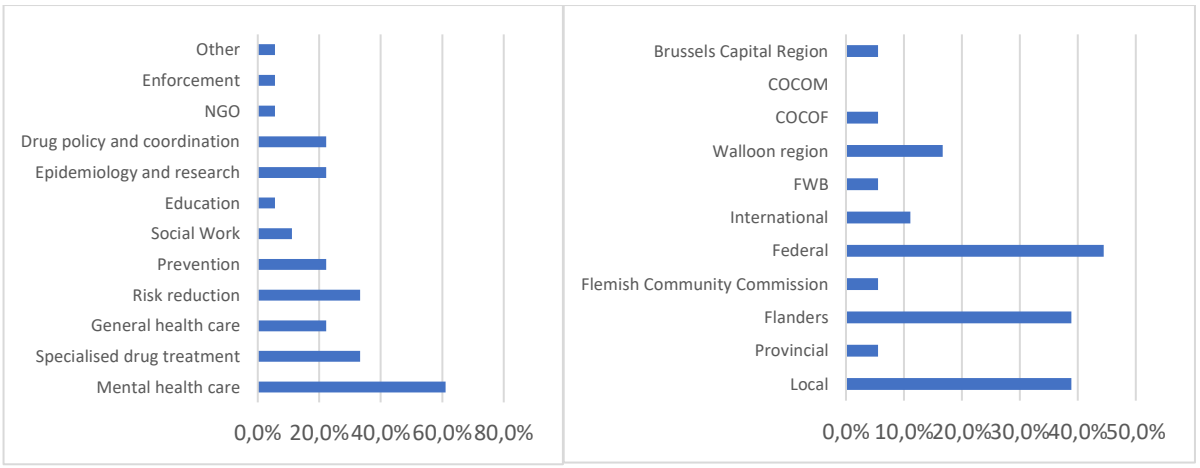

Figure 13 Domains and policy levels that respondents of the pillar Treatment, risk reduction and re-integration 'represent

Most survey respondents have a long experience in the drug field. Two respondents have 3-5 years of experience, two respondents have 5-10 year of experience, and all other respondents indicate to work more than 10 years in the drug field. One respondent did not answer the question.

Lastly, it is important to consider the limitations of the survey when interpreting the results. As mentioned earlier, the questions concerned the realisation of a certain action. Respondents were encouraged to answer only those questions that they were aware of, so the number of responses per action varied between 15 responses for the most answered action ('horizontal and vertical expansion of treatment'), and 2 responses for the least answered actions ('Integrated framework' and 'transnational agreements in the Euregio to decrease drug tourism in methadone'). In addition, the actions already date from 2001 and 2010, and since then, the prevention field has evolved extensively (cf. supra). So, the respondents sometimes had to fall back on their recollection from actions realised several years ago. Finally, as was also highlighted in the critical appraisal of the logic models, some actions are very broadly formulated or difficult to measure. This causes differences in interpretation among respondents.

5.1.1.1 Results

First, we will present a summary of the results before we will elaborate on the realisations of each objective more in detail.

Summary of the results

With regards to the extent of realisation, we found that:

[70] For more information about the methodology, we refer to chapter 2 'Methodology'

- ⇨ The document review reveals that there is no structural follow-up of the implementation of the Federal Drug Note and Joint Declaration, nor of other developments in the drug treatment field. We had to puzzle the overview in retrospect, which resulted in a very fragmented and anecdotical picture.
- ⇨ There have been many developments in the treatment field, both actions that were intended by the Federal Drug Note and the Joint Declaration, as well as other developments within the drug treatment field. Some objectives were fully realised. For other objectives, the actions were not realised in the way that was intended by the Federal Drug Note and the Joint Declaration, for example because the concept has changed or the action was given a broader interpretation (e.g. in the wider mental health field). The developments for the objective 'to fund each care circuit' are much more modest. It is also noteworthy that for various objectives a lot of additional actions have been realised, which were not foreseen in the Federal Drug Note and the Joint Declaration. The additional realisations of the risk reduction objective, however, are not entirely in line with the general framework set out by the Federal Drug Note and the Joint Declaration, for example with the pilot project of controlled heroin distribution and with the drug consumption rooms.
- ⇨ There are a lot of discrepancies in the level of perceived realisation. This is sometimes explained by regional or policy-level differences. Still, there are some discrepancies that cannot be explained by regional or policy-level differences. Discrepancies can be due to differences in interpretation, non-quantifiable or measurable actions, or the lack of overview on the different prevention realisations in the prevention field.
- ⇨ When we compare the results of the document review with the survey, we learn that for most objectives, there are discrepancies between the actual and perceived realisation. In most cases, we see that, although the document review identifies certain actions as realised, survey respondents indicate them as partially or even not realised. For some actions, it is the other way around. This show that actions may be implemented (cf. document review), but they do not necessarily operate in the best possible way and improvement is necessary (cf. survey).

A. Realisations of the objective 'To create a comprehensive and integrated treatment offer'

a. Extent of realisation: a document review

There is **no centralised overview of the realisations** for the objective 'to create a comprehensive and integrated treatment offer'. The information on the various achievements of the objective is spread over many publications, report and websites by different institutions and organisations. The description of the realisations in this section, mainly relies on the documentation from psy107, VAD and several scientific publications. As a result of this fragmentation, this section presents **an anecdotal overview** of the achievements within the objective that is not a complete representation of the field.

The document review reveals that **several actions** intended by the Federal Drug Note and the Joint Declaration for the objective **'To create a comprehensive and integrated treatment offer' were partially realised, but not fully realised.** The document review clarified that, concerning the treatment networks and circuits, a Joint Declaration was established on 24 June 2002 by all the Ministers of Health and Social Affairs. This Joint Declaration set the scene for the future policy for mental health care, and committed itself to further optimizing the provision of mental health care (in which 'people with addiction'

was an explicit target group), including with the development of care networks and circuits (Vlaanderen, 2010). This way, treatment is adapted as much as possible to the needs and demands of clients and patients (Decoster, 2012). The policy of care networks and circuits was developed parallel in drug addiction and mental health care in the 2000s, before being merged at the federal level in 2010. The mental health care reform fits within the broader recommendation to de-institutionalization by the implementation of community-based initiatives and the construction of integrated care networks (Aga et al., 2020; Nicaise et al., 2014). A legal basis was created in Article 11 and Article 107 of the Law on Hospitals and Other Care Institutions[71]. This law provided a legal base for psychiatric hospitals to reallocate funds for long-term beds to networks with community-based services (Nicaise et al., 2014).

After many deliberations, the inter-ministerial conference of 28 September 2009 decided to implement Article 107 of the Law on Hospitals and other Care Institutions. The first step was taken with the "Guide to better mental health care through the creation of care circuits and networks". This guide defined five goals for the mental health reform: (i) 'deinstitutionalization', (ii) 'inclusion', (iii) 'de-categorization', (iv) 'intensification' of treatment in hospitals, and (v) 'consolidation' (Nicaise et al., 2014). The guide requested to implemented five functions. The first function concerns prevention activities, promotion of mental health care, early detection, screening and diagnosis (Mental Health Centers, Medical Homes, General Practitioners, Home Care Services, Forum, PCSWs, police, etc.). The second function concerns acute and chronic mobile teams. These teams try to respond to requests within 48 hours or a little more. The third function concerns rehabilitation and social inclusion through Work-based Training Enterprises, Functional Rehabilitation Centers, users' committees, local schemes for integration through culture, etc). The fourth function concerns hospitalizations, the aim being to provide acute care and to remain in permanent contact with the other functions in order to guarantee continuity of care with the outpatient and the person's living environment. The fifth function concerns specific residential formulas for the provision of care when it is impossible to organize the necessary care at home or in an alternative home environment (sheltered housing initiatives, supervised flats, psychiatric care homes, etc.) (Vlaanderen, 2010). This guide was implemented as a bottom-up strategy, with guidelines from the Federal authorities being embodied in concrete projects in the field. Wallonia was consequently reorganized into 8 networks Mental Health Care, and Flanders was reorganized into 12 networks Mental Health Care. The German-speaking community managed its own health competences. Yet, at the time, specialized addiction treatment was often not integrated (some projects did, other projects did not), nor was specialized addiction treatment (always) involved within these networks (VAD, 2015).

With the transfer of a substantial number of addiction treatment competences to the regions during the sixth state reform, the communities further developed their own vision on addiction treatment. In Flanders, specialized addiction treatment has been integrated in mental health care in Flanders since 2016. Nevertheless, the inclusion of specialized addiction treatment in the mental health care is not without risk. For example, there may be less attention to people with drug problems, researchers and practice voice. Indeed, with the current trend toward specialization in psychiatric hospitals, it appears that target groups other than people with drug problems are often chosen (Vander Laenen et al., 2020; Vander Laenen et al., 2019). To complicate the matter further, the competences relating to (psychiatric) hospitals for people with drug problems have remained at the Federal level. On top of that, practitioners state that after the communitization of specialized drug treatment, the Flemish Community did not sufficiently take the necessary investments (Vander Laenen et al., 2020).

Another example of a partially realised actions that was Concerning the Local Coordination Groups 'Drugs' in Wallonia most respondents of the survey indicate that they were partially implemented in Wallonia. There are 6 psychiatric consultation platforms (or 'Mental Health Consultation Platforms') to adjust the offer of care to needs, bringing together the mental health partners of a territory corresponding to a province (Hainaut has two). Within these platforms, consultation groups have been set up by patient age categories, aimed at facilitating the creation and operation of networks of complementary care

[71] Gecoördineerde wet op de ziekenhuizen en andere verzorgingsinrichtingen van 10 juli 2008 (BS 7/11/2008)

offers. It is unclear whether the Local Coordination Groups were implemented in Flanders, however most respondents of the survey indicate that this was not the case. The Mental Health Consultation Platforms, on the other hand, were – like in Wallonia - fully established. In Flanders, there were five mental health consultation platforms – one for each province – that grouped general hospitals, psychiatric hospitals, psychiatric care homes, centres for mental health care, sheltered housing initiatives and services with a RIZIV/INAMI convention with a specific treatment offer.

A third example, is the mental health care reform towards care networks and circuits, children and young people were also considered. The 'Guide to a new mental health policy for children and young people' was developed by the federal government and the regions, and was approved at the Interministerial Conference (IMC) on Public Health on 30 March 2015[72]. Flanders was reorganized into five networks for children and young people. Wallonia was reorganized into five networks for children and young people. Brussels was reorganized into one (Bru-Stars) networks for children and young people. And the German-speaking community was reorganized into one (kijupsy) network for children and young people. Nevertheless, these networks do not include specialised services for drug-addiction, even if they may face drug issues.

Another example of an actions that is only partially realised, is the actions with regards to reaching out to the group of migrants and ethnic minorities, there have been some (minor) developments. A previous BELSPO project (De Kock et al., 2020) mapped good practices for this target group, which resulted in 'A guide to accessible and intercultural drug treatment' for drug treatment professionals. This guide is promoted and dispersed through the VAD website to support practitioners in the field.

Although several intended actions were realised, **some intended actions were not (fully) realised.** For example, the Local Coordination Groups 'Drugs' were never realised as intended in 2001. Therefore, all the related actions are also never implemented. Nevertheless, several sources mention the 'Mental Health Consultation Platforms', of which there are 6 in Wallonia and 5 in Flanders. These platforms adjust the treatment offer to the needs, bringing together the mental health partners of a territory corresponding to a province (Hainaut has two). Within these platforms, consultation groups have been set up by patient age categories, aimed at facilitating the creation and operation of networks of complementary care offers. Since October 2019, the 5 Flemish provincial consultation platforms for mental health have merged into one new Flemish Consultation Platform for Mental Health.

Additionally, **there have been several additional realisations** within this objective, that were not foreseen by the Federal Drug Note and the Joint Declaration. After the defederalization of some competences regarding addiction treatment (cf. supra), the regions further developed their vision on addiction treatment. In Flanders, recovery in all its dimensions was centralised in several policy documents (Vander Laenen, 2016; Vander Laenen et al., 2020). Crucial for this, was the Flemish Concept Note on Addiction Treatment, which was established in 2016 and aimed to improve the health, quality of life, and recovery of all those with an addiction problem by integrating the current 'categorically-oriented' addiction treatment into the broader mental health care system. This was formalized with the Flemish Decree Mental Health Care of 8 April 2019[73], which includes all existing regulations of the mental health sectors. The decree addresses, among other things, stigma, experts by experience (in policy and in healthcare), the context of the person with a mental health problem, the recognition, programming and composition of mental health networks and levels of care. The further development through implementation decrees is yet to follow. Nevertheless, at the Flemish level, communitization has led to a policy framework that is committed to a broad interpretation of recovery, not just focused on clinical recovery (Vander Laenen et al., 2020; Vander Laenen et al., 2019).

[72] Gids naar een nieuw geestelijk gezondheidsbeleid voor kinderen en jongeren (https://www.psy0-18.be/images/Guide_0-18/GIDS-KJ_definitief_20150330.pdf)

[73] Decreet 5 april 2019 betreffende de organisatie en ondersteuning van het geestelijke gezondheidsaanbod (Staatsblad 17/05/2019)

From the document review it is clear that **most of the actions** mentioned by the Federal Drug Note and the Joint Declaration **were only partially addressed, and several actions were not realised.** However, the main action - the organisation of addiction treatment in care circuits - was with its introduction in the mental health reform, implemented in a different way than envisaged in 2001. **The realisations therefore show that the vision has changed over time, without an overarching crosscutting drug plan** giving direction**.** Also**,** after the defederalization of some competences regarding addiction treatment (cf. supra), the regions further developed their vision on addiction treatment. It therefore seems that **the regions are further fuelling the objective, without an overarching crosscutting drug plan** giving direction.

b. Perceived realisation: a survey amongst experts

The survey reveals that most respondents perceive the actions as partially to not realised, although there are differences in perception between and within the different regions.

Flemish respondents for example indicate that the actions 'integrate RIZIV/INAMI funded institutions into the care circuits', 'to implement the care circuits' and 'care trajectory for double diagnosis' are fully, partially and not realised. For the action 'create a specific care pathway for patients with a dual diagnosis' there is discrepancy on the answers of the Walloon and Brussels respondents: For most of the respondents the action is not realised, and yet there are some respondents that indicate that the action is partially realised. One respondent from Walloon region even indicates that it was fully realised. These differences within the regions suggest unclarity about the realisation of these actions in the field.

There are also some differences between the regions in perceived realisation. For example, the actions 'Care trajectories for young people' and 'attention to culture in trainings' are partially realised according to most Flemish respondents, but not realised according to most Walloon and Brussels respondents. Vice versa, the actions 'local drug coordination groups' and 'increase the number of treatment workers with a migration background' are partially realised according to most Walloon and Brussels respondents, and not realised according to most Flemish respondents. These results shows regional differences in the perceived realisation of the actions. As several addiction treatment competences were defederalized, this is not surprising: there are differences in actual realisations too.

The survey responses thus demonstrate **little consistency in the perceived realisations** for the objective 'to create a comprehensive and integrated treatment offer'. Some discrepancies can be explained by **regional differences**, but some appear **within a region**. These cases suggest that there is still some lack of clarity and/or overview on 'what's out there' within the field.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **a number of (minor) discrepancies between the actual realisation and the perceived realisation**. Although the document review found only a partial realisation of an action, several survey respondents mention that the same action is fully realised. For example, the care circuits were not fully realised, yet there are survey respondents who indicate that this action is fully realised.

These discrepancies could indicate two things. First, this could indicate that **different respondents interpret the same action in a different way.** Second, it could mean that, there are more initiatives in practice than the document review could identify.

B. Developments within the objective 'To fund each care circuit'

a. Extent of realisation: a document review

There is little information on the funding of the care circuits, especially since the care circuits were never realised as was intended by the Federal Drug Note and Joint Declaration (cf. supra).

The document review could not find evidence of a terms of reference on the treatment functions and modules, nor of a structural evaluation of the caseload of treatment services or to attend to non-ensured people with addiction problems in contact with the criminal justice system.

After the defederalization of some competences regarding addiction treatment (cf. supra), **there were additional initiatives within the regions.** For example, in Flanders; the reimbursement of care in rehabilitation (in services that had an agreement with the RIZIV before the state reform and now with the Flemish Community) has been integrated into the Flemish social protection system. Although the conventions of specialised addiction centres that offer care to illegal drug users are part of rehabilitation care, the sector is an exception because the principle of demand-driven care, which is one of the basic principles within Flemish social protection, cannot be applied to the entire group of persons with an addiction. Also, the Brussels health plan 2018 mentions the funding of the care circuits and mentions to look for a solution for people without health insurance.

The document review has not found evidence on the realisation of these actions. However**,** after the defederalization of some competences regarding addiction treatment (cf. supra), **there were additional initiatives for the funding of addiction treatment and (mental health) care circuits within the regions**.

b. Perceived realisation: a survey amongst experts

Most of the actions within this objective have not been realized according to almost all survey respondents. All respondents unanimously confirm that there has never been a term of reference of the treatment functions and treatment modules established based on the current local needs. All except one Walloon respondent also indicate that there has never been an evaluation of the caseload of the RIZIV/INAMI ambulant centres. And again, all but one Walloon survey respondent also state that a solution for the insurance problem of drug users on conditional release who are not covered by health insurance has never been developed.

The survey responses thus demonstrate **coherent answers in the perceived realisations** for the objective 'fund each care circuit'. Only one respondent indicates that there were at least some initiatives in this area.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey show consistency between both. It is clear that very little has happened within this objective.

C. Developments within the objective 'To introduce case management in addiction treatment'

a. Extent of realisation: a document review

A summary of what was implemented of this objective, can be found the report of the General Drug Policy Cell with the realisations of the period 2014-2019. Additional information was found in BELSPO reports.

The document review reveals that **both actions** intended by the Federal Drug Note and the Joint Declaration for the objective **'to introduce case management in addiction treatment' were partially realised.** Indeed, in 2002, a pilot project 'crisis units with case manager' was implemented, which integrated two objectives: (1) to introduce case management and (2) to organize an emergency and crisis unit. A case manager was appointed to outline a care process for (and with) the patient. In 2019, there were nine residential crisis units with four beds for people in a mental and/or psychiatric crisis situation. They are all led by a multidisciplinary team, with a case manager taking a central role (Algemene Cel Drugs, 2019). These pilot projects were positively evaluated in 2011 by a BELSPO project (Bruffaerts et al., 2011), however there is no structural implementation yet. The actions is thus implemented, but in a different way than foreseen in 2001. Moreover, the project remains a pilot project.

Apart from the pilot projects 'crisis units with case managers', the case management method was applied within certain addiction treatment services in Flanders. In Eastern-Flanders for example, there were several case managers in addiction treatment: For example, a pilot project subsidized by the Province (PopovGGZ) established a case manager in 2003, a case managers within the MSOC, and within El Wahda (De Maeyer et al., 2007; Vanderplasschen et al., 2009). Another example are the 'dismissal managers' in psychiatric hospitals in Tienen, Lede, Grimbergen and Oosterzele (Geenens et al., 2005).These initiatives had a diverse target audience (e.g. migrants and ethnic minorities, mothers with a drug problem, …) and used different approaches.

Simultaneously, a BELSPO research project conceptualized case management (Geenens et al., 2005). According to this project, the intention to implement case managers within criminal justice, was never realized because of a lack of clarity about the concept of a case manager in the justice system, but also because of doubt about the compatibility of the method within the current structure (Geenens et al., 2005). In practice, we again notice that certain pilot projects introduced so called case managers are appointed. For example: the liaisons in the Drug Treatment Court in Ghent, or the 'Proefzorgmanager' in the 'Proefzorg' project in Ghent.

Within the framework of the Psy 0-18 network, the concept of case management has been implemented in Wallonia and Brussels. This case management system is found in various French-speaking provinces (Liège, Hainaut, Namur, Luxembourg), as well as in the Brussels Capital Region (Réseau Bru-star).

Lastly, basic feature of the outreach teams (2b) of the mental health reform is also case-management. However, within this context, it is dominant to consider that case-managers should be implemented for people with multiple needs, and not specifically for people with addiction problems.

From the document review it is clear that **both actions** mentioned by the Federal Drug Note and the Joint Declaration **were partially implemented**. However, although there are different case management initiatives, the actions were not implemented as intended in 2001. The main issue with case management, is that **concepts have changed over time, and that the implementation of the objective has taken a different form.**

b. Perceived realisation: a survey amongst experts

There were only two actions within this objective. There is no absolute consensus on the actions. Flemish respondents indicate that the funding of the local coordination groups for case management projects was not realised in Flanders, a Walloon respondent indicated it was realised. For the second action 'Stimulating case management, especially for specific target groups', the answers vary across all categories. Flemish respondents indicate it was partially to fully realised, the Walloon respondents indicate it was partially realised, and one Brussels respondent indicates that it is not realised. This either suggests regional differences, but could also be due to differences in interpretation of the action.

The survey responses thus demonstrate that there is a **relative consensus on the perceived level of realisation** of the objective 'to introduce case management in drug treatment'**.** The existing

discrepancies either suggests regional differences, but could also be due to differences in interpretation of the action.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **a number of (minor) discrepancies between the actual realisation and the perceived realisation**. Although the document review identifies both actions as partially realised, survey respondents indicate them both as fully, partially or even not realised. These discrepancies could indicate two things. First, it could mean that **practitioners** are not always aware of the existence of these initiatives, and that **they lack an overview of the concrete developments** within the objective 'To implement strategic measures targeted at psychoactive drugs. Second, it could suggest different appreciation levels.

D. Developments within the objective 'To create a treatment offer for drug users with a dual diagnosis'

a. Extent of realisation: a document review

A summary of what was implemented of this objective, can be found the report of the General Drug Policy Cell with the realisations of the period 2014-2019. Additional information was found in BELSPO reports.

The document review reveals that **all the actions** intended by the Federal Drug Note and the Joint Declaration for the objective **'To create a treatment offer for drug users with a dual diagnosis' were (at least partially) realised.**

Indeed, the Federal Public Health Service finances two units in psychiatric hospitals (PC Gent-Sleidinge and ISOSL) for the treatment of people with a dual diagnosis. A multidisciplinary team (psychiatrists, nurses, psychologists, social workers, occupational therapists, etc.) of seventeen FTEs for fifteen beds offers integrated treatment for a maximum of six months, renewable once. Furthermore, a case manager is responsible for preparing the treatment process (Algemene Cel Drugs, 2019). The pilot projects were positively evaluated by a BELSPO project (Sabbe et al., 2008; Van Ham & Sabbe, 2005). These units are financed by the Federal Public Health Service, with annual contracts through the hospitals' financial budgets. There is no structural embedding of both pilot projects (yet).

Concerning dual diagnosis, a feasibility study (financed by Belspo) was carried out for the evaluation of treatment centres for patients with a dual diagnosis (2003), by the University of Antwerp, and a second study following this was carried out on the effectiveness of treatment programs for patients with a dual diagnosis (2004).

Additional actions in this context of the care of patients with a dual diagnosis – not foreseen in 2001 and 2010 -, are for example the local initiatives, more specifically in the context of homelessness. Through the initiative 'Housing First Belgium' (since 2013) offers individualized care and support for chronically homeless people with addiction and mental health problems in a process of integration. A pilot project has been launched from 2013 to 2016, followed by implementation in Flanders (10 cities), Wallonia (5 cities) and Brussels. During the experimental phase, these projects were financed by the federal government (through the National Lottery). Since June 2016, the Regions are responsible for Housing and Welfare. Since then, the regions support a number of teams, but the largest financial support comes from the various local authorities (Housing First Belgium, z.d.).

From the document review it is clear that **all actions** mentioned by the Federal Drug Note and the Joint Declaration **were (at least partially) implemented**. There are also examples of additional realisations, not foreseen by the Federal Drug Note and the Joint Declaration. It thus seems that

practice further fuels the objectives, without input of an overarching and cross-cutting drug policy plan.

b. Perceived realisation: a survey amongst experts

The survey reveals a lot of discrepancies. None of the actions had unanimous answers. For the actions 'to launch and evaluate the experiments with double diagnosis' and 'pilot projects in psychiatric hospitals', the discrepancies can be explained by differences both within and between regions. Most Flemish respondents indicate that these actions are fully to partially realised, whereas Walloon and Brussels respondents mention the actions are not realised. This suggests regional differences. However, for the action concerning pilot projects, there are also discrepancies within the Flemish answers. Flemish respondents indicate that the action is fully, partially and not realised. The latter suggest unclarity about the realisation of these actions in the field or local differences, whereas the first result demonstrates regional differences in the perceived realisation.

The survey responses thus demonstrate that there is a **little consensus on the perceived level of realisation** of the objective 'to create a treatment offer for drug users with a dual diagnosis'**.** The existing discrepancies either suggests regional differences, but could suggest unclarity about the realisation of these actions in the field or local differences.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **a number of discrepancies between the actual realisation and the perceived realisation**. Although the document review identifies certain actions as (partially) realised, several survey respondents indicate them as not realised. For example, there are two units for dual diagnosis, one in Flanders and one in Wallonia, yet still, some of the Walloon experts mention this action has not been realised. And although a BELSPO study mention that there are training programs and cross-trained team, most survey respondents indicate this is not realised.

These discrepancies could indicate two things. First, could mean that **practitioners** are not always aware of the existence of these initiatives, and that **they lack an overview of the concrete developments** within the objective. Second, it could suggest that, **although the actions are implemented** (cf. document review), the actions **do not necessarily operate in the best possible way** and improvement is needed according to the experts (cf. survey).

E. Developments within the objective 'To organize an emergency and crisis response network'

a. Extent of realisation: a document review

A summary of what was implemented of this objective, can be found the report of the General Drug Policy Cell with the realisations of the period 2014-2019. Additional information was found in BELSPO reports.

The document review reveals that **the first action** intended by the Federal Drug Note and the Joint Declaration for the objective **'To organise an emergency and crisis response network' is partially realised.** Indeed, in 2002, a pilot project 'crisis units with case manager' was implemented. This project integrated two objectives: (1) to introduce case management and (2) the organization of an emergency and crisis unit. These crisis units are oriented towards people in a crisis situation related to the use and/or abuse of psychoactive substances, in particular illegal drugs. The aim is to accommodate these patients for a short period of time (maximum 5 days) in such a unit, to stabilize their situation and refer them to other services/care forms. A case manager is appointed to outline a care process for (and with) the patient. There are currently 9 residential crisis units with each 4 beds for people in a mental and/or

psychiatric crisis situation in Belgium. The advice of the National Council of Hospital Facilities (NRZV) regarding the crisis units' 'drugs' stated in 2014 that the crisis units must be integrated in the reform of the mental health care (art. 107). The Federal Council of Ministers indicated that funding would only be continued if this was the case. For a long time, it was not clear what place the units would have in the reform (Algemene Cel Drugs, 2019). These unit therefore evolved towards crisis units for people with an acute psychiatric crisis situation, rather than solely being reserved for people with drug problems. The actions is thus implemented, but in a different way than foreseen in 2001.

However, since these projects are still pilot projects, the structural expansion in all hospitals, is not realised.

From the document review it is clear that **the actions** mentioned by the Federal Drug Note and the Joint Declaration **are not fully implemented**. The main issue is that **concepts have changed over time, and that this initiative is no longer focused solely at people with addiction problems.**

b. Perceived realisation: a survey amongst experts

The answers of the survey respondents for this objective are very diverse. Whereas some respondents deem these actions fully realised, other respondents only assessed them as partially realised, and some respondent even indicated that these actions were not realised. The inconsistency in the answers for the action 'Legal framework for accreditation and funding' is apparent between the federal policy level and the Flemish level: Flemish respondents indicate this action was not realised, whereas respondents at the federal level indicated that this action was fully realised. The discrepancies in survey responses for the first action, can be attributed to a different answer from one Flemish respondent.

Also, only one Walloon and Brussels respondent provided an answer to this objective. This suggests that there is little visibility on these actions in the field.

The survey responses thus demonstrate that there is a **little consensus on the perceived level of realisation** of the objective 'to organise a crisis and emergency response network'**.** The existing discrepancies suggest unclarity about the realisation of these actions in the field, or local differences.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **a number of discrepancies between the actual realisation and the perceived realisation**. Although the document review identifies one action as (partially) realised and one actions as not realised, several survey respondents indicate differently. These discrepancies could indicate two things. First, could mean that **practitioners** are not always aware of the existence of these initiatives or vice versa, have more insight into (local) initiatives that support the objective. In any way, there is a **lack of an overview of the concrete developments** within the objective. Second, it could suggest that, **although the actions are implemented** (cf. document review), the actions **do not necessarily operate in the best possible way** and improvement is needed according to the experts (cf. survey).

F. Developments within the objective 'To organize initiatives towards the target group of minors'

a. Extent of realisation: a document review

There is **no centralised overview of the realisations** for the objective 'to organize initiatives towards the target group of minors. The information on the various achievements of the objective is spread over many publications, report and websites by different institutions and organisations. The description of the realisations in this section, mainly relies on the documentation from psy0-18, VAD, Flemish Youth Care,

and ASBL. As a result of this fragmentation, this section presents **an anecdotal overview** of the achievements within the objective that is not a complete representation of the field.

The document review reveals that **both actions** intended by the Federal Drug Note and the Joint Declaration for the objective **'to organise initiatives towards the target group of minors' is partially realised.** For example, some of the intended initiatives were merged with the reform of the mental health care reform towards care networks and circuits for children and young people. The 'Guide to a new mental health policy for children and young people' was developed by the federal government and the regions, and was approved at the Interministerial Conference (IMC) on Public Health on 30 March 2015[74]. This reform meant a reorganization of the mental health care into care networks. Taking into account children and young people, as well as their environment, the focus in emphasised on early detection, screening and orientation, diagnostics, treatment, inclusion in all life domains and exchange and joint use of expertise together with closely related sectors. In Flanders, the special youth care committees took on a different name with the Youth care support centres (NL: Ondersteuningscentrum Jeugdzorg, and they too play a role in assisting young people with addiction problems and their parents (Beaten et al., 2016).

There have been several additional actions within this objective. For example, in Flanders, the Flemish government installed Integral Youth Aid in 2014[75], that prioritized customized care, radical and specialized help reserved for those who really need it and 'socialization' of care (focusing on strengthening the client and his/her environment). Specialized Addiction Care towards the group of children and young people, is integrated in this framework. An example in Wallonia, can be found at the level of the Walloon addiction network. There, certain actors (Asbl) working in the field of risk reduction and the reintegration of drug users have set up partnerships with youth support services for the specific care of under-age drug users, following local initiatives (e.g. Phoenix since 2014, Trempoline since 2015 and Modus Vivendi). These projects are financed in part by the Walloon Region and to a large extent with own funds. As for many other action points, there are local actions and initiatives especially oriented towards minors, but there is no global policy specifically oriented and coordinated towards this target group.

From the document review it is clear that **the actions** mentioned by the Federal Drug Note and the Joint Declaration **are partially implemented,** and the regions have further developed their own policies.

b. Perceived realisation: a survey amongst experts

There were only two actions within this objective. According to the respondents of the survey, both the action on the role of the Committees for Special Youth Care (now: Youth Care Support Centre) in treatment, as well as the action to emphasise the involvement of parents, are only partially or not realised. The survey responses are consistent across regions and policy levels. It should be emphasised that there are a limited number of responses for the first action, which suggests a limited view on this action in the work field.

The survey responses thus demonstrate that there is a **relative consensus on the perceived level of realisation** of the objective 'to organize initiatives towards the target group of minors**.**

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **a coherency in the findings from the actual realisation and the perceived realisation**.

[74] Gids naar een nieuw geestelijk gezondheidsbeleid voor kinderen en jongeren (https://www.psy0-18.be/images/Guide_0-18/GIDS-KJ_definitief_20150330.pdf)
[75] Decreet van 12/07/2013 betreffende de integrale jeugdhulp

G. Developments within the objective 'To organize aftercare for (delinquent) drug users'

a. Extent of realisation: a document review

There is **no centralised overview of the realisations** for the objective 'to organize aftercare for (delinquent) drug users. The information on the various achievements of the objective is spread over several publications, report and websites by different institutions and organisations. As a result of this fragmentation, this section presents **an anecdotal overview** of the achievements within the objective that is not a complete representation of the field.

The document review reveals the action regarding the emphasis on aftercare with the drug contracts and security contract**, is not realized today**. The Framework Note on Integral Safety (2016-2019) did mention that prevention, early detection and intervention, harm reduction, treatment , **aftercare** and social integration are essential pillars of a drug policy, and are also relevant to security policy (p. 65). There are initiatives funded by the Strategic Prevention and Security Plans that integrate aftercare (Pauwels et al., 2017). However, the Strategic Prevention and Security Plans are aimed at " public nuisance due to drug use"[76] (amongst other crime phenomena) – which is only a small group within the group of "drug users". In practice, there are of course many (specialized) facilities that provide aftercare, both in Flanders, in the Walloon region and in Brussels. However, previous research has shown that, so far, there is a shortage of aftercare programs in the context of continuous care, especially for high-intensity follow-up programs that facilitate the transition to daily life (e.g. one individual conversation every two weeks) (Vos & Van Hal, 2017).

The second action, an action plan towards employment of people who (have) use(d) drugs (e.g. within the OCMW/CPAS), **was partially implemented**. For example, in Flanders, the Strategic Plan treatment and service provision to detainees and internees 2020-2025 emphasises the importance of maximizing the cooperation with the treatment and service provision partners outside prison, such as the houses of justice, CAW, OCMW/CPAS and local authorities. For a long time now, the VDAB has had a specific mediation programme for detainees, namely 'Aan de Bak'. In addition, various prisons also run many projects via the European Social Fund (ESF). For example, the Learning Inside Out project has made the services of the Leerwinkel West-Vlaanderen accessible in the prisons of Ypres, Ruiselede and Bruges since 2017, in order to offer a sustainable and high-quality learning career guidance for detainees to increase the connection to the labour market after detention[77].

The last action, the implementation of old sanctions should not impede the reintegration process, is only **partially realized**. We elaborate on this objective in the 'Enforcement' chapter.

From the document review it is clear that **the actions** mentioned by the Federal Drug Note and the Joint Declaration **are not fully implemented**, and the regions have further developed their own policies.

b. Perceived realisation: a survey amongst experts

Most of the actions within this objective have not or only partially been realised according to the survey respondents. The survey responses are consistent across the regions and policy levels. Only for the last action, there is are regional discrepancies in the perceived realisation: most Flemish respondents indicate that this action is partially realised, whereas most French-speaking respondents indicate that

[76] Ministerieel besluit van 5 december 2019 tot bepaling van de indienings-, opvolgings- en evaluatievoorwaarden en tot bepaling van de toekennings-, aanwendings- en controlevoorwaarden van de financiële toelage van de strategische veiligheids- en preventieplannen 2020

[77] Vlaams strategisch plan hulp- en dienstverlening aan gedetineerden en geïnterneerden 2020-2025, VR 2020 1311 DOC.1230/3BIS (https://www.departementwvg.be/sites/default/files/media/strap_2020_2025.pdf)

this action is not realised. For the action 'release money in the framework of drug contracts and city contracts', the majority of the French-speaking respondents 'don't know' if the action is realised or not. Only one respondent (who has experiences on Federal, Walloon region and local level) said that it wasn't realised. And for the action 'To develop an action plan in collaboration with the CPAS/OCMWs and the drug user treatment sector', most of the French-speaking respondents (Federal, Walloon and Brussels region, and local level) said that it's not realised.

The survey responses thus demonstrate that there is a **relative consensus on the perceived level of realisation** of the objective 'to organise aftercare for (delinquent) drug users'**.**

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **a coherency in the findings from the actual realisation and the perceived realisation**.

H. Developments within the objective 'To further develop risk reduction'

a. Extent of realisation: a document review

There is **no centralised overview of the realisations** for the objective 'to further develop risk reduction'. The information on the various achievements of the objective is spread over many publications, report and websites by different institutions and organisations. The description of the realisations in this section, mainly relies on the documentation from VAD, the overview of the realisations of the General Drug Policy Cell, and several scientific publications. As a result of this fragmentation, this section presents **an anecdotal overview** of the achievements within the objective that is not a complete representation of the field.

The document review reveals that **all actions** intended by the Federal Drug Note and the Joint Declaration for the objective **'To further develop risk reduction' were (partially) realised, but not fully realised.** For example, the law of 22 August 2002[78] regulates substitution treatment for drug users, together with its Royal Decrees of 19 March 2004[79] and 2006[80]. The revision of the current regulations concerning the treatments with substitutes was initiated by the Minister of Health, in order to improve the cooperation between the sub-areas concerning (1) the (psychosocial) support of the patients through a better cooperation with the (specialised) centres and (2) the organisation of (basic) training for doctors who treat patients in the context of substitution treatment. However, in 2019, the further discussion was postponed to the next (now current) legislature (Algemene Cel Drugs, 2019; Windelinckx, 2014). The IPhEB (the Belgian Pharmaco-Epidemiological Institute) carried out the national registration of substitution treatments between 2006 to 2009.The legal basis of the National Registration of Substitution Treatments (ENTS) is Article 9 of the Royal Decree of 19 March 2004 - amended by the Royal Decree of 6 October 2006.

Another example is syringe exchange in Flanders. At the end of 2000, the Flemish government decided to release funds to develop a syringe distribution and exchange system in the five Flemish provinces. VAD outsourced the coordination of this project to Free Clinic. It became operational in January 2001 (Windelinckx, 2014; Windelinckx, 2019). The syringe exchange project evaluates its projects on a yearly basis through a survey in the five Flemish provinces (Windelinckx, 2019). For substitution treatment, most methadone (maintenance) programs are organized through low-threshold drug services, such as

[78] Wet van 22 augustus 2002 strekkende tot de wettelijke erkenning van behandelingen met vervangingsmiddelen en tot wijziging van de wet van 24 februari 1921 betreffende het verhandelen van de giftstoffen, slaapmiddelen en verdovende middelen, ontsmettingsstoffen en antiseptica.
[79] Koninklijk besluit van 19 maart 2004 tot reglementering van de behandeling met vervangingsmiddelen.
[80] Koninklijk besluit van 6 oktober 2006 tot wijziging van het koninklijk besluit van 19 maart 2004 tot reglementering van de behandeling met vervangingsmiddelen.

MSOC/MASS and day centres (Vander Laenen, Vanderplasschen, & Smet, 2013). The MASS/MSOC receive the majority of the clients per week (Vander Laenen, Vanderplasschen, & Smet, 2013). These programs are combined with psychosocial counselling. In smaller cities or rural areas, methadone is prescribed by the general practitioner (Vander Laenen, Vanderplasschen, & Smet, 2013; Windelinckx, 2014; Windelinckx, 2019), but research showed that even in this case, GP's indicate that they either try to provide psychosocial support themselves and/or refer clients further (Vander Laenen et al., 2013). The BELSPO research SUBANOP revealed that the specialized centres receive the highest number of clients, followed by the pharmacists. General practitioners see the least number of clients, however, this differs in the Wallonia, where they receive more clients than the hospitals (Vander Laenen et al., 2013). There are also great variation in geographical spread of substitution treatment, with for example West-Flanders, Flemish-Brabant, Walloon-Brabant and the German-speaking community having the least providing pharmacists and GPs (Vander Laenen et al., 2013). Regular training and education is mainly the case in specialized centres (although there are regional differences), and hospitals, but less for pharmacies (often on a voluntary base) and among prison staff (Vander Laenen et al., 2013).

Lastly, the actions relating to controlled heroin distribution took a different turn to what was foreseen in the Federal Drug Note of 2001. Between 2012 and 2013, the TADAM pilot project was implemented in Liège. This project provided free pharmaceutical heroin to users for whom methadone treatment was not an option. TADAM was positively evaluated by all possible agencies (the health of users improved, the nuisance for the neighbourhood decreased, crime decreased significantly), but was not continued (Van Caillie, 2013). The TADAM project deviates from what the Federal Drug Note had prescribed. There it was emphasised that Belgium would not implement this, but monitor the results with this project in neighbouring countries. There was no such initiative in the other regions.

Additionally, **there have been several additional realisations** within this objective, that were not foreseen by the Federal Drug Note and the Joint Declaration and are not completely in line with the framework set by the Federal Drug Note and the Joint Declaration. For example, both in Liège and in Brussels, drug consumption rooms were introduced. The Horizon 2030 policy document also mentions to raise awareness to the Federal Government in order to change the legislation and thus be able to put in place appropriate public health measures like low-risk drug consumption rooms. Furthermore, it refers to the development of a legal framework for several other harm reduction initiatives (e.g. SCMR, testing, diacetylmorphine, naloxone), and to projects such as: Opération Boule de Neige (awareness-raising and advice on harm reduction by peers for peers), Projets récup (collection of syringes in public spaces by drug users after appropriate training).

The Brussels Global Security and Prevention Plan 2017-2020, focuses on risk reduction, aftercare and social integration, with particular attention paid to "low threshold" approaches. In the 2017 Eurotox report, it is mentioned that the Brussels-Capital Region has lobbied to amend article 3 of the 1921 law, in order to allow the implementation of measures that respond to current realities (in particular projects for the distribution of TADAM-type diacetylmorphine treatment or other experimental measures). Currently, this advocacy is led by the Brussels Federation of Institutions for Drug Addicts (Eurotox report 2017). In the Brussels Global Security Prevention Plan 2017-2020, several measures have been identified related to risk reduction. These actions aim to limit the risks of viral transmission and to promote the recovery of used equipment as the financing of injection equipment in line with the needs identified by the specialized services; strengthening the teams of existing syringe exchange counters in the region; ensuring full access to information, risk reduction materials, substitution treatment and psychological support (equivalence of health care between the prison environment and the free society) for people incarcerated in Brussels prisons (Brussels Global Security Prevention Plan 2017-2020).

In Flanders, we mention the examples of the Quality Nights Charter and Safe 'n Sound who are committed to responsible drug use in nightlife (VAD, 2017a), or projects like C-Buddy to inform and support people who use or have used drugs in treatment, including through support with buddies (Free Clinic vzw, z.d.).

From the document review it is clear that **most of the actions** mentioned by the Federal Drug Note and the Joint Declaration **were addressed, and sometimes completed in a different way than intended by the Federal Drug Note.** However**,** there have also been many additional realisations, often fuelled by practice, and supported by the Walloon and Brussels region. It is clear that the risk reduction field has evolved extensively since 2001, without **an overarching crosscutting drug plan** giving direction. Some of these additional actions are not in line with the framework of the Federal Drug Note and the Joint Declaration.

b. Perceived realisation: a survey amongst experts

There is quite some discrepancy in the survey answers for the objective 'to further develop risk reduction'. The discrepancies appear both between and within regions.

Flemish respondents for example indicate that the actions 'uniform registration' and 'monitor international research' are fully, partially and not realised. Similarly, Walloon and Brussels respondents indicate that the actions 'attention to substitution treatment in the penitentiary drug policy', 'monitor international research' and 'funding of syringe exchange conform the royal decree' are both fully, partially and not realised. These differences within the regions suggest unclarity about the realisation of these actions in the field, or indicate local differences.

Furthermore, the survey reveals regional differences in perceived realisation. For example, most Flemish respondents indicate that the training and coaching of general practitioners for substitution treatment and their involvement in psychosocial networks is partially realised in Flanders, whereas they are not realised according to Brussels respondents. Similarly, Flemish respondents indicate that a thematic working group on controlled heroin distribution was realised, whereas Walloon respondents indicated this was not realised.

The survey responses thus demonstrate that there is a **little consensus on the perceived level of realisation** of the objective 'to further develop risk reduction'**.** Discrepancies appear **across region,** which suggests regional differences in realisation. However, some discrepancies **appear within a region, and** suggest unclarity about the realisation of these actions in the field, or local differences.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **a number of (minor) discrepancies between the actual realisation and the perceived realisation**. Although the document review found (partial) realisation of most actions, several survey respondents mention that the same action is not realised. These discrepancies could indicate two things. First, this could indicate that **different respondents interpret the same action in a different way.** Second, it could suggest that, **although the actions are implemented** (cf. document review), the actions **do not necessarily operate in the best possible way** and improvement is needed according to the experts (cf. survey).

I. Developments within the objective 'To support the MSOC/MASS'

a. Extent of realisation: a document review

There is **no centralised overview of the realisations** for the objective 'to support the MSOC/MASS'. The information on the various achievements of the objective is spread over various publications, reports and websites by different institutions and organisations. The description of the realisations in this section, mainly relies on the documentation from VAD, the MASS/MSOC websites, and several scientific publications. As a result of this fragmentation, this section presents **an anecdotal overview** of the achievements within the objective that is not necessarily a complete representation of the field.

The document review reveals that **all actions** intended by the Federal Drug Note and the Joint Declaration for the objective **'To support the MSOC/MASS' were partially realised.** For example, the document review showed that, in Flanders, the MSOC are integrated into the networks mental health care (cf. supra), together with the other specialized drug treatment facilities. The Memorandum of the VAD clarifies that clarifying that collaborating in networks is an essential part of the operation of specialized drug treatment , but for which one must provide a clear framework so that it is not at the expense of the client (VAD, 2018). Some of the MSOC have (at least informal) cooperation agreements with other ambulant and residential facilities (Vander Laenen, Vanderplasschen, & Smet, 2013).

In the Walloon/Brussels region, the MSOCs are active, but as many other service types, they developed their own care strategy and, therefore, are sometimes included in local networks (as well as in the 107 mental health networks), but this is not systematically the case.

Another example of a partially realised action, is BELSPO evaluation on MSOC/MASS. There is indeed an evaluation of the MSOC/MASS, however it is unclear whether policy was adapted to the evaluation. Also, the evaluation dates back to 2001.

From the document review it is clear that **the actions** mentioned by the Federal Drug Note and the Joint Declaration **were (at least partially) addressed.**

b. Perceived realisation: a survey amongst experts

There is again quite some discrepancy in the survey answers for the objective 'To support the MSOC/MASS'. These discrepancies in survey responses can be explained by variations within and between the answers of a region, or policy level.

For the action 'integrate MSOC/MASS in local network', Flemish respondents confirm a partial to no realisation, whereas a respondent from the federal level considers the action fully realised. For this action there is also a discrepancy between answers of the Walloon respondents, with Walloon respondents indicating the actions is both fully, partially and not realised. This suggests differences in perceived realisation across policy levels, but also with the Walloon region. The discrepancies could also indicate a lack of overarching overview in the field on this action, or respondents could interpret the actions in a different way.

Furthermore, for the action 'establish clear cooperation agreements', Flemish respondents indicate both a full, partial and no realisation. One Walloon respondent indicates the action is fully realised. Local differences could explain the diversity in the answers. The discrepancies could also indicate a lack of overarching overview in the field.

Also, for the last action, none of the French-speaking respondents could indicate the extent of realisation. The answers are purely based on the respondents of Flemish respondents. This suggests that there is little overview on the realisations for the actions among French-speaking respondents.

The survey responses thus demonstrate that there is a **little consensus on the perceived level of realisation** of the objective 'to support the MSOC/MASS'**.** Discrepancies appear **across regions and policy levels,** which could indicate regional differences in realisation. However, most discrepancies **appear within a region, and** suggest unclarity about the realisation of these actions in the field, local differences, or differences in interpretation of the actions.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **a number of discrepancies between the actual realisation and the perceived realisation**. Although the document review found partial realisation of most actions, several survey respondents mention that the same action is not realised or fully realised. These discrepancies could indicate two things. First, this could indicate that **different respondents interpret the same action in a different way.** Second, it could suggest that,

although the actions are implemented (cf. document review), the actions **do not necessarily operate in the best possible way** and improvement is needed according to the experts (cf. survey).

J. Developments within the objective 'To develop a diverse range of cure and care'

a. Extent of realisation: a document review

There is **no centralised overview of the realisations** for the objective 'to further develop risk reduction'. The information on the various achievements of the objective is spread over many publications, reports and websites by different institutions and organisations. The description of the realisations in this section, mainly relies on the documentation from VAD, the Sociale Kaart, VVBV, and websites of different treatment organisations. This section therefore presents **an anecdotal overview** of the achievements within the objective that is not a complete representation of the field.

The document review has found **at least partial support for all three actions** intended by the Federal Drug Note and the Joint Declaration for the objective **'To develop a diverse range of cure and care'.**

For example, for the first action 'a diversified range of services for problem users, allowing for cure, care and counselling, with a wide range of both medium-specific facilities and more general health and welfare services', several sources list the diverse treatment offer in the regions. In Flanders, there is a divers treatment offer for people with addiction problems. Some initiatives are therapeutic, some are more educational, and some are more medical. There are initiatives for drug-addicted parents with children, employment projects, home-based care, etc. The inclusion of the specialised drug treatment offer in the mental health care further broadened the treatment offer, although there is a need for further optimisation (De Vlaamse revalidatiecentra voor drugverslaafden, 2019).

Another example of a partially realised actions, is the development of a specific support strategy for hard-to-reach target groups. There are some initiatives that try to reach out to hard-to-reach target groups. Examples are the initiatives towards migrants and ethnic minorities (cf. supra), but also initiatives towards homelessness (cf. Housing First). However, they are mostly bottom-up initiatives within facilities or sectors, and not part of an overall strategy aimed at these target groups. In several regional policy document, these 'hard to reach' target groups are listed. For example, the prevention and health promotion plan for Wallonia, Horizon 2030 focuses on the development and strengthening of specific services or projects aimed at groups that are difficult to reach through "global" projects for "all groups": women, young people, MENA, migrants, etc. The Brussels Global Security and Prevention Plan 2017- 2020, adds the access to health care for illegal residents to this list.

From the document review it is clear that **most of the actions** mentioned by the Federal Drug Note and the Joint Declaration **were partially addressed.** However**,** since the actions are **formulated in a very broad manner,** it is hard to verify whether they are realised.

b. Perceived realisation: a survey amongst experts

All survey respondents indicate that the actions are either partially realised or not realised. For each region (Flanders, Brussels and Wallonia), there are respondents indicating that an action is partially realised, whereas other respondents indicate that the action is not realised. The discrepancy in the answers are not surprising, as – like with the document review – respondent probably had difficulties with appreciating very broad actions. It is plausible that the respondents interpreted the actions in a different way. Nevertheless, the perceived realisation reveals that there is still room for (a lot of) improvement for the respondents.

The survey responses thus demonstrate that there is **little consensus on the perceived level of realisation** of the objective 'to develop a diverse range of cure and care', although there are no

extreme discrepancies. Discrepancies appear **within a region, and** suggest differences in interpretation, as well as the need for improvement for these actions.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **no large discrepancies between the actual realisation and the perceived realisation**. The small discrepancies present, could indicate that **different respondents interpret the same action in a different way.** Also, it could suggest that, **although the actions are implemented** (cf. document review), the actions **do not necessarily operate in the best possible way** and improvement is needed according to the experts (cf. survey).

K. Developments within the objective 'To stimulate the cooperation between CJS and treatment'

a. Extent of realisation: a document review

There is **no centralised overview of the realisations** for the objective 'to stimulate the cooperation between CJS and treatment'. The information on the various achievements of the objective is spread over many publications, report and websites by different institutions and organisations. The description of the realisations in this section, mainly relies on the documentation from VVBV, the overview of the realisations of the General Drug Policy Cell, and several scientific publications (e.g. BELSPO studies). As a result of this fragmentation, this section presents **an anecdotal overview** of the achievements within the objective that is not a complete representation of the field.

The document review reveals that **all actions** intended by the Federal Drug Note and the Joint Declaration for the objective **'To further develop risk reduction' were (partially) realised**. For example, there are indeed several initiatives to enhance and elaborate the cooperation between both sectors, however, they are often pilot projects, and barriers remain (De Vlaamse revalidatiecentra voor drugverslaafden, 2019; Vander Laenen et al., 2020; Vander Laenen et al., 2019). This will be discussed more elaborately in the chapter 'Integral and integrated approach'. Here we focus on the referral and cooperation protocols, as well as the preconditions for collaboration between both sectors.

Another example of a partial realised action, are the several (pilot) projects in which criminal justice and treatment services work together at the different levels of the criminal justice system Examples are the Drug Treatment Court in Ghent (De Ruyver et al., 2010; Vander Laenen, Vanderplasschen, Wittouck, et al., 2013) and similar initiatives in Liège, Antwerp and Bruges or Proefzorg in Ghent (De Ruyver et al., 2008), etc. Central in the cooperation between both sectors are clear agreements about confidentiality and professional secrecy. Many of these projects established specific cooperation agreements for their pilot project.

The QUALECT research has some input on the action 'matching the treatment offer to the needs of the criminal justice system'. The study mentions that the expansion of projects that provide referrals from the justice system is not possible in some regions due to a lack of the necessary drug treatment facilities (Vander Laenen, Vanderplasschen, Wittouck, et al., 2013). The last action, to promote cooperation between the judiciary and the social services on the basis of mutual respect for the - different - objectives of both sectors,

Another example can be found in prison. In 2017, the IMC Public Health validated three joint pilot project (federal and federated entities) that aim to develop a model of treatment for people with drug problems in prison. This pilot project was developed in three prisons: Hasselt, Lantin, and Brussels (Berkendael and Saint-Gilles). The projects aim to achieve quality care for people in detention with a drug use problem, in order to develop a tailor-made care pathway for prisoners, taking into account the specific context of detention (Algemene Cel Drugs, 2019; Vander Laenen et al., 2019; Vandevelde et al., 2021).

The projects were evaluated in 2020 (Vandevelde et al., 2021), and are discussed more elaborately in WP3 of this research project.

Yet another example can be found in Wallonia: the Walloon plan states the commitment of the Walloon region with the objective of transferring health in prison competences from the Federal Justice department to the region. There was indeed a call for project from the Walloon Region published on January 2019 about care in prisons[81].

From the document review it is clear that **most of the actions** mentioned by the Federal Drug Note and the Joint Declaration **were partially addressed, but never structurally.**

b. Perceived realisation: a survey amongst experts

The survey shows that respondents deem the actions partially to not realised. However, there are differences across the regions and policy levels. For the first action, Flemish and federal respondents assess that the actions are partially realised, with two Flemish respondents indicating the action is not realised. For the second action, Flemish respondents indicate the action is not realised, whereas federal respondents indicate the action is partially realised. For the third action, all Flemish and federal respondents but one, indicate that the action is partially realised.

On the other hand, all Walloon and Brussels indicate that the actions are not realised. This discrepancy could suggest regional differences in perceived realisation.

The survey responses thus demonstrate that there are **some discrepancies on the perceived level of realisation** of the objective 'to stimulate the cooperation between CJS and treatment'**.** Discrepancies appear **across region,** which suggests regional differences in realisation. However, some discrepancies **appear within a region, and** suggest unclarity about the realisation of these actions in the field, or local differences.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **a number of (minor) discrepancies between the actual realisation and the perceived realisation**. Although the document review found partial realisation of most actions, several survey respondents mention that the same action is not at all realised. These discrepancies could indicate two things. First, this could indicate that **due to the lack of overview, even experts are not aware of 'what's out there'.** Second, it could suggest that, **although some actions are implemented** (cf. document review), the actions **do not necessarily operate in the best possible way** and improvement is needed according to the experts (cf. survey).

L. Developments within the objective 'To stimulate evidence-based practices'

a. Extent of realisation: a document review

There is **no centralised overview of the realisations** for the objective 'to further develop risk reduction'. The information on the various achievements of the objective is spread over many publications, report and websites by different institutions and organisations. The description of the realisations in this section, mainly relies on the documentation from VAD, the overview of the realisations of the General Drug Policy Cell, and several scientific publications. As a result of this fragmentation, this section presents **an anecdotal overview** of the achievements within the objective that is not a complete representation of the field.

81 https://www.ejustice.just.fgov.be/cgi/article_body.pl?language=fr&caller=summary&pub_date=19-01-31&numac=2019010603

The document review reveals that **most of the actions** intended by the Federal Drug Note and the Joint Declaration for the objective **'to stimulate evidence-based practices'' were only partially realised.** There have been several research projects, however the structural character and the extent to which it is used to guide strategic choices is not always clear. BELSPO, the Federal Science Policy with a specific Program on Drug research (cf. Chapter 'Epidemiology, research and evaluation'), clearly lists several research projects that fit within this objective. For example, research has been done into the evaluation of substitution treatment in Belgium, the effectiveness of treatment for patients with dual diagnosis, application of evidence-based guidelines in addiction treatment, evaluation of crisis and case management and integrated care for patients with alcohol use disorders, etc.[82] Apart from the projects funded by BELSPO, there were other evaluation project funded by for example government services (Habraken et al., 2013), the province (De Maeyer et al., 2007), or local government (Favril et al., 2015; Sys et al., 2020). There thus seems to be some evidence base on the organisation of addiction treatment and on different treatment methods, yet it is not always clear whether it leads to policy change. In the case of drug consumption rooms (Vander Laenen & Favril, 2018; Vander Laenen et al., 2018) for example, this was not the case.

We did not find evidence on the implementation of a research project to evaluate the organisation of the addiction treatment offer.

From the document review it is clear that **most of the actions** mentioned by the Federal Drug Note and the Joint Declaration **were addressed.**

b. Perceived realisation: a survey amongst experts

Most of the survey respondents indicate that the actions within the objective 'to stimulate evidence-based practices' are only partially to not realised. The inconsistencies are due entirely to differences within regions. For example, Flemish respondents indicate that 'research into the organisation of addiction treatment' is both fully, partially and not realised. For the action 'Stimulate evaluation for the demand side' most of the Walloon and Brussels respondents perceived the action as not realised, with the exception of one respondent who indicates it is partially realised. Similar scenarios appear for the other actions the discrepancies could indicate a lack of overview on the realisation of these actions in the field.

The survey responses thus demonstrate that there is a **little consensus on the perceived level of realisation** of the objective 'to stimulate evidence-based practices'**.** Discrepancies appear **within the different regions, and** suggest unclarity about the realisation of these actions in the field.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **a number of (minor) discrepancies between the actual realisation and the perceived realisation**. Although the document review found (partial) realisation of most actions, several survey respondents mention that the same action is not realised. These discrepancies could indicate two things. First, this could indicate that **respondents interpret the same action in a different way.** Second, it could suggest that, **although the actions are implemented** (cf. document review), the actions **do not necessarily operate in the best possible way** and improvement is needed according to the experts (cf. survey).

[82] For the full list of projects, we refer to the BELSPO website (http://www.belspo.be/belspo/drugs/)

M. Developments within the objective 'To engage in the EU drug policy'

d. Extent of realisation: a document review

There is **no centralised overview of the realisations** for the objective 'to engage in the EU drug policy', although the overview of the realisations of the General Drug Policy Cell does provide some insight. However, there are only two actions in this objective, and they are formulated in a very broad manner. As such, it is hard to measure them.

The document review reveals that the renegotiation of the UN treaties, specifically for harm reduction initiatives and a softer approach towards cannabis, **was not realised**. Yet, the recent removal of cannabis from Schedule IV of the UN Conventions, could apply within this action. Of course, this action was beyond the control of (solely) Belgian policy makers.

Furthermore, Belgium is involved in the EU strategy, both regarding the demand side and the supply side. An example is the initiative to define and implement some minimum quality standards at EU level. These standards aim to translate scientific evidence into the practice of demand reduction initiatives, (e.g. prevention initiatives, risk and harm reduction, treatment, social integration, recovery). A list of 16 quality standards were drawn up by a group of experts and translated into a technical document by professionals in the field. These quality standards were brought to the attention of the EU Member States in the form of a Council conclusion. Although Council conclusions are not binding, the Member States expressed their political will to organise demand-reducing interventions on the basis of scientific findings (Algemene Cel Drugs, 2019).

The international dimension of the Belgian drug policy extends further than solely these initiatives, but these will be discussed in the chapter 'Integral and Integrated approach'.

From the document review displays **some evidence for the realisation of the actions**.

e. Perceived realisation: a survey amongst experts

The survey respondents indicate that the actions are only partially to not realised. The discrepancies in the answers appear within the regions. Both amongst Walloon, Brussels and Flemish respondents, the answers vary between 'not realised' and 'partially realised'. As the actions are formulated in a very broad manner, it is possible that respondents have interpreted the actions in a different way.

The survey responses thus demonstrate that there is a **little consensus on the perceived level of realisation** of the objective 'to engage in the EU drug policy', although there are no major discrepancies**.** Discrepancies appear **within a region, and** suggest unclarity about the realisation of these actions in the field, or local differences, or that respondents interpreted the actions in a different way.

f. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey shows consistency **between the actual realisation and the perceived realisation**. Although the document review found (partial) realisation of most actions, several survey respondents mention that the same action is not realised. These discrepancies could indicate two things. First, this could indicate that **different respondents interpret the same action in a different way.** Second, it could suggest that, **although the actions are implemented** (cf. document review), the actions **do not necessarily operate in the best possible way** and improvement is needed according to the experts (cf. survey).

5.1.1.2 Conclusion of the extent of realisation

First of all, the document review reveals that there is no structural follow-up of the implementation of the objectives outlined in the Federal Drug Note and Joint Declaration, nor of other developments in the drug treatment field. This is not the case on the federal level, nor in the communities and the regions. There are many annual reports and other publications that list the developments in drug treatment or specific parts of the drug treatment policy, yet there is a lack of centralisation and overview. All of these reports and publications help to get a grasp of specific realisations within the drug treatment field, however, it paints a very fragmented and anecdotical picture. As a result, this fragmentation is reflected in this evaluation too.

Second, the document review shows that there have been many developments in the treatment field, both actions that were intended by the Federal Drug Note and the Joint Declaration, as well as additional developments within the drug treatment field. For most objectives however, the related actions are only partially rather than fully realised. Sometimes, there were implementation initiatives for an action, but they were not fully carried out. This was for example the case for the objectives 'to create a treatment offer for drug users with a dual diagnosis' and 'to stimulate the cooperation between CJS and treatment'. For other objectives, the actions were not realised in the way that was intended by the Federal Drug Note and the Joint Declaration, for example because the concept has changed or the action was given a broader interpretation (e.g. in the wider mental health field). This is for example the case with the objectives 'to introduce case management in addiction' and 'to create a comprehensive and integrated drug treatment offer' (care circuits). The developments for the objective 'to fund each care circuit' are much more modest. It is also noteworthy that for various objectives a lot of additional actions have been realised, especially within the regions, which were not included in the Federal Drug Note and the Joint Declaration. This is especially the case for the objective 'to further develop risk reduction', but also for the objectives 'to create a comprehensive and integrated treatment offer', The additional realisations of the former objective, however, are not entirely in line with the general framework set out by the Federal Drug Note and the Joint Declaration. For example, the pilot project of controlled heroin distribution and the drug consumption rooms. These additional realisations are often fuelled by practice, and prove that the risk reduction field has evolved extensively since 2001 and 2010, even without an overarching and crosscutting drug plan giving direction.

Nevertheless, it is important to emphasise that the realisations in the pillar 'Treatment, risk reduction and reintegration might not directly result from the Federal Drug Note and the Joint Declaration. For several objectives, the realisations were initiated by specific institutions or organisations, and fit within the broader framework of the Federal Drug Note and the Joint Declaration by chance. As mentioned earlier, there was no structural follow-up of the implementation of the Federal Drug Note or Joint Declaration. Additionally, this overview does not paint a picture on the performance or the difficulties that were encountered with the realisation of the objectives.

Third, the survey learns that there are a lot of discrepancies in the level of perceived realisation amongst our respondents. This is sometimes explained by regional differences or differences between policy domains, for example when actions are (partially) realised in one region, but not (or only partially) realised in another region. As several competences regarding treatment are defederalized, this might not be surprising. However, there are some discrepancies that cannot be explained by regional or policy-level differences. Often some actions are formulated very broad, so respondents could have interpreted the action in a different way. Another explanation might be that some actions are not quantifiable or measurable, so what is 'fully realised' for one respondent, might only be 'partially realised' for another respondent because this is not clearly specified. Yet, although some actions were very clear, some discrepancies remained. This suggests that even amongst experts in the drug policy field, there is no clear overview of the different realisations in the treatment field.

Fourth, when we compare the results of the document review and the survey, we learn that for many objectives, there are discrepancies between the actual and perceived realisation. In most cases, we

notice that, although the document review identifies certain actions as realised, survey respondents indicate them as partially or even not realised. This might indicate that actions may be implemented (cf. document review), but they do not necessarily operate in the best possible way and improvement is necessary (cf. survey) or their existence is not widespread. In some cases, it is the other way around (survey respondents indicating that an action is realised, when the document review could not find any proof). This suggests that there are many initiatives that support an objective, but that it is not necessarily widely documented.

5.1.2 Providing context to the stage of realisation: interviews with stakeholders

A third method used in the EVADRUG evaluation, are semi-structured interviews with stakeholders that have an expertise in one or more domains related to the Belgian drug policy. These semi-structured interviews aim to provide an explorative insight into the facilitators, barriers, bottlenecks, challenges and needs for the Belgian drug policy. The semi-structured interviews were conducted amongst 39 civil servants and practitioners at all policy levels (federal, regions and communities) and across the different policy domains (Integral and integrated approach; Epidemiology, research and evaluation; Prevention; Treatment, risk-reduction and reintegration; Enforcement).

This section summarises their views on the realisation of the objectives across the pillar 'Treatment, risk reduction and reintegration'. The interviews and the focus group are aimed at obtaining and understanding how Belgian drug policy is experienced by respondents. We examined how they shape the Belgian drug policy in daily practice, giving insight in how they translate "policy in practice", as opposed to "policy in the books".

It is important to note that semi-structured interviews are a qualitative method to gain an explorative and more in-depth insight into the drug policy. Therefore, this method does not give a representative view of all opinions in the field. The qualitative semi-structured interviews intended to report on recurrent perceptions, opinions and experiences that are prevalent in the drug field, to help explain why the realisation of certain objectives within the pillar of 'Treatment, risk reduction and re-integration' is hindered or facilitated, but also to record new barriers and bottlenecks, and to map what the field deems necessary for this pillar. Additionally, it is important to consider that the Belgian drug policy covers a very broad field of topics. Because of that, we were not able to describe every bottleneck in detail. In this section, each topic is touched upon briefly.

First, we will present a summary of the results before we will elaborate on the facilitators and barriers more in detail.

Summary of the 'context to the stage of realisation'

With regards to the context to the stage of realisation, practitioners and civil servants perceived that:

- ⇨ Cooperation and networking is important in order to provide an integral and integrated treatment offer, and there are many good examples of (local) cooperation initiatives, as well as working within networks. Yet, barriers and bottlenecks in this cooperation remain.
- ⇨ Although respondents mention a good understanding between treatment organisations and institutions with the regional and federal governments, a lack of vision and growth path for the expansion of the treatment offer lacks, as well as a specific expertise regarding addiction (treatment).
- ⇨ Respondents stress several issues related to the current treatment offer.
- ⇨ The lack of a clear and supporting framework for many of the harm reduction initiatives was noted as the main barrier for the risk reduction initiatives.

⇨ The role of scientific evidence in the treatment pillar is ambiguous according to respondents. On the one hand, the role of evidence was acknowledged as an essential part of further developing and ameliorating the treatment offer. On the other hand, there are limits of focusing on 'what works' and respondents stress the importance of the input of practice and lived experiences in the matter.

5.1.2.1 Facilitators and good practices with regard to the realisation of the 'Treatment, risk-reduction and re-integration'- pillar's objectives

We asked the respondents to identify facilitators in the realisation of the treatment objectives defined by the Federal Drug Note and the Joint Declaration. The respondents identified four facilitators:

1. A good working relationship with different governments
2. Networking and cooperation
3. Good local collaboration between the criminal justice sector and treatment sector
4. Research and evaluation to ameliorate and develop treatment initiatives

A. A good working relationship with the different governments

Some Flemish respondents identify a good working relationship between a treatment service and the local government, as a facilitator. They explain that a good working relationship facilitates the implementation of actions, and that it can improve the overall performance of an action.

> *"Het zou nog beter zijn, zoals je ziet in Gent, dat je een goede samenwerking hebt [tussen de hulpverlening en lokaal bestuur], en dat je eigenlijk elkaar kan faciliteren om nog een betere werking uit te breiden." (NL_2)*

With the Agentschap Zorg en Gezondheid too, the Flemish respondents indicate that there is room for a no-nonsense dialogue about the urgent needs, and respondents feel that for both harm reduction (syringe exchange) initiatives and treatment there is an open ear for negotiation.

Some Brussels and Walloon respondents mention this facilitator too. A Brussels respondent describes a good understanding with the regional authorities. Other respondents highlight that this good working relationship is also translated into political recognition of certain risk reduction initiatives, for example by commitments in political declarations. This in turn facilitates the further development and expansion of these approaches.

> *'Mais il faut dire qu'avant 2001, on en parlait dans aucun texte officiel fédéral. On reconnaissait la réduction des risques. C'est en même temps la première fois qu'elle est nommée en tant que telle. Donc, c'était une demi victoire'* (FR_8)

> *"Globalement, actuellement, on a une majorité à Bruxelles qui est plutôt progressiste et soutenante. En matière de politique drogue au sens large. On s'y retrouve. [...] Néanmoins, on est un petit secteur [...] Pour l'instant, on a plutôt de bons contacts avec eux, mais la fédération [FEDITO] gagnerait à être renforcée. Ce qui ne va pas, c'est que la fédération n'est payée que par la COCOF, alors qu'un organisme comme Bruxelles Prévention Sécurité [BPS-BPV] dépend de la Région. Donc, il y a quand même une forte concurrence entre acteurs dans le secteur. Et je pense aussi qu'il y a des tensions entre les opérateurs de la région et des communautés. Ce manque d'unité, cette dispersion crée un rapport de force qui est mauvais en toxico et le politique entend beaucoup plus la santé mentale, par exemple, qui est assez proche de nous, ou le social parce que ça s'adresse à toute la population. Le toxico, c'est quand même politiquement moins sexy"* (FR_14).

B. Networking and cooperation

Many respondents refer to the necessity for cooperation and networking. The facilitators were especially highlighted in the following two contexts:

a) Flemish respondents refer to the integration of specialised drug treatment in mental health care which led to a better cooperation with the broader mental health care in Flanders.
b) Brussels and Walloon respondents mention that networking facilitates complementarity

a. Integration of specialised drug treatment in mental health care facilitates multidisciplinary cooperation and reunites all addiction themes

Most Flemish respondents refer to the integration of the specialised drug treatment care into the broader mental health care in Flanders. The integration of the specialised drug treatment into the mental health care networks, is of quite recent date (cf. supra). According to the respondents, this integration facilitates the cooperation between different services in order to address drug problems in a multidisciplinary way, and describes this situation as better in comparison to the situation before the integration.

> *"Ik denk dat het bijvoorbeeld zeer goed is dat, als je vroeger met een drugsverslaafde werkte, dat je alleen werkte rond zijn verslaving, maar je had geen oog voor het feit dat er ook kinderen het verhaal waren, of, euh, of misschien ook partnergeweld of zo. (…) Die deden dan hun ding, maar er was geen overleg tussen die verschillende diensten, terwijl dat nu toch meer gebeurt. Het gaat ook over, om afstemming." (NL_3)*

Yet respondents emphasise that a smooth cooperation also depends on the role and profile of the coordinator of a mental health care network, and on the extent to which this coordinator consults the different actors.

> *"Wel in ieder geval is dat gesprek vergemakkelijkt, ook tussen de verschillende organisaties. Maar het hangt natuurlijk ook weer een beetje af van individuen hoe dat het allemaal loopt." (NL_10)*

Lastly, one respondent mentions that the integration also reunites all addiction themes, whereas in the past, alcohol, gambling and psychoactive medicine addiction were mostly treated within the mental health care, and illegal substances mostly within specialised drug treatment.

> *Maar nu zitten we met een andere situatie in de zin dat de verslavingszorg ingekapt geraakt in de GGZ. En van oudsher was gans de hulpverlening naar alcohol en naar gokken en naar psychofarmaca, dat zit veel meer bij de GGZ. Dus het komt bij wijze van spreken nu allemaal veel meer samen. (NL_16)*

In many ways, the respondents emphasised that a closer cooperation in networks benefited the working relationship.

b. Networking between the federations and on an international level facilitates complementarity in treatment offer

Several Walloon and Brussels respondents, describe a good collaboration within the federations (Fedito Wallonne and Fedito Bruxelles) and between the different treatment and prevention services. They describe a close network where information, tools and good practices are easily shared amongst one another. Working in networks facilitates the complementarity between for example, treatment and risk reduction actions. It also facilitates referral of clients to other services. In addition, they may have contacts with colleagues at the national and international level and usually share their views at these levels as well. That leads to a feeling of doing well and being recognised by their peers, providing them with legitimacy in their expertise, although this legitimacy is not always acknowledged by local authorities. Furthermore, it leads to recognition in the field, and it facilitates consensus as well as complementarity between field actors to share the same approaches.

> *'On est déjà tous ensemble dans des fédérations, et on se parle beaucoup, on travaille beaucoup en partenariat. On est obligé étant donné le parcours des gens. Au niveau des usagers, ceux qui n'ont pas de problèmes de dépendance, on travaille plus avec la prévention. Ceux qui en ont, on travaille avec l'assistance et les soins. Mais on travaille vraiment fort ensemble et c'est un dispositif très spécifique'.* (FR_8)

Actors involved in drug addiction treatment are members of these federations that act as corporatist actors, i.e. they represent a sector and try to defend the sector's interest, e.g. to preserve their funds. Yet, on the one hand, in order to reach consensus within the sector, several topics that may lead to disagreement between the federation members are left aside. Therefore, there is little discussion on the different approaches, because it could engender tension between members. On the other hand, collaboration with other sub-sectors (e.g. social services, mental health...) is sometimes hampered because of corporatist interests, e.g. the defence of funding parts for the different care sub-sectors.

However, whilst actors may consider that the level of collaboration is good, that collaboration is mainly informal and narrative, there is a lack of formal mechanisms to support collaboration, within and across sub-sectors.

C. Good local collaborations between the criminal justice sector and treatment sector

Some Walloon respondents, describe a good local collaboration between the treatment sector and criminal justice sector. The established agreements and collaborations between both sectors clearly clarify the roles and tasks of each sector. The respondents further indicate that a good communication between both sectors, the recognition of the respective roles of each other, as well as understanding and supporting each other's tasks, all facilitate this good collaboration. As a result, clients are smoothly referred from the judicial system to the social services. Several respondents emphasise how this is an opportunity to introduce treatment to a group of clients in need of treatment- who would not enter treatment otherwise.

> *'On n'a jamais eu de soucis. Chacun sait où est sa place, ce qu'il peut attendre de l'autre. Je n'ai jamais, pour ma part rencontré de difficultés. J'ai toujours pu dialoguer avec la justice'* (FR_7)

This good collaboration between local treatment partners and the criminal justice system is also described by some Flemish respondents. Here too, respondents refer to a good local collaboration, for example with the GAM projects or drug treatment chamber in Ghent, but stress that this is not necessarily the case everywhere. Just like the Walloon respondents have stressed above, this local cooperation is especially facilitated by drafting clear agreements identifying each other's roles and basic rules regarding for example professional secrecy and respecting each other.

> *Eigenlijk, die samenwerking verloopt goed, denk ik. Er zit daar wel verschil op tussen provincies, maar hier in (…) hebben wij een... Het is niet dat we heel veel overleg hebben, enzovoort, maar we weten heel duidelijk dat wij met dat cliënteel aan de slag gaan. Die worden vlot doorverwezen. En de communicatie... Men aanvaardt dat de communicatie, dat die beperkt blijft tot feitelijkheden, dus niet tot inhoudelijke dingen die cliënten inhoudelijk zijn, dat daar een verschil is in beroepsgeheim. En dat dat goed loopt. (NL_3)*

D. Research and evaluation to ameliorate and develop treatment initiatives

Most respondents refer to several advantages of research for this pillar. According to them, research facilitates further professionalisation and credibility of new treatment projects or treatment approaches. Furthermore, research and evaluation can identify barriers or bottlenecks in existing programs, for example in accessibility of services for drug users. Also, research is used to develop new projects: treatment workers often rely on the existing evidence base to develop a new project.

'Il y a des publics que je ne rencontre pas. Qu'est ce qui fait que je ne les rencontre pas ? …. Il y a beaucoup de réflexion, notamment par rapport aux femmes, aux assuétudes et le monde carcéral… c"est clair que vous êtes parfois plus crédible quand vous savez donner des chiffres Je pense que ça montre aussi une réflexion sur le problème des assuétudes et pas seulement des constats'. (FR_7)

5.1.2.2 Identified barriers and bottlenecks that hinder the realisation of the treatment pillar' objectives

We asked our respondents what they identified as a barrier or a bottleneck in the realisation of the treatment objectives defined by the Federal Drug Note and the Joint Declaration. Bottlenecks and barriers are problems that prevent or obstruct a successful realisation.

A. General barriers and bottlenecks

a. Differences between the regions and communities can be barriers for cooperation

During the interviews, many respondents pointed to barriers in the cooperation between the regions. There is cooperation, and respondents indicate that both Flemish and Walloon organisations are able to find each other when necessary, yet several elements act as barriers in this cooperation.

First, some respondents mention a language barrier between the Flemish and French-speaking colleagues.

Second, some respondents mention differences in treatment orientation between the north and the south of Belgium. Some respondents clarify that the "*culture*" differs across the language borders: Flanders often draws inspiration from the Netherlands and is more oriented to the Anglo-Saxon model, while the French speaking professionals draw inspiration from France and are more oriented towards a psychoanalytical approach[83]. According to our respondents, these differences are not insurmountable, but they make cooperation across language borders less likely.

Furthermore, some respondents point at organisational differences between the different parts of the country. In Flanders, treatment, especially for people with illegal drug using problems, is much more centralised in specialised facilities. In Brussels and Wallonia, this is much more organised by general practitioners or small scale networks, especially concerning substitution.

"Ik denk dat het grootste verschil zit hem hierin dat vooral het verschil met Wallonië, maar misschien ook wel in Brussel. In Vlaanderen is de zorg, de hulpverlening, de zorgverlening dan vooral dus met mensen met illegale drugsproblematiek veel meer gecentraliseerd in gespecialiseerde voorzieningen. In Brussel en in Wallonië wordt dat veel meer, zeker wat substitutie betreft, geregeld door huisartsen en zo hele kleine netwerken. Dat is denk ik een zeer groot verschil." (NL_16)

'Par exemple, les orthopédagogues n'existent pas en Wallonie alors qu'ils existent en Flandre. L'organisation des soins n'est pas la même en Flandre ou en Wallonie…. La Wallonie a mis en place une salle de consommation à Liège et peut être à Charleroi, ça, je ne sais pas si elle a été mise en place, mais en Flandre, rien n'a été mis en place. Donc, dans quelques années, si on change la législation par rapport à ça, il y aura une disparité. Il y aura plus de choses réalisées en Wallonie qu'en Flandre. Je ne dis pas que ça pose problème'. (FR_1)

[83] The predominant psychoanalytical approach, is changing. The weight of some "psychoanalytical traditions" is decreasing with a new generation of field actors and with changing research (also in France). This finding however shows that field actors are not always relying on scientific research, but they are (sometimes) rather inspired by some acknolwedged (French) scholars.

Some respondents also mention the difficulty of working on treatment-related projects that do not fall entirely within the competence of the federal government, or are not entirely the competence of the federated entities. Especially within the treatment field, there is a great interdependency between the federal level and the federated entities. Streamlining that cooperation, as well as streamlining new and existing initiatives, is a challenge that generates a great deal of consultation between both policy levels. This is specifically apparent in the conflict between treatment as a priority or security as a priority. The following respondent especially refers to the TADAM project and the drug consumption rooms, as there was/is a lack of consensus between the different policy levels for these projects.

> *'Ce qui me vient en tête, c'est quand même le travail sur le traitement à base de diacétylmorphine, l'expérience TADAM. Et la note sur les salles de consommation à moindre risque. Pour la diacétylmorphine et TADAM, on a pu mettre en place un dispositif expérimental, qui est fédéral, mais après, ça doit devenir un traitement ambulatoire, et là le fédéral n'est pas compétent. Et donc, il faut tout un travail de concertation, d'argumentation, comme il y a les communautés et régions, une région peut être favorable à la mise en place d'un tel projet et d'autres pas. Et au fédéral, on essaie de faire quelque chose de national. Ca demande beaucoup de concertation. Malheureusement.' (FR_1)*

These differences in point of view on some contested items, recur in various interviews. Indeed, sometimes the different policy choices between the federal level, and the different regions lead to tensions, as was the case with the drug consumption rooms for example. Another example respondent put forward, is the legalisation debate, in which many (treatment) actors in Wallonia express an outspoken position in favour of legalisation and regulation of cannabis, whereas according to some Flemish (treatment) actors the debate needs more time.

> *"En goh de discussies die daar zijn, dat is toch niet gemakkelijk. Die gaan bijvoorbeeld rond legalisering van cannabis, euhm, ja. Dan hebben ze een andere aanpak en vinden ze dat dat maar moet gebeuren. Waar dat we hier zien van, ja, als je de Vlaamse mentaliteit, als we de mensen, de achterban, mee willen hebben, kunnen we niet snel gaan. Dus dat, dat loopt niet gemakkelijk. Het is ook niet toevallig dat er in Luik een proefproject geweest is rond heroïne en dat dat in Vlaanderen, allé, dat we daar nog ver van af staan. Nu, je merkt dat ook in het contact met de collega's, dat daar anders over gedacht wordt." (NL_10)*

> *'La Belgique est un pays compliqué. Il n'y a pas les mêmes positions au nord qu'au sud par rapport à la réduction des risques' (FR_8)*

b. Lack of expertise and an explicit policy vision for the pillar 'Treatment'

Most Flemish respondents indicated that they miss expertise and vision in the Flemish government concerning the development of the provision of drug treatment.

After the sixth state reform, the funding of the specialised drug treatment has moved from the federal level to Flanders (cf. supra). However, most Flemish respondents indicate that Flanders does not yet have the same expertise and knowledge as the RIZIV/INAMI previously provided on a federal level. As a result, respondents indicated that the Flemish government lacks a vision and a growth path for the development of (drug) treatment provision in Flanders. For example, it remains unclear what growth path the Flemish government envisage for outpatient addiction treatment, outreach or for the expansion for crisis treatment in Flanders.

> *"Vlaanderen is nu het engagement moeten aangaan, we gaan wat dat je vroeger kreeg van het RIZIV, gaan wij nu doorbetalen, maar welk groeipad gaat men leggen? Welk groeipad dat men heeft vanuit Vlaanderen voor toch zeker de ambulante verslavingszorg, dat is, allee, ik denk dat dat nu een van de grootste problemen is." (NL_16)*

Respondents denounce that this lack of vision is especially felt in concrete and practical issues, such as the development and implementation of BelRAI, quality standards for treatment, and the role of the

Flemish Minister of Justice for the drug field. There are many questions left unanswered, which leads to concerns in practice.

A Brussels respondent confirms this too. After the Sixth State reform, Iriscare replaced the INAMI/RIZIV, and maintained the old model. Little has changed, and the respondent stress a need for vision. Furthermore, respondents from Brussels and in Wallonia stated that the regions tried to maintain the existing framework and to reproduce the mechanisms and procedures that were those of the INAMI/RIZIV, without vision for an integrated, regional policy.

> '*Le changement principal pour moi, c'est pour les conventions de revalidation. Pour les autres, il n'y a pas de changement. '.(FR_16)*

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On the level of Flanders:
  - A clear vision and an decisive approach to the expansion needs of the treatment offer.
- On the Brussels level:
  - Carry out a concerted plan with all the stakeholders at the level of the various ministries (Health, Justice, Youth, etc.), and the actors on the ground in the various sectors

c. Division of competences between federal facilities and regional facilities

Some respondents mention the division of competences between federal facilities and regional facilities as a barrier, for example within the mental health care networks in Flanders. Nearly all Flemish respondents mention that the interdependence between the federal level and the regional level complicates the performance of the treatment field. Flemish respondents unanimously refer to the covid-19 pandemic in that regard, which exposed those stumble blocks in healthcare even further. Respondents refer to the division of competence as a complex puzzle.

> *En vooral dat is zeker, door het feit dat het ene federaal is en het andere Vlaams is, is dat toch niet evident. (NL_3)*
>
> *Nu zitten de MSOC's daar ook, euhm, regionaal en dat maakt het eigenlijk allemaal moeilijker hanteerbaar, maakt de puzzel nog veel complexer. (NL_10)*
>
> *Maar van het moment dat die patiënt uit het ziekenhuis stapt, eender waar het naartoe gaat, is het gemengde bevoegdheden. Gaat hij naar een huisarts, is het federaal. Maar gaat hij naar het centrum GGZ, is deelstaten. Gaat hij naar een ambulant centrum, is het deelstaten. Euh, blijft hij thuis en komt er een mobiele equipe, dan is het gemengd gefinancierd, federaal, maar mee erkend door de deelstaten, dus dat is een interdependentie, ongelooflijk. (NL_1)*

Reference is made to the different policy frameworks to which one organisation is bound and the other is not, but also to funding (federal, federated entities or mixed funding), and for example potential problems with wage differences between the two policy levels.

d. Professional secrecy

Another issue remains the balance of information sharing in cooperation with criminal justice. The respondent below reiterates that shared professional secrecy with criminal justice actors is not possible, and must be respected during a collaboration.

> *"Samenwerking met justitie, denk ik, heel belangrijk, daar kan men ook wel heel wat aan verbeteren. Nu ook dat is een moeilijk veld natuurlijk, ook omwille van beroepsgeheim. (…) En dat blijft ontzettend moeilijk wanneer u in contact bent met justitie en met justitie-assistenten.*

En een gedeeld beroepsgeheim met justitie, dat is eigenlijk niet echt mogelijk. En toch is overleg nodig, dus dat moet allemaal met de nodige zorg, euhm, behandeld worden." (NL_15)

One Walloon respondent mentions the professional secrecy as one of the biggest challenges of working in a network. The challenge was to put in place tools that allow the exchange of *information on patients between several institutions with their consent but without their presence*

'C'était quelque chose d'innovant. Les gens n'avaient pas l'habitude de se parler, de partager des événements sur un patient, sans sa présence, mais avec des différents intervenants de structures différentes. Et je pense que ça a été une des plus grosses difficultés, mettre en place des outils qui nous permet aujourd'hui d'échanger à vingt institutions, sur des patients avec des éléments concrets' (FR_2)

e. Different network structures

As identified within the pillar of prevention (see infra), the many different ways that networks are organised is identified as a barrier. Healthcare actors participate in different networks, but depending on the topic, those networks are organised differently, as is for example the case with the networks mental health care and the 'eerstelijnszones'. Also, respondents mention that these networks have changed or were rearranged over the years. With establishing new networks, or rearranging network structures, new connections have to be established with new partners, which takes a lot of time and energy.

Moreover, one respondent mentions that it is sometimes proclaimed that mental health care is a patchwork, but, as another respondent indicates, that patchwork was reinforced by the fact that network zones were continually divided differently in the past.

"Dat is ook het probleem he. Ze overlappen soms voor een deel en soms helemaal niet dus euhm, daar zal moeten in gekozen worden en dat is, vrees ik, ook weer een stukje de ego's." (NL_10)

Some Walloon respondents also refer to the different network structures. **The creation of the Psy107 networks '' were set up differently than the networks of the Walloon decree on addiction[84]** , and those do not align with one another.

'Même s'il y avait des défauts, c'était déjà une vision de permettre de travailler par territoire, en rassemblant des acteurs de tous les secteurs qui, à un moment donné, sont confrontés avec des problématiques de consommation. Je pense aux maisons médicales ou aux services d'aide à la jeunesse. L'intention s'est un peu dématérialisée avec l'arrivée des réseaux 107 parce que ce ne sont pas les mêmes territoires, et la réforme 107 n'a pas les mêmes intentions. C'est compliqué. L'articulation ne s'est pas faite de manière idéale' (FR_10)

B. Barriers and bottlenecks for creating a comphensive and integrated treatment offer

a. Barriers and bottlenecks in the reform of the mental health care

Some barriers and bottlenecks come into play with the mental health reform. First of all, respondents emphasise that the sixth state reform has created a different context.

Specifically, for Flanders, one respondent mentioned that the reduction of psychiatric beds as part of the reform, have mainly been to the disadvantage of addiction care beds:

Ik heb toch jammer genoeg moeten vaststellen dat er toch heel veel bedden gesneuveld zijn die bedoeld waren voor mensen met een verslavingsproblematiek. (…) Er is geen enkel planmatig

[84] The decree on the approval and subsidisation of support and care networks and services specialising in addiction – 2003

beleid op dat vlak, van hoeveel crisisbedden moet je in een bepaalde regio hebben of hoeveel ambulante zorg moeten zijn. Daar is geen duidelijke planning op. (NL_3)

Flemish respondents also identified some bottlenecks and barriers with the integration of the specialised drug treatment in mental health care in Flanders. First and foremost, respondents indicated that drug-specific treatment needs a sound position in mental health networks that considers the specificity of the sector and its target group. The challenge therefore is to raise awareness for the specificity as much as possible.

"Ja, wel, theoretisch, academisch lijkt me dat allemaal goed in elkaar te zitten. Ik denk op het terrein wat dat er gebeurt, en ik heb er toch wel wat zorgen over, in die zin van dat onze sector en ons thema... Ik bedoel, in zo'n grote molen als GGZ, betekent dat uw soortelijk gewicht wat begint te verminderen. (…) Ik ga dat illustreren met bijvoorbeeld, er is nu een masterplan van de GGZ, je kunt dat terugvinden op de website van de Staten-Generaal, daar staat een van de uitgangspunten. Vanaf nu is verslavingszorg onderdeel van de GGZ en dat is integraal onderdeel ervan. Voor de rest van de tekst komt het woord verslaving niet meer voor, het verdwijnt daarin. Dus uw eigenheid, uw specifieke issues, knelpunten, ik denk dan substitutie, harm reductie, gebruikers. Dus al dat soort dingen. (NL_16)

Next, respondents point out that there is a certain lack of expertise within the broader mental health care regarding addiction, which in itself requires a different approach than that which the mental health services traditionally face. On that level, respondents therefore emphasise the need to develop expertise on addiction within the mental health care.

"Aan de andere kan zien we dat de algemeen geestelijke gezondheidszorg op veel plaatsen niet de deskundigheid heeft om met de verslavingsproblemen om te gaan. Dat het vaak toch wel een andere aanpak vraagt. Als je bijvoorbeeld denkt aan iemand met psychotische, euhm, problematiek of iemand met verslavingsproblematiek, dat vraagt een andere structuur, een andere cultuur op de andere regels, op de andere hantering. En dus dat is niet altijd zo gemakkelijk om dat samen te brengen." (NL_10)

Finally, the extra workload generated by consultation in the various networks is also highlighted by one respondent. Participating in both the mental health care networks for adults and for adolescents, as well as maintaining the drug-specific consultations, quickly creates a lot of extra consultation moments. The same respondent also mentions that when the specialized drug treatment was integrated, the East Flanders care coordinator was discontinued, because that task could be carried out by the coordinator from a mental health network. But since the coordinator has to coordinate all mental health topics, the sector is also losing its specificity, not to mention the loss of expertise.

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On the level of Flanders:
  - More and better collaboration with all partners of health care, including general practitioners, psychologists, etc. in networks. At the same time, the collaboration with partners from other domains (e.g., criminal justice, employment, housing, etc.) should be enhanced.
    - Maintaining a specific offer for addiction treatment within mental health networks
    - Cooperation in networks requires a serious investment of time for which the necessary framework and incentives must be provided.
    - Expertise promotion to remove the stigma within the broader mental health care on clients with addiction problems.

        - In this collaboration, (shared) professional secrecy should be handled with care. One respondent emphasises that the client should have some degree of control over the information exchanged.
        - An overlap period between residential treatment and outpatient treatment. This allows an easy transition between both the treatment teams and treatment itself.
- On the level of Wallonia and Brussels:
    - The silo's functioning and financing through separate sectors and services leads to a kind of corporatist attitude (addiction sector against other treatment sectors such as mental health or care for young people), and therefore, specific mechanisms for better integration are required.

b. Treatment provision: a need for more diversity in the treatment offer

There are several barriers and bottlenecks respondents identify in the addiction treatment provision.

Another bottleneck identified by a respondent from German-speaking Belgium, is the fact that there is **no diverse treatment offer for people with addiction problems in Ostbelgien**. The implementation of a broad range of facilities of both care and cure is limited, because it would not be cost-effective in a small community like Ostbelgien. However, the lack of certain facilities, for example a crisis care unit, poses a problem when these crisis situations do happen. Since there is no crisis unit, some of the counsellors drive with their client to specialized units in Germany when a client has a crisis. Although this does not happen often, it does pose a problem when it happens, as the quote illustrates.

> *"Ja, bijvoorbeeld, dit heb ik al heel vaak meegemaakt. Als iemand met een acute psychose naar mij komt en als, hoe noem je dat, die aan zelfverminking doet, dus een gevaar voor eigen leven. (…) En als die dan tegenover mij zit, dan moet ik gewoon iets doen, want die is in zo'n labiele toestand, die kan gewoon niet naar huis. Maar ik kan ze ook niet naar het ziekenhuis sturen, want die sturen die gewoon weer weg. En met zo'n labiele mensen rij ik dan naar Duitsland, met mijn privéauto, en ja, dat is geen goeie oplossing. Want als ik de ziekenwagen bel, dan gaat die ziekenwagen naar Sint Nicolas in Eupen, en als die daar toekomt, zegt men daar, ja, da's gewoon, die is psychisch niet in orde, maar daar kunnen we hier helemaal niets mee doen. En dan sturen ze die daar gewoon weer weg. Dan komt die mevrouw weer bij mij terug. Als zoiets gebeurt, is dat een groot probleem, maar het komt wel niet zo vaak voor. Dit probleem heb ik zo'n vijf keer per jaar. Maximum. Maar iedere keer als het gebeurt, denk ik, ow shit." (NL_21)*

Furthermore, one Flemish respondent criticises the fact that in **Flanders people with cannabis problems are often treated together with people with other drug problems**. The respondent compares this approach , with, for example, the separate cannabis consultation in the Brugmans hospital (Brussels). In this hospital the client groups are kept separate, which is more favorable according to the respondent.

Some respondents both in Flanders as well as Wallonia mention a certain **rivalry between treatment facilities**. For example, when there is less funding available.

> *"Om projecten binnen te halen, dat men dan in plaats van in samenwerking, iets voor zichzelf wil binnenhalen. Een of twee jaar geleden is er een verandering geweest in Antwerpen… Nu, ik denk dat over het geld van de stad ging, enfin. En het stad had het niet gepland, maar het gevolg was dat een aantal dingen gingen wegvallen. En dan is er enorm gevochten tussen iedereen die z'n eigen ding wou behouden." (NL_10)*

> *'On a vu les premières initiatives de réseau se constituer il y a presque 20 ans maintenant déjà. Mais ça ne se fait pas du jour au lendemain. Il faut apprendre à se faire confiance. Je dois dire aussi avec des financements qui parfois mettent aussi les opérateurs en concurrence, ce sont des réalités*

auxquelles il faut être attentif. Pour certains services, ils doivent avoir un taux d'occupation satisfaisant pour pouvoir survivre. On travaille à la prestation pour certains services.' (FR_10)

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On all policy levels:
  - Expand the capacity in outpatient alcohol and drug treatment, to create close treatment and the opportunity for outpatient centres to engage in outreach. Furthermore, respondents highlight the support the MSOC/MASS.
  - Involving the client's context in treatment on all levels is essential. Recognition and funding of environment-based care is needed, especially since this method is time-consuming.
  - More reflection on the most vulnerable groups who do not have access to treatment services
  - Continued commitment to case management for specific target groups.
  - And lastly, the need for innovation is stressed. Respondents often refer to the previous fund to fight addiction as a facilitator for innovation. It is essential to reach out to new target groups, and to continue to innovate and adapt methodologies according to the evolution of the drug phenomenon. To do that, there is a need for funding. Some Flemish respondents also emphasise the importance of these bottom-up innovation initiatives, because they are adapted to the specific field, target group and local context.

- On the level of Flanders:
  - Orientation point for clients with addiction problems, like the orientation point in Antwerp.
  - Implement peer support. There is a need for a clear framework for experience experts and related compensation. Facilities should be encouraged to structurally implement experience expertise into their operation.

- On the Walloon and Brussels level
  - The need for organizational mechanisms (funding, agreements) in order to stabilise the existing projects and services and better integrate the addiction sector and other sectors.
  - More flexibility from the authorities so that new issues or approaches can be developed and supported.

c. Working in silo's

One Brussels respondent indicates that, in Brussels, the treatment field is still organised in silos. In terms of access to a more cross-cutting treatment offer, for example considering employment, housing, citizenship, participation, training, sexual and reproductive health, the field is still fragmented and lacks integration. There is a need for coordination across these 'silo's'. The respondent refers to the way services are financed as a possible explanation.

'C'est un peu comme ça que l'aide sociale est construite à Bruxelles, ce sont des silos. (...) En termes d'accès à des offres plus transversales emploi, logement, citoyenneté, participation, formation, santé sexuelle et reproductive, on est trop en silo, donc on doit s'ouvrir dans le circuit de soins à ces aspects là où les intégrer… Quand tu vois l'organisation politique des soins de santé, si tu prends la Cocof, il y a 10 domaines, 10 secteurs …Il y a des volontés un peu partout d'être des plus transversaux. Mais c'est difficile…' (FR_16)

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On the level of Brussels:
  - There is a need for coordination across these silo's
  - Rethinking the way services are financed.

C. Barriers and bottlenecks in the objective 'to stimulate the cooperation between the criminal justice system and the treatment sector'

The barriers and bottlenecks in the cooperation between treatment and criminal justice that the respondents within the pillar treatment identified, especially relate to two projects i.e. the drug treatment courts and the treatment offer in prison.

First of all, some Flemish respondents mentioned the current plans to install a **Drug Treatment Chamber** within each court of first instance, which is an initiative to be encouraged. The concern of some respondents however, is how those Drug Treatment Chambers will be implemented. They are especially concerned about the role of the legal assistant (which will replace the treatment liaison) and what profile of clients are admitted to the Drug Treatment Chamber. The current plans make reference to targeting people who are coming into contact with the justice system for the first time. As one respondent indicates, the specific type of case management offered in a Drug Treatment Chamber might not necessarily be the appropriate way of working for people with this low risk, low need profile. The fact that they won't longer work with a treatment liaison officer, as is the case in Ghent, but with legal assistants, as is the case in Antwerp, raises some concerns about confidentiality and working context.

> *"Als men vanuit justitiehuis zich vooral gaat richten op mensen die voor de eerste keer in contact komen met justitie, dan gaat het toch wel een ander profiel zijn, dat veel dichter bij proefzorg ligt en euhm, waarvoor dat case-management, denk ik, niet zozeer aan de orde ligt. Omdat case-management zich ja, ik denk toch gauw over een iets langere periode uitstrekt, hé. Waar dat je de mensen toch minimum een paar maanden opvolgt." (NL_22)*

Second, some respondents criticise the lack of a **(diverse) treatment offer in prison**. Currently, there is a minimal provision of drug treatment in prison, and funding is problematic according to some of the respondents.

> *"Het aanbod binnen de gevangenissen zelf, is eigenlijk nog altijd miniem. Is nog niet zo uitgebouwd, de financiering daarvan, dat trekt eigenlijk op niks. Die middelen moeten, komen blijkbaar soms uit de pot van het werk dat de gedetineerden doen in de gevangenissen. Da's een heel onlogische financiering." (NL_3)*

Respondents stress that there are differences between prisons in treatment offer, with some prisons having drug-free wings, other prisons providing group counselling, and others having none of those. In general, though, the treatment offer remains limited, mainly because there is limited budget available to further develop that offer. This is problematic for several reasons, including the discontinuation of treatment upon transfer.

> *"Ik vind het heel moeilijk om over continuïteit betreffende gezondheid te spreken, als er in de gevangenis ja, wat betreft drugs dat dat beperkt is." (NL_6)*

Almost all Flemish respondents mention the structural underfunding of the prisons, which has been the case for decades. These current budget constraints cause prisons to creatively seek revenue. For example, revenues from "Cellmade," the workshops in prisons, are being used to start group counselling in some prisons. In this way, an attempt is made to expand the treatment offer during detention. Although this is still on the initiative of the prisons themselves.

Apart from the underfunding, however, there is also an issue of competences. The division between health competences (federal and regions) and justice (federal) competences, often causes difficulties. One respondent clarifies that this division jeopardises the development of an effective and diverse treatment offer in prison.

> *"Ze zeggen altijd van 'die gevangenissen ze doen nooit iets omtrent de drugsproblematiek'. Dan denk ik van, integendeel, [zij] doen misschien zelfs dingen die normaal niet mogen. Als je het puur bekijkt op bevoegdheid (…) Maar dat zou vooral gefaciliteerd moeten worden, er zouden daar geen stokken in de wielen mogen worden gestoken van 'nee je mag dit niet doen of dit of dat'. Ja dat is vertrekken vanuit de nood hé, maar dat is het probleem hé. We vertrekken niet van de nood, we vertrekken van wie is bevoegd, en dat is heel moeilijk." (NL_6)*

Respondents clarify that there are still many problems in the way health care is organised in prison. Nevertheless, some respondents from the health sector indicate that the justice department is still taking initiatives with regard to health care in prison. One respondent describes that this gives the impression that there is a hierarchy of competences, and that criminal justice is superior to treatment.

> *'Un autre exemple, c'est la santé en prison. On a beaucoup de problèmes pour mettre des choses en place en prison, même si normalement, il est censé y avoir une équivalence de soins depuis la loi Onkelinx. Pourtant, c'est toujours la justice qui a la compétence santé en prison… C'est un exemple qui montre vraiment la hiérarchie entre les deux'. (FR_8)*

Furthermore, specifically in Flanders, some respondents mention the insufficient funding for TANDEM. After the sixth state reform (cf. supra), the prison-based (drug-specific) registration points (NL: CAP) were re-oriented to a broader target audience, including persons with mental health problems, without an increase in budget or personnel. In the meantime, the Flemish government has announced that the funding for TANDEM will be doubled (De Kiem, 2020).

> "*Het CAP van vroeger, dat in die nota nog als in die vorm omschreven wordt, en nu TANDEM noemt, dat was ook zoiets. Dat was drie en een half medewerkers, en van de ene dag op de andere moet je niet alleen met drugsverslaafden werken in de gevangenis, maar moet je ook nog een keer de oriëntatie en doorverwijzing doen van gelijk wie met gelijk welke psychiatrische problematiek. En da's eigenlijk... Eigenlijk is de afkolving van middelen hè."* (NL_3)

Also, some respondents mention the (already widely known) resistance to provide substitution treatment in prison among some of the prison physicians. For example, due to ideological belief, physicians sometimes refuse to prescribe substitution treatment, despite the regulatory framework and the coaching of staff.

> *"Je blijft zien dat er heel wat weerstand is bij artsen in gevangenissen, uit… ik zal maar zeggen onwetendheid, hé? (…) maar ik sta er van versteld. Dat zijn een paar artsen, die zeggen allemaal hetzelfde. Collega's die dat [substitutie] niet willen doen, die daar niet aan willen of durven beginnen en die daar ook eigenlijk principieel tegen zijn, om dat te doen. Dus dat zijn zo van die dingen waarvan je zegt, het is tijd dat we daar in Vlaanderen, zeker in Vlaanderen, daar werk van maken."* (NL_16)

Additionally, one Flemish respondent denounces the fact that certain harm reduction initiatives in a prison context are not even discussed, let alone considered, despite research providing positive outcomes.

> *"Dan hebben we nog niet eens gehad over spuitenruil in de gevangenissen. Dat is iets waar we nog niet eens durven over praten, maar in feite zou dat soort zaken die anders zo'n grote evidentie heeft."* (NL_16)

Some respondents mention a lack of aftercare when people with drug problems leave prison. The respondents not only refer to addiction treatment but also treatment in other life domains, such as housing. Furthermore, there is a lack of facilities to guide long-term detainees who are released from prison, and facilities that facilitate their reintegration into society.

''On a de grosses difficultés pour le logement avec ce public là… Pour des personnes qui ont commis de gros délits, il faut reconstruire les liens avec la famille, avoir accès à un logement, c'est compliqué. Les hébergements d'urgence sont souvent complets, il y a ce maillon manquant de structures qui peuvent accueillir des détenus sortant de prison pendant un certain temps pour leur permettre de se réinsérer plus facilement dans notre société' (FR_2)

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On all policy levels: Strengthen the cooperation between the criminal justice system and treatment in a structural way.
- On a Federal level:
  - Structural implementation of the pilot projects on Proefzorg and Drug Treatment Chambers, with attention to the preconditions for a good cooperation between criminal justice and treatment.
  - Structural financing of Projects Judicial Alternatives by FOD/SPF Internal Affairs
- On the level of Flanders:
  - Structural funding of a differentiated treatment offer in all prisons. This treatment offer should be developed in cooperation with external treatment facilities.
    - Attention to defendants to make a first contact with treatment
    - Possibilities for individual and group treatment
    - Therapeutic communities in prison
  - The elaboration of the capacity of TANDEM.
- On the level of Brussels:
  - A modification of the legal framework (the law 1921) related to "harm reduction/reintegration" initiatives, the current penalisation of illegal drugs hampers a public health approach of drugs.

D. Barriers and bottlenecks of the objective 'to organise an emergency and crisis response network

Some respondents also discusses the bottlenecks and barriers in crisis care. A first bottleneck relates to the long waiting lists within crisis care, because of a lack of crisis beds.

"Die zitten met enorme wachtlijsten. Die zitten met wachtlijsten die oplopen tot drie maanden, wat een beetje contradictorisch is met de term crisisopnames hè. En dus ze kunnen wel nog ontwenning doen. Maar eigenlijk heel vlugge opnames voor de mensen die echt in de problemen zitten, die in functie van een ontwenning komen of van stabilisatie, ja die moeten kweetnie hoe lang wachten. Dat is... alle dagen bellen om maar uw plaatsje vrij te houden. Dat is echt wel problematisch. Dus we hebben op dat vlak echt wel bedden tekort." (NL_3)

Furthermore, all crisis care projects are still pilot projects. Although the projects now receive permanent funding, there is still no structural and systematic implementation of the projects. One respondent clarified that this is related to a number of preconditions, such as requesting advice from the Federal Council for Hospital Facilities and mapping out the needs, but also the verification in the work field and political support are indicated as preconditions:

"Maar eigenlijk is het de bedoeling om die dingen wat meer structureel in te bedden in uw zorgsysteem, en dan heb je allerlei processen die moeten worden gevolgd zoals adviezen vragen aan de federale raad voor ziekenhuisvoorzieningen; ge moet een eigenlijk de noden in kaart brengen, je moet ook uw projecten goed geëvalueerd hebben, ge moet uw projecten afgetoetst hebben bij het werkveld, er moet een politieke steun zijn. En dat is zeer moeilijk, wat er toe geleid heeft dat we dus tot nu toe nog altijd met pilootprojecten zitten. Dus dat is geen structureel aanbod, dat is een nog altijd een pilootfase." (NL_1)

Because crisis care consists of individual pilot projects, each project has been implemented within its own context, leading to operational differences. For example, as one respondent mentions, some pilot projects are only aimed at people with alcohol problems, whereas other pilot projects are only aimed at people with illegal drug problems.

> *Van hoe zit dat met die crisis en dan als je dat dan naast uw vindingen vanuit categorale hulpverlening, dat was dat zeer wisselend. In sommige waren bijvoorbeeld enkel mensen met alcoholproblematiek en moesten ze geen hebben met illegale drugsproblematiek en in andere was dat dan juist omgekeerd. (NL_16)*

One respondent also indicated that the monitoring and evaluation of crisis care did not run smoothly. Especially the fact that there is no possibility for longitudinal follow-up is identified as a gap.

In addition, when respondents discuss crisis care, case management is often mentioned too. Respondents confirm that the objective of crisis care and case management have been merged in the implementation of the crisis units. By pinning case management on the pilot projects of the crisis units, a full expansion of case management was never realized. As a result, case management has not been able to fulfil its potential, according to some respondents.

> *"Als een casemanager aan één voorziening gaat vastkleven, dan zit je meestal met een probleem. Tegelijk ja, die mensen moeten van ergens uit opereren. Maar eigenlijk het meest ideale is dat ja, een torenfunctie ergens kunnen, ja, meer het veld overschaduwen. Of overschouwen beter." (NL_22)*

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On a federal level: Expand crisis care structurally and provide sufficient beds for people with addiction problems.

E. Barriers and bottlenecks related to reintegration

Both Flemish and Walloon respondents mention barriers and bottlenecks with reintegration. Some respondents indicate in particular issues with aftercare and reintegration for people released from prison. Some of the Walloon respondents indicate, for example, that this group of people often did not keep track of their administration, or had a limited network to fall back on. To date, there is no proper aftercare for these kinds of problems.

Apart from people being released from prison, there is also a (structural) barrier to regular aftercare, one respondent mentions. On an individual level, it has been more difficult to engage clients in work in the current covid-19 situation, compared to recent years.

> *"Natuurlijk, als je het op individueel niveau bekijkt voor de drugverslaafde, re-integratie is niet altijd zo evident. We hebben geluk, we komen gelukkig uit een periode waar dat er voldoende werkgelegenheid was en dat ze redelijk vlot allemaal, allé, qua zinvolle tijdsbesteding of aan werk geraakten. Ik weet niet, of ja, op dit moment is dat echt wel heel moeilijk." (NL_3)*

One Brussels respondent mentions that people with drug addiction problems have multiple and complex needs, as well from the care side as from the social side. And because of the different operators and field schemes, it is difficult to offer them an integrated care approach. For example, people with drug problems are not well received in social services for employment rehabilitation because of their specificities.

> *'Les toxicomanes, ils ne sont pas faciles du tout à gérer. On avait pas mal de nos gars ou de nos patients qui avaient envie de se réinsérer, mais ils étaient bloqués par rapport à leurs parcours*

passé, ou leur physique, ça se voit souvent… Ils ont des marques…Alors c'est une difficulté qu'on rencontre dans le secteur quand on veut travailler dans une démarche inclusive…'. (FR_2)

The debate risen by this respondent is related to different approaches to rehabilitation, one which is supposed to be inclusive (people with different problems should be cared for by generic social services) or another which is specific-oriented. In Belgium, we do not have many inclusive services (because of the fragmentation of sectors), but we also lack of specialised services (there are no or few social services offering employment support for people who use drugs).

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On all policy levels:
  - Attention to aftercare and re-integration when developing a vision for the drug treatment offer.
  - Specific attention to people with drug problems who do not have insurance (for example hospitalization insurance).
  - In addition to the commitment to non-specialised community treatment, it remains important to focus on the reintegration of the client. Additionally, respondents mention that a long-term and serious addiction problem is often accompanied by other social problems such as poverty, homelessness, etc. Therefore, the need to address underlying social issues of addiction is highlighted. Projects aimed at these underlying problems, like Housing First for example, should be expanded, with capable staff.
- On a Walloon level:
  - Strengthen actions/projects aimed at people's recovery
  - Prepare for release from prison with drug-free units (in prisons), who will do educational and therapeutic work.
  - To facilitate the administrative and financial commitment of people who have used or are using drugs.

F. Barriers and bottlenecks with the objective 'to create a treatment offer for drug users with double diagnosis'

According to the respondents, a first bottleneck is how to define dual diagnosis. For example, respondents indicated that a serious addiction problem is frequently accompanied by a psychiatric problem. The question that respondents are raising, is where to delineate this.

"Een dubbele diagnose is natuurlijk iets zeer ruim begrip en is zeer ruim in te vullen he. Ik bedoel dubbele diagnose is bijna, hoe zal ik het zeggen? Dat is bijna gelijk aan een ernstige verslavingsproblematiek he, ik bedoel er zijn weinig ernstige verslavingsproblematieken zonder dat er dubbele diagnose is." (NL_16)

In addition, as with the crisis units, data collection and evaluation are not straightforward with the two pilot projects, one respondent emphasises. And here again, these projects have been pilot projects for almost 20 years.

Maar dus daar ook is de dataverzameling, de evaluatie, niet evident. En wat ook niet evident is, is dat het allemaal nog pilootprojecten zijn van in 2002, dus dat is ondertussen 18 jaar. (NL_1)

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On a federal level: Structurally implement the double diagnosis projects.

G. Barriers and bottlenecks with the objective 'To stimulate evidence-based practices'

Respondents often refer to bottlenecks and barriers related to establishing evidence-based initiatives.

Many respondents criticize the lack of structural embedding of positively evaluated projects. Consequently, according to our respondents, this cannot be regarded as an evidence-based policy.

> *"Evidence based initiatieven ondersteunen, dat evaluatie onderzoek. Daar zie ik toch niet veel van op de werkvloer. Euh. En als het dan toch gebeurt. (…) Da's geëvalueerd geweest, als positief bevonden, maar goed, dat is het dan hè. Daar gebeurt daar niks verder. Terwijl, denk ik, voor elk project dat je zou doen, dat je daar eigenlijk wel serieus onderzoek zou moeten op doen, omdat je daar heel veel kunt leren en dat het dan ook aangetoond is of dat iets is dat werkt of niet werkte hè. Daar daar zit, vind ik, zit nog altijd geen consistente lijn in. Van als we al een project doen, en we evalueren het, en het wordt goed bevonden, dat het dan ook effectief euhm, structureel gefinancierd of geregeld wordt."* (NL_3)

During the interviews, various examples were given of projects that were positively evaluated but never structurally embedded. Among other things, reference was made to the evaluations of case management, the crisis units, 'Proefzorg', Drug treatment Chamber (until recently, cf. supra), "Drugs the boss" project in prison, etc.

Some respondents give possible explanations as to why these pilot projects were not structurally implemented. They refer for example to issues with the level of competence (after the Sixth State Reform, it became the competence of the regions), or a lack of funding. As a result, respondents mention a disengagement of the actors in the field for these projects.

> *''Nous avons aussi été, le promoteur d'un projet qui était soutenu il y a quelques années par le ministre de la Justice, à propos de l'orientation et de l'accompagnement en prison. Qui s'est clôturé en 2016 et qui a fait l'objet d'une étude Belspo, qui a validé l'intérêt de ce dispositif, mais il n'a pas été renouvelé au niveau fédéral, principalement pour une question de compétence, estimant que cela revenait à la santé de s'impliquer dans ce type de projet' (FR_10)*

> *'Le projet Tadam n'a pas été prolongé, parce que ça avait un coût important et que certains ne trouvaient pas ça prioritaire, en tout cas pas au niveau budgétaire…' (FR_1)*

A Flemish respondent however warns against going too far with evidence-based policy. The respondent gives the example of the Netherlands, where the emphasis is mainly on "does it work or doesn't it work", which objectifies the situation as much as possible. This does not leave room for the subjective story nor for the narrative of the client or practice. In this sense, he emphasises the importance of evidence-informed practice.

> *"Dat betekent niet dat we met de weegschaal, vind ik, moeten zitten aflezen van dat werkt en dat werkt niet. Want het is niet bewezen. Maar ik vind wel dat we mogen de dingen promoten waarbij dat er goed, duidelijk onderzoek gebeurd is en die werken." (NL_16)*

According to the respondents, there are limits to evidence-based work. For example, the research conducted is often not in line with what practice encounters. Moreover, it deals with very complex problems in which cause and effect are difficult to distinguish.

> *"Dat is, dat laat zich echt allemaal niet zo gemakkelijk meten in RCT, en in dat soort dingen he. Ik bedoel allee ja, die RCT's en dan meestal monodiagnoses, want het gaat over alcohol. Hoeveel keer komen we dat tegen in de praktijk? Dat kom je bijna nooit tegen." (NL_16)*

Therefore, respondents stress the importance of the input of practice and lived experiences too.

Ik denk dat dat absoluut een goed idee is om evidence based of evidence informed uit te voeren, en daarnaast ook veel meer het middenveld, civil society organisations te betrekken, omdat wij op zijn minst practice based werken en heel veel voelen van wat er op het werkveld leeft, maar wat er ook werkt, en ook voelen wij wat er niet werkt. (FG_RC_R2)

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On all policy levels:
  - An evidence-informed policy, inspired by (inter)national research and good practices.
  - Structurally implement positively evaluated pilot projects, with attention to local context and in cooperation with local actors.
- On the level of Flanders:
  - Encourage evaluation and research into clinical practice and methods

H. Barriers and bottlenecks in the objective 'to further develop risk reduction'

There are also a few barriers and bottlenecks related to the initiatives taken for risk reduction.

For **substitution treatment,** some Flemish respondents cite a number of yet-to-be-made improvements in the current legislation on substitution treatment:

"Ik denk bijvoorbeeld aan de start dosis die vrij laag bepaald is. Zeker bij gekende mensen soms wel eens hoger zou mogen. Of uhm, bij een dreigend herval mogen mensen eigenlijk niet opgestart worden op substitutie als er geen bewijzen in de urine zitten terwijl dat, voor mij toch een preventief iets zou kunnen zijn. Om die tijdelijk effe kort te sluiten op die substitutie, kort een afbouw schema maken." (NL_2)

Another respondent mentions that the amendment of legislation with regard to substitution is not easy. The political sensitivity of the issue was one of the reasons mentioned.

"Euh, substitutiebehandeling bijvoorbeeld hebben we lang geprobeerd om de wetgeving aan te passen. We hebben dat ene keer een klein beetje gekund en daarna nooit meer. Omdat het politiek altijd zo moeilijk was en zo allé, ja. Dat is wel niet evident om dan inderdaad een wetgeving te hebben die voldoende rekening houdt met de verschillende realiteiten." (NL_1)

Other respondents also refer to this political sensitivity, in the sense that governments (local or Flemish) sometimes have a narrow view of what the objectives of an MSOC/MASS, or even syringe exchange, should be. Mostly, the emphasis is put on the prevention of nuisance. The respondents emphasise their impression that from a policy perspective the discussion is closely linked to morality and that these types of harm reduction are mainly considered in a normative way.

En we zien dat wanneer er moet gesubsidieerd worden dat, euhm, de overheid, vanuit politieke overwegingen ook, eigenlijk meer kijkt naar de overlast dan naar de zorg voor die mensen. En dat het dus meer om overlastbestrijding gaat dan om, euhm, effectieve zorg. (NL_10)

Il y a aussi, je pense, des barrières morales à la réduction des risques. Pour certains, c'est une approche cynique… (FR_8)

Walloon respondents also describe different political points of view on risk reduction between the north and the south of Belgium, as well as differences in the distribution of substitution treatment between both sides of the country.

'Toujours pour la même chose, parce que les gens n'ont pas la même vision politique de la problématique, notamment la vision au nord et au sud du pays est assez divergente sur ces sujets-

là. Les traitements de substitution, sur le papier, c'est la même chose, mais j'ai vu quand même des modèles de traitement de substitution très différents..(FR_4)

In the same context, one respondent proposes to add an additional pillar for risk reduction, next to the pillars 'Prevention' and 'Treatment'. Today, risk reduction is recognised together with 'Treatment' for some of its initiatives, but with 'Prevention' for other initiatives, whereas it has a different purpose aimed at preventing (further) harm.

'Mais ça reste encore très difficile au niveau fédéral que la réduction des risques soit reconnue en tant que telle, seule. Nous on défendait le modèle suisse, les quatre piliers prévention, réduction des risques, soins et répression/Justice, ce sont quatre piliers équivalents. Ici on n'est jamais arrivé à les avoir…La réduction des risques peut être vue comme incitante. En Flandre, on ne peut pas parler de réduction des risques au niveau festif, même s'il y a des associations qui font la même chose que nous, mais ils sont obligés de garder l'appellation prévention. Donc, ce sont des soins, mais il y a toute une partie des actions de réduction des risques qui sont dans le pilier prévention' (FR_8)

Furthermore, one Walloon respondent mentions that the current Drug Law of 1921 is a barrier for the further development of risk reduction initiatives. For example, respondents refer to the development of drug consumption rooms. The Drug Law of 1921 prohibits the facilitation of drug use. This prevents the establishment of drug consumption room. Yet, in Liège, a drug consumption room was established, with the support of the Walloon government.

'Et puis, même chose pour la note sur les salles de consommation. J'ai fait revenir ça en cellule générale de politique drogue, mais ça demande un aménagement de la loi, puisque la loi de 1921 indique on ne peut pas faciliter la consommation de drogues. Au niveau fédéral, il y a eu un refus de changer la législation'. (FR_1)

Finally, respondents refer to syringe exchange. Respondents indicate that when it comes to syringe exchange, they are limited by the current legislative framework. Restrictions on the number of syringes they can share with someone, as well as on who they can share syringes with, or the distribution of, for example, sterile water, prevent a wider deployment of syringe exchange, according to respondents.

A more structural barrier, is the stigma surrounding syringe exchange or substitution treatment, both in the wider community, and among other care providers. When someone comes to collect syringes, it has a societal label of "being a marginalized user". But there is also a certain amount of resistance to syringe exchange among treatment workers and counsellors.

"Spuitenruil blijft toch nog wel een taboe. Er zijn heel veel hulpverleners kunnen zich daarin vinden. Van, ok, goed dat het bestaat. Maar als ge dan vraagt van 'Ja, zou je 't dan zelf aan bieden aan u cliënten wanneer dat nodig is', dan is dat een moeilijke. Het blijft toch wel steken in, en misschien dat ik daar ook wel de link naar substitutie mag leggen, substitutie wordt heel snel bekeken als de ene verslaving met de andere vervangen." (NL_2)

This reservation of counsellors about syringe exchange is, in turn, also reflected by their clients. Clients often say that when they are in a more abstinence-oriented process, for example, they go and get syringes elsewhere because they don't want their counsellor to think of them in that way.

"Als gij als hulpverlener zegt van 'zou je dat wel doen', ja dan stopt het hé. Goh, ik denk dat de maatschappij daar ook nog altijd een zekere druk oplegt, een zeker stigma oplegt van 'spuiten is het allerlaatste wat je doet, en daar ben je heel slecht bezig'. Ja, en zeker voor jonge mensen denk ik dat dat dan een moeilijke gaat zijn om daar open over te praten. Dus ja, ik denk wel dat het stigma rond injecteren, dat dat bij bepaalde mensen toch een zekere remming zet op, euh, ik ga naar daar." (NL_2)

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On all policy levels: Expand and strengthen the position of harm reduction:
  - An extension of the legislation on syringe exchange, to include paraphernalia in order to reach other target groups than people who inject drugs.
  - To implement drug consumption rooms in Flanders.
  - Legislative framework for the distribution of naloxone.
  - Legislative framework supporting drug consumption rooms.

I. Barriers and bottlenecks in the objective 'to organise initiatives towards the target group of minors'

Among the Flemish respondents, only one barrier came up related to young people, and that might be explained by the fact that, to date, there is still a great deal of unclarity about the treatment offer towards this group.

Some respondents emphasise that the population of minors has been forgotten for a long time in the accreditation of treatment services, as well as in the general addiction policy. The projects related to this issue are poorly or not funded, so institutions often fund themselves. Furthermore, there are not enough outreach services for minors who use drugs or who have drug problems to which the juvenile justice services can turn.

> *'Les mineurs sont quand même aujourd'hui peut-être une population un peu oubliée, Je sais que beaucoup de choses sont mis en place depuis plusieurs années. Mais malgré tout, ça a été une population longtemps oubliée dans les agréments au niveau des services assuétudes et de la politique générale des assuétudes' (FR_7)*

One Walloon respondent mentions the difficulty in involving parents in the care of young (minors) drug users too. There is no specific policy regarding "minors" except the reform of mental health networks for children and adolescents, but that do not specifically address drugs

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On the Walloon level:
  - Promote and better support prevention actions among young people, especially in schools (e.g. operations 'Boule de neige')

J. Barriers and bottlenecks in the objective 'to fund the care circuits'

Some respondents mention that even though addiction networks have been institutionalised by territory in Walloon region, they do not all function in the same way because they do not have access to the same resources. There are Walloon specific drug addiction networks. However, in each network, one specific institution was chosen in order to organise the network, and each institution has its own practices and objectives.

> *'En Wallonie cette notion de réseau assuétudes a été institutionnalisée. Ça ne veut pas dire pour autant qu'elle fonctionne de la même manière sur chacun des territoires. Parce qu'il faut qu'on donne des moyens à ces réseaux de remplir les missions qu'on leur confère, et c'est pas toujours le cas' (FR_10)*

Some respondents mention that the long-term project are funded with annual funding (optional funding – financement facultatif). As a result, there is a lot of uncertainty on whether or not they will receive funding the next year, and it is hard to develop on the long term.

'Mais toujours avec le risque de ne pas être reconduit l'année après' (FR_7)

Some respondents highlight the lack of funding for civil society advocacy and the lack of legitimacy, which reinforces the complaint about a lack of flexibility for new approaches.

'Ce qui est difficile, c'est aussi qu'il faut tout le temps faire un travail de lobbying, on n'est pas payés pour ça. Et dès qu'on parle, on va voir les politiques et on leur dit : "il faudrait changer le cadre légal", ils disent : "ah ben oui, mais vous devez convaincre la société civile", "la population"…., mais ça aussi, ça demande de l'argent de faire des campagnes, ça demande du temps de travail' (FR_8)

Some respondents therefore identified local support (municipalities) and certain regional subsidies (optional funding from the Walloon region) as a driving force for starting up specific approaches for certain target groups (e.g. youth care).

'On a été interpellés notamment par la Ville de Namur qui s'inquiétait de cette augmentation de jeunes adultes avec des comportements de décrochage scolaire, de consommation de cannabis, de consommation d'alcool, de zonage en rue... Donc avec leur soutien. Nous avons introduit un dossier à la Région Wallonne en leur parlant de notre modèle… Ils sont intervenus avec des subventions annuelles, soi-disant pour mieux vérifier l'impact au niveau qualitatif et quantitatif' (FR_2)

However, this type of funding is also identified as a bottleneck when used on a long-term basis for projects that have been in existence for several years.

In both Wallonia and Brussels, specific legislation was implemented as to frame the organisation of care: the Walloon networks (cf. supra) and the ambulatory decree in Brussels. Obviously, they are facilitators as they frame how care is organised and funded. Yet, as mentioned several times, these documents support existing services and programmes, but do not provide orientations nor set objectives and do not support formal collaboration.

'C'est la particularité de la Wallonie, on a un décret qui institue des services et des réseaux, il n'y a ça nulle part ailleurs. Ce n'est d'ailleurs parfois pas très compréhensible pour nos collègues bruxellois et flamands, ce n'est même parfois pas connu de nos propres responsables politiques en Wallonie. C'est une vision avec des défauts, mais c'est déjà une vision de permettre de travailler par territoire, en rassemblant des acteurs de tous les secteurs qui, à un moment donné, sont confrontés avec des problématiques de consommation' (FR_10)

5.1.2.3 Perceived unintended consequences of the objectives

Respondents were also asked to identify possible positive or negative unintended consequences of the implementation of the objectives.

One positive unintended consequence was identified by our respondents: the implementation of harm reduction initiatives like substitution treatment, syringe exchange and controlled heroin distribution, have not only prevented harmful use, but have also (unintentionally) led to a decrease in the nuisance caused by people who use drugs. Although respondents state that they would have identified this decrease in nuisance as a second objective relating to substitution treatment and syringe exchange, besides the prevention of harmful use.

When the respondents were asked about negative unintended consequences, three issues were raised

First of all, the stigmatization of people with drug problems within broader mental health care and treatment was mentioned. The integration of specialised drug treatment into mental health care should

have created more openness between the two, but just about all Flemish respondents mentioned that there is still a lot of stigma among counsellors and treatment workers towards people with addiction problems. Some of them identify this as an unintended consequence, although this could also be considered as a bottleneck for the integration of specialised drug treatment in the broader mental health care in Flanders.

> *"Mensen met een verslavingsproblematiek - zeker met een zeer ernstige verslavingsproblematiek - die hebben overal een slechte naam. Die hebben denk ik van al de grote groepen van ggz, mensen met ernstige psychiatrische stoornissen, die hebben ongeveer de grootste vorm van stigma. Meer nog dan zware psychiatrische patiënten. Van deze mensen denkt men dat ze daar niet aan kunnen doen, van verslaafden zeggen ze dat het hun eigen schuld is. Dus dat speelt op alle niveaus van de welzijns- en gezondheidszorg." (NL_16)*

Second, one respondent mentions that the Belgian drug policy is mostly aimed at illegal drugs. Although both the Federal Drug Note and the Joint Declaration mention in their introduction that they are also aimed at alcohol, tobacco and psychoactive medication, most actions mainly focus on illegal drugs.

And third, one respondent refers to the fact that with the integration of specialised drug treatment into mental health care in Flanders, many existing initiatives had to broaden their target groups, without an increase in funding, which is a - perhaps unintentional - reduction in resources.

> *De dingen die daarin zaten, ofwel zijn die ingekanteld in de bestaande conventie. Euh, ofwel heeft men eigenlijk gezegd, ja, dat moet verruimen. Dus de projecten rond aandacht voor de kinderen binnen Pittem, bij mensen met een psychische problematiek, dat is verruimd van enkel drugsverslaafden, naar alle soorten problematieken. Als je in ene keer een veel grotere doelgroepen moet behandelen met hetzelfde personeel dan. Dan heb je eigenlijk voor die doelgroep van verslaafden een vermindering van middelen, dus dat is wel gebeurd. (NL_3)*

5.1.2.4 Conclusion of the context to the stage of realisation

The semi-structured interviews and the focus group with practitioners, civil servants and experts gave insight in how the Belgian drug policy is shaped in daily practice, and how "policy in the books" is translated to "policy in practice". First of all, many respondents emphasise the importance of cooperation and networking in order to provide an integral and integrated treatment offer. The organisation in networks (e.g. the mental health networks in Flanders, and the addiction networks in Wallonia) facilitates complementarity and matching the treatment offer, and there are several examples of good local cooperation, for example between law enforcement actors and the treatment sector.

Yet, barriers and bottlenecks remain. Respondents describe practical and organisational difference between the north and the south of Belgium as a restriction for this cooperation. They also describe how the division of competences can be a barrier to the treatment field where there is an enormous interdependency between the different policy levels. Brussels respondents also refer to the treatment field still being organised in silo's. Lastly, the fact that there are many different network structures in which organisations and institutions have to cooperate, is also perceived as a barrier for efficient cooperation.

Other barriers related to the cooperation of treatment organisation and institutions with the regional and federal governments. Many respondents described a good understanding and cooperation with the regional governments, although they also stress the lack of clear vision and growth path for the treatment offer.

Furthermore, respondents stress several issues related to the current treatment offer. They for example refer to the lack of a diverse treatment offer in Ostbelgien, to the rivalry in funding, the lack of a (diverse) treatment offer in prison, issues with crisis care and treatment of double diagnosis, as well as the lack of structural initiatives for reintegration and aftercare and minors.

Additionally, the lack of a clear and supporting framework for many of the harm reduction initiatives was often noted as the main barrier for the development of risk reduction initiatives. The divided political context is often referred to as the main barrier.

Lastly, several respondents referred to the role of scientific evidence in the treatment pillar. Although all respondents acknowledge the role of evidence as an essential part of further developing and ameliorating the treatment offer, respondents also stress the limits of focusing on 'what works' and stress the importance of the input of practice and lived experiences in the matter. Respondents also stress that the uncertain, year-by-year extended funding for positively evaluated projects is a barrier too. There are several other regions with the same needs, who are not addressed this way.

5.2 Lessons learned

The pillar 'Treatment, risk reduction and reintegration' is the second pillar of the Belgian drug policy, after 'Prevention' and before 'Enforcement'. This chapter the pillar was evaluated relying on a theory—based approach. These are the lessons learned.

POLICY INTENTIONS:

A critical appraisal of the policy logic found that:

- ⇨ The pillar 'Treatment, risk reduction and reintegration' is generally **explicit in its objectives and central actions, but often remains vague about the concrete intended outputs and outcomes**. This is illustrated by the lack of explicit outputs for almost all of the actions, and half of the outcomes. The objectives and actions are generally detailed and concrete.
- ⇨ The pillar 'Treatment, risk reduction and reintegration' is not explicitly based on a (recent) situation analysis.
- ⇨ The pillar 'Treatment, risk reduction and reintegration' **almost never distinguishes between short-term, medium-term and long-term outcomes,** although starting points for this distinction are present.
- ⇨ The pillar 'Treatment, risk reduction and reintegration' has a few inconsistencies. There are few inconsistencies in terminology to refer to people with addiction problems (various concepts are used to refer to the same thing), and the use of stigmatising language. Also, although the Federal Drug Note and Joint Declaration are aimed at both legal and illegal drugs, the actions for risk reduction all refer to intravenous drug use and the use of opiates, while in practice risk reductions addresses different substances.
- ⇨ The pillar 'Treatment, risk reduction and reintegration' is **barely explicit about the processes through which change is achieved**. Its main focus is on the policy design.

MEASUREMENT OF POLICY INTENTIONS:

With regards to the extent of realisation, we found that:

- ⇨ The document review reveals that there is no structural follow-up of the implementation of the Federal Drug Note and Joint Declaration, nor of other developments in the drug treatment field. We had to puzzle the overview in retrospect, which resulted in a very fragmented and anecdotical picture.
- ⇨ There have been many developments in the treatment field, both actions that were intended by the Federal Drug Note and the Joint Declaration, as well as other developments within the drug treatment field. Some objectives were fully realised. For other objectives, the actions were not realised in the way that was intended by the Federal Drug Note and the Joint Declaration, for example because the concept has changed or the action was given a broader

interpretation (e.g. in the wider mental health field). The developments for the objective 'to fund each care circuit' are much more modest. It is also noteworthy that for various objectives a lot of additional actions have been realised, which were not foreseen in the Federal Drug Note and the Joint Declaration. The additional realisations of the risk reduction objective, however, are not entirely in line with the general framework set out by the Federal Drug Note and the Joint Declaration, for example with the pilot project of controlled heroin distribution and with the drug consumption rooms.

- ⇨ There are a lot of discrepancies in the level of perceived realisation. This is sometimes explained by regional or policy-level differences. Still, there are some discrepancies that cannot be explained by regional or policy-level differences. Discrepancies can be due to differences in interpretation, non-quantifiable or measurable actions, or the lack of overview on the different prevention realisations in the prevention field.
- ⇨ When we compare the results of the document review with the survey, we learn that for most objectives, there are discrepancies between the actual and perceived realisation. In most cases, we see that, although the document review identifies certain actions as realised, survey respondents indicate them as partially or even not realised. For some actions, it is the other way around. This show that actions may be implemented (cf. document review), but they do not necessarily operate in the best possible way and improvement is necessary (cf. survey).

With regards to the context to the stage of realisation, practitioners and civil servants perceived that:

- ⇨ Cooperation and networking is important in order to provide an integral and integrated treatment offer, and there are many good examples of (local) cooperation initiatives, as well as working within networks. Yet, barriers and bottlenecks in this cooperation remain.
- ⇨ Although respondents mention a good understanding between treatment organisations and institutions with the regional and federal governments, a lack of vision and growth path for the expansion of the treatment offer lacks, as well as a specific expertise regarding addiction (treatment).
- ⇨ Respondents stress several issues related to the current treatment offer.
- ⇨ The lack of a clear and supporting framework for many of the harm reduction initiatives was noted as the main barrier for the risk reduction initiatives.
- ⇨ The role of scientific evidence in the treatment pillar is ambiguous according to respondents. On the one hand, the role of evidence was acknowledged as an essential part of further developing and ameliorating the treatment offer. On the other hand, there are limits of focusing on 'what works' and respondents stress the importance of the input of practice and lived experiences in the matter.

CHAPTER 7

PILLAR 3: ENFORCEMENT

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6 PILLAR 3: ENFORCEMENT

This chapter discusses the pillar 'Enforcement' of the Belgian drug policy.

The pillar 'Enforcement' was – like the other pillars - developed on the findings described in the report of the Parliamentary Working Group on Drugs in 1997. The Parliamentary Working Group (PWG) on Drugs described the drug supply market in 1997 as a global phenomenon. Globalization of the production of illicit drugs was accelerating, and the production of illicit drugs was increasing worldwide, both geographically and quantitatively. The PWG emphasised the role of Belgium in the worldwide drug supply. First, they acknowledged that Belgium played a role as a transit country for illicit drug destined for the European market. Second, they stressed the features of Belgium as a production country for cannabis, amphetamines and related synthetics (Parliamentary Working Group on Drugs, 1997; Colman et al., 2018). Criminal organizations involved in the professional drug production and trafficking in Belgium, were internationally active and most of the actors involved in these high-level, professional activities, consisted of non-Belgians, such as Turkish groups and West Africans. The PWG highlighted that their activities impacted the legal economy, amongst others by laundering money and by investing this criminal obtained money back into the legal economy. The Cell for Financial Information Processing had observed that drug trafficking generated a large proportion of money laundering activities in Belgium, however criminal convictions in these cases were rare. Additionally, the PWG noted that Belgium had to deal with local nuisance phenomena attributable to the drug retail market (Parliamentary Working Group on Drugs, 1997). The drug retail level caused local nuisance phenomena in certain neighbourhoods and suburbs of large cities. The PWG described how drug dealing activities, often committed by "problem users[85]" financing their drug use by dealing drugs, frequently lead to insecurity problems, sometimes to such an extent that it disrupted the quality of life in certain neighbourhoods. Furthermore, the PWG described drug tourism in Belgium (the consequences of the nuisance caused by drug tourism from northern France to the Netherlands) and emphasised that a large part of the activities on the retail market are merely out of lucrative considerations. Additionally, the PWG observed that some drug users were still the subject of a criminal intervention (and even prison sentences), even if the drug user had not committed crimes disrupting the social order. In addition, at all levels of the criminal justice system– i.e. investigation, prosecution, sentencing and execution of sentencing level - there had been a massive increase in drug-related crime. This was illustrated by the number of people detained due to drug-related crime, rising from 1% in 1970, to 30% (and sometimes more) in 1996. Lastly, the PWG stressed the various problems related to the omnipresence of drugs in the Belgian prisons.

Subsequently, the PWG advised to introduce a pillar 'Enforcement' in addition to the pillars focussing on 'Prevention' and 'Treatment, risk reduction and reintegration'. According to the PWG, this pillar should highlight the principle of repression as an "*ultimum remedium"* and emphasise that the priority of this pillar should be on (drug-related) crimes that disrupt the social order. The Federal Drug Note (2001) answered these recommendations and introduced a pillar 'Enforcement', in addition to the pillar 'Prevention' and 'Treatment, risk reduction and reintegration'. This philosophy was confirmed in 2010 with the Joint Declaration of the Interministerial Conference Drugs. In this policy document too, 'Enforcement' was considered as one of the three central pillars.

This chapter discusses the pillar 'Enforcement' and the different related actions stressed in the Federal Drug Policy Note (2001) and the Joint Declaration of the Interministerial Conference Drugs (2010). We

[85] We adopt the same terminology as used in the policy documents. This has two consequences. First, the policy documents often use certain concepts interchangeably (e.g. 'addicts' or 'addiction' with 'problematic user' or 'problematic use'). We know these concepts do not have the same meaning. However, since the description of the logic model is a representation of these policy documents, we adopt the terminology as used in the policy documents. Second, some of the concepts used in the policy documents (and therefore also in the description of the logic models) are considered stigmatizing language. We discuss the two problems with these concepts further on in the chapter.

first explain the logic model of the pillar 'Enforcement', i.e. how the actions identified in the pillar 'Enforcement' intend to achieve change. Subsequently, we conduct a critical analysis of the logic model. This way, discrepancies, inconsistencies and omissions in the policy's theory are raised and discussed. Next, we present the results of the process evaluation, i.e. whether the actions have been implemented the way it was intended and whether the aims and actions are still relevant to the current issues and needs within the Belgian drug field.

6.1 What were the policy intentions? A logic model of the pillar 'Enforcement'

In this section, we address the first research question 'What are the identified aims, action points, intended outputs and intended outcomes of the Belgian drug policy?'. To do so, we rely on logic models as an evaluation framework (see Chapter 2Methodology). Logic models are a systematic and coherent description of a policy that identify the objectives, actions, inputs, intended outputs and intended outcomes underpinning a certain policy (EMCDDA, 2017a). The logic models make the underlying assumptions of how a policy aims to achieve change, explicit. Logic models identify and describe how a policy fits together in a simple sequence. The policy's theory is described in a logical, linear depiction of how policy makers intend to achieve change.

To estabish a logic model for the pillar 'Enforcement', we conducted a document analysis of the two central and overarching policy documents of the Belgian drug policy: the Federal Drug Note of 2001 and the Joint Declaration of the Interministerial Conference of Drugs of 2010. We extracted the aims, the actions, the inputs, the intended outputs and the intended outcomes (where possible) word for word from these documents, and rearanged them in a logical sequence (Figure 15. *Summary of the logic model of* ***the pillar 'Enforcement'***) We additionally analysed the report of the Parliamentary Working Group on Drugs (1997) to further contextualise these aims and actions (if actions were unclear)[86].

The logic model on 'Enforcement' shown by Figure 15. *Summary of the logic model of* ***the pillar 'Enforcement'*** thus describes how the aims and actions under the pillar 'Enforcement' – according to the Belgian drug policy - contribute to the central aims of the Belgian drug policy.

Since the description of the logic model is a representation of the central policy documents, we adopt the terminology mentioned in the policy documents to describe the actions, inputs, intended outputs and intended outcomes. That means that sometimes stigmatising language is used, or old names of institutions that have since changed names are used. For the latter, we added the current name between brackets.

6.1.1 Five main objectives and several corresponding actions

The Federal Drug Note (2001) and the Joint Declaration of the Interministerial Conference of Drugs (2010) identify five main objectives within the pillar 'Enforcement'. Four objectives specifically focus on enforcement, and two objectives fit within the wider transversal themes (however are explicitly emphasised within this pillar too):

1. To control drug supply
2. To respond proportionally to criminal offences
3. To develop a penitentiary drug policy
4. To stimulate research and evaluation in the pillar 'Enforcement'
5. To commit to an integrated and integral drug policy in the pillar Enforcement

[86] An elaborate description of the methodology can be found in chapter 2.

6.1.1.1 Objective 1: Actions aimed at controlling[87] drug supply

The **first group** of actions within this objective, strive for an effective international cooperation for drug supply control. A first action describes how the Belgian criminal justice system wants to engage in the UN and EU drug policy. A second actions expresses the will to keep track of the changes of drug policy in neighbouring countries an assess their impact on drug supply in Belgium. Another action promises to also do the opposite, namely to assess the impact of Belgian policy measures to restrict illicit drug supply on its neighbouring countries. Furthermore, one action emphasises the need for policy coordination, thorough international cooperation and consultation in the various phases of the criminal justice system, in a structural way. Other actions mentioned to intensify police and judicial cooperation and consultation with neighbouring countries and to examine the possibilities of asset-sharing in the context of international cooperation.

The **second group** of actions within this objective, aims to build synergies between policy plans of different departments. Actions concretely emphasise the importance of Federal Security and Detention plans to combat illicit drug trafficking, especially the policy plan elaborating on organized crime and white-collar crime. Furthermore, actions prioritized the establishment of a Framework on Integral Security, where special attention should be given to the security chain. The National Security Plan and the subsequent action plans should take the priorities and principles of this Framework on Integral Security into account. In anticipation of the Framework, the preparation of concrete integrated action plans, in particular between the judicial and police authorities, is prioritized.

6.1.1.2 Objective 2: Actions aimed at responding proportionally to criminal offences

A **first group** of actions within this objective are aimed at **reinforced repressive responses towards drug trade**. One action mentions the drafting of a ministerial guideline by the Minister of Justice in consultation with the Board of Prosecutors General. This ministerial guideline will list the priorities in the prosecution policy towards drug trafficking. Another action mentions to intensify the fight against the improper production and trafficking of precursors. A similar action emphasises the fight against the production of synthetic drugs. One action focuses on the increased attention for cocaine import and trafficking of heroin. The following action wants to develop a legal regulation and infrastructure for the proactive criminal investigation and special investigation techniques. Another action stresses that the 'Drug program' centralising information on drug-related crime of the "National Guard" (Dutch: *Rijkswacht*) will be integrated into the program of the federal police. The policy strategy further mentions that the operation will be extended in time to the intelligence level. Furthermore, the policy strategy mentions that all measures will be accompanied by specialised and extensive training and further education of the magistracy on the one hand and police actors on the other hand. Additionally, the federal government emphasised the development of a preventive and treatment dimension to address drug tourism. A last action is aimed at confiscating profits from drug trade. The policy strategy mentions several ways to fulfil this action, namely by optimizing the possibilities for seizure and confiscation and urging the rapid seizure of drug money through a directive of the Minister of Justice, by taking initiatives to enable the effective forfeiture of the estimated proceeds of drug trafficking, by accompanying an investigation of drug trafficking by a financial analysis at the level of investigation or prosecution, by preventing to delay the additional sentence of confiscation, and lastly, by investigating whether confiscated drug money can be used to finance drug treatment and drug prevention (including therapeutic advice).

A second group of actions is aimed at identifying differentiated judicial responses towards drug use. There are numerous different actions grouped here. A first (and perhaps the most notable) action, is the amendment of the Drug Law of 1921 in order to make a distinction between cannabis and other illegal

[87] The Joint Declaration of the Interministerial Conference of Drugs of 2010 uses the concepts of "controlling" and "restricting" as interchangeable

drugs and to no longer criminalize the use of illegal drugs in group. Linked to this action, is the action of the federal government to draw up a Royal Decree (application of art. 1 of the Drug Law of 1921) obliging administrative and criminal policy actors to integrate prevention, treatment and security into a single policy concept. The policy documents emphasise the importance of an early intervention by the care workers with someone who uses drugs, instead of a repressive intervention. This way, they want to stress repression as an ultimum remedium. At the same time, the policy documents highlight that the criminal justice system has to take the individual situation of the (drug-using) offender into account. Problematic drug users who come in contact with the criminal justice system will be referred to treatment. Still, the policy documents acknowledge that drug dependence is no reason to pardon criminal behaviour. The Royal decree should distinguish between three categories: (1) importing, producing, possessing a small quantity of illegal drugs for personal use, without an indication of problematic use or use that causes public nuisance (2) Importing, producing, transporting, possessing a quantity of illegal drugs exceeding the qualification "possession for own use" (category 1) and/or committed under the aggravating circumstances provided for in the drug law and (3) drug-related offences, other than those covered by category 1 and category 2. Elaboration on all three categories is given in Figure 14. Three categories in prosecution policy according to the Federal Drug Note (2001).

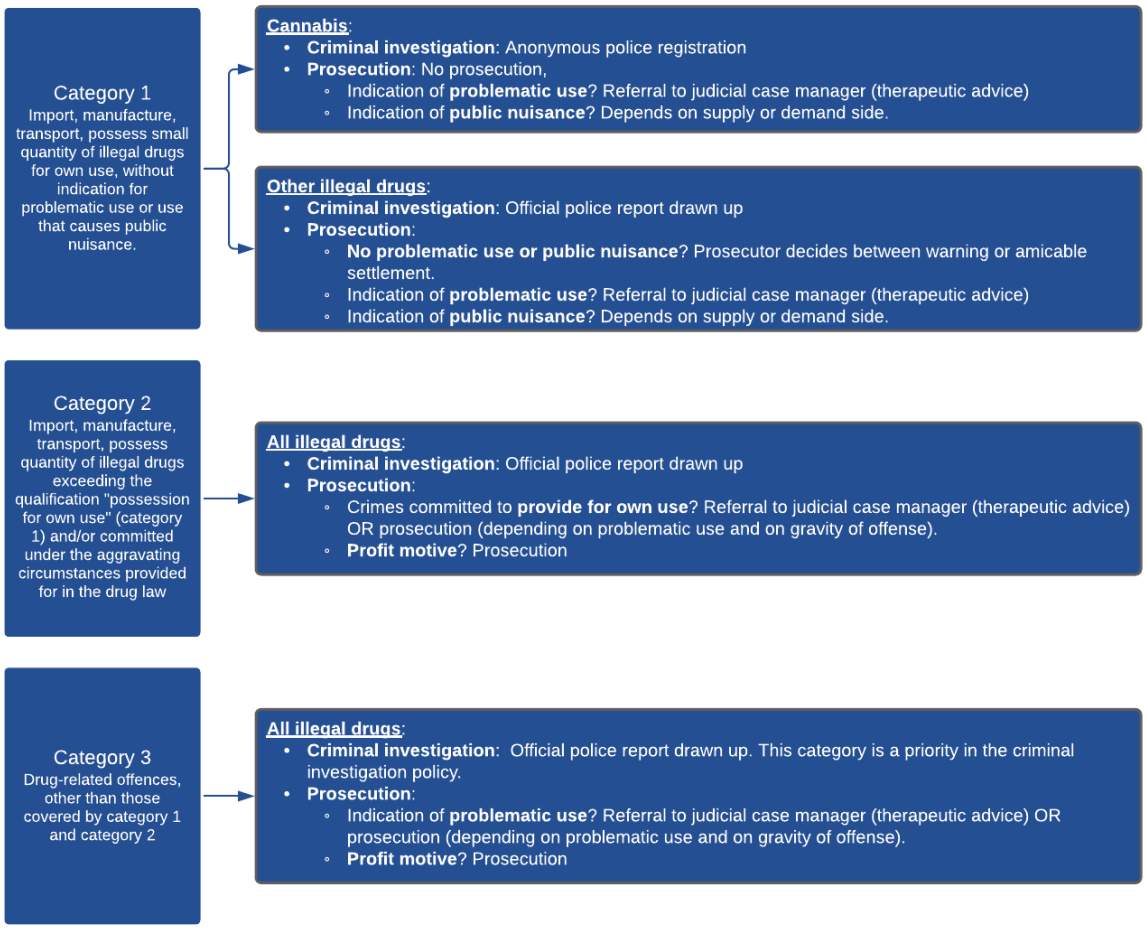


Figure 14. Three categories in prosecution policy according to the Federal Drug Note (2001)

Other actions in this group are: the creation of an efficient internal control system for the application of the Royal Decree, assigning the final responsibility of all drug cases within a district to one magistrate (the so-called 'reference magistrate for drugs'), to organise regular meetings between all reference magistrates for drugs' of all Belgian districts, to develop an effective, simple and uniform measuring

instrument to assess these categories and emphasising the role of the Zonal Security Committee as a forum for a local drug policy.

Furthermore, another action focuses on the removal of the first postponed conviction on the excerpt from the criminal record if this conviction relates to drug-related offences (other than trafficking). Two other actions focus on abroad application of social surveys when imposing individual probation conditions and a call for the broad application of probation of drug-related crime (e.g. through legislative amendments). Other actions specify that the Federal government wants to implement the obligation for prosecutors to motivate why they did not request the application of the Probation Law before a judge. In a more general way, some actions want to stimulate alternatives to punishment and a maximum referral to the treatment at all levels of the criminal justice system and to develop the cooperation between the judiciary and treatment services, in case of judicial coercion for treatment. Judicial case managers should help with the latter. In this regard, one action will review the subsidization of the alternative measures through the Global Plan, so that criminal justice can rely on the treatment offer of Public Health, despite the coercion element. One action (originally placed under the pillar 'Treatment, risk reduction and reintegration') also emphasises the importance of referral protocols and cooperation protocols between criminal justice and the care sector, with respect for each other's individuality and finality. Lastly, the Federal government will urge the communities to legally recognize therapeutic advice as an option for judicial referral to treatment.

6.1.1.3 Objective 3: Actions aimed at developing a penitentiary drug policy

There are quite some actions aimed at developing a penitentiary drug policy, all stemming from the Federal Drug Note (2001). Through a Directive on a penitentiary drug policy, the actions take measures to prevent drugs being brought into prisons, while respecting human rights and maintaining social relations with significant others; educate and train the staff of the penal institutions in the prevention of drug use and in the reduction of its harmful effects; ensure that external health care providers can take preventive and health care measures within the penitentiary institutions (with preference going to the services that have established cooperation agreements between the communities and the Justice department); obligate penitentiary institutions to respond to the medical and psychosocial needs of the detainees, to manage crisis situations and to orient the detainees towards an appropriate solution. In line with these actions, one action mentions that detainees must be able to maintain contact with at least one external treatment service during his or her detention, which will be able to supervise the detainee after his or her release. Information of the release date should be communicated as soon as possible to this treatment service.

Another action appoints a doctor attached to the psycho-social service as reference doctor so that continuity of treatment could be ensured when a detainee goes to another penitentiary institution or is released from a particular penitentiary institution.

Furthermore, one action ensures specific attention to penitentiary substitution treatment (originally, the Federal Drug note listed this action under the pillar 'Treatment, risk reduction and reintegration', we replaced the action to 'Enforcement'). This substitution treatment will mainly be reserved for pregnant women, prisoners serving short sentences and persons who are seropositive or infected with hepatitis. In all other cases, substitution treatments will only be prescribed if the aim is to reduce the addiction and an abstinence plan is drawn up. Additionally, active vaccination and detection policy will be implemented in each penitentiary institution.

Besides that, measures will be taken to prevent the overrepresentation of migrant drug users in penitentiary institutions. Moreover, actions want to ensure that they have the same access to drug treatment as Belgian drug users.

Lastly, the drug-free departments and similar projects will be evaluated.

6.1.1.4 Objective 4: Actions aimed at stimulating research and evaluation in the pillar 'Enforcement'

Two actions are mentioned under this objective: (1) to systematically evaluate the actions taken to help drug users or reduce risks in terms of their impact on the supply market and the negative effects of their drug use, and (2) to map the entire criminal drug chain, including the investigation of the origin of the drugs, the principals and top of the organization, the market, the criminal proceeds, …

6.1.1.5 Objective 5: Actions committing to an integral and integrated drug policy

This objective only mentions two actions: (1) Emphasise that criminalization is an essential component of prevention policy, as a signal that the government does not accept drug use, and (2) to move away from the often-misinterpreted concept of "tolerance policy" and to speak consistently of a "policy of dissuasion".

6.1.2 Inputs

The inputs displayed in *Figure 15. Summary of the logic model of the pillar 'Enforcement'* , show the human, financial, organizational, and community resources needed to implement the actions under the pillar 'Enforcement'. The inputs are not always clearly defined in the policy documents. Therefore, not every action was allocated a specific input.

For the first group of actions, namely the **actions aimed at controlling drug supply**, not a single input was indicated in the policy documents: no budget, nor other resources were set for these actions.

Some actions aimed at group 2, **responding proportionally to criminal offences**, do mention the input attributed to implement them. The actions aimed at reinforced repressive responses towards drug trade, do not generate extra costs to the regular budgets. Moreover, the policy documents mention that the confiscation of drug money even has positive budgetary effects. The actions aimed at a differentiated judicial response towards drug use, do have budgetary repercussions. The precise budget is not indicated, but disposed as 'to be discussed during budgetary control'. The actions 'calling for removal of the first postponed conviction on the excerpt from the criminal record if this conviction relates to drug-related offences (other than trafficking), but also for a broad application of social surveys when imposing individual probation conditions and a call for the broad application of probation of drug-related crime (e.g. through legislative amendments)' can rely on a large budget the Minister of Justice has at his disposal. The action on therapeutic advice, can rely on funds within the framework of the security and community contracts, the prevention contracts and the drug contracts of the municipalities, but also on funds made available for judicial alternative measures, criminal mediation or Praetorian probation.

For the actions aimed at group 3, **developing a penitentiary drug policy**, the policy documents mention that 'the Minister of Justice has a large budget at his disposal' to implement all the actions. One other input mentioned however, is the drafting of a Directive on penitentiary drug policy.

The actions aimed at group 4, **stimulating research and evaluation in the pillar 'Enforcement'**, can rely on the financial resources of the Federal Science Policy (cf. Pillar 'Epidemiology, evaluation and research').

For actions aimed at group 5, reducing **committing to an integral and integrated drug policy**, no budget or other inputs are mentioned.

6.1.3 Intended outputs

The outputs displayed in *Figure 15. Summary of the logic model of the pillar 'Enforcement'*, show the immediate outputs (deliverables) that result from the implementation of the actions under the pillar 'Enforcement'. The intended outputs are, similar to the inputs, not always clearly defined in both policy documents. Some outputs are not mentioned, but could be deduced from (parts of) the policy documents. These outputs are indicated in grey. Sometimes, there is no output defined (not literally, not deducible). In these cases, we left the spaces blank.

The outputs of the actions aimed at group 1, **controlling drug supply,** are diverse. The **first group** of actions striving for an effective international cooperation for drug supply control, comprises of the following outputs: alignment of the Belgian criminal justice policy with the EU and UN policies, initiatives for the systematic evaluation of the drug policies of neighbouring countries in turns of drug supply, initiatives for the systematic evaluation of the Belgian supply reduction measures at regional and international level, initiatives exploring asset-sharing in the context of international cooperation, cooperation and consultation initiatives between police and judiciary in neighbouring countries and the structural consultation platforms for cooperation with neighbouring countries in the administration of criminal justice. The second group of actions within this objective, aiming to build synergies between policy plans of different departments, results in the following outputs: Federal Security and Detention Plans, a Framework on Integral Security and action plans implementing the National Security Plan, and the alignment of the National Security Plan and the action plans of the Public Prosecutor's Office (e.g. College of Procurators General, Federal Public Prosecutor's Office, public prosecutor's offices) with the Framework on Integral Security.

The outputs of the actions aimed at group 2, **responding proportionally to criminal offences,** has several outputs. A first group of actions within this objective are aimed at **reinforced repressive response towards drug trade**. A first output mentioned for this group, is a directive of the Minister of Justice (together with the Board of Prosecutors-General) on tacking drug trafficking. A second output is focused at specific measures restricting trafficking and production of synthetic drugs. Furthermore, the policy documents refer to an information platform on drug-related police actions, training and refresher courses for the judiciary and the police for the aforementioned measures, initiatives to develop the preventive and treatment dimension with regard to drug tourism, legislation that regulates and further develops proactive investigation and special investigation techniques, a guideline and refined legislation expanding possibilities for confiscation, initiatives to enable the effective confiscation of the estimated proceeds of drug trafficking, financial preliminary analysis in criminal investigations and lastly, an initiative that investigates whether confiscated drug money can be used to finance drug treatment and drug prevention.

The outputs of the second group of actions (aimed at a **differentiated judicial response towards drug use)** are more detailed. Some of these actions produce legislative amendments that distinguish between drug retail for sole profit and drug retail to finance drug use, a Royal Decree introducing three categories of drug-related offences, an internal control system to monitor the application of the Royal Decree in the districts, reference magistrates for drugs, recurring meetings between the reference magistrates of the different districts, a measuring instrument for registration and statistics of the three categories, the local and integrated drug policy of the Zonal Security Committee, and the directive of the Minister of Justice and Board of Prosecutors General. Furthermore, outputs in this group mention a clean criminal record in the case of a postponed conviction, an increase in the use of social surveys, initiatives and/or legislative changes that stimulate magistrates to appeal to the Probation Act, and motivations for deviating from the premise to refer problem users from the criminal justice system to treatment. Lastly, criminal justice referral to treatment, initiatives for cooperation between the judiciary and care workers, case managers in every House of Justice, funding of alternative legal measures via the Global Plan to the FPS Justice and the legal recognition of therapeutic advice are defined as outputs too.

The outputs of the actions aimed at group 3, **developing a penitentiary drug policy** are: a directive on a penitentiary drug policy, the measures to prevent drugs being brought into prisons, training courses of the staff of the penal institutions in the prevention of drug use and in the reduction of its harmful effects; external health care providers within the penitentiary institutions; initiatives to obligate penitentiary institutions to respond to the medical and psychosocial needs of the detainees, initiatives that enable detainees to maintain contact with at least one external treatment service during his or her detention, quick communication on the release date to this treatment service, reference doctors, penitentiary substitution treatment, active vaccination and detection, measures to prevent the overrepresentation of migrant drug users in penitentiary institutions, actions to ensure that they have the same access to drug treatment as Belgian drug users and lastly, evaluation reports on the drug-free departments and similar projects.

The outputs of the actions aimed at group 4, **stimulating research and evaluation in the pillar 'Enforcement',** are research reports on the impact of measure for drug users or measures reducing risks and their impact on the supply market, and research reports on the mapping of the criminal drug chain.

The outputs of the actions in group 5, **committing to an integral and integrated drug policy** are initiatives that implement the term 'policy of dissuasion', and initiatives that emphasise the criminalization is an essential component of prevention policy, as a signal that the government does not accept drug use.

6.1.4 Intended outcomes

The summary depictured in *Figure 15. Summary of the logic model of the pillar 'Enforcement'* , shows the outcomes of the actions under the pillar 'Enforcement'. These outcomes demonstrate the mid- and long-term effect the policy makers sought to achieve by implementing the actions above. The policy documents often not mention a clear outcome. Therefore, some of the described actions do not have a clear outcome.

The outcomes of the actions aimed at the first group, **controlling drug supply,** are various. The **first group** of actions striving for an effective international cooperation for drug supply control, only mentions an outcome for the action 'intensifying police and judicial cooperation in neighbouring countries' and for the action 'emphasise the need for policy coordination, thorough international cooperation and consultation in the various phases of the criminal justice system, in a structural way'. The first action should eventually result in **structural cooperation** in the field of police and criminal justice **to (1) more efficiently combat cross-border drug crime, (2) exchange of information to the maximum extent possible, (3) adequately follow-up requests for legal assistance**. The second action should result in **enhanced cooperation** and **policy alignment** between police and criminal justice actors. The other actions in this group did not define a specific outcome.
The second group of actions striving to build synergies between policy plans of different departments, is intended to lead to a better synergy between the plans of all the different departments and policy domains, as well as consistency in the Belgian criminal investigation and prosecution policy.

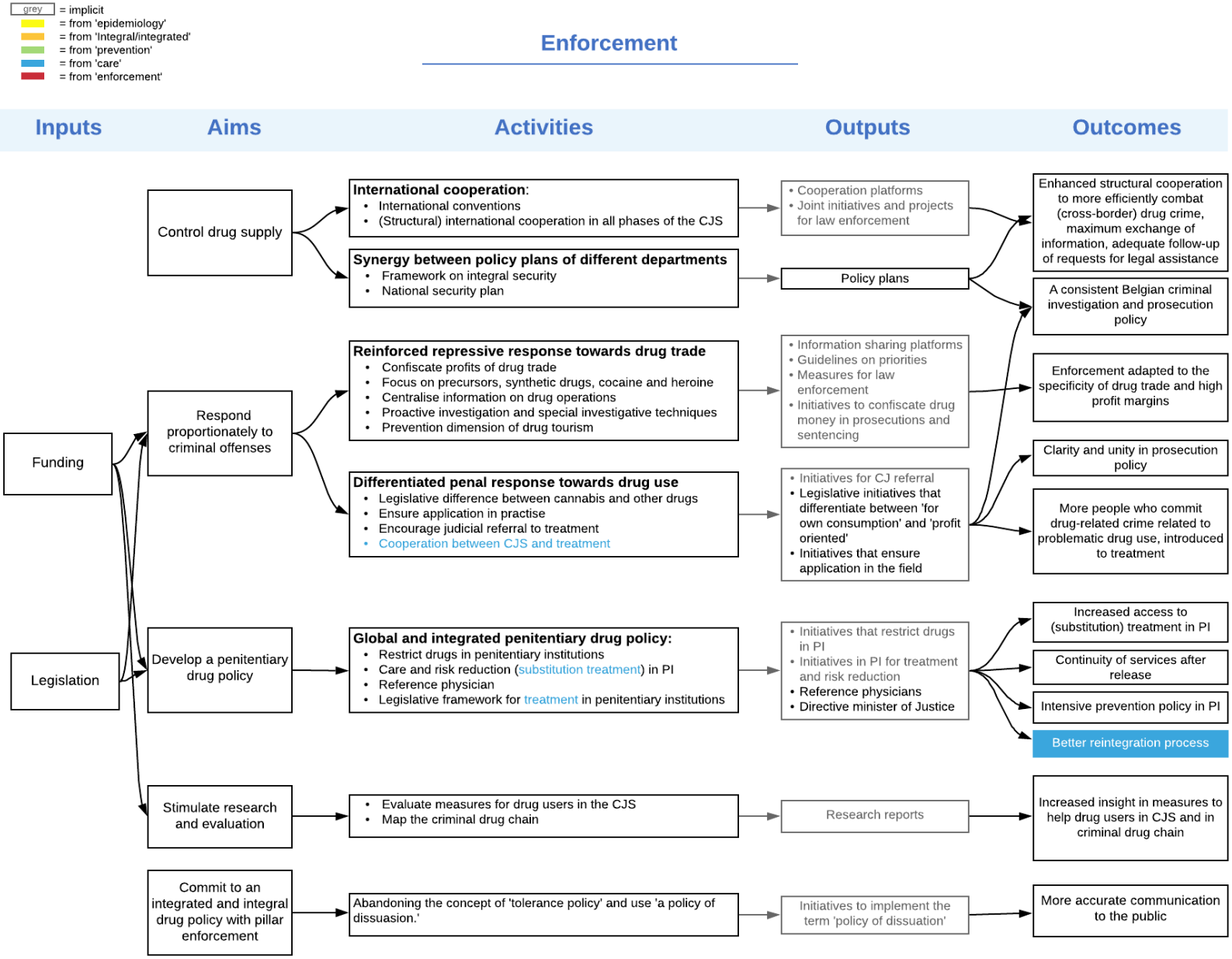
The outcomes of the actions aimed at **responding proportionally to criminal offences**, are split into two groups.
A **first group** of actions is aimed at a **reinforced repressive response towards drug trade.** These actions should result in a reduction in drug trade and precursors (more generally also referred to as a reduction in drug supply) through centralized information on drug-related police operation and specialization of magistrates and police. Another outcome is an improved criminal law enforcement through adaptation to the high profits margins of drug supply. The last outcome defined (specifically for the action 'to investigate whether confiscated drug money can be used to finance drug treatment and drug prevention'), is the financing the treatment of non-insured drug users.

The **second group** of actions (aimed at a **differentiated judicial response towards drug use)** should eventually result in clarity about the margins of discretion in the criminal investigation and prosecution policy, uniform application of the prosecution policy in all districts, but also towards the police services, peer learning and sharing of best-practices and unambiguous registration. All these outcomes eventually mention clarity and unity in prosecution policy. Another outcome in this group, is the limitation of prosecution and imprisonment to those who, in addition to drug use, have committed offences that disrupt social order and require a social response. The outcomes of the other actions in this group are: no stigmatization of the criminal record, individualization of the sentencing of drug law offenders, people who commit drug-related crime related to problem drug use introduced to treatment, better cooperation between criminal justice and treatment services, and lastly, unity in all House of Justices in the criminal justice referral to treatment.

The outcomes of the actions aimed at **developing a penitentiary drug policy**, have several outcomes: an improved reintegration process to prevent relapse, access to substitution treatment in penitentiary institutions, a reduced drug supply in penitentiary institutions, an intensive prevention policy, continued treatment when leaving the penitentiary institution, a reduction of drug induced infectious diseases, a reduction of addiction, access to treatment for immigrant drug users, and orienting detainees with drug problems towards appropriate treatment.

The outcomes of the actions aimed at **stimulating research and evaluation in the pillar 'Enforcement'** are twofold: insight into the effectivity of measure taken towards drug users and a structured approach towards the priorities on the supply side.

The outcomes of the actions **committing to an integral and integrated drug policy** should lead to a better and renewed communication towards society.


grey = implicit
= from 'epidemiology'
= from 'Integral/integrated'
= from 'prevention'
= from 'care'
= from 'enforcement'
Enforcement
Inputs
Aims
Activities
Outputs
Outcomes
Funding
Legislation
Control drug supply
Respond proportionately to criminal offenses
Develop a penitentiary drug policy
Stimulate research and evaluation
Commit to an integrated and integral drug policy with pillar enforcement
International cooperation:
• International conventions
• (Structural) international cooperation in all phases of the CJS
Synergy between policy plans of different departments
• Framework on integral security
• National security plan
Reinforced repressive response towards drug trade
• Confiscate profits of drug trade
• Focus on precursors, synthetic drugs, cocaine and heroine
• Centralise information on drug operations
• Proactive investigation and special investigative techniques
• Prevention dimension of drug tourism
Differentiated penal response towards drug use
• Legislative difference between cannabis and other drugs
• Ensure application in practise
• Encourage judicial referral to treatment
• Cooperation between CJS and treatment
Global and integrated penitentiary drug policy:
• Restrict drugs in penitentiary institutions
• Care and risk reduction (substitution treatment) in PI
• Reference physician
• Legislative framework for treatment in penitentiary institutions
• Evaluate measures for drug users in the CJS
• Map the criminal drug chain
Abandoning the concept of 'tolerance policy' and use 'a policy of dissuasion.'
• Cooperation platforms
• Joint initiatives and projects for law enforcement
Policy plans
• Information sharing platforms
• Guidelines on priorities
• Measures for law enforcement
• Initiatives to confiscate drug money in prosecutions and sentencing
• Initiatives for CJ referral
• Legislative initiatives that differentiate between 'for own consumption' and 'profit oriented'
• Initiatives that ensure application in the field
• Initiatives that restrict drugs in PI
• Initiatives in PI for treatment and risk reduction
• Reference physicians
• Directive minister of Justice
Research reports
Initiatives to implement the term 'policy of dissuation'
Enhanced structural cooperation to more efficiently combat (cross-border) drug crime, maximum exchange of information, adequate follow-up of requests for legal assistance
A consistent Belgian criminal investigation and prosecution policy
Enforcement adapted to the specificity of drug trade and high profit margins
Clarity and unity in prosecution policy
More people who commit drug-related crime related to problematic drug use, introduced to treatment
Increased access to (substitution) treatment in PI
Continuity of services after release
Intensive prevention policy in PI
Better reintegration process
Increased insight in measures to help drug users in CJS and in criminal drug chain
More accurate communication to the public

Figu

6.2 Critical appraisal of the logic models

In this section, we address the research question 'To what extent are the logic models of the pillars and transversal themes consistent, coherent and logical?'. This critical appraisal of the logic model is a first step of the process evaluation, in the sense that it allow us to verify whether possible policy issues are attributable to a poor theoretical/conceptual framework.

Building further on the document analysis of the central policy documents, we critically assess the logic models, relying on indicators of internal validity (Funnell & Rogers, 2011). This way, discrepancies, inconsistencies and omissions in the policy's theory are raised and discussed.

The internal validity of the logic models shows to what extent the policy theory is clear, realistic and logic about what the policy aims to achieve, and how the policy wants to achieve these outcomes (Funnell & Rogers, 2011). In this section, we assess this internal validity based on five indicators (ref): Clarity of description, the outcome chain, demonstration of how the outcomes are related to the problem, the logical argument of the policy theory, and the articulation of mechanisms for change.

6.2.1 Clarity of description

A first measure of internal validity is 'clarity of description'. It assesses whether the logic model describes how the policy works in a detailed way.

The pillar 'Enforcement' refers to a clear definition of the problem the policy wants to address. The report of the Parliamentary Working Group on Drugs includes a thorough description of the extent, the nature, the causes and consequences of the drug phenomenon. Both the Federal Drug Note and the Joint Declaration refer to this well-developed problem description in the report of the Working Group, and build their policy objectives and actions around it. Yet, the question remains to what extent this problem description of the late nineties is still relevant, especially because the Joint Declaration was established more than 10 years later.
The Federal Drug Note provides a 16-page-long 'state of affairs', however mostly focuses on the extent of implementation of the recommendations of the Parliamentary Working Group and provides only limited additions to the problem description and drug supply in Belgium. This may not be surprising since the Parliamentary Working Group published its report only four years prior to the Federal Drug Note. The Joint Declaration on the other hand, only lists the accomplishments per authority and policy level. Neither policy document gives a detailed description of the problems they want to address, **seemingly (partially) relying on a problem description dating back to the 1997**, as outlined in the report of the Parliamentary Working Group on Drugs. It is not clear whether or not this problem description is still relevant for 2010.

Most objectives and actions are described with lots of details. Two examples are 1) the action where the federal government indicates to draw up a Royal Decree to introduce three categories of drug-related crime, or 2) the objective to develop a penitentiary drug policy. There are a few exceptions to this, especially regarding the actions mentioned in the Joint Declaration: some actions provide an unclear description, e.g. 'an active vaccination and detection policy in penitentiary institutions' not specifying what kind of policy or its target population, and some actions are formulated in very generic terms, e.g. 'Encourage alternatives to a legal sanction and a maximum referral to the treatment to the group of drug users and addicts, at all levels of the criminal justice system'. As with the pillars 'Prevention' and 'Treatment, risk reduction and re-integration', this confirms that the Joint Declaration gives rather vague guidelines on how the Belgian drug policy should develop. Remarkably, however, is that the actions regarding 'Reinforced repressive response towards drug trade' are much less detailed than the actions regarding 'Differentiated penal response towards drug use'.

Although the pillar 'Enforcement' is- in general- **explicit about its objectives and central actions, it often remains vague about the intended outputs and outcomes**. In contrast to the clarity of the objectives and actions, the policy documents are **less clear about the outputs and outcomes**. The direct output of the actions is often implied, rather than specified. For example, the action 'emphasizing the need for policy coordination, thorough international cooperation and consultation in the various phases of the criminal justice system, in a structural way' implies structural cooperation and coordination platforms with other countries, however does not explicitly says so. Vague or implied outputs could raise difficulties for implementation.

There is more clarity on the outcomes, although it is **not always clear which actions and outputs lead to the desired outcome**. Similar comments made about the outputs above, could be made about the outcomes. Some outcomes are not explicitly stated. This is particularly the case for the actions concerning probation, but also for the actions outlined in 'development of a penitentiary drug policy' i.e. the action 'take measures to prevent drugs being brought into prisons' never explicitly mentions a reduced drug supply as an outcome, although that is what seems implied by the second part of the action: 'to combat drug supply in prison'. Some outcomes are not mentioned, for example the actions related to 'development of a prevention and treatment dimension with regards to drug tourism'. One could logically reason that this particular outcome would be 'a reduction in drug tourism' or 'a decrease in drug-related nuisance', however, this is not explicitly mentioned in the pillar Enforcement. Strikingly, there are no outcomes mentioned in the group of actions aimed at a 'reinforced repressive approach towards drug trade', except for the actions focusing on the confiscation of the profits of drug trade. This is problematic, because outcomes are the changes a policy maker wants to achieve, and when this is omitted, the actions lack direction.

The same analysis relates to input. Except for therapeutic advice and research and evaluation, no budget was defined. This does not mean that there was no budget allocated, it was however not specified in the policy documents. Other inputs than budget allocations were only mentioned when outlining the actions regarding the development of a penitentiary drug policy (i.e. a directive would be established to implement the actions).

6.2.2 The outcome chain

A second measure of internal validity is whether the logic model is built around the outcomes it aims to achieve. Are the outcomes central to the logic model, or are there other elements that are accentuated?

A first observation, is that the policy documents **often list the intended outcomes, without indicating to what action or output the outcome relates**. As such, it is not always clear which specific action leads to which specific outcome. For example, the objective 'develop a penitentiary drug policy' spells out a list of actions, and alternates it in between with intended outcomes. This way, it is not clear whether an outcome is related to a specific action, respectively a group of actions, or if it does not relate to an action at all. The critical questions about the necessity of certain actions and/or missing outcomes, can therefore not be answered.

Although some outcomes indicate a difference in type of outcomes, most outcomes mentioned in the policy documents **do not distinguish between medium-term and long-term outcomes**. For example, the actions aimed at international cooperation mention the outcome 'structural cooperation in the field of police and criminal justice in order to (1) more efficiently combat cross-border drug crime, (2) exchange of information to the maximum extent possible, (3) adequately follow-up requests for legal assistance'. Although the outcome (implicitly) mentions short-term outcomes (structural cooperation), medium-term outcomes (exchange of information to the maximum extent possible; adequately follow-up requests for legal assistance'), and even long-term outcomes (more efficiently combat cross border drug crime), the policy documents do not make this explicit distinction.

Changes like 'clarity and unity in prosecution policy', 'the limitation of prosecution and imprisonment to those who, in addition to drug use, have committed offences that disrupt social order and require a social response' and 'access to substitution treatment in penitentiary institutions' are often described as an end-point of the drug policy. Although these outcomes are essential to understand the policy logic, they do not illustrate the long-term changes the policy makers want to achieve. These long-term changes should be made explicit, all the more, because these long-term outcomes explain how the actions contribute to the three central outcomes of the Belgian drug policy[88].

In general, we can conclude that the logic model on 'Enforcement' seems to emphasise on the actions and the objectives, and less on the outputs and outcomes. The pillar 'Enforcement' is therefore more centred around what the policy (already) does (e.g. establish a penitentiary drug policy, responding proportionally to crime), than the concrete results it wishes to see in the future.

6.2.3 The demonstration of how the outcomes that are related to the problem

A third measure of internal validity questions whether the logic model indicates how the outcomes address the problem(s) that the policy aims to address. This means that we assess if and how the problem(s) leading to the establishment of the policy, are linked to the intended outcomes.

We previously established that the problem description is elaborate and thorough, though dates from the 1990's (Parliamentary Working Group on Drugs). The objectives and actions described in the pillar 'Enforcement' address to a large extent the problems described in the Parliamentary Working Group, as we illustrate below.

There is however one exception. The report of the Parliamentary Working Group on Drugs described **four main trends** concerning drug supply. The first trend was **the globalisation of the drug supply** because of diversification of the supply offer in drug-producing countries and the creation of new drug production hubs in new countries. This concerns both legal (more specifically psychopharmaceuticals) and illegal substances. A second trend, was the **impact of the massive increase in drug trafficking on Belgium** as a transit country (heroin, cocaine and cannabis), as well as a production hub (for synthetic drugs). This trend is characterized with the involvement of ethnic and non-Belgian groups in network structures, an increase in poly-drug trade, the consequences for the legal economy and a diversification of criminal activities with drug trafficking and money laundering as the two most important ones. A third trend described the **local public nuisance due to retail activities** accompanied by security issues. In this context, the drug law offences, drug tourism, but also the lucrative considerations for drug trade are mentioned. The working group noted that despite the fact that personal drug use was not punishable – though possession was -, some drug users were still the subject of a criminal intervention, even if they had not committed crimes that disrupt the social order. The fourth trend described the increase of drug-related crimes in the criminal justice system. At all levels – investigation, prosecution, sentencing and execution of sentencing – an increase in drug-related offences could be observed. Linked to this observation, were the various problems related to the omnipresence of drugs in the Belgian prisons.

The Federal Drug Note gave a brief update of the problem description regarding enforcement, amongst others based on the annual reports of Interpol and Europol. The Federal Drug Note described that the EU deploys existing tools (e.g. development aid, trade instruments) to help drug production countries to combat illicit drug production. The results of crop substitution projects (alternative development), however, remained limited. The other phenomena were mainly perpetuated. The 'state of affairs' furthermore highlighted sections that were already implemented.

[88] Defined by the Federal Drug Note (2001) as: (1) a reductions of the number of dependent drug users, (2) a reductions of the physical and psychosocial damage caused by drug use, and (3) a reductions of the negative impact of the drug phenomenon on society.

The first, second and fourth trend are clearly addressed in the policy documents. There are objectives, actions and especially outcomes formulated to strengthen international cooperation, to combat drug trafficking in Belgium and to develop a penitentiary drug policy. All objectives have specific actions focusing on specific parts of the problem (e.g. actions focusing at confiscating large profits). The fourth objective (Develop a penitentiary drug policy), seems at first sight to be an addition of the Federal Drug Note, as no trends were described under 'Drug Supply' in the report of the Parliamentary Working Group on Drugs. Yet, this is mentioned in another chapter of the report (The use of legal and illegal drugs within the perspective of a qualitative and liveable society); which means that also this part of the logic model is based on the thorough problem description.

The third trend is only partially addressed: the differentiated penal response towards drug use concentrates on differentiating between consensual drug-related offences and drug trade for profit, is the primary focus. However, the focus on local public nuisance is only mentioned with one action 'development of a prevention and treatment dimension with regards to drug tourism' (and under a different objective 'reinforced repressive response towards drug trade'). Whereas the report of the Parliamentary Working Group on Drugs and the Federal Drug Note's update also clearly mentions the importance of administrative measures for mayors, neither the Federal Drug Note nor the Joint Declaration prioritize this in their actions.

6.2.4 The logical argument of the policy theory

A fourth measure of internal validity is 'the strength of the logical argument'. This means that we measure the extent to which the logic model is 'logic' in terms of coherence, sequence and completeness.

The logic model on 'Enforcement' is mostly logical. In general, the actions follow logically from the central objectives, the intended outputs (when they are defined) follow logically from the actions, and the intended outcomes result logically from the intended outputs (Culley et al., 2012). Objectives and actions are aimed both at the supply side (drug production, drug trade), and the demand side (drug use), and are fairly even divided. Also, there is consistency between the two policy documents: both the Federal Drug Note and the Joint Declaration, mention the same priorities (with the Federal Drug Note being more elaborate and concrete than the Joint Declaration). Lastly, the pillar 'Enforcement' is mostly consistent in the terminology to refer to drug use. Throughout almost the entire document they use 'drug use(r)' and 'problematic drug use(r)'. Once, 'problematic drug use(r)' is interchanged with 'addicts'. Whether or not these are the right concepts to use, is a different question. Previous BELSPO research already described the problems with and the complexity of the concept 'problematic use' (Decorte et al., 2005). This was confirmed by the Court of Arbitration on 20 October 2004. Art. 16 of the new Drugs Act of 3 May 2003 (which inserted art. 11 into the Drugs Act of 1921) was then annulled on the grounds that the notions of `public nuisance' and `problematic use' were not sufficiently precise to define an offence (cf. infra). In addition, research has shown a variety of negative consequences that stigmatizing language like 'addicts', 'drug abuser' 'drug misuser' entails (Ashford et al., 2019; Kelly & Westerhoff, 2010; Pivovarova & Stein, 2019). The repetitive use of the concepts drug user', 'problematic drug use(r)' and 'addicts' in the policy documents, is thus in itself problematic.

The pillar 'Enforcement' is primarily aimed at illegal substances, with the exception of actions referring to 'problematic use(r)'. The problematic use can be both of legal, as well as illegal substances.

There are a few exceptions to the logical policy theory. First of all, because not every action has a clear, explicit output and outcome, it is not possible to control for the 'logic' of these actions. They are simply incomplete. The same can be concluded for the lack of a concrete budget allocation for certain actions that require a certain input (e.g. the actions aimed at 'controlling drug supply' that should result in enhanced structural cooperation).

Apart from this observation, there are some inconsistencies in the logic model on 'Enforcement'. A first inconsistency, can be found with the actions in the group 'a reinforced repressive response towards

drug trade'. There are a relatively limited amount of actions listed in this group, especially when we compare it to the amount of actions in the group 'differentiated judicial response towards drug use' (the other group under the central objective 'respond proportionately to criminal offences'). There could be several explanations for this. What does stand out though, is that half of the actions from the group 'a reinforced repressive response towards drug trade' are discussed in very general terms and with little detail. The actions mention 'a directive with priorities', 'increase attention for cocaine import and trafficking of heroin' and 'intensifying the fight against improper manufacture and trafficking of precursors and the production of synthetic drugs'. Compared to the very detailed description of some of the actions in the group 'differentiated judicial response towards drug use', this is remarkable. It suggests a more defined emphasis on a judicial response towards drug use than towards drug trade. Also, the actions in this group are focused at the production and trafficking of precursors, the production of synthetic drugs, cocaine import and trafficking of heroin. There is no explicit mention of cannabis or other illegal drugs as a priority in this group.

Lastly, there are some actions 'out of place' under their objective. For example, in the group 'reinforced repressive response towards drug trade', one action mentions the development of a prevention and treatment dimension with regards to drug tourism. Drug tourism is a phenomenon associated with the retail level, so this action does not belong under this objective. It can also not be associated with the outcomes of the actions under this objective, again confirming that this action belongs somewhere else (even under a different pillar).

It is also remarkable that the only action that should be evaluated, is the one aimed at drug users (to systematically evaluate the actions taken to help drug users or reduce risks in terms of their impact on the supply market and the negative effects of their drug use), whereas the supply chain should only be 'mapped'.

We can conclude that globally, the pillar 'Enforcement' is logical, but some inconsistencies remain.

6.2.5 The articulation of mechanisms for change

The last measure of internal validity is 'the articulation of the mechanisms for change'. This entails the question 'Does the logic model clearly identify the assumed mechanisms of change that underpin its selection of outcomes and activities'. Funnell et al. (2011) describe these mechanisms for change as the 'because' statements: if A happens, then it will result in B, because of C. 'C' is the mechanism for change in this case.

In this area we can be brief. Almost none of the actions explicitly mention the mechanisms for change that lead to their outcome. This means that whereas for most actions a sequence of 'if-then' statements can be made; these sequences are often not accompanied with a 'because'. Therefore, these 'mechanisms for change' are almost completely absent from the logic model.

For some actions this 'because' can be found in the report of the Parliamentary Working Group on Drugs. Although this is not one of the central policy documents (cf. supra), it does help to uncover the mechanisms for change for some parts of the logic model. We found some (limited) explanations for mechanisms for change for the following objectives: criminal justice referral to treatment and penitentiary drug policy:

> Certain types of drug-related crime (in particular acquisition crimes and consensual crimes) are one reason why (problem) users of legal and illegal drugs end up in the criminal justice system. Criminal justice is not suited to stop the use of legal and illegal drugs, let alone to treat an addiction. The view that drug-related crime is a symptom of the underlying addiction problem and can therefore even disappear if the latter is resolved, dominates. Therefore, opportunities are created to refer (problem) users who have committed drug-related crimes from the criminal

justice system to treatment and thus keep them out of prison. In this way, policy makers want to adequately counteract the cause of these types of drug-related crime: problematic drug use.

Prison is not equipped to deal with drug use or addiction and to respond adequately to all the effects of drug problems in prison. Moreover, a concentration of people who use drugs in prison, increases the chances of illegal drug trade in prison. Therefore, it is the intention to ensure that the addicted prisoner is in contact with therapeutic facilities outside the prison, because they are able to adequately deal with addicts.

These 'mechanisms of change' are very robust, lack detail and are clearly incomplete. Apart from questioning whether these assumptions are valid (or rather: are they valid in every context, for all target audiences, and under every circumstance[89]), an important observation is that the logic model on 'Enforcement' does not entirely (and explicitly) reflect the assumptions from the Parliamentary Working Group on Drugs. The policy logic for 'criminal justice referral to treatment' stops at 'more people who commit drug-related crime related to problematic drug use are introduced to treatment, and for 'penitentiary drug policy' at 'prevention' and 'access to treatment'. Elaborations on mechanisms for change for the other actions (mostly focused at the supply side) were absent.

It is essential for a policy to explain how the intended outcomes and impact will be achieved, not only through how a policy is designed and set up (and so focus on the sequence of actions, deliverables and inputs). It is also crucial to describe the processes through which change comes about (and so focus on the relation between outcomes and eventual impact). It is clear that the pillar 'Enforcement' **focuses on the first aspect (policy design), but not on the latter (mechanisms for change).**

6.2.1 Conclusion of the policy intentions

In terms of shape of the Belgian drug policy, we first of all see that the policy documents were often explicit about the objectives and actions, and thus about what the policymakers intent to undertake. Objectives and actions are mostly described with much detail. There is one exception: the actions of the Joint Declaration remain vague and are formulated in a broad way that is hardly measurable. As with the pillars 'Prevention' and 'Treatment, risk reduction and re-integration', this confirms that the Joint Declaration gives rather vague guidelines on how the Belgian drug policy should develop. The downside if this, is that these unclear actions do not give any guidance for implementation, nor as to how to measure them. These actions are therefore difficult to implement as intended by the policy makers, as the 'intention' is not clear in the first place.

Second, although most actions and objectives were clearly defined (with the exception of the actions from the Joint Declaration), the policy documents were less concrete about the expected changes that an action should bring about. Although outputs and outcome are often explicitly mentioned, they were often a little vague or the link between an action and an outcome were unclear. There were no clear outcomes defined for the objective 'Reinforced repressive response towards drug trade'. Vague or implied outputs and outcomes cannot show how the objectives and actions are related to the intended changes in practice. This might produce problems with accountability. If it is not clear what change a certain action has to produce, then why is the action introduced? It also hinders the monitoring and evaluation of the policy plans. If it is not clear what change an action should bring about, how can we measure whether this change has occurred at all?

Third, whenever the outcomes are defined, there is no differentiation between short-term, medium-term and long-term outcomes. This makes it seem as if the short-term outcomes are the final destination of the drug policy, which they are not.

In terms of what the policy makers implicitly or explicitly emphasised, the critical analysis showed consistency between the Federal Drug Note and the Joint Declaration. There are no contradictions

[89] To measure this, the focus is put on 'effect', and that it not the intention of this evaluation.

between both policy documents and they show similar priorities. There is, however, an inconsistency between the actions related to ‘Reinforced repressive response towards drug trade’ and the actions related ‘Differentiated penal response towards drug use’. Whereas the actions of the latter are clearly defined, and the policy documents mentions specific outputs and outcomes for many of the actions, the opposite is true for the actions of the former. This seems to suggest a clear vision on the judicial response towards drug use, and less towards drug trade. Furthermore, it is remarkable that evaluation is only focused at the judicial actions towards drugs use, with the supply side only having to provide evidence for ‘mapping’. The premise of an evidence-based drug policy seems to only apply to the demand side, and not to the supply side.

6.1 Have the policy intentions been realised: a measurement

In this chapter, we describe whether the policy intentions, summarised in the logic models, were actually realised.

We discuss the results in two steps. First of all, we examine to what extent and how the policy intentions were realised. Second, we measure how the realisation of the policy intentions is perceived, discussing the facilitators, barriers, bottlenecks, challenges and needs, by different stakeholders and experts in drug policy.

To examine to what extent and how the policy intentions were realised, the analysis consists of two parts. First, we examine which objectives were implemented, based on a document review. Second, we describe the results of the online survey, to report on the perceived realisation of the different actions defined by the Federal Drug Note and the Joint Declaration. Both parts will be summarised in the section 'realisation of the policy intentions'. To measure how the realisation of the policy intentions is perceived by different stakeholders and experts in drug policy, we rely on semi-structured interviews. The results are discussed in the section 'Providing context to the stage of realisation'.

6.1.1 Realisation of the policy intentions

In this section, we map the extent to which the policy intentions, summarised in the logic models, are actually realised. We map this out in two ways[90].

We start with an analysis **of the main developments** in the field within the various objectives of the 'Enforcement' pillar. We do this through a **rapid document review** of the websites, reports and other publications from various institutions with a role in the Belgian drug policy. In this section, we describe the major developments in the field for each objective. We refrain from presenting a full inventory of all actions that have been realised in micro detail, because it is not feasible to do so. The Belgian drug policy field is fragmented among many different competences and many different policy levels (cf. infra and supra). The follow-up of the realisations of the Federal Drug Note and the Joint Declaration was not centralised in one institution. Therefore, piecing together the puzzle in retrospect for all actions in all policy levels and domains, scattered over reports from different institutions, is not only virtually impossible, it is also not the core objective of this research. This section rather seeks to summarise the key developments within the different objectives, as they feed into the overall performance in the pillar 'Enforcement'.

We therefore opted to list some of the major developments within the various objectives. We have mapped out these developments with a rapid document review, using the websites, reports and other publications from various institutions, such as the General Drug Policy Cell, Belspo, VAD, Fedito, Sciensano, many different addiction care institutions, the public prosecutor's office, federal and local police, NGO's, etc.

The result of this section is limited to an overview of the realisations within each objective, but does not reveal whether or not the realisations work as intended, whether they sufficiently meet the needs in the field, nor whether they are executed in a good way. Moreover, many of the realisations from the rapid document review are not necessarily a direct result of the Federal Drug Note or the Joint Declaration. Often, realisations fit as if coincidentally into the framework outlined by the Federal Drug Note and the Joint Declaration, but were no direct implementations of the two policy documents.

Second, we map the **perceived realisation** through **an online survey** amongst practitioners working within one or more domains related to the drug policy. The survey gained an explorative insight into the

[90] For a more elaborate description of the methods used in this project, we refer to Chapter 2 'Methodology'.

perceived realisation of the different actions defined by the Federal Drug Note and the Joint Declaration from a large number of experts at all policy levels (federal, regions and communities, local level) and across the different policy domains (integral and integrated approach; epidemiology, research and evaluation; prevention; care, risk-reduction and re-integration; enforcement)[91]. The survey thus provides a first insight into how the work field evaluates the realisation of the policy intentions. The online survey was distributed amongst practitioners working within one or more domains related to the drug policy.

Nine respondents completed the section on 'Enforcement'. The respondents represented different policy domains and policy levels.

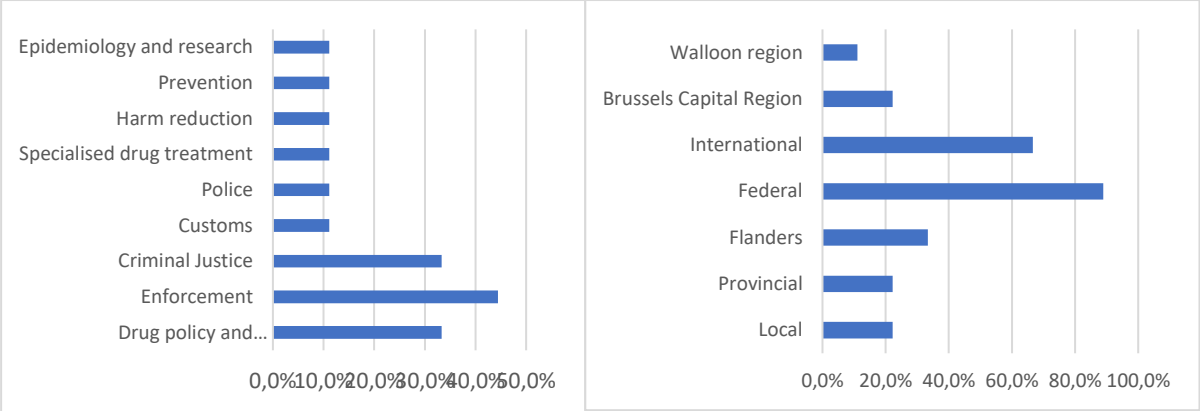


Figure 16 Domains and policy levels that respondents of the pillar 'Enforcement' represent

The respondents have a long experience in the drug field. Two respondents indicate to have worked in the drug field between 3-10 years. Al the other respondents have an experience in the drug field for more than 10 years.

Lastly, it is important to consider the limitations of the survey when interpreting the results. Respondents were encouraged to answer only those questions that they were aware of, so the number of responses per action varied between 9 responses for the most answered action ('International cooperation between for police and criminal justice'), and no responses for the least answered actions ('Therapeutic advice'). In addition, the actions already date from 2001 and 2010, and since then, the prevention field has evolved extensively (cf. supra). So, the respondents sometimes had to fall back on their recollection from actions realised several years ago. Finally, as was also highlighted in the critical appraisal of the logic models, some actions are very broadly formulated or difficult to measure. This causes differences in interpretation among respondents.

6.1.1.1 Results

First, we will present a summary of the results before we will elaborate on the realisations of each objective more in detail.

Summary of the extent of realisation

With regards to the extent of realisation, we found that:

- ⇨ First of all, the document review reveals that there is no structural follow-up of the implementation of the Federal Drug Note and Joint Declaration, nor of other developments in the enforcement field. There is a lack of centralisation and overview of the actions. Different reports and publications help to get a grasp of

[91] For more information about the methodology, we refer to chapter 2 'Methodology'

the specific realisations within the enforcement field, however, it paints a very fragmented and anecdotical picture.

- ⇨ There have been many developments in the enforcement field, both actions that were intended by the Federal Drug Note and the Joint Declaration, as well as other developments within the enforcement field. It is especially clear that there have been a lot of developments in the field of international cooperation and security policy. For the other objectives, however, the actions are partially rather than fully realised. The developments for the objective 'to develop a penitentiary drug policy' are much more modest, with several actions not addressed at all.
- ⇨ The survey learns that there are a lot of discrepancies in the level of perceived realisation. This cannot be explained by differences between regions and communities - as was the case with the previous pillars -, as most actions are situated at the federal level. However, the discrepancies could be explained by local differences, e.g. locally implemented in one place, but not in another. As there is no complete overview of the realisations, this could indicate that experts and practice are encountering the same barrier of fragmentation as the researchers of this research have.
- ⇨ When we compare the results of the document review with the survey (only for the objectives where there were enough respondents), we learn that for most objectives, there are discrepancies between the actual and perceived realisation. This suggests that actions may be implemented (cf. document review), but they do not necessarily operate in the best possible way and improvement is necessary (cf. survey).

A. Realisation of the objective 'To control drug supply'

a. Extent of realisation: a document review

There is **no centralised overview of the realisations** for the objective 'to control drug supply'. Information about the various achievements of the objective is spread over many publications, reports and websites by different institutions and organisations. The description of the realisations in this section, mainly relies on the documentation from the Federal Prosecution office, annual reports of the Federal Police, documentation of customs, policy documents like the Framework Note integral Security and several BELSPO publications. As a result of this fragmentation, this section presents **an anecdotal overview** of the achievements within the objective and won't be able to present a complete representation of the field.

The document review reveals that **several actions** intended by the Federal Drug Note and the Joint Declaration for the objective **'to control drug supply' were realised.**

For the first group of actions within this objective, '**strive for an effective international cooperation**', **several actions were fully realised**. For example, the document analysis clarified that the Belgian legislation is indeed in line with the requirements of the international conventions. The Drug Act of 1921 (and its related Royal Decrees) provides for a criminal response to the possession, importation, exportation, manufacture, transportation, possession, sale, offering for sale, and acquisition of illegal drugs (cf. infra), as is required by the UN Conventions (cf. supra, chapter 3). Another example of a realised action, is the international collaboration of the different enforcement partners, with both structural and ad hoc initiatives of coordination. There is especially extensive cooperation between Belgium and (neighbouring) countries, especially with the Netherlands - given the intertwined drug markets (Colman et al., 2018). This refers to both inter and intra related collaborations.

Police services participate in structural international collaboration, for example the Hazeldonk consultations, but also in ad hoc collaborations through for example Joint Investigation Teams(Colman

et al., 2018). Customs also participates in international collaboration, for example through the Customs Cooperation Working Party, a platform for operational cooperation among national customs administrations. Another example is the information exchange through the Naples II convention (FOD Justitie - DGWL & Dienst voor het Strafrechtelijk beleid, 2019). Criminal justice actors furthermore collaborate internationally through for example legal requests (on an ad hoc basis). An example of a more structural cooperation is the enrolment of the Federal Prosecutors' Office in the Iberico platform, a contact group of Spanish and Latin American prosecutors, the purpose to quickly exchange questions about drug cases with one another (Federaal Parket, 2019). There are also initiatives in which multiple partners participate, e.g. the Fedland platform where judicial, police and customs authorities and those responsible for precursors from Belgium and the Netherlands collaborate or different working groups regarding specific topics such as for example the production and trafficking of synthetic drugs. Lastly, there is also international collaboration on a local level, especially in the border regions. For example, the local Turnhout police, together with the Kempen N-O (Arendonk, Retie and Ravels) and Noorderkempen (Hoogstraten, Merksplas and Rijkevorsel) police zones, have been participating in a consultation with colleagues from the municipalities of Breda and Tilburg for years (Colman et al., 2018). The collaboration between EU operational police and judicial actors is also facilitated through Europol, Eurojust and the European Judicial Network in a wide variety of areas. Within that international cooperation, we could also mention the Euregional Information and Expertise Centre (EURIEC). The purpose of EURIEC is to strengthen cross-border administrative cooperation on a case level to tackle organized crime between Belgium, Germany and the Netherlands.

Some of the actions within this first group of actions 'strive for an effective international cooperation for drug supply control'' ere only partially realised. For example, there are research projects that focused on the evaluation of (inter)national drug policy initiatives on the supply market, like the BELSPO research projects of SUPMAP (Smet, De Ruyver, Colman et al., 2013), CANMARKT (Decorte & Paoli, 2013), HILCAN (Van Damme et al., 2017), and DISMARK (Colman et al., 2018). However, none of them could be seen as systematic or measured any form of impact. The researchers involved in DISMARK stressed several times that the monitoring and evaluation of the drug supply market, both nationally and internationally, is inadequate, ad hoc and that Belgian authorities do not have a comprehensive and systematic overview of the illegal drug trade (Colman, 2018).

As such, two actions within this group were not realised: (1) Systematic evaluation of the impact of drug policy of other countries on the Belgian supply offer, and (2) asset-sharing within the context of international cooperation.

For the second group of actions within this objective, 'To build synergies between policy plans of different departments', all actions intended by the Federal Drug Note and the Joint Declaration **are realised**. The document review found that there have been two Framework Notes Integral Security since the Federal Drug Note of 2001: one in 2004 , and one in 2016. The Framework Notes are established by the Minister of Justice and the Minister of Internal Affairs, and borne by the entire government. The Framework Note of 2016, was also drafted in collaboration with the federated entities through the Interministerial Conference (IMC) Security and Enforcement Policy. A National Security Plan was drawn up every four years, based on the Framework Notes. There were no Framework Notes during the period between 2008-2015 (although the timing of the Framework Note of 2004 was not defined). In this period, there were only National Security Plans.

From the document review it is clear that **most of the actions** mentioned by the Federal Drug Note and the Joint Declaration **are addressed, only a few actions were not realised.** International cooperation has clearly been extensively emphasised, as was the development of a security policy. Efforts to evaluate the impact of drug policy on supply remained limited.

b. Perceived realisation: a survey amongst experts

The survey reveals little consistency in the level of realisation of the objective 'to control drug supply', especially for the subgroup of actions concerning 'international cooperation'.

For the first group of actions within this objective 'Strive for an effective international cooperation for drug supply control,' respondents unanimously agree that that Belgium in engaged in the international drug policy. For the other actions, there are discrepancies with answers varying from 'fully realised', partially realised' to even 'not realised'. The discrepancies in the answers are given by both respondents with expertise at the local level and respondents at the federal level. The discrepancies cannot be explained by differences in response between customs, police or judiciary.

For the second group of actions within this objective, 'To build synergies between policy plans of different departments', the discrepancies are less pronounced. The actions 'implement a Framework Note Integral Safety' and 'Alignment of the National Security Plan' are partially to fully realised according to the respondents. Respondents do disagree whether or not 'the integrated action plans' were realised or not.

The discrepancies in perceived realisation could suggest a lack of overview of the realisation of the actions in the work field. They could also suggest that there are local, regional or district differences in the realisation of the actions. Another explanation could be the broad formulation of some of the actions, as these actions leave room for personal interpretation. The fact that the discrepancies were more pronounced for the first group of actions, and less for the second group of actions, suggests that there is more clarity for the second group of actions.

The survey responses demonstrate **little consistency in the perceived realisations** for the objective 'to control drug supply'. The discrepancies cannot be explained by domain of expertise of the respondent, and not by the policy level the respondents expertise relates to. The results suggest that there is **a lack of overview of the realisation of the actions** in the field (especially for the first group of actions), but the discrepancies may also be due to the fact that respondents interpret the actions differently. After all, some actions are formulated quite broadly.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **a number of discrepancies between the actual realisation and the perceived realisation**. Although the document review found (partial) realisation of most actions, several survey respondents mention that the same action is not realised. For example, there are a lot of examples of judicial/police international cooperation (cf. document review), however, there is still a respondent who indicates this is not realised (cf. survey). Vice versa, the systematic evaluation of the impact of drug policy of other countries on Belgian supply, was clearly not realised (cf. document review), and yet there is a respondent who indicates this is fully realised (cf. survey).

These discrepancies could indicate two things. First, this could indicate that different respondents interpret the same action in a different way and thus **show different appreciation levels,** although this mainly explains small discrepancies**.** Second, it could mean that there are more initiatives in practice than the document review could identify. Second, it could suggest that, **although the actions are implemented** (cf. document review), the actions do not necessarily operate in the best possible way and **improvement is needed** according to the experts (cf. survey).

B. Realisation of the objective 'to respond proportionally to criminal offences'

a. Extent of realisation: a document review

There is **no centralised overview of the realisations** for the objective 'to respond proportionally to criminal offences'. The information on the various achievements of the objective is spread over many publications, reports and websites by different institutions and organisations. This section mainly relies on the documentation from the Federal Prosecution office, annual report of the Federal Police, policy documents like the Framework Note integral Security, legislation and some BELSPO publications. As a result of this fragmentation, this section presents **an anecdotal overview** of the achievements within the objective that is not a complete representation of the field.

The document review reveals that **several actions** intended by the Federal Drug Note and the Joint Declaration for the objective **'to respond proportionally to criminal offences' were partially realised, but not fully realised.**

For the first group of actions within this objective, '**reinforced repressive response towards drug trafficking',** several actions are fully realised. For example, the document review clarified that the production of cannabis, the smuggling of cocaine and the production and smuggling of synthetic drugs have been a priority in the security policy: both the Framework Note on Integral Security and the National Security Plan prioritise the professional and commercial production of cannabis; the production and trafficking of synthetic drugs as well as the import and export of (pre-) precursors for the production of synthetic drugs; and the import and export of cocaine (mainly through vulnerable targets (such as (seaports and airports)). The trafficking of illicit drugs on international, national and local level is another priority. Especially towards the trafficking of cocaine, there have been several initiatives, such as the 'Stroomplan' policy plan (Colman, 2018). The Stroomplan is an action plan for dealing with both the import and transit of cocaine through the Port of Antwerp and related crime phenomena. Through four axes, it seeks to create barriers, tackle the Antwerp clans and the parallel economy, improve the investigation of organized crime, and develop an integrity and anti-corruption policy within government departments. There are administrative, judicial, inspection officials, custom officials and police (both local and federal) working together in this policy initiative. This project was evaluated in 2019 using logic models (Colman, Janssens, et al., 2020).

There have also been several initiatives towards the detection of synthetic drugs. For example, the customs services in Liège and Zaventem aim to carry out regular checks on the various courier services (Colman et al., 2018). Various partners (customs, federal police, FAGG, FAVV) also participate in (inter)national coordinated control actions in the regional hubs of courier services or in postal sorting centres for the control of postal items (Colman et al., 2018).

With regards to NPS, there has also been some evolution in legislation. Until the Law of 7th of February 2014 and the Royal Decree of 26 September 2017, the Belgian drug market was subject to the 1998 Royal Decree regulating psychotropic substances[92]. This Royal Decree contained a nominative list of substances subject to control. On 6 September 2017[93], this nominative list of substances was replaced by a generic classification for the NPS. This list starts from chemical or molecular groups, rather than individual substances. In addition, this Royal Decree also regulates a legal framework for gamma-butyrolactone (GBL) and 1,4-butanediol (1,4-BD). Because these substances are converted to gamma-hydroxy-butyric acid (GHB) after ingestion, in the human body, these substances were further regulated.

Regarding proactive policing and special investigative techniques, there have been some initiatives, for example towards the emerging phenomenon of online drug markets. The introduction of Article 46sexies

[92] Koninklijk besluit van 22 januari 1998 tot houdende regeling van sommige psychotrope stoffen en betreffende risicobeperking en therapeutisch advies.
[93] Koninklijk besluit van 6 september 2017 houdende regeling van verdovende middelen, psychotrope stoffen.

Sv. by Article 7 of the Law of 25 December 2016, which regulates online infiltration as a new method of investigation, is an example of this.

Furthermore, with regards to the confiscation of profits of drug trade, both the Framework Note on Integral Security and the National Security Plan encourage a profit-oriented approach and "*financial investigations aimed at determining the financial assets of perpetrators with a view to possible later forfeiture*" (pp.33). The ability to seize the assets of a criminal organisation and/or confiscate property is recognised by police as a very efficient method of targeting criminals, although barriers remain. It often happens that law enforcement encounters difficulties in confiscating the assets of a criminal organisation when these assets were invested abroad (e.g. in real estate). In these cases, it depends on the country where the assets were invested in, and the possibility of international cooperation with that particular country (Colman et al., 2018).

Focusing on the action of "The preventive dimension of drug tourism**", no explicit initiatives could be identified that involved the drug treatment sector or the drug prevention sector**. The importance of international cooperation within the context of drug tourism is mentioned in the Framework Note on Integral Security and the National Security Plan, but there is no specific focus on prevention. Drug tourism is however addressed by different enforcement actors.

For the second group of actions within this objective, '**A differentiated penal response towards drug use'**, several actions have been realised, although most actions are **only partially addressed**. For example, the action of making a distinction between cannabis and other illegal drugs is partially realised. The Law of 4 April and of 3 May 2003 adapted the Drug Law of 1921, and was supplemented by a Royal Decree and a Ministerial Circular. One of the mayor changes this legislation introduced, was the division of violations of the Drug Law of 1921 into three categories: (1) Importing, producing, possessing a small quantity of illegal drugs for personal use, without an indication of problematic use or use that causes public nuisance (2)The violations of the first category accompanied by the aggravating circumstances referred to in Article 2bis of the Law of 24 February 1921 (3)All other violations than those covered by category 1 and category 2.

Also, the personal consumption of a user quantity of cannabis by an adult, without public nuisance or problematic use, will only result in an anonymous police registration. The ministerial circular of May 16, 2003 unsuccessfully attempts to define "possession for personal use" several times, in different ways. However, the law, the Royal Decree and the Ministerial Circular did not succeed in clearly defining 'problematic use', 'public nuisance', 'possession for own use', and ultimately the Court of Arbitration annuls art. 16 Drug Law 3 May 2003 (Decorte et al., 2005; Fijnaut & De Ruyver, 2014; Gelders & Vander Laenen, 2009). It was until 2005 that the joint directive of the Minister of Justice and the College of PG addressed the gap, with a circular (COL 2/2005). This circular was updated in 2015 (COL 15/2015), and again revised in 2018 due to the Royal Decree of 6 September 2017. Nevertheless, this differs from the anonymous police registration that was intended by the Federal Drug Note in 2001.

Table 9 Summary of the timeline of the cannabis debate (Gelders & Vander Laenen, 2009)

1999	Verhofstadt Government: 'legislative framework on drugs is inappropriate' ⇒ need for new legislation
2000	Minister for Public Health announced legalization ⇒ tension within the Federal Government (between Liberal and Green party)
2001	Agreement within the Federal Government but main concepts unclear. Public advertisements and leaflets circulated to make the agreement clear but they presented the announced new legislation as if it was already adopted
2002	Bill in Parliament
2003	New Law, Royal Decree and Common Circular finally adopted. An important issue in the federal elections (new Minister of Justice; Green party no longer in government)
2004	Court of Arbitration annulled the central article of the new Drug law because it is too vague
2005	Common circular from Minister of Justice and Board of Prosecutors-General clarifying central concepts including 'amount of cannabis for personal use' and replaces 'public nuisance' by the more clear concept of 'public order' and deleting the concept of 'problematic drug use'

There were several actions to ensure the application of the Drug Law in practice. For example, to ensure the application of the Drug Law, reference magistrates for drugs have been appointed in the prosecutors' offices.

Actions to encourage judicial referral to treatment were mostly realised, although some of these actions remained hollow phrases. Regarding the action of encouraging judicial referral to treatment, we could identify at least one referral point at all distinct levels of the criminal justice system (from investigation level to execution of sentencing level) to divert offenders with an underlying drug problem to treatment. Additionally, specific (pilot) projects exist in different judicial districts facilitating the judicial referral to treatment (cf. as mentioned supra in pillar 'Treatment, risk reduction and reintegration'). Examples are the Drug Treatment Court in Ghent (Colman et al., 2010; De Ruyver et al., 2008; De Ruyver et al., 2010; Vander Laenen, Vanderplasschen, Wittouck, et al., 2013) and similar initiatives in Liège, Antwerp and Bruges, or the Proefzorg pilot project in Ghent (De Ruyver et al., 2008). Many of these projects established specific cooperation agreements between the criminal justice system and treatment services. Judicial case managers were however never implemented (Geenens et al., 2005), nor was the subsidising of the judicial referral to treatment (including therapeutic advice) through the 'Global Plans'. FOD Justice does finance the 'Judicial Alternative Measures'. In addition, according to the memorandum of the VAD, more structural resources should be made available for apprenticeships and treatment options in Alternative Justice Measures in collaboration with drug counsellors everywhere. The GAM projects for drug users have existed for 25 years, but have not received any structural resources to date. The distribution of the GAM projects offer also varies widely at a regional level (VAD, 2018).

Although several intended actions were realised, within this group of '**A differentiated penal response towards drug use', some intended actions were not realised.** We could not find evidence for the following actions: A simple and uniform measuring tool for the registration and monitoring of drug-related crime, a suspended sentence is not mentioned on a criminal record, prosecution should motivate why they do not require a probation sentence, and appoint judicial case managers in each House of Justice.

From the document review it is clear that **many of the actions** mentioned by the Federal Drug Note and the Joint Declaration **were addressed, although not all actions are fully realised.** However, for each subgroup, some actions were not realised or realised in a different way then was intended by the Federal Drug Note and the Joint Declaration.

b. Perceived realisation: a survey amongst experts

There is no clear line in how the survey respondents perceived the realisation of actions within this objective. However, it is clear that most respondents consider the actions of the first subgroup ' 'A reinforced repressive response towards drug trafficking, focusing on the supply side of drugs to have been realised more often than the actions of the second subgroup 'A differentiated penal response towards drug use', focusing more on the demand side.

For the first subgroup of actions regarding '**a reinforced repressive response towards drug trafficking'**, the results vary across all categories for most actions. Only three actions in this subgroup had a unanimous answer: 'Focus on the production and trade of precursor/synthetics', 'Confiscated drug money is invested into treatment' and 'expand the treatment dimension for drug tourism'. Some actions are perceived as partially to fully realised, for example 'attention to cocaine import', 'train magistrates and police' and 'proactive policing and special investigation'. Other actions are perceived as partially to not realised, for example the 'ministerial circular on drug trafficking', 'confiscation with quick seizure' and 'reversing the burden of proof'. Lastly, there is a large group of actions where most respondents indicate that the actions are partially realised, for example 'attention to heroin trafficking', 'optimise confiscation with ministerial circular' and 'financial analysis by police or prosecution'. However, for these actions, there are also respondents that indicate that the actions are also 'not realised' and other respondents claiming the actions are 'fully realised'. These discrepancies within an action, could suggest a lack of

overview of the realisation of the actions in the work field, or to local, regional or district differences in the realisation of the actions.

For the second subgroup of actions regarding **'a differentiated penal response towards drug use'**, respondents indicate it has been perceived as partially to not realised, with the exception of 'reference magistrates for drugs in each prosecution's office' and 'autonomous alternative punishment'. For the latter actions, most respondents indicate that they have been fully realised. There are discrepancies in the survey responses for two actions: 'reference magistrates for drugs in each prosecution's office' and a 'meeting of the reference magistrates for drugs'. For each of these actions, there are respondents indicating they have been fully realised, partially realised and not realised. In this second group of actions, there are noticeably more respondents who say they 'don't know' whether the action has been realised or not. The last three actions ('Add therapeutic advice to the legislation', 'Finance therapeutic advice through security contracts' and 'Judicial funds for judicial alternatives') were not even answered by any respondent. The lack of responses could indicate little visibility in the enforcement field for these actions.

The survey responses demonstrate **little consistency in the perceived realisations** for the objective 'to respond proportionally to criminal offences'. These discrepancies suggest that there is still some lack of clarity and/or overview on 'what's out there' within the field. Also noteworthy are the **limited number of responses to various actions from the second subgroup**.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **a number of discrepancies between the actual realisation and the perceived realisation, especially for the actions related to '**A differentiated penal response towards drug use'. Although the document review found a (partial) realisation of several actions, several survey respondents mention that the same actions are not realised. For example, there are reference magistrates for drugs, yet still respondents indicate that this action was not realised. These discrepancies could indicate two things. First, this could indicate that different respondents interpret the same action in a different way, thus displaying different levels of appreciation**.** Second, it could mean that, although the actions are implemented (cf. document review), the actions are not widely known or do not necessarily operate in the best possible way according to the experts (cf. survey).

C. Realisation of the objective 'To develop a penitentiary drug policy'

a. Extent of realisation: a document review

There is **no centralised overview of the realisations** for the objective 'to develop a penitentiary drug policy'. The information on the various achievements of the objective is spread over many publications, report and websites by different institutions and organisations. The description of the realisations in this section, mainly relies on the documentation from the Federal Public Service Justice, year reports from organisations with projects in prison, and several scientific publications. As a result of this fragmentation, this section presents **an anecdotal overview** of the achievements within the objective and is not able to draft a complete representation of the field.

The document review reveals that **several actions** intended by the Federal Drug Note and the Joint Declaration for the objective **'To develop a penitentiary drug policy' were partially realised, but not necessarily fully realised.** For example, the document review found that in 2006, the issue of drug use in prisons was brought to the attention of the government with the Ministerial Circular number 1785. However, it was until 2009 that the Justice Department released financial resources to translate this penitentiary drug policy into concrete initiatives, aimed both at drug supply and drug demand (Favril & Vander Laenen, 2013). There are indeed several initiatives that are part of a penitentiary drug policy. For example: to prevent HIV and other sexually transmitted infections in prison, inmates are able to

obtain a packet containing a condom and lubricant from the prison medical unit since 2009. There are also information campaigns to point out behaviours that increase the risk of infection (FOD Justitie, 2021). Apart from this, there is also the possibility of substitution treatment in prison, where a prison physician may prescribe substitution treatment with methadone or Subutex® (FOD Justitie, 2021). However, the access to substitution treatment varies between prisons (Vandevelde et al., 2016). Finally, some prisons have specific projects, such as the 'B.Leave program' in Ruislede, the drug-free sections in Bruges and Hasselt or the 'Détenus Contact Santé'-project in Walloon prisons. B.Leave is a therapeutic program that prepares drug using prisoners for a life in recovery through education, therapy and sports (Vlaamse Overheid, 2018). The drug-free department accommodates detainees who want to live drug-free and not be confronted with drugs during their detention. The 'Détenus Contact Santé'-project provides training on all kinds of health topics. However, these are often local initiatives that are limited to one or a few prisons/target groups, and therefore have not been widely adopted (Algemene Cel Drugs, 2019; De Vlaamse revalidatiecentra voor drugverslaafden, 2019; Favril & Vander Laenen, 2013; Kazadi Tshikala & Vander Laenen, 2015; Vander Laenen, 2015).

In addition, there used to be **central registration points for drugs in prisons** (NL: CAP, FR: STEP): external drug treatment providers ensuring that inmates have access to treatment services in society. These registration points were positively evaluated by a BELSPO project in 2017 (Vandevelde et al., 2016). After the sixth state reform, the central registration points for drugs however ceased to exist. In Flanders, they were translated into the project TANDEM. The target group does not merely exist for drug users but on all persons having mental health problems. TANDEM aims to guide prisoners with mental health problems to appropriate care and treatment after detention, and is but in the mental health consultation platforms (VAD, 2017b). The target group broadened, whereas the funding remained the same. This resulted in long waiting lists (Vander Laenen et al., 2019). The Walloon region, has incorporated the principles of central registration points into its announcement to call for project to improve the health of detainees, particularly regarding mental health and addiction issues (Algemene Cel Drugs, 2019).

Furthermore, The Basic Law of January 12, 2005 on the Prison System and the Legal Status of Prisoners, indicates that treatment within prison should be the same as treatment in society. Moreover, the treatment should be adapted to the needs of the inmate (Art. 88) (Vandevelde et al., 2016). In Flanders, the Flemish Strategic Plan for Treatment and Service to Prisoners (STRAP) 2015-2020 wants to address this issue. The ambition was to examine the preconditions and, if possible, work out a local action plan to actively address addiction by 2016. In addition, a policy framework would be developed to implement an integrated policy on drug abuse/addiction problems among detainees. In 2013, the STRAP was anchored by decree (BS April 11, 2013), which means that a new STRAP will be developed every legislature (Vander Laenen et al., 2019). The new STRAP 2020-2025 also explicitly addresses detainees with addiction problems (as part of the target group of detainees with mental health problems), and refers to specialised treatment, as well as a new and future-oriented model for penitentiary healthcare together with FPS Justice.

A last example of a (partially) realised actions, is the action to tackle drug supply in prisons: detainees and cells may be searched, and drug dog checks are conducted. Techno-prevention at the entrance is inadequate (Van Malderen, 2012; Van Malderen et al., 2011).

However, **there have been additional realisations**, that were not foreseen by the Federal Drug Note or the Joint Declaration. As mentioned earlier, drug treatment pilot projects exist in the prison of Hasselt, Lantin and Saint-Gilles (cf. supra). In 20 November 2017, the IMC Public Health validated three joint pilot projects (federal government and federated entities) to develop a model of treatment for people who use drugs in prison. The aim was to achieve quality care for people in detention with a drug use problem, in order to develop a tailor-made care pathway for prisoners, taking into account the specific context of detention. This pilot project was evaluated in 2020 (Vandevelde et al., 2021), and will be evaluated in more detail within the third work package of this project and within RECOPRIS-bis (in press).

Although several intended actions were realised, **some intended actions were not (fully) realised.** We did not find evidence supporting the implementation of the following actions: 'An obligated response to psychosocial needs, crisis and other solutions in prisons', 'Reserve substitution treatment for pregnant women & short sentences', 'Measures to decrease number of detainees with migration background' and 'Guaranteed access to contact with external treatment provider in prison'.

From the document review it is clear that **several of the actions** mentioned by the Federal Drug Note and the Joint Declaration **are addressed, but often not fully realised (as intended).** There are also several actions that have not been addressed. Nearly all the actions that have not been addressed, are actions related to (drug) treatment in prison. There have also been some additional realisations that were not included by the Federal Drug Note and the Joint Declaration.

b. Perceived realisation: a survey amongst experts

There are very few responses for the objective 'To develop a penitentiary drug policy', as such, we cannot make reliable conclusions for this objective. It seems that the few respondents that did reply, agree that most actions are not realised. Two actions are indicated as partially realised (the evaluation on drug free wings, and admitting external treatment facilities in prison), By only one respondent.

The lack of responses for this objective seems to indicate little visibility in the field on these actions.

The survey displays a **limited number of responses to most actions within this objective**. The lack of responses could indicate little visibility of the penitentiary drug policy in the enforcement field.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey cannot be made as very few respondents could indicate whether or not the actions were realised or not.

D. Realisation of the objective 'To stimulate research and evaluation'

a. Extent of realisation: a document review

There is **no centralised overview of the realisations** for the objective 'to stimulate research and evaluation'. The information on the achievements are mostly collected on the BELSPO website, that gives an overview of all the studies related to drug supply, however, not all Belgian research concerning the drug issue is summarised there.

The document review reveals that **several actions** intended by the Federal Drug Note and the Joint Declaration for the objective **'To support research and evaluation' were partially addressed.** For example, regarding mapping the criminal drug chain, we could mention CRYPTODRUG focusing on Belgian vendors on online drug markets (Colman, Bronselaer, et al., 2020), DISMARK describing the cannabis, cocaine and synthetic supply market in Belgium (and its connection to the Netherlands) or CANMARKT, an evaluation of the nature, harmfulness and implications of cannabis production in Belgium. Regarding the evaluation of drug measures for drug users in the CJS we could mention the study on effects of alternatives to prison (De Ruyver, Macquet, et al., 2007), the drug treatment projects in prison (Vandevelde et al., 2021) process evaluations of Proefzorg (De Ruyver et al., 2008) and the Drug Treatment Chamber (De Ruyver et al., 2010) and the outcome of pilot projects like the Drug Treatment Court in Ghent (Vander Laenen, Vanderplasschen, Wittouck, et al., 2013). These monitoring and evaluation initiatives happened on a rather ad hoc basis and are not structurally implemented.

From the document review it is clear that **most of the actions** mentioned by the Federal Drug Note and the Joint Declaration **were partially addressed, although not in a structural way.**

b. Perceived realisation: a survey amongst experts

Respondents could only give their perception on one of the actions within the objective 'To stimulate research and evaluation': to map the criminal drug chain. Respondents perceived this action as only partially realised. The respondents could not indicate whether an evaluation of measures aimed at drug users in the criminal justice system to impact supply, were realised. The lack of responses seems to indicate little visibility in the field for this action.

The survey displays a **limited number of responses to most actions within this objective**. The lack of responses could indicate little visibility of the research and evaluation efforts in the enforcement field.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey cannot be made as very few respondents could indicate whether or not the actions were realised or not.

E. Realisation of the objective 'Commit to an integrated and integral drug policy with enforcement'

a. Extent of realisation: a document review

There is only one action within this objective. We did not found evidence that this action has been addressed.

b. Perceived realisation: a survey amongst experts

The action mentioned within this objective was never realised according to the survey respondents.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **consistency between the actual realisation and the perceived realisation**.

6.1.1.2 Conclusion of the extent of realisation

First of all, the document review reveals that there is no structural follow-up of the implementation of the Federal Drug Note and Joint Declaration, nor of other developments in the enforcement field. This is not the case on the federal level, nor in the communities and the regions. There are many year reports and other publications that list the developments in the enforcement field, but they always focus on specific parts of the enforcement field or on the realisations of a specific actor. There is a lack of centralisation and overview. All of these reports and publications help to get a grasp of specific realisations within the drug treatment field, however, it paints a very fragmented and anecdotical picture. As a result, the fragmentation is reflected in this evaluation too.

Second, the document review shows that **there have been many developments** in the enforcement field, **both** actions that were **intended** by the Federal Drug Note and the Joint Declaration, **as well as other developments** within the enforcement field. For the first objective 'to control drug supply', most actions were realised. It is clear that there have been a lot of developments in the field of international cooperation and security policy. For the other objectives, however, the actions are partially rather than fully realised. Sometimes, there were implementation initiatives for an action, but they were not fully seen through. This was for example the case with some actions of the subgroup 'a differentiated penal response towards drug use' of the objective 'to respond proportionately to criminal offences'. For other objectives, the **actions were not realised in the way that was intended by the Federal Drug Note**

and the Joint Declaration, for example because there were problems of legal certainty because the central concepts could not be clearly defined. This is for example the case with some actions from the objectives 'to respond proportionately to criminal offences', in the subgroup related to drug use. The developments for the objective 'to develop a penitentiary drug policy' are **much more modest, with several actions not addressed at all**. It is also noteworthy that for various objectives **some additional actions have been realised, which were not foreseen in the Federal Drug Note and the Joint Declaration.** This is especially the case for the objective 'to develop a penitentiary drug policy', as several competences were transferred to the regions after the Sixth state reform, and the regions took initiative themselves.

Nevertheless, it is important to emphasise that the realisations in the pillar 'Enforcement' do not necessarily directly result from the Federal Drug Note and the Joint Declaration. For several objectives, the realisations were initiated by specific institutions or organisations, and fit within the broader framework of de Federal Drug Note and the Joint Declaration by chance. As mentioned before, there was no structural follow-up of the implementation of the Federal Drug Note or Joint Declaration. Additionally, this overview does not paint a picture on the performance nor of the difficulties that were encountered with the realisation of the objectives.

Third, the survey learns that there are **a lot of discrepancies in the level of perceived realisation**. This cannot be explained by differences between regions and communities - as was the case with the previous pillars -, as most actions are situated at the federal level. However, the discrepancies could be explained by local differences, e.g. locally implemented in one place, but not in another. As there is no complete overview of the realisations, this could indicate that experts and practice are encountering the same barrier of fragmentation as the researchers of this research have. Another explanation could be that some actions are formulated very broad, so respondents could have interpreted the action in a different way. Depending on how the action is interpreted by the respondent, replies may vary. Another explanation lies in the fact that some actions are not quantifiable or measurable, so what is 'fully realised' for one respondent, might only be 'partially realised' for another respondent because this is not specified clearly. However, some actions were very clear, and still discrepancies remained. Together with the fact that almost none of the respondents could indicate whether the actions of 'a penitentiary drug policy' and 'differentiated penal response towards drug use' were realised, this support the conclusion that even amongst experts, there is no overview of the different realisations in the enforcement field.

And lastly, when we compare the results of the document review with the survey (only for the objectives where there were enough respondents), we learn that for most objectives, there are discrepancies between the actual and perceived realisation. In most cases, we see that, although the document review identifies certain actions as realised, there are survey respondents indicating them as partially or even not realised. For some actions, it is the other way around. This shows that actions may be implemented (cf. document review), but they do not necessarily operate in the best possible way and improvement is necessary (cf. survey). In some cases, it is the other way around (survey respondents indicating that an action is realised, when the document review could not find any proof). This suggests that there are probably initiatives that support an objective, but that it is not necessarily widely known or documented, or they are organised on a local level.

6.1.2 Providing context to the stage of realisation: interviews with stakeholders

A third method used in the EVADRUG evaluation, are semi-structured interviews and one focus group with stakeholders that have expertise in one or more domains related to the Belgian drug policy. These semi-structured interviews aim to provide an explorative insight into the facilitators, barriers, bottlenecks, challenges and needs for the Belgian drug policy. The semi-structured interviews were conducted amongst 39 civil servants and practitioners at all policy levels (federal, regions and communities) and across the different policy domains (Integral and integrated approach; Epidemiology, research and evaluation; Prevention; Treatment, risk-reduction and reintegration; Enforcement).

This section summarises their views on the realisation of the objectives across the pillar 'Enforcement'. The interviews and the focus group are aimed at obtaining and understanding how Belgian drug policy is experienced by respondents. We examined how they shape the Belgian drug policy in daily practice, giving insight in how they translate "policy in practice", as opposed to "policy in the books".

It is important to note that semi-structured interviews are a qualitative method to gain an explorative and more in-depth insight into the drug policy. Therefore, this method does not give a representative view of all opinions in the field. The qualitative semi-structured interviews intended to report on recurrent perceptions, opinions and experiences that are prevalent in the drug field, to help explain why the realisation of certain objectives within the pillar of 'Enforcement' is hindered or facilitated, but also to record new barriers and bottlenecks, and to map what the field deems necessary for this pillar. Additionally, it is important to consider that the Belgian drug policy covers a very broad field of topics. Because of that, we were not able to describe every bottleneck in detail. In this section, each topic is touched upon briefly.

First, we will present a summary of the results before we will elaborate on the facilitators and barriers more in detail.

Summary of the context to the extent of realisation

With regards to the context to the stage of realisation, practitioners and civil servants perceived that:

- ⇨ There is a high performant international network, as well as international cooperation both within the police, customs as well as justice. Nevertheless, respondent still describe barriers and bottlenecks within this international cooperation, as well within national cooperation between enforcement partners.
- ⇨ A second recurrent theme in the interviews and the focus group, was the legislative framework presenting a dichotomous picture. For example, 'the lowest priority on cannabis within a framework that prohibits illegal drugs' shows how enforcement respondents need a clear and unambiguous legislative framework to start from.
- ⇨ Respondents described several organisational barriers and bottlenecks, for example in the Port of Antwerp, as well as limited budgets for diverse enforcement actors (for example the federal police) making it difficult to answer to identified priorities
- ⇨ Respondents also identified several logistical and financial barriers in the investigation of drug production and drug trafficking, as well as on the sentencing level of drug production and drug trafficking. They refer for example to the digitization gap, lack of expertise and resources for financial investigations, how investigation is often linked to specific expertise manifesting in individuals, and to a third district level next to the federal police level and the local police level without a clear coordination between these levels.
- ⇨ Furthermore, almost every respondent emphasised the lack of a clear drug policy in prison
- ⇨ Although scientific research to support practice and operational services, is praised by many respondents, the respondents mostly denounce that fact that research on the supply side is focusing on mapping the current situation, rather than visualising the output and outcome, therefore focusing on achievements rather than listing implementation (barriers). The poor measurement of supply indicators is also mentioned.
- ⇨ Linked to these barriers and bottlenecks, respondents voice a need for a shared action plan, with a clear framework for information exchange.

6.1.2.1 Facilitators with regard to the realisation of the 'Enforcement'- pillar's objectives

We asked our respondents what they identify as a facilitator in the realisation of the enforcement objectives defined by the Federal Drug Note and the Joint Declaration. Three facilitators were recognised: (1) a high performant international network and cooperation, (2) scientific research to support practice and operational services, and (3) drug coordinators, and cooperation with external treatment facilities to facilitate a penitentiary drug policy.

A. High performant international network and cooperation

Respondents from customs, police and justice departments unanimously indicated that they can rely on an extensive international network and that international cooperation is a well-established practice within the investigation and prosecution of drug phenomena, including the development of a common approach to a cross-border tackling of drug trafficking.

Several respondents emphasise that in the past years, they have intensively invested in building out an international network. They also indicate that they have good contacts with a number of specific countries (including Spain, the Netherlands, but also a number of South American source countries, ...) facilitating formal and informal cooperation. They indicate that this international network and cooperation allows them, for example, to engage in capacity building and exchange good practices, to exchange information or reporting suspicious shipments, to set up actions to support each other but also to strategically look at how to deal with bottlenecks or new phenomena.

> *"Dus er zijn allerhande acties die worden opgezet om te zien van hoe kunnen we elkaar ondersteunen in het kader van operaties die we opzetten of het aangeven van verdachte zendingen. (…) zo'n samenwerking die leidt ertoe dat we capacitief building kunnen doen." (NL_13)*

Rather than symbolic actions, cooperation should focus on effective actions and those that have an impact to reduce supply, which respondents describe as "doing the right thing". They describe this focus on effective enforcement actions as an important factor in (international) cooperation, and explain that some international cooperation initiatives or networks have been established for that reason.

> "*Dat is misschien een van de dingen die wij mee uit de wereld moeten helpen, om de juiste dingen te doen. Zeker met de partners Nederland, Spanje, Antwerpen wij hebben eigenlijk nood aan organisaties die de juiste dingen doen voor ons op supranationaal vlak. (…) Dus er is een hoop waste of time, een hoop inspanningen die eigenlijk kant nog wal raken en we moeten ons focussen op de dingen die belangrijk zijn voor die grote havens, daarom is die group of trust ook opgericht*. (…) *Hoe is het mogelijk maar, laten we ons focussen op de dingen waar we impact op hebben, zo redeneer ik altijd maar*." (NL_13)

Respondents stress that also at national level, these international meetings are fruitful to foster collaboration between diverse entities active in enforcement (i.e. customs and police) and to develop a better coordination of reducing drug supply.

> *'Je reviens aussi quand même sur l'importance de l'international pour le national. (…). Ce sont des travaux internationaux qui concernent tant le volet policier que douanier, voire administratif de contrôle pour les précurseurs. Du fait des réunions internationales, ils sont obligés aussi de collaborer et de mieux se coordonner au niveau belge'. (FR_5)*

Furthermore, respondents also indicate that Belgium strongly opts for international cooperation, both strategically and operationally. In this regard, some mention the fact that they are active at the level of Europol, especially concerning synthetic drugs. In addition, cooperation with specific countries such as the Netherlands (as a transit country) and South American (as a source country) is mentioned. One respondent identifies that this kind of cooperation acts as a facilitator to exchange information, for judicial

investigations, regional actions and (in the case of the Netherlands, for example) jointly tackling cross-border phenomena. Both formal and informal contacts are highlighted as facilitators.

Structural cooperation is mostly aimed at building trust. Partners across national borders get to know each other and each other's structures, and can therefore work more specifically on each other's strengths and weaknesses.

> *«Dat samenwerkingsverband is vooral om mekaar te leren kennen, te weten wat elkaar sterktes en zwaktes zijn en om samen te werken.» (NL_20)*

Criminal justice respondents especially stress the role of the federal prosecution office as a facilitator for international cooperation, and emphasise the fact that Belgium through the federal prosecution's office, has a single point of contact, which clarifies and facilitates this international cooperation. This national contact point is often not implemented in other countries, for example in Germany. In that case, contact has to be established at each of the regions/districts separately, hindering international cooperation.

> *"Je pense qu'on a quelque chose qui est très positif en Belgique et qui n'existe pas forcément dans beaucoup de pays, c'est la notion du parquet fédéral. Les enquêtes internationales passent par le parquet fédéral. Lorsqu'on a besoin de donner une autorisation pour une observation transfrontalière, pour une livraison contrôlée ou autre, le parquet fédéral peut donner l'autorisation pour l'ensemble du pays." (FR_5)*

B. Scientific research to support practice and operational services

Several respondents emphasise the importance of scientific research in supporting practice and operational services in a very concrete way. For example, respondents refer to Yilcan and Hilcan, focusing on the revenue determination of an illegal indoor cannabis plantation, or the hazards of illicit cannabis cultivation.

> *'Comme ça, on a une base scientifique qui permet de dire, par exemple : "on sait que si vous avez cultivé du cannabis sur une surface de 20 mètres carrés pendant 2 ans, donc on sait que vous avez gagné autant".(FR_4)*

C. Drug coordinators, and cooperation with external treatment facilities to facilitate a penitentiary drug policy

For the development of a drug policy in prison, the respondents mainly mention a number of bottlenecks and barriers (cf. infra). However, respondents also describe a few facilitators that support(ed) the development of a drug policy in prison. Respondents describe for example that at a certain point, there were drug coordinators in prison, tasked with organising and putting on the agenda the drug theme in prison, as well as a special steering group within FPS Justice on drugs. Both facilitated a communication between the different actors, and therefore facilitated the further development of a drug policy in prison.

> *'Il y avait un pilotage central au niveau du SPF Justice, un groupe de pilotage central drogue. Et il y avait des coordinateurs dans les prisons chargés spécialement de la problématique des drogues. (…) c'est important de construire une meilleure communication entre les parquets et les prisons pour avoir une gestion plus harmonieuse de la problématique'* (FR_4)

Some respondents also describe (informal) consultation moments between the various treatment actors and (specific) prisons actors, which in turn facilitates cooperation on an operational level.

> *'On a rencontré très peu de difficultés pour être intégrés à la prison, peut-être aussi parce qu'on y est depuis longtemps et qu'à l'époque, il n'y avait pas beaucoup de services. On a toujours participé aux plateformes, aux groupes de concertation, aux groupes de travail, pour toujours faire avancer'* (FR_7)

Finally, respondents also suggested that a collaboration with the external treatment facilities in a prison context is a facilitator, partly to promote collaboration between both staff within the prison and the external treatment facilities. For example, the example of the drug-free wing is given by one respondent. According to the respondent, when the social services are involved in the project beforehand, it creates a different dynamic. Other respondents describe the signing of specific cooperation agreements between organisations offering treatment to drug users and mutual insurance companies and general practitioners as a facilitator for the continuity of care on release from prison.

> *"In Hasselt, eigenlijk is dat Katarsis, externe hulpverleners die van bij het begin intensief betrokken zijn bij het over het nadenken over het concept, waardoor dat er ook al meer hulpverleners georiënteerd weten hoe het eruit ziet van bij het begin. Uhm...in Brugge is dat eigenlijk minder gebeurd, in Brugge werd er ook aanvankelijk gezegd van, we gaan hier twee opvoeders aanstellen op de afdeling, ook omdat hulpverleningsgezichten in die afdeling te kunnen inbedden, maar die zijn er nooit gekomen." (NL_6)*

> *'Et donc, Icare, ils ont signé des protocoles avec la mutuelle ou avec certains médecins généralistes. Ils vont en prison et disent aux usagers : "quand tu sors de prison le vendredi, tu viens directement chez nous", et Transit leur donne leur traitement de substitution jusqu'au lundi. Puis, le lundi après, ils demandent à l'usager de revenir et ils mettent ses papiers en règle'.* (FR_9)

6.1.2.2 Barriers and bottlenecks

We asked our respondents what they identified as a barrier or a bottleneck in the realisation of the Enforcement objectives defined in the Federal Drug Note and the Joint Declaration. Bottlenecks and barriers are problems that prevent or obstruct a successful realisation.

First, we describe general barriers, afterwards we clarify perceived barriers related to a specific objective. For almost every objective, one or more barriers and bottlenecks were identified.

A. General barriers and bottlenecks that obstruct the performance of the pillar 'Enforcement'

a. Cooperation between enforcement partners

All respondents describe that there is a lot of cooperation within and between the different Enforcement partners: police, customs, justice, but also with FAGG/AFMPS, often on a voluntary basis or on their own initiative. Yet, barriers and bottlenecks occur in this cooperation.

First, many respondents mention **the lack of shared actions plans**. Different law enforcement actors each have their own action plans that define their priorities. For example, the police have a National Security Plan, customs have a Management Plan, Respondents describe how a clear overarching drug-oriented action plan, with shared priorities is lacking. Cooperation between specific enforcement actors (e.g. between the federal police and the precursor cell), but also the conclusion of protocol agreements (e.g. between the federal police and customs), thus relies on the initiative of individuals. Some partners consider this problematic, as it makes cooperation very person-related instead of structural and systematic.

Second, respondents within the police and justice departments describe **barriers and bottlenecks in the cooperation between the federal level and the local level**. The COL2/2002[94] defines the division of tasks between the federal and the local police. For example, one respondent explains that where the

[94] 20 FEBRUARI 2002. - Richtlijn tot regeling van de taakverdeling, de samenwerking, de coördinatie en de integratie tussen de lokale en de federale politie inzake de opdrachten van gerechtelijke politie.

federal police focus on organised crime and international drug trafficking, the local police focus on the retail level. In practice, however, respondents increasingly notice a shift from a division of tasks based on the nature of the facts, investigative acts, and geographic distribution, to a phenomenon-based approach. In practice, for example, it appears that in some districts cannabis cultivation always ends up with the local police, and the trafficking of cocaine and production of synthetic drugs, with the federal police.

> *"We zien in bepaalde arrondissementen dat het meer is op basis van de fenomenen zelf, dat er een verschil wordt gemaakt. Bijvoorbeeld in grote arrondissementen zoals Antwerpen, uhm, de cannabisplantage, dat is voor de bevoegdheid van de lokale politie, het maakt niet uit of het internationaal of georganiseerde misdaad is. Het is voor de lokale politie en de federale politie doet alles wat draait rond de handel, de internationale trafiek van cocaïne of de productie van synthetische drugs." (NL_7)*

Moreover, the local police are spread over 185 police zones, which means that there is no central point of contact for the local police. Each zone has its own local policy under the leadership of the mayor and in cooperation with a local public prosecutor. According to the respondents, the fact that the local police zones are increasingly involved in phenomena that go beyond their own zones, requires consultation between the local zones (at least the ones that are involved in these phenomena) and the federal police. If each partner takes initiatives on his own, problems with the exchange of information, policy coherence and even international cooperation might occur. For instance, when a local police zone invests in equipment, without other police zones or the federal police being aware of it, there is no possibility of joining forces.

> *"Als een morgen een politiezone in staat is om samenwerkingsakkoorden af te sluiten met Colombia of met Brazilië, ja, oké, dat is goed mooi, misschien met operationeel resultaat. Maar we moeten inderdaad zorgen voor de nodige coherentie in het systeem met andere initiatieven." (NL_7)*

In addition, respondents note major differences between resources at the local level, and resources at the federal level. There is a lack of resources, infrastructure and capacity at the level of the federal police. These contrasts, according to our respondents, with many local police zones who have more and better resources to deal with the drug phenomenon. In this regard, one respondent also mentions the intention of the current Minister of Internal Affairs to invest more in the Belgian police, but because of the existing general saving rule for the federal police, there is a substantially larger proportion of that investment for the local police compared to the federal police:

> *"Er wordt gezegd door de minister van binnenlandse zaken dat ze 1 miljard heeft voorzien voor de politie, waarvan dat ze 500miljoen gaat geven aan de lokale en 500miljoen aan de FGP. Alleen vergeten ze erbij te zeggen dat de FGP alweer een deel moet afgeven omdat die in de algemene besparingsregel terechtkomt. Terwijl de lokale politie daar niet moet afgeven. (…) De federale politie moet bij de lokale politie materiaal gaan lenen om te kunnen werken."* (NL_20)

Another respondent indicates that this also results in an exodus of personnel from the federal to the local level, which often goes hand in hand with a loss of expertise.

One respondent also mentions the lack of credibility of the central drug unit due to their lack of field experience, although other respondents claim the opposite or contextualise this further within budget cuts. The respondents partially explained this by the limited resources available to the central drugs unit, but also indicated that they were having difficulty attracting manpower to the central drugs unit, preferring to remain divided in the major cities, as is the case in Antwerp. However, respondents described the importance of the central drugs unit, especially in terms of specialisation, coordination and experience in tackling drug trafficking.

> *'Et donc, on se retrouvait dans les services centraux avec des membres du personnel policier, mais qui n'avaient pas une longue expérience de terrain, donc manquaient de crédibilité'* (FR_12)

Respondents within criminal justice describe a good relationship between the local public prosecutors and the federal public prosecutor, but emphasise that when a file remains at a local public prosecutor's office, the actors active at the higher level of the drug supply chain, including those financing the drug supply are never in the picture. Therefore, the respondents emphasise that coordination and cooperation with the federal public prosecutor's office is often necessary in these phenomena.

Third, respondents within customs also mention **barriers and bottlenecks in the cooperation between customs and police**. Respondents for example refer to the hesitance of cooperation in regions where the drug trade is a less acute problem, the lack of trust on some operational levels, and the lack of a clear delineation in tasks. Nevertheless, the respondents emphasise that today, there is a better cooperation between the two partners than there was before. Respondents also indicate that cooperation in Belgium is much better than what they see abroad, where customs often work more isolated than in Belgium.

> *Dus wij hebben gezegd onderzoeksmatig doen wij niets. Als ge dan in Nederland komt en je zit met de Nederlandse douane samen dan zeggen die: Nou, we hebben onderzoek gedaan naar de terminal en in de security. Ik zeg: ja is dat niet meer een politiezaak? "ja dat is een politiezaak maar dat kunnen wij ook". Ik zeg: ja, jammer dat is nu net heel het probleem. (NL_13)*

Respondents describe that when necessary, customs and police intensively work together, for example in Antwerp. When the need for cooperation is less critical, for instance at the airport, cooperation is less obvious.

> *We moeten ook wel eerlijk in zijn, en dat moet ook gezegd worden, dit is wat in Antwerpen zo goed werkt, dit kunt ge niet veralgemenen naar gans het land he. Dat heeft ook te maken met… Die cocaïneproblematiek is zo een dusdanige problematiek dat dat ook natuurlijk dwingt tot wat nauwere samenwerking. (…) En daar heb ik zeker niet mee gezegd dat bijvoorbeeld in Zaventem of in Bierset dat daar de samenwerking niet goed zou zijn, alleen in Antwerpen heeft dat zo een omvang dat men, dat ge daar structureel heel goede afspraken gaat maken want dan zit ge met grote leger, dat is een groot woord, daar hebt ge grote teams die daarop zitten. Op de luchthaven is dat allemaal, of niet de luchthaven, is de problematiek veel, allee veel … omdat ge daar met veel kleinere equipes zit. (NL_11)*

> *Nu, draai het of keer het hoe je wil. Als wij bijvoorbeeld met een FGP samenwerken van het binnenland is dat altijd wel moeilijk. Al goed dat wij hier zo die jarenlange samenwerking met de FGP Antwerpen maar soms is het vertrouwen er ook niet. (NL_13)*

Respondents also refer to the fact that the will and openness to cooperate is present at the different levels. However, this cooperation must be built on a constant basis in practice. Respondents pointed out that there are still individuals who lack the will to cooperate, which could cause friction. Keeping a good cooperation on every level, is fragile, according to our respondents. That is why it is important to involve everyone in the collaboration, so that it is not just the merit of a few individuals within the organisation. Respondents therefore emphasise transparency and loyalty.

> *Daarom is het belangrijk dat wij allemaal op één lijn zitten en dat dat niet zomaar kan. Als er een volgende komt, dat die niet zomaar kan ineens een andere koers begint te varen. He, dat is waarom we elkaar allemaal betrekken. Omdat dat anders te fragiel en voor dat ge het weet ligt het op zijn gat een stuk he. (NL_13)*

> *Ik wil maar zeggen, ge kunt samenwerking ook op papier zetten, maar dan hebt ge geen echte samenwerking. Samenwerking dat wordt opgebouwd door in praktijk samen te werken en door uw gedrag: door loyaal te zijn transparant te zijn. Zo komt samenwerking he. (…) Ik heb vroeger*

> *ook samengewerkt met mensen van de politie. Ik dacht, met die werk ik nooit meer samen want die respecteert mij niet. He, maar over het algemeen he, allee, oke, is die context volledig veranderd met 99% of 90% van de politie daar kunt ge goed mee samenwerken. (…) En er zijn mensen die niet die attitude hebben, dat klopt. Maar zeker op hoger niveau, dat die intentie er echt wel is. En niet meer zo van neerbuigend te kijken, het is maar de douane. Nee, ik voel dat respect. (NL_12)*

Respondents also emphasise respect for each other's tasks and goals in the collaboration as an essential basis for a good collaboration. According to the respondents, there is a clear demarcation of tasks between customs the police, however in practise, this demarcation is not always respected. Without clear agreements on who does what, and without coordinating these activities with each other, there is a fundamental problem, according to the respondents.

In the port of Antwerp, for instance, clear agreements were made with the federal police and with the maritime police about who focuses on which tasks. In this context, respondents also mention the bottleneck in the cooperation between the federal and the local police, where these clear agreements are sometimes lacking. This could cause this fragile balance to falter, as also indicated by the respondents below.

> *Het komt erop neer dat, wil de lokale zich inschakelen in dat plan op een correcte wijze, dan moeten er juiste afspraken worden gemaakt met de scheepvaartpolitie in de eerste plek he, willen ze in die haven ziften he. Ze hebben al een paar keer eigenlijk dat ze op eigen houtje aan het boteren waren, zonder ons te kennen, zonder de PSN te kennen, zonder de FGP te kennen. (NL_13)*

When the condition of a clear division of tasks is met, it comes down to respecting that division. When police start doing the work of customs, or vice versa, things might go wrong. In addition, respondents point to communication between each other, amongst other relating to the flow of information, as an essential basis on which to build trust between partners.

> *Maar die multi-agency approach is: iedereen blijft wel in zijn domein maar er moet wel voldoende uitwisseling van informatie zijn, dat kan digitaal zijn, dat kan op een andere manier zijn maar dat zijn voor mij de twee akten voor succes van die multi-agency approach. (NL_11)*

Lastly, respondents within police suggest to work in a shared workplace to enhance cooperation between the different enforcement partners, whereas respondents within customs are more reluctant to such initiatives. According to the latter, there are too many differences in culture and attitude, and working in the same workspace could possibly work counterproductive.

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On all policy levels:
  - Develop a shared action plan with all law enforcement partners, with clear priorities.
  - A more coherent drug policy at all levels (policy and field level)
- On a federal level:
  - Encourage a multi-agency approach with a clear and non-overlapping task delineation. The different tasks for each partner should be clearly agreed, and overlap between tasks should be avoided.
  - Provide a clear framework for cooperation and information sharing
  - Encourage multi-disciplinary teams
  - Establish cooperation with local government and the private sector, as a way of developing crime prevention.

- Include drugs in the priorities of the Framework Note Integral Security and the National Security Plan and provide the necessary means and a real follow-up of the priorities

b. Barriers and bottlenecks with the legal framework

All respondents mentioned barriers and bottlenecks with the (inter)national legal framework. They referred to barriers with the UN conventions as well as the Belgian Drug Law.

First of all, one respondent explains that the **current UN conventions are to some extent outdated, or at least not adapted to the current context**. The respondent refers to the current cannabis situation, where the use of cannabis is much more widespread than it was the case when the conventions were established. Moreover, the respondent mentions, there are many countries that do not comply with the established framework of the UN conventions, e.g. the cannabis shops in the Netherlands. An adaptation of the framework is also desirable in other, more technical areas, for example the fact that toxicology labs must report to Belgian EWS. The respondent however stresses that adaptations to the UN Conventions are very difficult to make because there are so many countries involved, each with very different views, that need to be aligned.

A second bottleneck, mentioned by all respondents within police and criminal justice, is **the dichotomy in the Belgian legislation and prosecution policy**. According to all respondents, this legal framework gives two contradicting messages: On the one hand, there is legislation that prohibits the possession of all illegal drugs. On the other hand, there is a ministerial directive saying that there is no/less consequence related to the possession of cannabis for personal use. The respondents stress that this contradicting message, prevents prosecutors and police to deliver a coherent prosecution policy to the general public.

> *"Oui, c'est comme ça qu'on fait de la politique en Belgique, mais ce n'est pas comme ça qu'on donne au Ministère Public les moyens d'organiser une politique cohérente. Non seulement on sabote le travail du législateur en laissant croire qu'on ne l'exécutera pas, mais on sabote aussi le travail du Ministère Public, qui est là pour garantir le respect de la loi, mais à qui on demande de fermer les yeux sur certaines choses, et enfin on sabote la communication à l'égard du citoyen en semant la confusion en lui disant à la fois que ça reste interdit, mais que s'il le fait, il ne lui arrivera quand même rien. C'est catastrophique à tous les égards." (FR_4)*

> *"Het aspect krijgt het laagste niveau op niveau van vervolging, de politie wordt geconfronteerd dat dat op niveau van justitie de laagste prioriteit krijgt. En langs de andere kant, de politie moet ook de strijd tegen het aanbod realiseren, en dan, dat is een totaal ander landschap. Dat is een topprioriteit voor justitie. Dat is echt een dichotomie (…), tussen twee aspecten. Maar de politie moet het doen met die realiteit." (NL_7)*

Moreover, it prevents, according to the respondents, the development of a coherent cannabis policy, as the perception in the general population is that there is a 'tolerance policy' towards cannabis, which is not really the case.

> *" On n'a jamais eu cette politique de tolérance, même si on a essayé de la faire croire. Avec l'Arrêté Royal de 2017 et avec la circulaire, on a bien rappelé qu'il n'y a pas de tolérance à avoir. Maintenant, je ne veux pas dire que forcément, il faut systématiquement mettre tout le monde en prison... Il ne faut pas forcément faire des poursuites, mais au minimum : 1.Confiscation de substance ; 2. Rappels de la norme, c'est un minimum qui doit être fait." (FR_5)*

One respondent refers to the different interpretations of the directive at local level. Depending on rural and urban areas, the guideline is interpreted differently. According to the respondent, it prevents a coherent and consistent vision for the whole territory. In addition, respondents referred to some contradictions that were included in the directives, which contradicted existing legislation, for example, regarding the confiscation of the amount of cannabis for personal use.

> *"Une autre chose qui était aberrante en 2003 et en 2005, c'est qu'il y avait une illégalité flagrante de considérer que, pour les petites quantités de cannabis, quand on fait un procès verbal simplifié, on ne devait pas les saisir. C'est complètement contraire à la loi puisque l'article 35 du Code d'instruction criminelle dit que le Procureur du Roi "saisit", on ne dit pas "peut saisir"… Ca a créé la confusion totale dans les services de police, plus que la confusion..."* (FR_4)

This has created a lot of ambiguity in the past, at the level of the prosecutor's office and at the police level. Respondents emphasise that those problems were not corrected until 2015, when a new COL provided an overview with different categories.

> *"Ik heb de indruk dat voor bepaalde aspecten, bijvoorbeeld het beleid rond het bezit van cannabis, dat de principes niet altijd goed begrepen werden door de politie, door de eerste lijn. Uhm, dat heeft inderdaad voor problemen gezorgd, minder denk ik sinds 2015. Sinds 2015 is er een nieuwe omzendbrief geweest."* (NL_7)

Some respondents also point to the lack of political will at ministerial level to take a stand on the issue of drugs and the need to clarify the national position concerning drugs.

> *'Parce que politiquement, on a souvent senti du côté du ministre, que les drogues, c'était trop polémique, trop politique. Il n'avait pas envie de faire parler de lui sur les drogues'* (FR_4)

That situation leads to frustration among the police, one respondent indicates, as it lead to a banalisation of the use of drugs:

> *"Maar dat kan wel zorgen voor een zekere frustratie en sommige collega's zeggen ja dat zorgt ook voor een vorm van banalisatie van het gebruik." (NL_7)*

In addition, respondents also emphasise that several elements mentioned in ministerial directives were never implemented in practice, for example, judicial case managers and public health case managers.

> *Il y avait une loi, il y avait un Arrêté Royal et il y avait une circulaire, une directive ministérielle. Je ne sais pas qui a écrit ça, et comment ça a pu sortir d'un cabinet ministériel, mais c'est une honte. (…) Avec ça, c'est devenu illisible. D'abord, les conseillers, (…) les case managers justice, les cases managers de santé publique et les conseillers thérapeutiques, qui ont été mis en place par la réforme de 2003, n'ont jamais vu le jour. Pourtant ces fonctions sont dans la circulaire. Puis, un arrêt de la Cour d'Arbitrage a annulé la disposition relative au simple enregistrement policier qui était aussi une belle aberration sur le plan constitutionnel. On a une loi avec une infraction. Et puis une autre loi avec certaines infractions qui ne seront pas constatées. Allez, qu'est ce que c'est, ça? C'est pas sérieux. (FR_4)*

Lastly, one respondent refers to the tethering problems with the generic legislation that came into force in 2017. There are a number of (minor) adjustments that have to be made, but due to a lack of personnel for the preparatory work, these problems have not been addressed yet.

<u>In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:</u>

- <u>At a federal level</u>:
  - Abandon the concept of 'tolerance policy', and install a clear and coherent legal framework regarding illegal substances.
  - Update the generic legislation.

c. Budget constraints

Both FAGG and police respondents mention budget constraints which limits them in the tasks they can fulfil. Both sectors mention opportunities they would like to explore such as focus more on priorities such as synthetic drug production and heroin trafficking, but are unable to do so for the time being, due to a limited budget and/or personnel.

Furthermore, the allocated budgets do not always align with the issues identified as priorities (drugs) in policy plans, one respondent stresses.

> *'Mais le problème, une fois encore, il faut que ce soit suivi d'effets. Si on dit qu'on accorde une priorité à tel phénomène plutôt qu'à un autre, mais qu'on y met pas les moyens pour l'appliquer, ça ne sert pas à grand-chose'* (FR_5)

d. Several practical problems at the operational level at the airports and the port of Antwerp

The respondents within customs describe a number of organisational bottlenecks in the port of Antwerp and at the airport.

For instance, customs at the airport receive an overview of courier companies for the purpose of risk analysis, but these overviews often contain very little information and often arrive rather last minute. This in turn creates problems for risk analysis. The respondents strongly emphasise '(air)port community systems' to avoid these problems in the future.

A number of operational bottlenecks in the Port of Antwerp are also pointed out. Respondents indicate how on an operational level, law enforcement encounters problems with the ISPS code, for example, and with the linked ALFAPASS. Since the ISPS code does not define a standard, respondents describe that "everyone does something". This in turn makes control difficult to enforce. In practice, the system appears to be anything but watertight.

Another practical problem regarding the tackling of drug-related problems in the port of Antwerp is that the port is spread over two judicial districts (Antwerp and Ghent) hindering an efficient way of working.

Finally, one respondent points out that it is essential to constantly question the efficiency of methods used, new equipment and investments. All too often, a lot of bells and whistles are invested in equipment to increase efforts in the Port of Antwerp yet this equipment often manifests clear limitations. In those cases, it is important to recognise those limits and consider what is needed to overcome them.

> *Zoals ik al zei: alles heeft zijn limieten, het is vooral rekening houden met die limieten om te kijken van ja: moeten we nog verder gaan of hebben we alles nu wel gehad? (NL_13)*

Another example which respondents refer to is the Stroomplan, which was extensively mentioned in media, but never actually existed on paper.

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- 100% scanning of all risk containers in the Port of Antwerp, by systematically installing scans at the terminals.
- Access of customs to the port and airport community systems, to strengthen the information position of customs.
- Establish a precursor team in customs.

B. Barriers and bottlenecks related to 'international cooperation' of the objective 'to control drug supply'

When it comes to **international collaboration**, various barriers are raised.

First, all respondents mention that an intensive cooperation exists with the Netherlands, but that this cooperation does not always run smoothly. Respondents from the police and customs emphasise that the Netherlands and Belgium do not always share the same priorities. When something is a priority in Belgium, but not a priority in the Netherlands, there is often no cooperation and few resources will be allocated to it. Whereas in Belgium, even if it is not a priority, they are looking for ways to allocate resources to it. The difficulty is to find a balance between the common interests of both countries

> *'Les Néerlandais sont capables de dire que c'est très intéressant, mais que ce n'est pas prioritaire, ou qu'on n'a pas les moyens. Du côté belge, on dira toujours que ce n'est pas prioritaire, mais on cherchera malgré tout toujours les moyens'* (FR_12)

The fact that judicial and administrative procedures differ in both countries is also mentioned as a barrier, as well as a lack of police capacity to focus on such international cooperation and legal restrictions, for example to share evidence.

> *"We worden nog altijd geconfronteerd met hindernissen in de samenwerking met Nederland. Dat is [een probleem van] prioriteit, dat is een probleem van capaciteit, dat zijn nog juridische problemen, in de onderzoeken zelf, om bewijsstuk te recupereren (…). Ik denk, dat zorgt voor frustraties op niveau van de onderzoekers. (…) Ook bijvoorbeeld, als er mensen gearresteerd worden in Nederland, dan… dat neemt soms veel tijd, he. Bepaalde dossiers duren een jaar soms, om die mensen naar België te sturen. En ik denk… Dat moet flexibeler, dat moet inderdaad sneller gebeuren. En daarom missen wij een echt gezamenlijke procedure, een gezamenlijke doelstelling." (NL_7)*

Furthermore, respondents mention that each country asks for its own approach. For example, respondents mention that in their cooperation with the Netherlands, there is a need for straightforwardness and creating a win-win, otherwise chances of a good cooperation are small.

The difficulty according to the respondents, is to find a balance between the common interests of each country, especially since they do not necessarily share the same priorities.

> *'C'est difficile de trouver un équilibre entre les différents intérêts (…) Le cadre légal est une des difficultés, les objectifs poursuivis sont différents et pas toujours en équilibre, les mentalités, les cultures sont un obstacle ou une autre difficulté qu'il faut surmonter lorsque l'on parle de coopération structurelle'* (FR_12)

> *'Les Français, ils ont fait ça du bout des lèvres, et le Luxembourg n'en voulait pas tellement non plus. Tout le monde avait l'air de dire que c'étaient juste des histoires de politique'*. (FR_4)

Second, respondents also mention that structural cooperation, certainly with South American source countries, is sometimes difficult. They however note that when this cooperation becomes too formalised, it produces the opposite effect, slowing down the process even more. Respondents indicate that often, cooperation with source countries relates to a matter of establishing a contact person in the field.

> *"Nu euhm, het samenwerking met zo'n ver land, dat is absoluut niet evident, integendeel zelfs, het komt er eigenlijk op aan, en dat vind ik altijd heel triest, dat je mensen moet kennen die in het veld aan het werken zijn opdat je snel vooruit kunt gaan. Eigenlijk zou het structureel moeten zijn, maar we stellen nog altijd vast dat structurele samenwerking met zo'n landen in Zuid-Amerika dat dat absoluut niet vooruitgaat. Dat is al jaren een grote problematiek, het is van mensen te kennen en proberen contacten te hebben met mensen die daar een key-positie hebben om ervoor te zorgen dat je vooruit geraakt." (NL_20)*

> *"Ik wou naar één dingetje nog even verwijzen, dat is die samenwerking met die derde landen en vooral met die Zuid-Amerikaanse landen, want ik weet niet… Hoe meer dat dat geformaliseerd gaat worden, hoe minder dat dat eigenlijk gaat werken." (NL_13)*

> *"Dat is ook zo dat je niet meer vrij kan handelen, je bent gebonden aan allerlei procedures en dan is er veel vertraging op het heel het systeem want dan moet je natuurlijk via allerlei kanalen gaan, dat is een nadeel daarvan. (NL_12)*

Third, some respondents criticise the fact that many international initiatives are being set up, but that these are often insufficiently coordinated at the European level. Respondents see this fragmentation, where many different organisations are working on similar topic, as problematic. At the moment, all the organisations seem to want to demonstrate their viability, whereas there is a need for a certain synchronisation in that cooperation. The cooperation should have a practical relevance and transcend the theoretical level. Respondents indicate that there is a need to look at how these international initiatives can reinforce each other.

> *"Maar ge ziet dus ook Europees, hier ook allemaal in de opsomming, het is verschillende slides. Allé, soms, eerlijk gezegd, ik zie het bos door de bomen ook niet meer. Viel von das guten zu viel, ist auch niet gut, he. Euhm, dus op zich zijn die initiatieven wel goed. Maar dat komt uit die hoek, dat komt uit die hoek, …. En volgens mij geeft dat aan dat op niveau van Europa er toch een zeker gebrek is aan coördinatie tussen dat allemaal." (NL_11)*

Fourth, respondents mention that there are often problems with the legal basis to exchange information at the international level. When there is no legal basis, there is no possibility for sharing information. In order to be able to share information, a cooperation agreement must be established, which is delaying the cooperation. Respondents share that frustration in the sense that "Criminals don't have those barriers" and are once again one step ahead of us. One respondent even indicates that the GDPR legislation is interpreted in such a strict way by some countries, that it can be a barrier too.

> *"Dus de samenwerking met derde landen dat is dus tussen douanediensten en is gebaseerd op verschillende verdragen die ook niet altijd toereikend zijn. Die daar soms ook met de GDPR problemen stelt enzovoort." (NL_12)*

A fifth bottleneck is the fact that competences of legal bodies such as the federal prosecution office or the district court, differ between countries. This might negatively impact the progress of certain cases, but also discourage Belgian public prosecutors from getting involved in international cooperation.

> *''Landelijk parket', par exemple aux Pays-Bas, n'a pas de rôle en matière de coordination. Il n'a de rôle qu'en termes de coopération internationale et surtout d'exercice de l'action publique à l'égard d'un certain nombre de phénomènes jugés prioritaires par l'autorité politique néerlandaise ; là où en Belgique, le parquet fédéral, outre l'action publique, a également en la coopération internationale et surtout la coordination de ce qui se fait au sein des parquets d'arrondissement'*. (FR_12)

<u>In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:</u>

- <u>On an international level:</u>
  - Clear coordination and alignment of international cooperation initiatives to enhance the strength on the ground.
  - Maintaining international cooperation
- <u>On a national level:</u>
  - Align the Belgian drug policy priorities regarding supply, with the priorities in the Netherlands.
  - Share the assets that have been confiscated between the services that enabled my confiscation

C. Barriers and bottlenecks related to 'A reinforced repressive response towards drug trafficking' of the objective 'To respond proportionately to criminal offences'

a. The investigation of drug production and drug trafficking

First of all, a lack of capacity and resources, especially at the level of the federal police, is emphasised by respondents. The lack of resources and capacity in the federal police has already been described above. This lack of resources also extends to its technological infrastructure. For example, respondents indicate that the federal police has to rely on IT systems dating back to 2001. Often, the federal police has to look at the local police to ask for equipment. In addition to this lack of capacity and resources, several respondents also refer to the reduction of people working at the central drug unit of DJSOC as a bottleneck.

> *« il y a une quinzaine d'années maintenant, le service central drogue était composé de 30 à 35 personnes. Il est passé à 10-12 et maintenant, concrètement, ils ne sont plus que 5-6 » (FR_5)*

One respondent explains this reduction as a result of the optimisation of police services, with more capacity going to the district level, and because of the departure of colleagues who were not replaced. This is problematic according to some respondents, especially because of the loss of expertise when someone leaves. Today, expertise is too often individual-related and not structurally embedded, with the result that expertise is lost when that person leaves the organisation or institution.

> *"Uhm het resultaat denk ik van twee bewegingen. De eerste dat is de optimalisatie van de politiediensten. Dus met de jaren uhm, meer capaciteit op het niveau arrondissementen, minder op federaal niveau. En de tweede is gewoon het vertrekken van uhm collega's door verschillende omstandigheden, bijvoorbeeld collega's met pensioen of collega's die een nieuwe uitdaging hebben gevonden op lokaal niveau en dus een pijnlijk expertiseverlies met de jaren." (NL_7)*

In addition, respondents describe a shift from two levels of policing, the federal and local level, towards three levels of policing: the local level, the district level, and the federal level. Increasingly, a role is assigned to the major districts, and respondents also see the importance of the districts reflected in recent policy plans. According to respondents, it is therefore important to involve that new district level closely in criminal justice policy, because at this time, there is no clear, nor a common direction. At the same time, several respondents note a shift of tasks over the years, with tasks being transferred from the central level (including the central drugs unit) to the districts or local police. The result, however, is a lack of centralisation of all this information.

> *"Het accent werd inderdaad gelegd op de arrondissementen, ik heb soms de indruk dat wij nu een geïntegreerde politie met drie niveaus hebben. Niet meer met twee. Met de lokale, de arrondissementele en dan de federale politie." (NL_7)*

> *'Plutôt que d'avoir un volet central fort pour le démantèlement des laboratoires et pour avoir une vue globale sur les grands trafics. Les politiques ont réparti les compétences : 'NPS et cannabis' est du ressort de la direction générale judiciaire de Hasselt. Pour La cocaïne, c'est Anvers, mais c'est plus central (…) Si on ne met pas d'analyste, si on ne met pas de centralisation et si on n'alimente pas le service central d'information, à mon sens, ce n'est pas efficace, mais c'est un avis personnel' (FR_5)*

Another barrier in the investigation of drug production and drug trafficking is the fact that there are various obstacles to map financial flows. According to the respondents, there are too often blind spots in the mapping of financial flows i.e. where to and the mechanisms behind the channelling of money. Respondents therefore indicate the importance of tactical analysis (located between operational and

structural analysis) and infoflux, in multidisciplinary cooperation with the tax authorities and inspection services, for example.

> *Maar we stellen toch vast dat wij de follow the money of gewoon het drugsgeld in beslag nemen, dat wordt inderdaad ook steeds moeilijker. Gezien onze beeldvorming… Naar waar gaat het geld? (…) 'welke zijn de mechanismen, de concrete mechanismen die gebruikt worden'? Dat blijft nog altijd een blindspot. Dus daarom ook een tactische analyse en de infoflux is zeer belangrijk (NL_7)*

One respondent also refers to the fact that for some phenomena a proactive approach would be more effective, rather than the merely reactive way of dealing with it today. The respondent refers to the example of the involvement of Mexicans in the production of synthetic drugs in Belgium. This production site was discovered in a reactive way. According to the respondent, this indicates that their information position is not strong enough. Another example is the drug offer on Darknet, where the response so far has been purely reactive, based on a classic investigation.

Additionally, a respondent within criminal justice mentions that there is no legal basis in Belgium for handing over large sums of money in the context of an infiltration. The respondent indicates that these price scales could be increased, as is the case in for example the Netherlands so that there are more possibilities for the investigation of organised crime. The possibility of a secret search, which is not possible in Belgium at the moment, but is possible in other countries, is also put forward in that context.

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- At all policy levels:
  - Develop a shared action plan with all law enforcement partners, that identifies clear priorities. This action plan should be flexible enough to adapt to the changing phenomena. The action plan should rely on a strong, and up-to-date imaging of the supply side.
- On a federal level:
  - Invest in proactive policing, for example by improving the information position of the police.
  - Focus on tactical analysis, i.e. a better image of specific crime trends, mechanisms used and modus operandi, etc… to guide police actions.
  - Focus on financial flows and confiscate drug profits.
  - Amend the charter of the taxpayer, so that a cooperation between the police and the special inspection services is facilitated.
  - Build barriers for criminal organisations by installing administrative measures in cooperation with local government and with the private sector, as a way of developing 'crime prevention'. Respondents mention examples like revoking a licence when involved in drug trafficking, temporarily sealing homes when the owners are involved in the illegal production of drugs, targeting providers of phones regularly used by criminal organisations, or the cooperation with the chemical sector to detect suspicious transactions.
  - Inform local governments on the existing possibilities of an administrative approach towards drug trade.
  - Raising citizens' awareness of the signs of drug production.
  - Reinvest confiscated profits into drug prevention and treatment.
  - The need for further specialisation in the field. Some respondents in customs, police and criminal justice mention that there is a need to systematically look back at previous cases and incidents in order to improve the current operation.

b. The prosecution and sentencing of drug production and drug trafficking

Respondents also list a few barriers and bottlenecks regarding the prosecution and sentencing of drug production and drug trafficking.

First of all, many law enforcement respondents describe how the penalties for drug trafficking are too low and indicate that the penalties are too soft, specifically for high level traffickers. The current penalties are not sufficient to make a distinction between smaller scale dealers and international traffickers.

Second, one respondent clarifies that the investigative judge can be a barrier during investigation. After all, the investigating judge is not bound by criminal policy. Especially in international cases, cases are compartmentalized. This means that a large case is divided into several small cases, to ensure that each case is strong enough without risking the bigger whole. So, the case that is brought to the investigating judge is often part of a larger set of cases. However, the investigating judge does not have to comply with this compartmentalising approach, and, as respondents indicate, it therefore depends on the investigating judge whether they are inclined to do work with this approach too.

> *Die onderzoeksrechter die beziet zijn dossier. Die zegt ha, dat heb ik hier in mijn dossier. Maar hij is niet verplicht om dat in een groter geheel te zien snap je. De onderzoeksrechter is niet langer officier van justitie, dus die volgt eigenlijk niet het strafrechtelijk beleid dat wordt uitgeschreven. (NL_20)*

An unintended side effect of this, is that in some cases there are delays in arresting as suspect because it requires permission from the investigating judge.

A respondent also refers to the fact that the timing of the procedure between different special investigative methods is not aligned causing risk for confusion. For observation and infiltration, there is a three-month timing, whereas for a telephone tap, it is one month.

One respondent further mentions specific problems with the execution of sentences. Too often, the respondent highlights, people placed under electronical monitoring are arrested without the Flemish Electronic Monitoring Centre being aware that the person has left the house illegally.

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On a federal level:
  - Review the existing penalties for illicit drug trafficking and production, in order to differentiate better between high level traffickers and low-level dealers.
  - Align procedures of all special investigative methods.

D. Barriers and bottlenecks related to 'A differentiated penal response towards drug use' of the objective 'To respond proportionately to criminal offences'

In general, respondents describe a good cooperation between criminal justice and treatment. Respondents point to the diverse initiatives to refer people with drug problems from the criminal justice system to treatment at all levels of the criminal justice system.

> *« Ce principe a mis du temps à faire son chemin. Je ne peux pas dire qu'il soit effectif à cent pour cent, mais je pense que la politique de l'assistance est maintenant très bien intégrée partout dans les parquets. On a des solutions locales pour orienter les gens, pour avoir des mesures probatoires, pour que les gens soient accrochés dans un système de soins. » (FR_4)*

Yet, some barriers and bottlenecks regarding this cooperation are described. One respondent mentions that there is lack of screening in the judicial referral to treatment. The respondent acknowledges the importance of the individualisation of punishment tailored to the defendant's needs in order for judicial referral to treatment to work. As such, the respondent stresses the importance of assessment - which is not something a judge can do. The respondent refers to Liège where the Mental Health Platforms are called upon to establish a diagnosis.

> *Pour donner de bons résultats, elle doit être faite de façon sérieuse et individualisée. Et le problème numéro un dans la démarche des magistrats pour une bonne orientation, une bonne assistance, ou un bon traitement alternatif, c'est la question du diagnostic. (FR_4)*

The respondent also mentions the professional secrecy of treatment actors as a barrier in the cooperation with treatment. Judiciary have to take informed decisions, and perceive that professional secrecy sometimes prohibits this. The respondent indicates that a balance has to be found between what information can be shared and what information is needed to be able to make a proper judgement. Respondents from justice furthermore describe how they are concerned with the limited information position, as they have to make a judgement without knowing the whole situation.

> *'Les barrières, c'est d'abord, (…) l'absence d'information en amont, c'est à dire l'absence de diagnostic, (…), il y a des juges qui prennent des décisions en matière de drogues, mais qui ne savent pas de quoi ils parlent ou pas bien. Puis, une information du médical vers le pénal qui est aussi très fragmentée à cause du secret médical'* (FR_4)

Some respondents stress conflicting logics in the legislative framework. From a normative framework, respondents explain that a legislative framework should propagate a consist message. However, some respondents within law enforcement stress that this is not always the case. They for example point to the dual signal that is given when referring people from the criminal justice system to treatment. The respondent describes how, on the one hand, people are told 'you are guilty', but on the other hand, they are also told that they are 'sick' and will therefore not receive any punishment and are therefore referred to treatment. This is described by these respondents as the dichotomy made between the repressive model and the treatment model, presenting a division 'punishment vs treatment'. The respondents are especially worried about the dichotomous message this demonstrates to the wider public.

> *'C'est l'alternative 'Punition – Soins', d'un côté, on dit : « vous êtes coupables », de l'autre côté, on dit : « vous êtes malade ». C'est complètement schizophrénique, on est coupable ou on est malade ? (…) On envoie des gens vers les soins avec un discours très particulier en disant vous êtes coupables, mais si vous vous soignez, vous ne serez pas punis. Sur le plan logique, c'est aberrant comme discours'* (FR_4)

This paradox is explained by the respondent by two antagonistic positions: the need to maintain drug possession as a criminal offence in order to discourage use among young people, but at the same time to recognise on the field that drug users should no longer go to prison, and whenever drug problems are present, should be treated instead of punished. According to the respondent, this type of model cannot work until this principle of tolerance is enshrined in law because the judge cannot be asked to be tolerant.

> *'C'est important en tant que message à faire passer à la population, d'autant plus pour les mineurs. La détention constitue toujours une infraction. Mais (…) on n'est plus d'accord pour que ces usagers se retrouvent en prison, donc sur le terrain, on essaie que les usagers ne soient plus poursuivis et condamnés, mais qu'ils soient orientés vers un système de soins. Mais forcément, c'est boiteux. (…) Le problème, c'est que si on n'inscrit pas un principe de tolérance dans la loi, la décriminalisation, on ne peut pas demander aux juges d'être tolérants. La loi, elle doit être claire et elle doit être précise'* (FR_9)

Furthermore, one respondents points out some small barriers concerning penal mediation, e.g. it is restricted to six months, it is rather confined, i.e. you have to call on a legal professional. As a result, the

respondent describes how the prosecution therefore often prefers praetorian probation, as this gives the prosecution more freedom to revisit the case when the preconditions are violated.

> *'Le parquet préfère la probation car il ne faut pas faire appel à des assistants de justice pour assurer le contrôle des conditions. Dans le cadre de la probation prétorienne, il peut s'adresser aux services de police ou demander notamment de faire un test d'urine. Donc, pour lui, il y a plus de liberté'* (FR_9)

Lastly, several respondents refer to the lack of structural implementation of existing pilot projects, like the Drug Treatment Court (although there is a policy intention to implement this in each court of first instance), Proefzorg, TADAM, etc…

> *Je crois qu'on est quand même assez créatifs et inventifs, et qu'il y a des initiatives qui arrivent à se mettre en place, ou qu'on tire des enseignements des projets-pilote. Mais, Tadam, c'était un projet pilote et ça a donné de bons résultats. Mais lors de la fin du projet, les personnes suivies ont été brusquement laissées à leur sort et certaines sont décédées assez rapidement. (FR_4)*

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On a federal level:
  - To have judges specialised in drug issues (e.g. drug treatment chamber)
  - Increase the cooperation between the criminal justice system and the treatment sector so that both sectors get a sense of the way of working of the other side, and base this cooperation in clear agreements regarding information exchange.
  - Pay attention to adequate screening when diverting offenders from the criminal justice system to treatment (and repeat screening at different points).

E. Barriers and bottlenecks related to the objective 'To develop a penitentiary drug policy'

The barriers and bottlenecks described here, show overlap with the barriers and bottlenecks described under the pillar 'Treatment, risk reduction and re-integration'.

Some respondents criticise the (lack of a) **treatment offer in prison**. Currently, there is a minimal provision of drug treatment in prison, and funding is problematic according to some of the respondents.

> *"Het aanbod binnen de gevangenissen zelf, is eigenlijk nog altijd miniem. Is nog niet zo uitgebouwd, de financiering daarvan, dat trekt eigenlijk op niks. Die middelen moeten, komen blijkbaar soms uit de pot van het werk dat de gedetineerden doen in de gevangenissen. Da's een heel onlogische financiering." (NL_3)*

Another respondent highlights several problems related to access to care in prisons such as: limited access to care for prisoners, delays in starting treatment, substitution treatment doses that are much lower than those received on the outside, change of substitution treatment (suboxone replaces methadone), and even treatment that does not take into account the client's background or previous treatment.

> *'Il existe encore des réticences, une limitation d'accès, un retard au démarrage du traitement, des doses qui sont loin de celles qui étaient donnés à l'extérieur (…) Il y a l'arrivée du suboxone : il y a des gens qui étaient en traitement à la méthadone, parfois depuis 20 ans, et qui se retrouvent avec un changement de traitement qui ne leur convient pas forcément. Ca pose beaucoup de problèmes'* (FR_13)

Also related to the treatment offer in prison, some respondents highlight the understaffing of medical teams in prisons, but also the lack of training of these teams in dealing with drug-related problems, for example regarding psychiatric disorders.

Respondents for example acknowledge that there **are differences between prisons in treatment offer**, with some prisons having drug-free departments, other prisons providing group counselling, and others having none of those. In general, though, the treatment offer remains limited, mainly because there is very little budget available to further develop that offer. This is problematic for several reasons, for example the discontinuation of treatment upon transfer.

> *"Ik vind het heel moeilijk om over continuïteit betreffende gezondheid te spreken, als er in de gevangenis ja, wat betreft drugs dat dat beperkt is." (NL_6)*

Almost all Flemish respondents mention the **structural underfunding of the prisons**, which has been the case for decades. These current budget constraints cause prisons to creatively seek revenue. For example, revenues from "Cellmade," the workshops in prisons, are being used to start group counselling in some prisons. In this way, an attempt is made to expand the treatment offer during detention. Although this is still on the initiative of the prisons themselves.

Apart from the underfunding, there is also an **issue of competences**. The division of competences, causes difficulties sometimes, as indicated by the quote below. Other respondents in turn highlight that it seems as if criminal justice has the sole right to initiative. This shows that the division of competences is not entirely clear for issues relating to drug policy in prison, resulting in a lack of or hesitance of taking initiative from both policy domains.

> *'Un autre exemple, c'est la santé en prison. On a beaucoup de problèmes avec le fait de mettre des choses en place en prison malgré la loi Onkelinks. Mais c'est toujours la justice qui a la compétence santé en prison.'* (FR_8)

> *"Ze zeggen altijd van 'die gevangenissen ze doen nooit iets omtrent de drugsproblematiek'. Dan denk ik van, integendeel, [zij] doen misschien zelfs dingen die normaal niet mogen. Als je het puur bekijkt op bevoegdheid (…) Maar dat zou vooral gefaciliteerd moeten worden, er zouden daar geen stokken in de wielen mogen worden gestoken van 'nee je mag dit niet doen of dit of dat'. Ja dat is vertrekken vanuit de nood hé, maar dat is het probleem hé. We vertrekken niet van de nood, we vertrekken van wie is bevoegd, en dat is heel moeilijk." (NL_6)*

Furthermore, specifically in Flanders, the **insufficient funding for TANDEM** is mentioned. The prison-based registration points (drug-specific) were re-oriented to a broader public with mental health problems after the sixth state reform (cf. supra), without an increase in budget. same limited staff, had to attend to a larger group of clients at that time, with no capacity to do so. In the meantime, the Flemish government has announced that this funding will be doubled (De Kiem, 2020).

> "*Het CAP van vroeger, dat in die nota nog als in die vorm omschreven wordt, en nu TANDEM noemt, dat was ook zoiets. Dat was drie en een half medewerkers, en van de ene dag op de andere moet je niet alleen met drugsverslaafden werken in de gevangenis, maar moet je ook nog een keer de oriëntatie en doorverwijzing doen van gelijk wie met gelijk welke psychiatrische problematiek. En da's eigenlijk... Eigenlijk is de afkolving van middelen hè."* (NL_3)

In turn, some Walloon respondents mention a lack of continuity of care when drug users leave prison. According to the respondents, there is a missing link between the prison and treatment services outside prison as well as difficulties with several administrative procedures. Respondents refer to a lack of guidance to addiction treatment, as well as a lack of assistance on other life domains such as housing. Lastly, respondents refer to the lack of housing for people who use drugs and who are released from prison. As a consequence, they often end up on the streets.

As such, a respondent stresses that prison is not adapted to its public. Several services in prison do not take sufficient account of the vulnerability of the public they are dealing with. The respondent explains how the prison system works as if all prisoners have a social network, family and money.

Furthermore, some respondents mention the **resistance to provide substitution treatment** in prison among some of the prison physicians. This is a known problem that continues to cause problems. For example, because of ideological belief, physicians sometimes refuse to prescribe substitution treatment, despite the regulatory framework and coaching of staff.

> *"Je blijft zien dat er heel wat weerstand is bij artsen in gevangenissen, uit… ik zal maar zeggen onwetendheid, hé? (…) maar ik sta er van versteld. Dat zijn een paar artsen, die zeggen allemaal hetzelfde. Collega's die dat [substitutie] niet willen doen, die daar niet aan willen of durven beginnen en die daar ook eigenlijk principieel tegen zijn, om dat te doen. Dus dat zijn zo van die dingen waarvan je zegt, het is tijd dat we daar in Vlaanderen, zeker in Vlaanderen, daar werk van maken."* (NL_16)

One Flemish respondent denounces the fact that certain **harm reduction initiatives in a prison** context are not even discussed, let alone considered, despite research providing positive outcomes.

> *"Dan hebben we nog niet eens gehad over spuitenruil in de gevangenissen. Dat is iets waar we nog niet eens durven over praten, maar in feite zou dat soort zaken die anders zo'n grote evidentie heeft."* (NL_16)

Like in the other pillars, one respondent also highlights the short-term funding of pilot projects. This results in uncertainty and obstructs a structural and long-term vision. Even though some pilot projects show favourable results, they are still funded on a short-term basis without a long-term vision. This may have a negative impact on the quality of the work.

> *'C'est un projet pilote qui a aussi été financé par tranches de 6 mois, 3 mois, 9 mois, etc. Donc, on n'avait pas de long terme. Maintenant, on arrive à trois ans d'existence, mais on n'aurait jamais imaginé au départ avoir trois ans, ce qui a beaucoup compliqué la qualité du travail'* (FR_13)

Some respondents conclude that there is little cooperation between justice and prison policy in relation to drugs.

> *'En ce qui concerne la politique pénitentiaire, il y a un grand vide... Je ne dis pas qu'ils ne font rien... mais ils le font de leur côté.C'est une autre direction générale, dans un autre bâtiment, (…) c'est peut être un problème structurel…'* (FR_5)

<u>In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:</u>

- <u>On all policy levels level:</u>
  - A longer-term drug policy in prison based on evidence-based initiatives, and accompanied by proper monitoring and evaluation.
  - Clarify the role and responsibilities of clinical and security teams within correctional settings for treatment delivery.
  - Intensive support for prisoners in prisons by health workers (e.g. set up multidisciplinary teams in prison)
  - Training prison staff on the issue of drugs in prison
  - Facilitate aftercare and continuity of treatment on several life domains
- <u>On a federal level</u>:
  - Push for more uniformity and consistency in penitentiary drug policy
  - Support and encourage local managements to install local drug policies
  - Facilitate cooperation with treatment providers in prison.
- <u>On a regional level</u>:
  - Introduce extra-muros treatment facilities in prisons. Some respondents refer for example to therapeutic communities in prison, or outpatient services with an antenna in prison.
  - Invest in aftercare.

- Give additional attention to people who have never been in contact with health care providers, and people who spend only a short time in prison
- Increase funding for drug treatment in prison.

F. Barriers and bottlenecks related to the objective 'to stimulate research and evaluation'

With regard to research and evaluation, one of the bottlenecks highlighted by a respondent is the fact that the current evaluation research on law enforcement is focused rather on mapping, explaining the situation *as is*, rather than reporting on the actual results. There is no real monitoring of the achievement of projects, objectives or an enforcement policy. The following respondents clarifies that sometimes, monitoring and evaluation is carried out because it has to be done rather than because there is a real interest for the results. There seems to be a lack of monitoring and of actual interest or effect of the results when there is monitoring.

> *'Mais si on n'évalue pas, si on n'adapte pas sur base d'indicateurs, on reste dans une culture d'obligation de moyens plus que de résultats... On doit faire des recherches, alors on va faire des recherches, mais au risque d'être caricatural, peu importe, (…) qu'elle servent ou pas (…) on va se contenter de savoir que ça a été fait plus que le résultat'* (FR_12)

Furthermore, respondents denounce the fact that there is not clear and unambiguous monitoring of the several indicators or the supply side or from prison. This respondent for example refer to the fact that there is no overview on the rate of detention in prison, or the rate of consumption in prison.

> *'Pour connaître le nombre de personnes qui sont incarcérées pour des faits de drogue, qu'est ce qu'on va prendre ? On va prendre le numéro de notice 60, et on va estimer que ça concerne 50% de la population carcérale. Mais on n'arrive pas à affiner les chiffres (…) Je trouve hallucinant qu'à l'heure actuelle, on n'arrive pas à avoir de chiffres par rapport au taux de détention de drogues ou de consommation en prison'* (FR_9)

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On all policy levels: The need for an evaluation culture, especially regarding the policy plans concerning enforcement.

6.1.2.3 Challenges

We asked our respondents what they identified as a challenge for their work in the pillar 'Enforcement'.

A. Evolving phenomena at the supply side

Several respondents refer to challenges related to different phenomena at the supply side. The challenges that were described, are the resilience of organised crime groups, the displacement of trafficking to smaller ports and recreational craft, the extreme violence in drug trafficking, the infiltration of organised crime into legal structures, poly-criminal organisations, and the increasing production and trafficking of synthetic drugs.

The first challenge mentioned by some respondents, is that organised crime groups are resilient and become more and more creative. All partners describe that this evolution requires a similar creativity and anticipation in law enforcement to tackle these organised crime groups. Dozens of examples were given of how law enforcement already anticipates potential weak links and how they can be addressed. Technology can play a central role in that approach, according to our respondents.

Ze zijn heel creatief en wij moeten dan ook creatief kunnen uit de hoek komen he. (NL_11)

Dat is zo een eeuwigdurende dialectiek zo een beetje he. Zo van: het ene rolt en je moet weer anticiperen, dat is assimilatie. Ja, dat is, dat houdt ons natuurlijk ook scherp en fris he. (NL_13)

Second, some respondent refer to the displacement of trafficking (especially cocaine) to smaller ports and recreational craft. In smaller ports there is very little security and people can often enter the quay freely without any control. This phenomenon has been observed not only in Europe, but also in South America where smaller ports are targeted. They describe that these smaller ports are often overlooked when drafting a policy approach.

Third, one respondent describes the increase in extreme violence in drug trafficking especially in recent years. Not only the violence in Antwerp illustrates this, but also the recently hacked Sky-ECC phones gave an unprecedented insight into the level of violence. Respondents indicate that even very young offenders do not shun extreme violence.

Fourth, several respondents refer to the (risk of) infiltration of organised crime into legal structures. For example, respondents refer to the risk of dockworkers waiting for their (final) conviction, who have a port book, who could access the port but cannot be banned from the port until they are convicted.

Fifth, one respondent refers to the fact that organised crime groups are often poly-criminal organisations. The respondent notes that in these cases, the best approach should be applied, which might not always be a focus on the drug cases but rather on tackling the other type of offence(s).

De drugsorganisaties verhandelen drugs, maar onze ervaring leert dat, er organisaties zijn die ook andere criminele activiteiten ontplooien. De trafiek van wapens, die ook menshandel, prostitutie of andere types van criminaliteit. En ja, soms is een drugsaanpak niet de goeie manier he, of biedt niet de beste kans om een organisatie een poli-criminele organisatie te ontmantelen. Dus daarom moeten wij kijken naar andere mogelijkheden.(NL_7)

Lastly, the production and trafficking of synthetic drugs is rapidly expanding in Belgium, according to some respondents. This poses different challenges to law enforcement compared to the modus operandi used in cocaine trafficking, and requires law enforcement to keep a broad perspective on the different substances.

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- On a national level:
  - Develop a shared action plan with all law enforcement partners, that identifies clear priorities. This action plan should be flexible enough to adapt to the changing phenomena. The action plan should rely on a strong, and up-to-date imaging of the supply side.

6.1.2.4 Perceived unintended consequences

Respondents were also asked to identify possible positive or negative unintended consequences of initiatives. One positive unintended consequence was mentioned, and two negative unintended consequences. All unintended consequences that were described, are within prison.

A positive unintended consequence mentioned by one respondent, is that a drug search of the prison cells, can return tranquillity amongst detainees, especially when drugs are circling abundantly.

A first negative unintended consequence that a respondent describes, is the fact that drug-free wings can do much harm when a person participating in the program, is excluded from the program due to

drug use. According to this respondent, it should be acknowledged by the prison/program that relapse is part of the recovery process. This is not the case because you are immediately excluded when you relapse. The respondent however mentions that not both drug free wings (in Brugge and Hasselt) deal with drug use in this way. This shows that also in the pillar enforcement, there is a need for a broad vision on recovery.

> *Als een er incident is, iets van druggebruik of op die afdeling de gedetineerde toch drugs heeft genomen, als er dan meteen wordt gezegd van je wordt verwijderd. Dan doen we soms meer schade dan goed, want die gedetineerde wordt verwijderd van de afdeling en wordt weer in algemene cell gedropt, maar die drugsgebruiker bekijkt dat van ik heb gefaald en in het begin dat er dan nog vaak nog erger en dieper in het druggebruik gaan. (NL_6)*

A second negative unintended consequence, is the lack of anonymity when someone in prison seeks help for drug use. Prison acts as a small community, and although treatment workers apply their professional secrecy, everybody within a prison knows who for example receives substitution treatment, and who is looking for help for their drug use. Respondents therefore speak of a certain degree of stigmatisation of people who seek help for their drug use, which increases the barrier even further. Respondents also notice this, for example, when giving the name of a drug programme in prison. There is sometimes aversion to treatment amongst detainees, so when a treatment programme in prison is given a specific name, no reference is made to 'treatment' in that name.

6.1.2.5 Conclusion of the context to the stage of realisation

The semi-structured interviews and the focus group with practitioners, civil servants and (scientific) experts gave insight in how the Belgian drug policy is shaped in daily practice, and how “policy in the books” is translated into “policy in practice”.

First of all, respondents describe to rely on a high performant international network, as well as having good practices of international cooperation both within the police, customs as well as justice. Several respondents describe how this in turn allows law enforcement actors to more efficiently address drug trafficking, which is characterised with a transnational modi operandi. They also stress the role of the federal prosecution office as a facilitator for international cooperation. Nevertheless, respondents still describe barriers and bottlenecks within this international cooperation, for example the lack of shared priorities, differences in judicial and administrative procedures which prevent or delay cooperation and information exchange, a lack of coordination of the initiatives or problems with structural cooperation, especially with source countries. These barriers also apply to the cooperation between enforcement partners. Here too, respondents mention the lack of shared actions plans and shared priorities as a barrier. A lack of clear delineation of tasks (often in practice) is also jeopardising the cooperation between local police and federal police, as well as between police and customs.

A second recurrent theme in the interviews and the focus group, is the legislative framework presenting a dichotomous picture. Especially judicial respondents refer to the “schizophrenic” policy trying to unite the prohibition of all illegal drugs and still apply the lowest priority to the possession of cannabis in one framework. Similarly, respondents refer to the current practice of people with drug problems from the criminal justice system to treatment as illogical i.e. wanting to punish an offender but also treat him as if he were ill. Both examples show how enforcement respondents need a clear and unambiguous legislative framework to start from.

Besides these two main themes, respondents describe several organisational barriers and bottlenecks, for example in the Port of Antwerp, as well as limited budgets for example for the federal police (e.g. outdated infrastructure, short of staff, etc.) and other actors such as FAGG. Respondents also identify three main barriers in the investigation of drug production and drug trafficking. They described how investigation is often linked to specific expertise manifesting in individuals, rather than the organisation, how within police there seems to be a third district level next to the federal police level and the local

police level without a clear coordination between these levels, and barriers with the mapping of financial flows. On the level of sentencing, the range of punishment for high level traffickers as well as the need for clear screening for the diversion to treatment are mentioned.

Furthermore, almost every respondent emphasises the lack of a clear drug policy in prison. The drug coordinators (a position that doesn't exist anymore), but also the cooperation with external treatment facilities, were identified and praised as facilitators for a penitentiary drug policy. Nevertheless, the list of barriers and bottlenecks is much longer. The treatment offer is limited and differs between prisons, there is a structural underfunding of the sector, unclarity of competences (in practice) between justice and public health leading to a standstill in initiatives, and there are several (practical) issues with reintegration as well as harm reduction in prison.

Additionally, although scientific research to support practice and operational services is praised by many respondents, they mostly denounce the fact that research on the supply side is focusing on mapping the situation as is, rather than measuring the achievements and outcomes. Respondents also refer to poor monitoring of several supply indicators. Considering that all the respondents describe the resilience of the organised crime groups involved drug trade as a challenge, these barriers and bottlenecks hinder an efficient response towards drug supply.

Finally, respondents seem to be less aware of unintended (positive or negative) consequences, as they only identified unintended consequences in prison, but not for the other objectives or actions

6.2 Lessons learned

The pillar 'Enforcement' is the third pillar of the Belgian drug policy, after 'Prevention' and 'Treatment, risk reduction and re-integration'. Enforcement has historically always been an essential part of drug policy. This chapter has evaluated the pillar 'Enforcement'. These are the lessons learned.

POLICY INTENTIONS:

A critical appraisal of the policy logic found that:

- ⇨ The pillar 'Enforcement' is generally explicit in its objectives and central actions, but often remains vague about the concrete intended outputs and outcomes.
- ⇨ The actions of the Joint declaration for the pillar 'Enforcement' is not explicitly based on a situation analysis.
- ⇨ The pillar 'Enforcement' does not distinguish between short-term, medium-term and long-term outcomes.
- ⇨ The pillar 'Enforcement' is mostly logical, with some exceptions. For example, there is an inconsistency between the actions related to 'Reinforced repressive response towards drug trade' and the actions related 'Differentiated penal response towards drug use' that suggests a clear vision on the judicial response towards drug use, and less towards drug trade. Furthermore, the premise of an evidence-based drug policy seems to only apply to the demand side, and not to the supply side.
- ⇨ The pillar 'Enforcement' is not explicit about the processes through which change is achieved. Its main focus is on the policy design.

MEASUREMENT OF POLICY INTENTIONS:

With regards to the extent of realisation, we found that:

- ⇨ First of all, the document review reveals that there is no structural follow-up of the implementation of the Federal Drug Note and Joint Declaration, nor of other developments in the enforcement field. There is a lack of centralisation and overview of the actions. Different

reports and publications help to get a grasp of the specific realisations within the enforcement field, however, it paints a very fragmented and anecdotical picture.

- ⇨ There have been many developments in the enforcement field, both actions that were intended by the Federal Drug Note and the Joint Declaration, as well as other developments within the enforcement field. It is especially clear that there have been a lot of developments in the field of international cooperation and security policy. For the other objectives, however, the actions are partially rather than fully realised. The developments for the objective 'to develop a penitentiary drug policy' are much more modest, with several actions not addressed at all.
- ⇨ The survey learns that there are a lot of discrepancies in the level of perceived realisation. This cannot be explained by differences between regions and communities - as was the case with the previous pillars -, as most actions are situated at the federal level. However, the discrepancies could be explained by local differences, e.g. locally implemented in one place, but not in another. As there is no complete overview of the realisations, this could indicate that experts and practice are encountering the same barrier of fragmentation as the researchers of this research have.
- ⇨ When we compare the results of the document review with the survey (only for the objectives where there were enough respondents), we learn that for most objectives, there are discrepancies between the actual and perceived realisation. This suggests that actions may be implemented (cf. document review), but they do not necessarily operate in the best possible way and improvement is necessary (cf. survey).

With regards to the context to the stage of realisation, practitioners and civil servants perceived that:

- ⇨ There is a high performant international network, as well as international cooperation both within the police, customs as well as justice. Nevertheless, respondent still describe barriers and bottlenecks within this international cooperation, as well within national cooperation between enforcement partners.
- ⇨ A second recurrent theme in the interviews and the focus group, was the legislative framework presenting a dichotomous picture. For example, 'the lowest priority on cannabis within a framework that prohibits illegal drugs' shows how enforcement respondents need a clear and unambiguous legislative framework to start from.
- ⇨ Respondents described several organisational barriers and bottlenecks, for example in the Port of Antwerp, as well as limited budgets for diverse enforcement actors (for example the federal police) making it difficult to answer to identified priorities
- ⇨ Respondents also identified several logistical and financial barriers in the investigation of drug production and drug trafficking, as well as on the sentencing level of drug production and drug trafficking. They refer for example to the digitization gap, lack of expertise and resources for financial investigations, how investigation is often linked to specific expertise manifesting in individuals, and to a third district level next to the federal police level and the local police level without a clear coordination between these levels.
- ⇨ Furthermore, almost every respondent emphasised the lack of a clear drug policy in prison
- ⇨ Although scientific research to support practice and operational services, is praised by many respondents, the respondents mostly denounce that fact that research on the supply side is focusing on mapping the current situation, rather than visualising the output and outcome, therefore focusing on achievements rather than listing implementation (barriers). The poor measurement of supply indicators is also mentioned.
- ⇨ Linked to these barriers and bottlenecks, respondents voice a need for a shared action plan, with a clear framework for information exchange.

CHAPTER 7

TRANSVERSAL THEME 1: INTEGRAL AND INTEGRATED APPROACH

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7 TRANSVERSAL THEME 1: INTEGRAL AND INTEGRATED APPROACH

This chapter discusses the transversal theme 'Integral and integrated approach'.

An integral and integrated drug policy means that a drug policy is comprehensive and involves all relevant actors and services (Parliamentary Working Groups on Drugs, 1997).

An integral drug policy covers all relevant domains of the drug phenomenon (De Ruyver, 2009; Vandam et al., 2010). The drug phenomenon is multidimensional and therefore demands a policy that emphasises and invests in each of these domains i.e. safety, public health, social-economic issues and international issues (De Ruyver, 2009; Rogeberg et al., 2018). An integrated approach assumes the involvement and coordination of the representatives of those domains. For that, these actors and services should be aligned with one another, in both a horizontal (the different policy sectors) and a vertical (international, national, regional, local) way (Vander Laenen et al., 2010).

The term 'integral and integrated' was introduced to the Belgian drug policy by the Parliamentary Working Group on Drugs (1997), and afterwards consolidated as a central principle in the Federal Drug Note (2001). The Parliamentary Working Group stressed that the Belgian drug policy was not organised in an integral and integrated way. Although there were some initiatives at a national level to tackle the drugs phenomenon at the time (cf. infra), none of these measures were organised in a coordinated way. Moreover, they were heavily relied upon the personal commitment of policy makers at the various policy levels. The division of powers between the federal and community level further complicated this matter: The working group noted that professional actors (across the different sectors) experienced these different initiatives and policy options as very "chaotic" (p. 990). This fuelled the perception that no clear policy was prioritized, nor did it seem like there was any top-down policy guidance. Therefore, the Working Group prioritized coordination and international alignment as two of the three premises of an integral and integrated Belgian drug policy.

The Federal Drug Note (2001) in turn introduced an entire chapter on the development of an integral and integrated approach. The importance of this transversal theme was confirmed in 2010 with the Joint Declaration of the Interministerial Conference Drugs. In this document too, an integral and integrated approach was considered a corner stone of the Belgian drug policy.

This chapter discusses the pillar 'Integral and integrated approach' and the different actions to ensure this integral and integrated approach as stressed in the Federal Drug Policy Note (2001) and the Joint Declaration of the Interministerial Conference Drugs (2010). We first explain the logic model of the transversal theme, i.e. how the transversal theme 'Integral and integrated approach' intents to achieve its objectives. Subsequently, we conduct a critical analysis of this logic model. This way, discrepancies, inconsistencies and omissions in the policy's theory are raised and discussed. Next, we present the results of the process evaluation, i.e. whether the actions have been implemented the way it was intended and whether the aims and actions are still relevant to the current issues and needs within the Belgian drug field.

7.1 A logic model of the transversal theme 'integral and integrated approach'

In this section, we address the first research question 'What are the identified aims, action points, intended outputs and intended outcomes of the Belgian drug policy?'.

We therefore rely on logic models as an evaluation framework, as explained in the methodological chapter (cf. supra). To summarize: logic models are a systematic and coherent description of a policy that identifies the aims, actions, resources, intended outputs and intended outcomes underpinning a

certain policy (EMCDDA, 2017a). The logic models make the underlying assumptions of how a policy aims to achieve change, explicit. Logic models identify and describe how a policy fits together in a simple sequence. The policy's theory is described in a logical, linear depiction of how policy makers intend to achieve change.

Policy makers did not draft such a logic model i.e. explicate how the transversal theme 'Integral and integrated approach' would contribute to the central aims of the Belgian drug policy. Therefore, we reconstructed this logic model in retrospect. To estabish a logic model for the transversal theme 'Integral and integrated Approach', we conducted a document analysis of the two central and overarching policy documents of the Belgian drug policy: the Federal Drug Note of 2001 and the Joint Declaration of the Interministerial Conference of Drugs of 2010. We extracted the aims, the actions, the inputs, the intended outputs and the intended outcomes (where possible) word for word from these documents, and rearanged them in a logical sequence (Figure 17. *Summary of the logic model of the pillar 'Integral and integrated approach'*). We additionally analysed the report of the Parliamentary Working Group on Drugs (1997) to further contextualize these aims and actions (e.g. problem description, unclear actions).

The logic model on 'Integral and integrated approach' shown by Figure 17. *Summary of the logic model of the pillar 'Integral and integrated approach'*, thus describes how the aims and actions under 'Integral and Integrated Approach' – according to the Belgian drug policy makers - contribute to the central aims of the Belgian drug policy.

Since the description of the logic model is a representation of the central policy documents, we adopt the terminology mentioned in the policy documents to describe the actions, inputs, intended outputs and intended outcomes. That means that sometimes stigmatising language is used, or old names of institutions that have since changed names are used. For the latter, we added the current name between brackets.

7.1.1 Four main objectives with several corresponding actions

The core principle of the Belgian drug policy is the realisation of an integral and integrated drug policy, in which all relevant areas of a policy are included and all actions are coordinated.

This core principle is divided into four central objectives:

1. To coordinate the operationalisation of an integral and integrated drug policy;
2. To establish clear agreements between the criminal justice system and treatment;
3. To eliminate specific problems with the 'Drugs' section of the Global Plan
4. To engage in international treaties and policy plans;

All four objectives have several corresponding actions which will be elaborated on below.

7.1.1.1 Actions aimed at objective 1 'to coordinate the operationalisation of an integral and integrated drug policy'

Four actions could be distinguished to operationalise this objective.

The first action is the **establishment of a General Drug Policy Cell** to obtain a global insight into all aspects of the drug problem, to prevent drug abuse and limit the damage it causes, to optimise the treatment offer, to reduce the illicit drug production and trafficking, and to further develop the agreed policy according to an integral and integrated drug policy.
The Federal Drug Note mentioned several tasks of such a General Drug Policy Cell. First of all, the General Drug Policy Cell has to maintain and centralise a detailed inventory of the public services, the relevant research and the relevant authorities involved in the drug policy. This inventory also has to list all accredited and/or subsidised institutions, organisations, specialised centres, research centres and universities with a focus on (one or more) aspects of the drug problem. Furthermore, they have to

propose measures to coordinate the (planned) actions of different authorities with one another, as well as implement measures to increase the effectivity of these actions. In addition, they have to issue recommendations on drug policy coordination, either on its own initiative or at the request of the contracting authorities or of the Interministerial Conference Drugs. Other tasks comprise of evaluating the quality of the provided data and information, preparing cooperation agreements and drawing up a triennial policy report and an annual activity report.
A second action is the fact that the Federal government has to **draft a cooperation agreement between the Federal government and the governments of the Communities and Regions**, within the General Drug Policy Cell.

A third action mentions the **establishment of an Interministerial Conference Drugs**, in which the General Drug Policy Cell has a supporting and advisory role.

The last action of this objective emphasises the importance of **evaluating** the cooperation agreement and the operation of the General Drug Policy Cell within the Interministerial Conference Drugs.

7.1.1.2 Actions aimed at objective 2 ‘To establish clear agreements between the criminal justice system and treatment’

In order to set up these clear agreements between both sectors, various actions are suggested.

In a crucial action, the Federal government wants to set up a working group with representatives of both the treatment sector and criminal justice sector, in order to explore the limitations and opportunities of both sectors and streamline cooperation between them. Priority is to be given to professional secrecy, delineation between sectors and minimum formal communication about the implementation and timing of punitive measures. The guidelines of this Working Group would in turn serve as a basis of several local cooperation agreements between criminal justice actors and treatment services, on the initiative of the Local Coordination Group on Drugs. Central in these local cooperation agreements should be the principle of constructive cooperation with respect for each other' s specific purpose and uniqueness.

Another action concerns the appointment of judicial case managers for drug users in each courthouse. These judicial case managers would inform prosecutors and police services about the provision of treatment, but also on the desirability of coercive measures. This action is repeated under the pillar ‘Enforcement’. In order to be able to inform judiciary as quick as possible, a permanent presence during office hours in courthouses would be necessary. Furthermore, the Federal government wants to involve judicial case managers in the regional care circuits (Pillar ‘Treatment, risk reduction and reintegration’), by involving them in the Local Drugs Coordination Groups.

Lastly, the need for clarity about the possibilities for crisis treatment for drug users who have committed an offence, is emphasised. This concern would be considered in the development of regional care circuits (cf. Pillar ‘Treatment, risk reduction and reintegration’).

7.1.1.3 Actions aimed at objective 3 ‘To eliminate specific problems with the 'Drugs' section of the Global Plan’

At the time of the establishment of the Federal Drug Note (2001), the Federal government subsidised municipalities for the ‘drugs’ section of the Global Plans, security and community contract on the local prevention of drug (ab)use and (drug-related) crime. Many projects were financed in this way, however, there remained specific problems. These improvements aimed to establish a clear delineation of tasks regarding prevention between the police and the psycho- medico- and social sector, clarify the mandate and statute of outreach workers, prevention workers and care providers; and to better coordinate between initiatives through the section 'Drugs' of the Global Plan.

To clarify the mandate and statute of outreachers, prevention workers and care providers, the Federal government first of all stresses that outreach workers, prevention workers and care workers needed a clear assignment and a clear statute in their contract with the municipalities. Due to the integrated contract financing in the security contracts, this was not clear at the time. Furthermore, the Federal government planned on examining ways to hire street workers, prevention workers and care workers with contracts of indefinite duration. If the contracting municipalities were to transfer health workers paid for by the Drugs section of the Global Plan, they would be transferred to other existing health or welfare services. They would register health professionals paid for by the "drugs" part of the global plan (via a contractual obligation) in the prevention and health policy of the Community, the Region or the federal authority in which they are active through contractual guarantees and obligations.

To establish a clear delineation in prevention tasks between the police and the psycho- medico- and social sector, it is agreed upon that the psycho-medico-social sector would be responsible for the prevention of legal and illegal drug abuse, and the police for (possibly drug-related) crime prevention. Clear arrangements should be made between the two sectors in a permanent dialogue.

Lastly, to better coordinate between initiatives through the section 'Drugs' of the Global Plan, the Federal Government appoints the already existing VSPP (Permanent Secretariat for the Prevention Policy) as contact point for prevention of (drug-related) crime and social nuisance. Their tasks would consist of identifying the issue at a local and supra-local level, conducting a study on foreign experiences in the fight against social nuisances, consulting with the relevant governments, implement action points through a national campaign (taking account of local priorities) and developing evaluation methods and support instruments, next to their regular tasks. Furthermore, the national evaluation and monitoring committee would cease to exist. The General Drug Policy Cell would instead resume its tasks: Assess, implement and control the proposals of agreement for financing of local prevention projects.

7.1.1.4 Actions aimed at objective 4 ‘To engage in international treaties and policy plans’

The last objective, to engage in international treaties and policy plans, has nine corresponding actions.

The first action states that Belgium would call on European programmes (e.g. for aftercare), advocating the further development of European cooperation on every possible occasion. Furthermore, Belgium would plead for the establishment of a European monitoring system on legislation and practices in the field of drugs, which could be imbedded within the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). In addition, Belgium would attend activities within the Pompidou Group and the various United Nations organisation, and take a more active stance within the United Nations bodies working on drugs. The latter should eventually lead to presenting the results of experience with demand-reduction and risk-reduction in Belgium.

The General Drug Policy Cell would act as "national coordinator" at European level, an action that was implemented in order to comply with the EU Action Plan 2000-2004. The BMCDDA (now: Reitox National Focal Point, Sciensano) would in turn maintain relations with the EMCDDA. The General Drug Policy Cell should have an International Cooperation Unit that is concerned with the international dimension of the Belgian drug policy.

Lastly, the military should be involved in the international dimension through the use of military means in order to prevent the production or transport of drugs.

7.1.2 Inputs

The inputs displayed in *Figure 17. Summary of the logic model of the pillar 'Integral and integrated approach'*, show the human, financial, organizational, and community resources that are needed to implement the actions included in the transversal theme ‘Integral and integrated approach’. The inputs

are not always clearly defined in the policy documents. Therefore, no specific input was allocated to each action.

The first objective ‘to coordinate the operationalisation of integral and integrated drug policy’ provides funding for several of its related actions. A budget was allocated from 2002 onwards to establish a General Drug Policy Cell. This budget is based on a distribution key agreed upon between the various governments. Both policy documents further indicate that the Health Policy Unit Drugs (established in 2001, currently part of the General Drug Policy Cell) would be financed by 7 million Belgian francs per year, based on the same distribution key agreed upon between the different authorities. There was no input defined for the other actions involved.

The second objective, ‘to establish clear agreements between the criminal justice system and treatment’, does not need budgetary implications according to the Federal Drug Note. One action under this objective however mentions an adaptation to the existing legislation as an input. The action on the judicial case managers, requires a deletion of "to the commission and" in art. 7 in the Law of 5 March 1998 on conditional release and an amendment of the Law of 9 April 1930.

There are some mentions regarding input for the third objective ‘to eliminate specific problems with the 'Drugs' section of the Global Plan’. The delineation of tasks regarding prevention between the police and the psycho- medico- and social sector has budgetary implications for the Federal Government and for the Communities. The Minister of Home Affairs would negotiate with the Communities on allocated budgets. Furthermore, the VSPP also requires investments. The Federal government mentions that this would be discussed at the budgetary control. There was no input defined for the other actions outlined under this objective.

Lastly, objective 4, ‘to engage in international treaties and policy plans’, does not mention any inputs.

7.1.3 Intended outputs

The outputs displayed in *Figure 17. Summary of the logic model of the pillar 'Integral and integrated approach'*, show the immediate outputs (deliverables) that result from the implementation of the actions under the transversal theme ‘Integral and Integrated approach’.

The outputs of the actions corresponding to objective 1, **coordination of an integral and integrated policy**, are first and foremost an operational General Drug Policy Cell; an operational Interministerial Conference Drugs; a cooperation agreement between the Federal State, the Communities and the Regions on a global and integrated drug policy and the evaluation(s) (reports) of the cooperation agreement and the operation of the General Drug Policy Cell. The General Drug Policy Cell however, generates other outputs too.
These outputs consist first of all of a detailed inventory of all public authorities, all public services, the relevant research, the accredited and/or subsidised institutions, organisations and specialised centres, and the research centres and universities with a focus on (one or more) aspects of the drug problem. Another output of the General Drug Policy, are the substantiated measures to coordinate the (planned) actions of different authorities with one another, and the implemented measures to increase the effectivity of these actions. Other outputs of the General Drug Policy Cell, are the recommendations on drug policy coordination, the evaluation(s) (reports) on the quality of the provided data and information the preparation(s) of the cooperation agreements and the triennial policy reports and an annual activity report.

The outputs of the actions corresponding to objective 2, **establishing clear agreements between the criminal justice system and treatment**, are diverse. They comprise of an operational working group with representatives of both criminal justice as well as treatment, the local cooperation agreements between criminal justice actors and treatment services, initiatives that appoint judicial case managers in

each court house, initiatives that include judicial case managers in the Local Drugs Coordination Groups, initiatives that clarify the possibilities for crisis treatment for drug users who have committed an offence.

The intended outputs regarding objective 3, to eliminate specific **problems with the 'Drugs' section of the Global Plan**, can be divided into three subgroups.

Outputs that should result from the actions aimed at clarifying the mandate and statute of outreachers, prevention workers and care providers, are permanent contracts, contractual obligations and guarantees and initiatives to clarify the statute of outreachers, prevention workers and care providers, and secondments possibilities to other health or welfare services.

There are two outputs that should result from the actions aimed at establishing a clear delineation of prevention tasks between the police and the psycho- medico- and social sector. A structure for permanent dialogue between police and the psycho- medico- and social sector to come to agreements on prevention and initiatives that clarify the task description of both partners regarding prevention.

Outputs that should result from the actions aimed at a better coordination between initiatives through the section 'Drugs' of the Global Plan are twofold: VSPP is tasked with crime prevention and the reassignment of tasks from the national evaluation and guidance committee to the General Drug Policy Cell. Both outputs generate other sub-outputs too. The new tasks of the VSPP also result in reports on drug prevention on a local and supra-local level, studies on foreign experiences in the fight against social nuisances, consultation initiatives with the relevant governments, a national campaign, support on evaluation methods and supporting instruments. The newly appointed tasks of the General Drug Policy would be initiatives that assess, implement and control the proposals of agreement for financing of local prevention projects.

The intended outputs regarding objective 4, to **engage in international treaties and policy plans**, are: the use of European programmes (e.g. for aftercare), a European monitoring system on legislation and practices in the field of drugs, the attended activities within the Pompidou Group and the various United Nations organisation, the presentation of the results of Belgium's experience with demand-reduction and risk-reduction, the establishment of the General Drug Policy Cell as a 'national coordinator', close relations between the BMCDDA and the EMCDDA, the establishment of an International Cooperation Unit in the General Drug Policy Cell, and lastly, the involvement of the military to prevent the production or transport of drugs.

7.1.4 Intended outcomes

The last part of *Figure 17. Summary of the logic model of the pillar 'Integral and integrated approach'*, shows the outcomes, the changes over a longer period of time.

It becomes clear that the actions aimed at objective 1, **coordination of an integral and integrated policy** should result in more coherency in the Belgian drug policy, and an optimal operation of the General Drug Policy Cell.

The actions corresponding to objective 2, **establishing clear agreements between the criminal justice system and treatment services** should eventually lead to a more fluent cooperation between both sectors. Additionally, appointing judicial case workers, should lead to prosecutors and police being better informed about treatment services, the involvement of judicial case workers in the establishment of care circuits (cf. pillar 'Treatment, risk reduction and reintegration) and to a regional network for crisis treatment for drug users in the criminal justice system.

The actions corresponding to objective 3, **eliminating specific problems with the 'Drugs' section of the Global Plan,** have several outcomes. Actions aimed at clarifying the mandate and statute for outreach workers, prevention workers and care providers should lead to an improved working framework for outreach-, prevention- and care workers, meaning that the side effects of one-year contracts are

eliminated, a better management for care providers and improvement in their education and training. Actions aimed at clearing the delineation of tasks between the police and the psycho- medico- and social sector, should lead to a clear distinction regarding prevention between the police services and the psycho-medico-social sector. Actions aimed at better coordination with other prevention initiatives through the section 'Drugs' of the Global Plan, should eventually lead to a decentralized approach to drug-related nuisance, but also to better coordination with initiatives of the federal government, the communities, the regions, the provinces and the municipalities.

And lastly, the actions corresponding to objective 4, **engaging in international treaties and policy plans,** have several outcomes. First of all, some of the actions want to achieve an active representation of Belgium in European and international forums. Hence, the eventual goal is to establish innovative, realistic, integrated policy, taking a global approach to judicial, economic, social and health aspects. Other actions under this objective aim for a coherent policy across borders, harmonising as far as possible the internal legislation and practices in the field of drugs. One action even specifically intends to prevent drug trafficking.

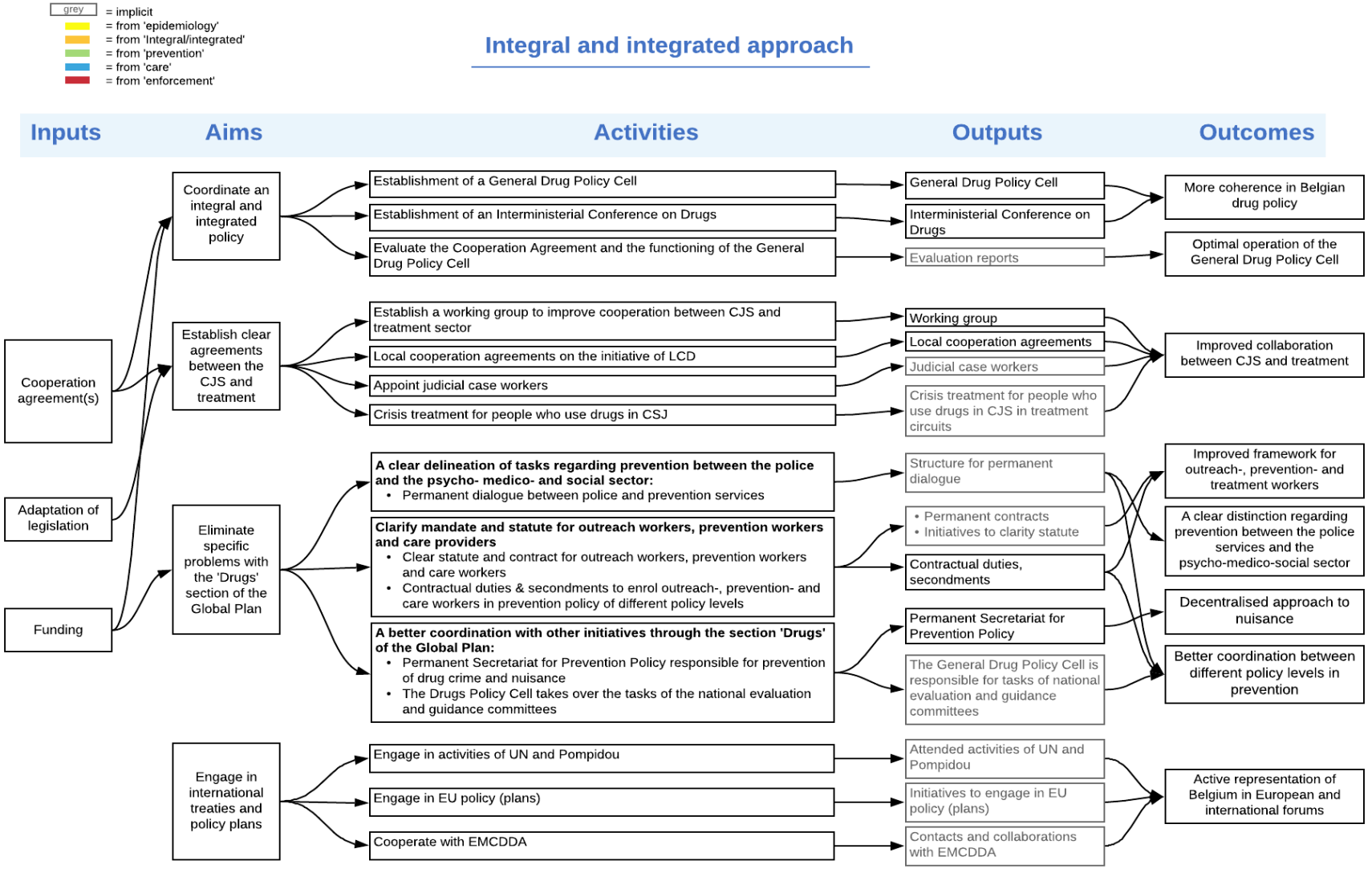

Figure 17. Summary of the logic model of the pillar 'Integral and integrated approach'

7.2 Critical appraisal of the logic models

In this section, we address the research question 'To what extent are the logic models of the pillars and transversal themes consistent and logical?'. This critical appraisal of the logic model is a first step of the process evaluation, in the sense that it allow us to control whether possible policy issues are attributable to a poor policy theory or not.

Building further on the document analysis of both drug policy documents, we critically analyse the logic models, relying on indicators of internal validity (Funnell & Rogers, 2011). This way, discrepancies, inconsistencies and omissions in the policy's theory are raised and discussed.

The internal validity of the policy theory shows to what extent the policy theory is clear, realistic and logical about what the policy wants to achieve (i.e. outcome), and how the policy wants to achieve these outcomes (Funnell & Rogers, 2011). In this section, we assess this internal validity based on five indicators: 1) Clarity of description, 2) the outcome chain, 3) demonstration of how the outcomes are related to the problem, 4) the logical argument of the policy theory, and 5) the articulation of mechanisms for change.

7.2.1 Clarity of description

A first measure of internal validity is 'clarity of description'. It assesses whether the logic model describes the policy detailed enough.

In general, the transversal theme 'Integral and integrated approach' clearly describes the elements of the policy theory. First of all, there is a clear definition of the problem the policy aims to address. The report of the Parliamentary Working Group on Drugs includes a thorough description of the issues related to cooperation and coordination in the Belgian drug policy (cf. supra). Both the Federal Drug Note and the Joint Declaration refer to this thorough, well-developed, problem description in their reports, and build their policy objectives and actions around them. Yet, the question remains to what extent this problem description of the late nineties is still relevant, especially because the Joint Declaration was established more than 10 years later. The Federal Drug Note provides a 16-page-long 'state of affairs', however mostly focuses on the extent of implementation of the recommendations of the Parliamentary Working Group and provides only limited updates to the problem description. The Joint Declaration on the other hand, only lists the accomplishments for each authority and policy level. Neither policy document provides an up-to-date description of the drug problems they want to address, but seemingly **relies on a problem description as described in** the Parliamentary Working Group on Drugs.

Most objectives and actions in the pillar "Integral and integrated approach" are described in detail. Furthermore, some actions not only describe what the action does, but also expand on specific subtasks of the actions (for example the establishment of the General Drug Policy Cell, the appointment of judicial case managers and the Permanent Secretariat for Prevention Policy). There are however a few exceptions. Some actions are formulated in **very generic, non-concrete terms**, e.g. 'the need for clarity about the possibilities for crisis treatment for drug users who have committed an offence was emphasised' or 'the General Drug Policy Cell should have an International Cooperation Unit that is concerned with the international dimension of the Belgian drug policy'. It is not clear what these very general actions do, making them difficult to implement, because what should be implemented really? Other actions do **not** provide **enough detail**. An example is 'the military should be involved in the international dimension through the use of military means in order to prevent the production or transport of drugs' or 'the Federal government stresses that outreach workers, prevention workers and treatment workers need a clear assignment and a clear statute in their contract with the municipalities'. The actions emphasise 'the role' and stress certain 'needs', but do not clearly specify how this should be addressed. Lastly, one action is **formulated in a very non-binding way**, i.e. 'the Federal government planned on

examining ways to hire street workers, prevention workers and treatment workers with contracts of indefinite duration' – with no indication what will happen after the examinations, which understates the relevance of the action. After all, why 'examine' something if nothing is to happen with it?

Although the pillar 'Integral and integrated approach' is generally explicit on its objectives and central actions, it often remains vague about the specific intended outputs . The direct output of the actions can often be deduced from the actions themselves, but are in about half of the cases not explicitly specified, leaving the researchers with vague output descriptions like 'initiatives for a permanent dialogue between police services and prevention sector'. Vague or implied outputs could raise difficulties for the implementation.

In contrast to the other pillars, there is more clarity on the outcomes in the logic model on 'Integral and Integrated approach'. Only two actions lack an explicit outcome: 'the appointment of judicial case managers for drug users in each courthouse' and 'a permanent presence during office hours in courthouses would be necessary'. Both actions should probably lead to better cooperation between the criminal justice actors and the treatment sector, but the policy documents do not indicate this explicitly.

And lastly, there is not much information on input available. Except for the action on the establishment of the General Drug Policy Cell and the Drug Cell Public Health, no clear budget was defined. This does not mean that there was no budget allocated, it just seems like it was not agreed upon at the time. The only other inputs, are the cooperation agreements, and an adaptation in legislation. This leaves a fair amount of actions with no clearly defined input, and thus a lot of uncertainties.

7.2.2 The outcome chain

A second measure of internal validity is whether the logic model builds upon the outcomes it wants to achieve. Are the outcomes central to the logic model, or are other elements accentuated?

A first observation is that the policy documents **often list the intended outcomes, without indicating to what action or output the outcome relates**. As such it is not always clear what specific action leads to which specific outcome. For example, the objective 'eliminate specific problems with the 'Drugs' section of the Global Plan' spells out a list of actions, and alternates it in between with intended outcomes like 'improvement in education and training of outreach-, prevention- and care workers' and 'a decentralized approach to drug-related nuisance', but also 'better coordination with initiatives of the federal government, the communities, the regions, the provinces and the municipalities'. This way, it is not clear whether an outcome is related to a specific action, respectively a group of actions, or whether it is not related to an action at all. The critical questions about the necessity of certain actions and/or missing outcomes, can therefore not be answered.

Also, the policy documents **do not distinguish between short-term, medium-term and long-term outcomes**, although the described outcomes in the logic model can be situated on a short-, a medium as well as a long-term time frame. For example, the action 'let judicial case workers participate in the Local Coordination Groups for Drugs' has defined the outcome 'judicial case workers are involved in the development of the care circuits'. This may be a short-term outcome. The middle-term outcome for this action may be the 'improved collaboration between the criminal justice system and the care sector'. This is an outcome defined for another action relating to this objective (establish clear agreements between the criminal justice system and the treatment sector). Nevertheless, the policy documents do not make a distinction in outcomes on a short, medium and long term, which in turn limits the policy logic. Policy makers should make these distinctions explicit.

However, while some outcomes imply a distinction between medium-term and long-term outcomes, most outcomes do not. Changes like 'a regional network for crisis' and 'a decentralized approach to public nuisance' are described as an end-point of the drug policy. Although these outcomes are essential to understand the policy logic, they do not illustrate the long-term changes the policy makers want to

achieve. These long-term changes should be made explicit, all the more, because these long-term outcomes explain how the actions contribute to the three central outcomes of the Belgian drug policy[95].

In general, we can conclude that the emphasis of the logic model on 'Integral and Integrated approach' seems to be on the aims and the objectives, and less on the outputs and outcomes. The pillar 'Integral and Integrated approach is therefore more centred around what the policy (already) does (e.g. eliminate problems with 'drug plan', cooperation between criminal justice system and treatment sector), than the concrete results it wishes to see in the future.

7.2.3 The demonstration of how the outcomes that are related to the problem

A third measure of internal validity questions whether the logic model indicates how the outcomes address the problem(s) that the policy aims to address. This means that we assess if and how the problem(s), that gave rise to the establishment of the policy, are linked to the intended outcomes.

We previously established that the problem description is elaborate and thorough, though dates back from the 1990's (Parliamentary Working Group on Drugs). The objectives and actions described in the logic model 'Integral and integrated approach' address to a large extent the problems described in the Parliamentary Working Group, as we illustrate below.

The report of the Parliamentary Working Group on Drugs describes that the Belgian drug policy was not organised in an integral and integrated way. A first - and most prominent - trend describes that there were some initiatives at a national level to tackle the drugs phenomenon at the time (cf. supra), although none of these measures were coordinated with one another. Moreover, they were heavily dependent on the personal commitment of policy makers at the various policy levels. The division of authorities divided between the federal and community levels further complicated this matter in practice: The working group noted that professionals in the field (across the different sectors) experienced these different initiatives and policy options as very "chaotic" (p. 990). This fuelled the perception that no clear policy was prioritized, nor did it seem like there was any policy guidance from above. A second trend described that drug policy plans were a very young practice and almost non-existing at local or provincial level. Major cities developed local policy approaches to drug-related nuisance and associated problems through security and prevention contracts, by introducing 'drug plans' oriented towards drug addicts. Although these 'drug plans' were – at the time – very recent, some structural issues were already described (e.g. problems in cooperation with police). Structural coordination between all relevant partners (police, care workers, prevention workers) was needed, but lacking. A third trend indicated that the international and European dimension of drug policy making, was expanding. The international dimension of policy making was illustrated both on the supply side and on the demand side.

In 2001, the Federal Drug Note gave a brief update of the problem description regarding an integral and integrated approach (which mostly consisted of an update on the implementation of the recommendations of the report of the Parliamentary Working Group on Drugs). In 2001, there was still no coordinated policy in place. Although the initiatives of cooperation and coordination were increasing - particularly in the domain of prevention –, these initiatives were not structurally built-in and cooperation initiatives often did not have decision-making powers. An inventory of all existing initiatives was (still) lacking.

All three trends are addressed by the policy documents. There are objectives, actions and particular outcomes formulated to strengthen coordination in the Belgian drug policy, to eliminate the specific problems with these 'drug plans' and to engage in the international treaties and policy plans (cf. logic

[95] Defined by the Federal Drug Note (2001) as: (1) a reductions of the number of dependent drug users, (2) a reductions of the physical and psychosocial damage caused by drug use, and (3) a reductions of the negative impact of the drug phenomenon on society.

model). Actions were implemented to eliminate specific parts of the problem description (e.g. structural coordination between police and prevention actors).

At first sight, it seemed that the objective 'establish clear agreements between the criminal justice system and treatment' was introduced by the Federal Drug Note and the Joint Declaration, as it was not discussed in the report of the Parliamentary Group with the other 'integral and integrated' issues. A closer watch of the report however, revealed that the needs for collaboration were discussed in different sections under 'drug supply' and 'drug demand'. The actions, outputs and outcomes discussed under 'establish clear agreements between the criminal justice system and treatment' address these needs properly.

We can conclude that the Belgian drug policy makers oriented their 'Integral and Integrated approach' towards the problems as described by the Parliamentary Working Group on Drugs, thereby making sure that the policy addresses the situations it wished to see changed. The main issue though, is that – although the Federal Drug Note gave an update (to some extent) of the problem description – this still is outdated, especially for the Joint Declaration.

7.2.4 The logical argument of the policy theory

A fourth measure of internal validity is 'the strength of the logical argument'. This means that we measure the extent to which the logic model is 'logic' in terms of coherence, sequence and completeness.

The logic model on 'Integral and integrated approach' is **mostly logical**. By this, we mean that – generally speaking - the actions follow logically from the central objectives, the intended outputs (when they are defined) follow logically from the actions, and the intended outcomes result logically from the intended outputs (Culley et al., 2012). This is especially the case for the actions under the objective 'coordinate an integral and integrated drug policy'. Furthermore, the logic model is **coherent across substances**. The emphasis on integrality in this logic model, entails - amongst others – that all substances should be addressed. This logic model therefore does not make a distinction between substances. Additionally, there is **no contradiction between the Federal Drug Note and the Joint Declaration**. Whereas the Federal Drug Note is more elaborate and addresses more themes than the Joint Declaration, on the objectives and actions that overlap, there are not inconsistencies.

There are a few exceptions in the policy logic. First of all, it is not possible to control for the 'logic' of some actions because some actions do not have a clear, explicit output and in a few occasions not even a clear outcome. In these places, the policy logic is simply incomplete.

Apart from this observation, there are only two inconsistencies in the logic model on 'Integral and integrated approach'. A first irregularity can be found under the objective 'eliminate specific problems with the 'Drugs' section of the Global Plan'. This objective seems to cluster a group of actions that are more or less related (they are all concerned with prevention at a local level), but describes very different problems and has very different outcomes. For example, some actions are aimed at a very specific problems (e.g. 'examining ways to hire street workers, prevention workers and care workers with contracts of indefinite duration' to address the recurring recruitment of limited duration), whereas other actions are aimed at problems on a more macro level (e.g. 'permanent dialogue between police and prevention services' to address the unclear demarcation of tasks between both). This 'rest group' could use some structure.

Additionally, the action 'the Federal Government appointed the already existing Permanent Secretariat for the Prevention Policy as contact point for prevention of (drug-related) crime and social nuisance' mentions the outcome 'a decentralized approach toward nuisance'. The policy documents do not elaborate on how this action results in a decentralized approach.

A second inconsistency can be found under the objective 'engage in international treaties and policy plans'. The action 'the military should be involved in the international dimension through the use of

military means in order to prevent the production or transport of drugs' feels out of place under this objective. This action intends specifically to prevent the production and trafficking of drugs, and so it is not clear how this action fits within the wider intend for cooperation and coordination in this transversal theme. The only link is the fact that they act on international grounds, however, this is not enough to categorize the action under this transversal theme.

The transversal theme 'Integral and integrated approach' thus appears globally 'logic' in terms of coherence, sequence and completeness.

7.2.5 The articulation of mechanisms for change

The last measure of internal validity is 'the articulation of the mechanisms for change'. This entails the question 'Does the logic model clearly identify the assumed mechanisms of change that underpin its selection of outcomes and activities'. Funnell et al. (2011) describe these mechanisms for change as the 'because' statements: if A happens, then it will result in B, because of C. 'C' is the mechanism for change in this case.

In this area we can be brief. None of the actions explicitly mention the mechanisms for change that lead to their outcome and eventual impact. This means that whereas for most actions a sequence of 'if-then' statements can be made; these sequences are often not accompanied with a 'because'. The Parliamentary Working Group on drugs brought no further clarity.

It is essential for a policy to explain how the intended outcomes and impact will be achieved, not only through how a policy is designed and set up (and so focus on the sequence of actions, deliverables and inputs). It is also crucial to describe the processes through which change comes about (and so focus on the relation between outcomes and eventual impact). This is not the case for the transversal theme 'Integral and integrated approach', which primarily focuses on the first aspect (policy design).

7.2.6 Conclusion of the policy intentions

In terms of shape of the Belgian drug policy, we first of all see that the policy documents were often explicit about the objectives and actions, and thus about what the policymakers intent to undertake. Objectives and actions are mostly described with a lot of detail. There are a few exceptions, but they are limited.

Second, in contrast to the other pillars the expected changes that an action should bring about were mostly made explicit. Although outputs and outcome are often explicitly mentioned, the link between an action and an outcome was not always clear, resulting in a list of action that had to bring a list of outcomes without a clear connection between both. This could give difficulties for the implementation of the actions, in the sense that it is unclear with what intention the action should be implemented.

Third, whenever the outcomes are defined, there is no differentiation between short-term, medium-term and long-term outcomes. This makes it seem as if the short-term outcomes are the final destination of the drug policy, which they are not.

In terms of what the policy makers implicitly or explicitly emphasised, the critical analysis showed consistency between the Federal Drug Note and the Joint Declaration. There are no contradictions between both policy documents and they show similar priorities. Coordination between the different policy levels and policy domains are the main theme of the transversal theme. There are only a few minor inconsistencies with the objective 'Eliminate specific problems with the 'Drugs' section of the Global Plan'. This objective seems to cluster a group of actions that are more or less related (they are all concerned with prevention at a local level), but describes very different problems and has very different outcomes. The objective and related actions fail to convey a clear vision on the cooperation between prevention partners and police, resulting in a chaotic set of initiatives.

7.1 Have the policy intentions been realised: a measurement

In this chapter, we describe whether the policy intentions for the transversal theme 'Integral and integrated approach', summarised in the logic models, were actually realised. We discuss the results in two steps. First of all, we examine to what extent and how the policy intentions were realised. Second, we measure how the realisation of the policy intentions is perceived by different stakeholders and experts in drug policy. This way, we get a view on facilitators, barriers, bottlenecks, challenges and needs in the field.

To examine to what extent and how the policy intention were realised, we rely on two methods: a document review and an online survey. The results are discussed in the section 'realisation of the policy intentions'.

To measure how the realisation of the policy intentions is perceived by different stakeholders and experts in drug policy, we rely on semi-structured interviews. The results are discussed in the section 'Providing context to the stage of realisation'.

7.1.1 Realisation of the policy intentions

In this section, we map the extent to which the policy intentions, summarised in the logic models, are actually realised. We map this out in two ways[96].

We start with an analysis **of the main developments** in the field within the various objectives of the transversal theme 'Integral and integrated approach'. We do this through a **rapid document review** of the websites, reports and other publications from various institutions with a role in the Belgian drug policy. In this section, we describe the major developments in the field for each objective. We refrain from presenting a full inventory of all actions that have been realised in micro detail, because it is not feasible to do so. The Belgian drug policy field is fragmented among many different competences and many different policy levels (cf. infra and supra). The follow-up of the realisations of the Federal Drug Note and the Joint Declaration was not centralised in one institution. Therefore, piecing together the puzzle in retrospect for all actions in all policy levels and domains, scattered over reports from different institutions, is not only virtually impossible, it is also not the core objective of this research. This section rather seeks to summarise the key developments within the different objectives, as they feed into the overall performance in transversal theme 'Integral and integrated approach'.

We therefore opted to list some of the major developments within the various objectives. We have mapped out these developments with a rapid document review, using the websites, reports and other publications from various institutions, such as the General Drug Policy Cell, Belspo, VAD, Fedito, Eurtox, Sciensano, many different addiction care institutions, the public prosecutor's office, federal and local police, NGO's, etc.

The results of this section are limited to an overview of the realisations within each objective, but does not reveal whether or not the realisations work as intended, whether they sufficiently meet the needs in the field, nor whether they are executed in a good way. Moreover, many of the realisations from the rapid document review are not necessarily a direct result of the Federal Drug Note or the Joint Declaration. Often, realisations fit as if coincidentally into the framework outlined by the Federal Drug Note and the Joint Declaration, but were no direct implementations of the two policy documents.

Second, we map the **perceived realisation** through **an online survey** amongst practitioners working within one or more domains related to the drug policy. The survey gained an explorative insight into the perceived realisation of the different actions defined by the Federal Drug Note and the Joint Declaration

[96] For a more elaborate description of the methods used in this project, we refer to Chapter 2 'Methodology'.

from a large number of experts at all policy levels (federal, regions and communities, local level) and across the different policy domains (integral and integrated approach; epidemiology, research and evaluation; prevention; care, risk-reduction and re-integration; enforcement)[97]. The survey thus provides a first insight into how the work field evaluates the realisation of the policy intentions. The online survey was distributed amongst practitioners working within one or more domains related to the drug policy.

Sixteen respondents completed the section on 'Integral and integrated approach'. The respondents represented different domains and policy levels.

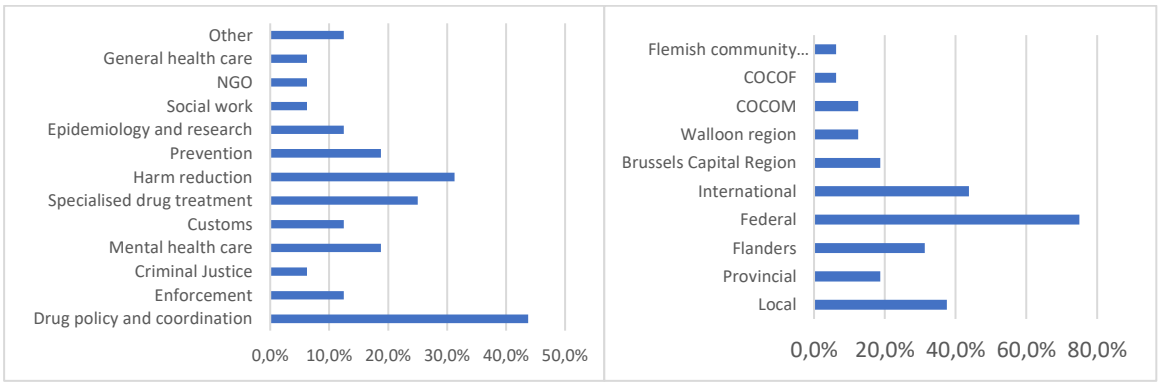

Figure 18 *Domains and policy levels that respondents of the transversal theme 'Integral and integrated approach' represent*

The respondents also have a long experience in the drug field. Three respondents have an experience between 3 and 5 years in de drug field. Again, however, most respondents have an experience of more than 10 years.

Lastly, it is important to consider the limitations of the survey when interpreting the results. Respondents were encouraged to answer only those questions they were aware of, so the number of responses per action varied between 14 responses for the most answered action ('Establish a General Drug Policy Cell'), and 2 responses for the least answered actions ('Secondment of prevention workers within Global Plan to health services'). In addition, the actions already date from 2001 and 2010, and since then, the field has changed. So, the respondents sometimes had to fall back on their recollection from actions realised several years ago. Finally, as was also highlighted in the critical appraisal of the logic models, some actions are very broadly formulated or difficult to measure. This causes differences in interpretation among respondents.

7.1.1.1 Results

First, we will present a summary of the results before we will elaborate on the realisations of each objective more in detail.

Summary of the extent of realisation

With regards to the extent of realisation, we found that:

- ⇨ First of all, the document review reveals that there is little structural follow-up of the implementation of the Federal Drug Note and Joint Declaration, nor of other developments in the transversal pillar 'Integral and integrated approach'. There are several reports and publications that help to get an overview on specific parts of an integral and integrated approach, however, it paints a very fragmented and anecdotical picture.

[97] For more information about the methodology, we refer to chapter 2 'Methodology'

- ⇨ Second, the document review shows that there have been many developments for an integral and integrated approach, especially for the actions related to the drug policy coordination and the international policy participation
- ⇨ Third, the survey learns that there are a lot of discrepancies in the level of perceived realisation (only three actions had a unanimous answer). These discrepancies could be explained by local differences, e.g. locally implemented in one place, but not in another. As there is no complete overview of the realisations, this could indicate that experts and practice are encountering the same barrier of fragmentation as the researchers of this research have.
- ⇨ And lastly, when we compare the results of the document review with the survey, we learn that for most objectives, there are discrepancies between the actual and perceived realisation. This shows that actions may be implemented (cf. document review), but they do not necessarily operate in the best possible way and improvement is necessary (cf. survey).

A. Realisation of the objective 'To coordinate an integral and integrated drug policy'

a. Extent of realisation: a document review

There is a **centralised overview of the realisations** for the objective 'to coordinate an integral and integrated drug policy'. The information on the various achievements of the objective is summarised in the annual reports of the General Drug Policy Cell and its list of realisations from 2014-2019. So, contrary to the other pillars, this section presents **a clear overview** of the achievements within the objective.

The document review reveals that **several actions** intended by the Federal Drug Note and the Joint Declaration for the objective **'to coordinate an integral and integrated drug policy' were fully implemented.** The document review clarifies that most of the intended actions within this objective were realised. For example, the cooperation agreement between the State, the Communities, the Joint Community Commission, the French Community Commission and the Regions for a global and integrated drug policy, was concluded in 2002[98]. This cooperation agreement establishes an Interministerial conference on Drugs, supported by a General Drug Policy Cell (NL: Algemene Cel Drugsbeleid; FR: Cellule générale de Politique en matière de Drogues), and mandates the federal Minister of Health to coordinate the implementation of the agreement. The cooperation agreement describes the composition of the General Drug Policy Cell between the federal government and the constituent governments and the allocation key for the endowment of the General Cell for Drugs. Furthermore, the Cooperation Agreement describes the following six objectives of the Interministerial Conference on Drugs (now: Interministerial Conference Public Health with a thematic meeting on Drugs):

1. To obtain a global understanding of all aspects of the drug problem, taking into account personal, national, cultural and other peculiarities;
2. The continuous prevention and decongestion of drug use and the reduction of the harm associated with such use;
3. The optimization and diversification of the range of services and treatment for drug addicts;
4. The curbing of the illegal production and trafficking of drugs;
5. The elaboration of consulted policy plans with a view to a global and integrated drug policy;
6. The preparation of any form of consultation in the context of representing Belgium at European and international drug forums.

[98] Samenwerkingsakkoord van 2/09/2002 tussen de Staat, de Gemeenschappen, de Gemeenschappelijke Gemeenschapscommissie, de Franse Gemeenschapscommissie en de Gewesten voor een globaal en geïntegreerd drugsbeleid.(BS 2 juni 2003)

Lastly, the cooperation agreement defines the tasks of the General Drug Policy Cell. In general, General Drug Policy Cell coordinates the Belgian drug policy. It prepares the dossiers in which the Thematic Meeting on Drugs eventually make a final decision. The concrete tasks of the General Drug Policy Cell are defined as follows:

1. To have a detailed, complete and updated inventory of all actors involved in the drug problem.
2. To propose justified measures to coordinate all the actions carried out or planned by the competent public services and administrations and by the signatory parties and to increase the effectiveness of those actions.
3. To issue reasoned opinions and recommendations on the realisation of the alignment of drug policies.
4. Together with the Monitoring Centre for Drugs and Drug Addiction, make an evaluation of:
    a) The quality of data and information provided to the General Cell by the signatories and public services and administrations.
    b) The speed of information exchange between the public authorities, the competent bodies and the General Cell.
5. To prepare cooperation agreements or protocols and proposals to implement integrated actions.
6. To prepare the reports for the Interministerial Conference and for the international bodies.
7. To encourage consultation and propose to the Interministerial Conference a joint Belgian position in European and international drug forums.
8. To formulate recommendations and proposals concerning the content and implementation of the policy notes on drugs drawn up by the signatory parties.

The agreement required consent by all competent legislative bodies. The final consent was given in September 2008. In early 2009, the Federal Minister of Health started the operationalization of the agreement by establishing the General Drug Policy Cell and the Interministerial Conference on Drugs (IMC DRUGS). One of the first tasks of the General Drug Policy Cell was to draft the 2010 Joint Declaration. In 2015, the Interministerial Conference of Drugs was integrated in the Interministerial Conference of Public Health, where a thematic meeting 'Drugs' would be held to discuss the matters concerning the drug phenomenon[99]. The activities of the General Drug Policy Cell are described in an annual report, and in 2018 it was decided to bundle all realisations of the General Drug Policy Cell of that legislature in one report (Algemene Cel Drugs, 2019). Although an evaluation of the cooperation agreement and the General Drug Policy Cell was scheduled, this action has not (yet) been realised.

The annual reports of the General Drug Policy Cell mention several themes to which the General Drug Policy Cell has contributed, or the General Drug Policy Cell has coordinated the alignment between the different policy domains and levels of policy. For example, the General Drug Policy Cell provided the input for the chapter 'Integral drug policy' in the Framework Note Integral Security (2016-2019). Another example is the proposal for an alcohol plan which was nonetheless discontinued twice without result (cf. supra). Other examples are the technical report on cannabis (2015), the synthesis note on gambling (2016), the vision note on drug consumption rooms (2016), and the synthesis note on doping (2017). The results of these preparations/reports/synthesis notes are then often discussed at the Interministerial Conference. However, for the themes of "Alcohol", "Cannabis", and "Drug consumption rooms", few concrete initiatives were subsequently undertaken after that cognizance. When initiatives were taken, they often remained limited to a certain region (Algemene Cel Drugs, 2019).

Some actions have not been realised or remain unclear. For example, the General Drug Policy Cell and the cooperation agreement have not (yet) been evaluated. Also, the annual reports do not clarify whether the General Drug Policy Cell has a detailed, complete and updated inventory of all actors involved in the drug problem, nor whether they have made an evaluation of the quality of data and

[99] Protocol Akkoord van 30/03/2015 betreffende het Huishoudelijk Reglement van de Interministeriële Conferentie Volksgezondheid.

information provided to the General Drug Policy Cell and the speed of information exchange between the public authorities, the competent bodies and the General Drug Policy Cell.

This document review **could not find additional realisations for this objective**.

From the document review it is clear that **most of the actions** mentioned by the Federal Drug Note and the Joint Declaration **are addressed, and fully implemented.** Not all the tasks of the General Drug Policy Cell have been implemented and an evaluation of the General Drug Policy Cell has not been conducted yet.

b. Perceived realisation: a survey amongst experts

The survey reveals little consistency in the level of realisation of the objective 'to coordinate an integral and integrated drug policy': the answers range from fully implemented to not implemented for all the actions, except for the drafting of activities reports.

Most survey respondents indicate that the actions within this objective have been partially to fully realised. However, for almost every action, there are one or two respondents who disagree and indicate that these actions are not realised. The discrepancies appear across all regions and policy levels, although for the action 'establish a general drug policy cell' and the subactions 'recommendations on policy coordination', 'stimulate policy alignment' and 'evaluate the quality of provided data and information', the deviating answers were consistently given by Flemish respondents.

These discrepancies could suggest a lack of overview of the realisation of the actions in the work field, especially for the regions. Also, the survey reveals that there are different interpretations of the actions. For example, according to some respondents, the evaluation of the Cooperation Agreement has not yet taken place, or only partially. Comments clarify that respondents are referring to this evaluation when stating this is partially realised. So, respondents who indicated that this evaluation was not realised (yet), might not have considered this.

The survey responses demonstrate **little consistency in the perceived realisations** for the objective 'to coordinate an integral and integrated drug policy'. The results suggest that there is **a lack of overview of the activities of the General Drug Policy Cell and the Interministerial Conference** amongst practitioners, but the discrepancies may also be due to differences in interpreting the distinct actions within this objective.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **a number of discrepancies between the actual realisation and the perceived realisation**. Although the document review found an implementation of most actions relating to 'coordinate an integral and integrated drug policy', several survey respondents mention that the same actions are not realised. For example, the General Drug Policy Cell has been implemented (cf. document review), however, there is still a respondent who indicates this is not the case (cf. survey).

These discrepancies could indicate two things. First, this could indicate that different respondents interpret the same action in a different way and thus **show different appreciation levels,** although this mainly explains small discrepancies**.** Second, it could suggest that, **although the actions are implemented** (cf. document review), the actions do not necessarily operate in the best possible way and **improvement is needed** according to the experts (cf. survey).

B. Realisations of the objective 'To establish clear agreements between the CJS and treatment'

a. Extent of realisation: a document review

There is no **centralised overview of the realisations** for the objective 'to establish clear agreements between the CJS and treatment'. The information on the various achievements of the objective mainly relies on scientific publications, as well as the websites of the prosecution office and several treatment facilities. There thus seems to be a certain fragmentation, and as a result this section presents **an anecdotal overview** of the achievements within the objective that is not a complete representation of the field.

The document review reveals that **none of the actions** intended by the Federal Drug Note and the Joint Declaration for the objective **'to establish clear agreements between the CJS and treatment' were implemented.** For example, the intention to implement case managers within the criminal justice system was never realised because of a lack of clarity about the concept of a case manager in the justice system, but also because of doubt about the compatibility of the method within the current judicial structure (Geenens et al., 2005). In practice, however, we notice that certain pilot projects did introduce case managers within the criminal justice system. For example: the liaisons[100] in the Drug Treatment Court in Ghent, or the 'Proefzorgmanager' in the 'Proefzorg' project in Ghent, and the judicial case managers in Antwerp that work in close collaboration with the CIC De Sleutel. Some of these pilot projects also established local cooperation agreements between the CJS and the treatment sector for their specific project.

With regards to the crisis treatment for people with drug problems within the CJS, the ECCAM study (Bruffaerts et al., 2011) found that "current judicial problems" could be a reason for not admitting clients to crisis care. When describing the judicial characteristics of clients in crisis care however, it also appears that the majority (71%) do not have a judicial record. For 19.3% of the patients, there is some form of conditional release by the prosecutor's office or a court ruling. Justice and police appear to be the referral source of clients in 12% of cases (Bruffaerts et al., 2011).

The action of developing a 'working group to improve the coordination between the CJS and the treatment sector' was never implemented. As a consequence, the working group has also not ensured a clear field demarcation, or agreements regarding communication. However, there has been a BELSPO project that evaluated the preconditions for interaction between the judiciary and drug treatment services (JUSTHULP) (De Ruyver, Macquet, et al., 2007). This research project resulted in an inventory of critical success factors for cooperation between treatment and the CJS, and a roadmap with the essential preconditions for setting up an interaction network between the judiciary and (drug) treatment workers.

The above developments clearly show that most of the intended actions for this objective have not been realised. However, from the described developments, it is also clear that there have been some (smaller) additional initiatives to establish clear agreements between the criminal justice system and the treatment sector, but were not necessarily listed in the Federal Drug Note, nor in the Joint Declaration. These initiatives are often situated at a local level. There are discrepant views between the justice and treatment sectors, and obviously these deep discrepancies sometimes lead to oppositions. Yet, there exist cases where agreements are reached, usually at the local level. These agreements may lead to new initiatives (such as Drug Treatment Chambers), or facilitate compromises on the implementation of initiatives (as is the case in organising security around festivals or in the case of the Drug Consumption Room in Liège).

From the document review it is clear that **none of the intended actions** mentioned by the Federal Drug Note and the Joint Declaration **are (fully) implemented.** There were initiatives supporting clear

[100] Although the recent policy plans in Flanders indicate that the Houses Of Justice will replace the liaisons in the drug treatment courts.

agreements between the criminal justice system and the treatment sector, but these examples are mostly on a local level.

b. Perceived realisation: a survey amongst experts

According to the survey respondents, most of the actions within this objective were partially to not realised. Respondents unanimously confirm that local cooperation agreements were not realised. The action and related subactions about the working group to improve cooperation, has mixed responses of 'partially' and 'not' realised.

There are two exceptions: the action related to the judicial case managers, and crisis treatment for people in contact with the criminal justice system. For these two actions, some respondents indicate it is fully realised, whereas others indicate this is only partially or not realised.

The discrepancies could suggest either a lack of overview in the field, a difference in defining the action or some local and/or regional differences in their application.

The survey responses thus demonstrate **some consistency in the perceived realisations** for the objective 'to establish clear agreements between the CJS and treatment'. The results suggest that there might be **a lack of overview of the realisation of the actions** in the field, but the discrepancies may also be due to differences in their definition and application.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **a number of discrepancies between the actual realisation and the perceived realisation**. Although the document review found little to no evidence of the realisation of most actions relating 'to establish clear agreements between the CJS and treatment', several survey respondents mention that the same actions are partially realised. For example, the judicial case managers have not been implemented (cf. document review), however, there is still a respondent who indicates this is fully realised (cf. survey).

These discrepancies could indicate two things. This difference may reflect local implementation of the specific actions, which remain poorly documented, but may also be due to the fact that different respondents interpret the same action in a different way and thus **show different appreciation levels,** although this mainly explains small discrepancies**.**

C. Realisations of the objective 'To eliminate specific problems with the 'Drugs' section of the Global Plan'

a. Extent of realisation: a document review

There is no **centralised overview of the realisations** for the objective 'to eliminate specific problems with the 'Drugs' section of the Global Plan'. The information on the various achievements of the objective mainly relies on scientific publications, like the SOCOST and SOCPREV reports and other scientific literature, the website of Internal Affairs concerning Strategic Prevention and Security Plans and VAD. It remains a challenge to find any clear and recent information of this objective, which indicates that there is little overview in this domain. There seems to be a certain fragmentation, and as a result this section presents **an anecdotal overview** of the achievements within the objective and not a complete, or full representation of the field.

The document review reveals that **several actions** intended by the Federal Drug Note and the Joint Declaration for the objective 'to eliminate specific problems with the 'Drugs' section of the Global Plan' **were partially implemented, although they often deviate from the policy intention.** This sections mainly concerns the Strategic Prevention and Security contracts, previously referred to as the security contracts. Local governments can apply for this funding from the Directorate of Local Integral Safety to

fund prevention projects that are aimed at crime prevention, in which drug-related social nuisance is one of the categories. As the Federal Drug Standard called for continuity in this plan, multi-year strategic plans that covered a period of 4 years were implemented in 2007 (De Ruyver, Pelc, et al., 2007). Some of the projects, were aimed at the general population, and therefore qualified as primary prevention. However, in 2007, a circular (PREV 30) explicitly excluded local administrations from including actions and projects on primary prevention and medical-therapeutic treatment of clients in their Strategic Safety and Prevention Plan, because the police are not best qualified to carry out prevention tasks (EMCDDA, 2008; Pauwels et al., 2017). As a result, the Strategic Prevention and Security contracts narrowed their application to crime prevention. However, the SOCPREV research describe this as too rigid funding for the prevention projects (Pauwels et al., 2017).

The actions within the Strategic Safety and Prevention Plan mainly focus on secondary drug prevention and social integration of people with a substance dependency problem (Moernaut, 2019). As mentioned before, according to FOD Internal Affairs, 57% of the projects funded by the strategic prevention and security plans, address drug-related nuisance (Federale Overheidsdienst Binnenlandse Zaken, 2020).

Furthermore, the Global Plan still provides for a security fund, under the supervision of the Minister of Interior, for the implementation of projects for alternative punishments and measures (Vlaamse Regering, 2013)The Royal Decree of 12 August 1994, establishing the conditions under which municipalities may receive financial assistance for the recruitment of additional civilian personnel in charge of the accompaniment of alternative criminal measures, crime prevention, and drug addiction counselling (the framework for financing Global Plan projects), was replaced in 2015 by Royal Decree establishing the conditions under which organizations may receive financial assistance for the recruitment of personnel in charge of the accompaniment of judicial measures, after the transfer of various competences from the federal level to the communities on 1 July 2014. Within these Global Plan projects, the Judicial Alternative Projects (cf. chapter ‘Enforcement’) are nowadays still financed (they remained a federal matter). These projects focus exclusively on people who use drugs and who are into contact with the judicial system.

The SOCPREV study also provides some clarification in terms of funding and staff appointments of prevention workers funded by the strategic prevention and security plans. The study describes in its results that stable funding is a crucial context factor, as is staff education and training. Nevertheless, some respondents describe too rigid funding for the prevention projects, and a lack of structural financing (Pauwels et al., 2017).

Some actions are outdated, for example the actions relating to the Permanent Secretariat for Prevention Policy. The tasks of the Permanent Secretariat for Prevention Policy were taken over by the Service for Local Integral Security Policy (SLIV) around 2004, after the Directorate for Security and Prevention Policy was put in charge of prevention policy in 2002 (Hebberecht, 2008). To this day, the Directorate of Local Integral Safety works together with cities and municipalities on local safety. It does so by issuing advice, encouraging local authorities to make citizens aware of safety prevention, developing knowledge with their partners, and evaluating prevention actions which they themselves undertake.

From the document review it is clear that **most of the actions** mentioned by the Federal Drug Note and the Joint Declaration **have been addressed in a different way, and have therefore not been (fully) implemented.**

b. Perceived realisation: a survey amongst experts

According to the survey respondents, most of the actions within this objective were partially or not realised. The majority of the respondents indicate that the actions are 'not realised'.

There are four exceptions: ‘a clear statute in the contracts with municipalities’, ‘contractual duties to subscribe prevention policy in other policy levels’, ‘VSPP contact point for the prevention of crime’, and

'General Drug Policy Cell takes over the tasks of the national evaluation committee, which ceases to exist'. For each of these actions, there is no consistency in the survey responses. Some respondents perceive the actions as fully realised, whereas others indicate they are partially or not realised. These discrepancies appear both within and between policy levels, for example, between Brussels and federal respondents, between Flemish and federal respondents, but also within the federal level. For the action 'General Drug Policy Cell takes over the tasks of the national evaluation committee, which ceases to exist', discrepancies appear in all policy levels and regions.

The discrepancies could suggest either unclarity amongst practitioners, or local and/or regional differences in realisation.

Lastly, for some actions, only two or even no Brussels or Walloon respondents could reply. This suggests a limited visibility of the actions for these regions.

The survey responses demonstrate **little consistency in the perceived realisations** for the objective 'to eliminate specific problems with the 'Drugs' section of the Global Plan'. The discrepancies cannot be explained by domain of expertise of the respondent, and not by the policy level the respondents expertise relates to. The results suggest that there is **a lack of overview of the realisation of the actions** in the field (especially for the first group of actions), but the discrepancies may also be due differences in local application.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **no big discrepancies between the actual realisation and the perceived realisation for most of the actions**. Both sections show a highly fragmented field, where actors do not have a clear or unanimous overview, and where it is hard to get an overview on 'what is out there'.

D. Realisations objective 'To engage in international treaties and policy plans'

a. Extent of realisation: a document review

There is a (limited) **centralised overview of the realisations** for the objective 'to engage in international treaties and policy plans'. The information on the various achievements of the objective is summarised in the annual reports of the General Drug Policy Cell and the list of realisations from 2014-2019. So, contrary to the other pillars, this section presents **a clear overview** of the achievements within this objective.

The document review reveals that **most actions** intended by the Federal Drug Note and the Joint Declaration for the objective 'to engage in international treaties and policy plans' **have been fully implemented.** Belgium is an active player in the international policy field. Recurrent international initiatives in which Belgium participates are for example the participation of the national drugs coordinator in the six-monthly meeting of the EU drugs coordinators, participation in the monthly meetings of the Horizontal Working Group on Drugs of the Council of the European Union, participation of a Belgian delegation in the annual regular and intersessional sessions of the Commission on Narcotic Drugs (CND-UNODC), participation in meetings of the Groupe Pompidou (Council of Europe), as well as participating in recurrent and ad hoc international questionnaires (e.g. Annual Report Questionnaire (ARQ), the WHO Global survey on alcohol and health, the INCB questionnaire on the availability of substances under international control) (Algemene Cel Drugs, 2019).

From April 19-21, 2016, a special session of the United Nations General Assembly was held in New York on global drug issues. This meeting resulted in the document "Our joint commitment to effectively addressing and countering the world drug problem" in which there are seven operational recommendations (UNGASS). According to the annual report of the General Cell, Belgium defended a far-reaching implementation of the UNGASS 2016 Outcome Document and draws international attention

to the second operational objective of this document, namely 'ensuring the availability of and access to controlled substances for medical and scientific purposes'. To this end, Belgium already sponsored and co-sponsored several side events (Algemene Cel Drugs, 2019).

Also, Belgium participates in the Reitox network of national focal points (NFPs) through the National Focal Point (Sciensano), which is perceived as a cornerstone of the work and activities of the EMCDDA, whose main task is to monitor and disseminate information on the drug situation throughout Europe in a harmonized and standardised way (Algemene Cel Drugs, 2019).

In 2010, the Interministerial Conference decided not to set up the Cell "international cooperation" unit because there were too many overlaps with existing coordination systems. The international themes, were handled directly by the ACD (Algemene Cel Drugsbeleid, 2011).

Only one action has not been addressed: the use of military means to prevent the production or the trafficking of drugs.

From the document review it became clear that **almost all of the actions** mentioned by the Federal Drug Note and the Joint Declaration **are realised and present active domains of the Belgian drug policy field.** International policy participation has been extensively emphasised, as well as the coordination of the Belgian drug policy.

b. Perceived realisation: a survey amongst experts

According to most survey respondents, almost all the actions within this pillar are fully to partially realised, with the exception of 'the role of the department of Defense in preventing the trafficking of illicit drugs'. Yet, for nearly all actions within this pillar, there is also one or two respondents who indicate that the actions are not realised. The deviating answers for the actions 'to establish a monitoring of legislation and good practices at the level of the EMCDDA', 'General Drug Policy Cell as national coordinator', 'Good relations with the EMCDDA', and 'active participation in the UN', can be attributed to Brussels respondents. These discrepancies could suggest a lack of overview of the realisation of the actions in the work field, especially for the regions.

The survey responses thus demonstrate **some consistency in the perceived realisations** for the objective 'To engage in international treaties and policy plans'. The results suggest that there is **a lack of overview of the international policy participation** amongst practitioners, although the discrepancies may also be due to differences in interpretation.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **a relative consistency between the actual realisation and the perceived realisation**. Yet, a **number of discrepancies** remain. Although the document review found (partial) realisation of most actions, several survey respondents mention that the same actions are not realised. For example, there is a cell international cooperation within the General Drug Policy Cell (cf. document review), however, there are still respondents who indicates this is not realised (cf. survey).

These discrepancies could indicate three things. First, this could indicate that different respondents interpret the same action in a different way and thus **show different appreciation levels,** although this mainly explains small discrepancies**.** Second, it could be that there is a lack of overview **of the international policy participation** amongst (local or regional) practitioners. Third, it could suggest that, **although the actions are implemented** (cf. document review), the actions are not widely known or might not necessarily operate in the best possible way and **improvement might be needed** according to the experts (cf. survey).

7.1.1.2 Conclusion of the extent of realisation

First of all, the document review reveals that there is a lack of structural follow-up of the implementation of the Federal Drug Note and Joint Declaration, well as of other developments in the transversal pillar 'Integral and integrated approach'. There are many annual reports and other publications that list the developments for this transversal theme, but they always focus on specific parts of the of the transversal theme, for example the coordination of the Belgian drug policy (through the General Drug Policy Cell) or the international policy participation. All of these reports and publications help to get an overview on specific parts of an integral and integrated approach, however, it paints a very fragmented and anecdotical picture. As a result, this fragmentation is reflected in this evaluation too.

Second, the document review shows that there have been many developments in the area of an integral and integrated approach, especially for the actions related to the 'drug policy coordination' and 'international policy participation'. For the first objective 'to coordinate an integral and integrated drug policy', most actions have been realised, as well as for the objective 'to engage in international treaties and policy plans'. For the other objectives, however, the actions are to a much lesser extent implemented. Almost no actions have been realised for the objective 'to establish clear agreements between the CJS and the treatment sector'. For the objective 'to eliminate specific problems with the 'Drugs' section of the Global Plan', several actions have been implemented, but they did not always match the intended actions. Also, for the latter objective, it is hard to find an overview of any of the implementations.

Third, the online survey learns that there are a lot of discrepancies in the level of perceived realisation amongst the respondents. These discrepancies could be explained by local differences, e.g. locally implemented in one place, but not in another. As there is no complete overview of the realisations, this could indicate that our respondents are have a fragmented … on the matter. Another explanation could be that some actions are defined very broad, so respondents could have interpreted the action in a different way. Depending on how the action is interpreted by the respondent, replies may vary. Another explanation might be that some actions are not quantifiable or measurable, so what is 'fully realised' for one respondent, might only be 'partially realised' for another respondent because this is not clearly specified. However, some actions were very clear, and still discrepancies remained, which suggest that even practitioners do not have a clear view on the realisations.

And lastly, when we compare the results of the document review with the survey, we learn that for most objectives, there are discrepancies between the actual and perceived realisation. In most cases, we see that, although the document review identifies certain actions as realised, some survey respondents indicate them as partially or even not realised. This shows that actions may be implemented (cf. document review), but they are not widely known or do might not operate in the best possible way and improvement might be necessary.

7.1.2 Providing context to the stage of realisation: interviews with stakeholders

A third method used in the EVADRUG evaluation, are semi-structured interviews and one focus group with stakeholders that have an expertise in one or more domains related to the Belgian drug policy. These semi-structured interviews aim to provide an explorative insight into the facilitators, barriers, bottlenecks, challenges and needs for the Belgian drug policy. The semi-structured interviews were conducted amongst 39 civil servants and practitioners at all policy levels (federal, regions and communities) and across the different policy domains (Integral and integrated approach; Epidemiology, research and evaluation; Prevention; Treatment, risk-reduction and reintegration; Enforcement).

This section summarises their views on the realisation of the objectives across the transversal theme 'Integral and integrated approach'. The interviews and the focus group are aimed at obtaining and understanding how Belgian drug policy is experienced by respondents. We examined how they shape

the Belgian drug policy in daily practice, giving insight in how they translate “policy in practice”, as opposed to “policy in the books”.

It is important to note that semi-structured interviews are a qualitative method to gain an explorative and more in-depth insight into the drug policy. Therefore, this method does not give a representative view of all opinions in the field. The qualitative semi-structured interviews intended to report on recurrent perceptions, opinions and experiences that are prevalent in the drug field, to help explain why the realisation of certain objectives within the transversal theme of ‘Integral and integrated approach’ is hindered or facilitated, but also to record new barriers and bottlenecks, and to map what the field deems necessary for this transversal theme. Additionally, it is important to consider that the Belgian drug policy covers a very broad field of topics. Because of that, we were not able to describe every bottleneck in detail. In this section, each topic is touched upon briefly.

First, we will present a summary of the results before we will elaborate on the facilitators and barriers more in detail.

Summary of the context to realisation

With regards to the context to the stage of realisation, practitioners and civil servants perceived that:

- ⇨ First of all, respondents described how the integral and integrated approach of the drug phenomenon reaches its limits, especially on a federal and state level. Respondents describe how the container concept ‘integral and integrated’ is hardly operationalised on a federal and state level, as opposed to the integral and integrated approach of some well-defined initiatives on a more local level.
- ⇨ Apart from the difficulties operationalising the concept and the cooperation being dependant on the initiative of individuals or organisations, respondents refer to barriers with coordination. Respondents acknowledge the General Drug Policy Cell as an open forum for discussion where new drug phenomena as well a recent research results are brought to the attention of all policy. Nevertheless, they mention a lack of continuity in its members, a lack of political mandate for some of the members, problems with the number of members, the difficulties to reach a compromise between the different policy domains and levels, and the need for a strong president are defined as barriers for a more decisive General Drug Policy Cell.
- ⇨ According to respondents, the lack of a clear vision and direction in Belgian drug policy is an additional obstacle in the integral and integrated approach of Belgian drug policy. The current policy documents are outdated, and recent policy documents are not overarching.
- ⇨ Additionally, some respondents highlight the benefits of participating in the international drug policy to facilitate the relationship between the different member states. However, they also describe difficulties translating these European discussions and demonstrating its relevance on a national, regional and local level.
- ⇨ Respondents further describe the challenge of making the drug phenomenon relevant to policymakers, as the topic is often not high on the political agenda.

7.1.2.1 Facilitators with regard to the realisation of the 'Integral and integrated approach'- theme's objectives

We asked the respondents what they identify as facilitators for the realisation of the objectives of an integral and integrated approach. Four facilitators were identified: The General Drug Policy Cell as an open forum for discussion, a local integral and integrated drug policy, a good collaboration and understanding between partners within the Horizontal Working Party on Drugs, and the evolution in the international debate.

A. The General Drug Policy Cell as an open forum for discussion

Most respondents emphasise that the General Drug Policy Cell acts as a facilitator to openly discuss different drug related topics. It ensures, for example, that certain topics are shared with all policy levels. It also allows the available data and scientific research to be more widely distributed and brought to the attention of the various actors. Moreover, the General Drug Policy Cell has been able to serve as a forum to speak freely about new phenomena. One respondent illustrates this by stating that even though no consensus on certain topics, such as the alcohol plan or drug consumption rooms, was reached, this forum has enabled them to have a lively and interesting discussion amongst all stakeholders.

> *Je zit daar met een ongelooflijke expertise aan tafel, (..) ook mensen met een vorm van anciënniteit die ondersteuning kunnen geven, er zit administratie voor, ... Dus je zit daar met eigenlijk een heel mooie tool dat je eigenlijk kunt gaan gebruiken, die je voorbereiding doet voor in het ministerieel conferentie natuurlijk. (NL_8)*

> *Je pense que c'est parfois difficile, mais c'est bien d'avoir tout le monde autour de la table qui parle de débattre de toutes les thématiques. (…) Le processus en soi est facilitateur. (FR_1)*

One respondent even refers to the General Drug Policy Cell as a forum to share the existence of and discuss new phenomena. Whenever a new phenomenon occurs, it can be discussed amongst the relevant stakeholders, so that at the very least the phenomenon will not go unnoticed.

The respondents also mention preconditions that strengthen the role and position of the General Drug Policy Cell, including the role of the president and priority setting.

All respondents mention the impact of the involvement of a politically independent, engaged and experienced president on the operation of a drug policy cell. The president should be someone who is not tied to any of the cabinets, especially since the drug phenomenon is such an ideological field. This balance between political sensitivity on the one hand, and social, scientific and practical relevance on the other, is deemed essential to facilitate the performance of the General Drug Policy Cell. Finally, authority is also emphasised in the role of the president. Some respondents refer to the late prof. dr. Brice De Ruyver, the previous president of the General Drug Policy Cell, to illustrate the role of such a president. to

> *Dus die moet een soort van politieke gevoeligheid hebben en eigenlijk ook wel weten wat de maatschappelijke relevantie is van bepaalde thema's. Het is niet de bedoeling op de Algemene Cel om allerlei kleine probleempjes aan te pakken. (NL_1)*

Priority setting in the beginning of legislature is also emphasised as a precondition for an adequate operation of the general drug policy cell. It sets a clear agenda for the legislature, gives direction to the meetings, and serves as a reminder when certain priorities have not yet been addressed. Lastly, one respondent mentions a sense of political urgency, for example when an incident occurs or when an urgent need emerges.

> *On détermine des priorités pour la cellule générale chaque année et ces priorités font l'unanimité. Alors, les dossiers avancent beaucoup plus vite, c'est un facilitateur. On peut récolter des informations des différents niveaux. Par exemple, à un moment donné, on avait fait*

un groupe de travail sur la politique cannabis et on avait récolté beaucoup d'informations assez rapidement. Donc, c'étais facilitateur. (FR_1)

B. Concrete needs facilitate an integral and integrated local drug policy

Different respondents have their doubts as to whether the Belgian drug policy can be considered as working in an integral and integrated way (cf. infra). Nevertheless, most respondents explain that within delineated cases, often at local and/or operational and field level, there are numerous examples of integrated and integral cooperation.

En veel, de meeste daarvan, hebben niet… Behalve op het lokale vlak, want daar is er wel veel geïntegreerd werken. Maar op een iets hoger niveau om het zo te zeggen, is het niet zo de gewoonte dat die structuren zo met elkaar samenwerken. (NL_1)

Several respondents refer to concrete needs or problems that practitioners are confronted with, forcing the various stakeholders to work together. Respondents acknowledge that this integral and integrated approach is not easy. It is time-consuming and the different partners have to invest time and effort in order to reach a compromise. Yet, they provide several examples where different stakeholders eventually succeeded in working together in an integral and integrated way answering a concrete need such as tackling the cocaine smuggling through the Port of Antwerp, or developing a drug policy plan for festivals.

Bijvoorbeeld één van de laatste... op festivals. Als je ziet dat daar zowel politie, festivalorganisatoren, preventiewerkers en burgemeester, als je die partijen allemaal op één lijn moet zetten, en samen moet werken aan een beleidsmatige aanpak op het festival… Dat is niet evident. Daar gaat.. Compromis ligt daar niet onmiddellijk hè. De ene is voor nultolerantie en de andere zegt 'Ja, maar er wordt gebruikt'. We moeten hier wel tot de afspraken komen. Dat is uiteindelijk gelukt hè. En we hebben een beleidsmatige aanpak voor festivals waarin alle partners zich vinden en dat er voor elke partner, duidelijk op papier gekomen is wat dat ze van elkaar verwachten hè. Of kunnen verwachten. Dat is niet evident. Die hebben tegenovergestelde belangen. Maar toch is het heel belangrijk dat als je een drugsbeleidsplan wilt uitwerken voor een evenement, dat die drie partners of vier partners aan tafel moeten zitten. En dat ze tot consensus moeten komen. Dat ze weten en moeten beseffen dat ze met elkaar moeten praten. En tot de gemeenschappelijke visie komen over hoe ze die hun drugsproblematiek gaan aanpakken op die momenten. (NL_4)

C. Good collaboration and understanding between European Member states, in particular among the Horizontal Working Party

At the EU level, respondents describe a good relationship between the different Member States, but also with the Commission, especially in the Horizontal Working Party on Drugs. Despite the large number of participants and the many -and often diverse- agenda items, respondents describe the Horizontal Working Party as valuable, in the sense that there is trust and openness between all partners. Both the practical and scientific branches are present, as well as civil society. One respondent especially emphasises the informal meetings for example the drug coordinators meetings, as a good practice.

Lastly, one respondent mentions that the Belgian involvement in the international drug policy, for example at the level of the CND, has added value for Belgium. The respondent explains that this international connection is relevant because the international debate is shaped by the involvement of not only law enforcement actors and representatives of the member states, but also the involvement of WHO, UN Aids and civil society, displaying an evolution throughout the last 15 years. So, certainly in the long term, the debate is evolving, albeit slowly, according to the respondent.

7.1.2.2 Barriers and bottlenecks with regard to the realisation of an 'Integral and integrated approach'

We asked the respondents what they identified as a barrier or a bottleneck for the transversal theme of an 'Integral and integrated approach'. Bottlenecks and barriers are problems that prevent or obstruct a successful realisation. In this section, we list general barriers and bottlenecks, but also barriers and bottlenecks related to the specific objectives of the pillar 'Integral and integrated approach'.

A. General barriers and bottlenecks that obstruct the realisation of the transversal theme 'Integral and integrated approach'

a. Include the needs of practitioners and lived experiences in a systematic and structured way

Drug policy is often described by the respondents as an ideological domain, where values play a significant role. Almost all respondents regret that the needs in the field and lived experiences are not or only to a limited extent taken into account. They emphasise the importance to start from the needs in the field, as well as from the evidence base, to balance out an approach fuelled only by values. Yet, according to the respondents, these "people from the field" are rarely heard in a structured way, nor are they actively involved in developing the drug policy.

> *Maar er is zo geen aftoetsing met het werkveld. En dan bedoel ik écht: focusgroepen met straathoekwerkers, met mensen die gebruiken, met mensen die spuitenruil doen, mensen die dagelijks de hulpverlening doen voor verschillende strekkingen. En niet met coördinatoren en met directies. (NL_2)*

Many respondents mention the importance of involving practitioners and their needs when developing drug policy. According to some respondents, civil society could play an important role here. However, not all respondents agree on how civil society should be operationalised. Some respondents mention a broad interpretation of civil society, focusing not only on specialised drug treatment, but also on general practitioners, hospitals, welfare workers and people in the field in general. Other respondents stress the need to have an integer civil society, not too ideological nor political in order to balance the debate. Respondents also question whether or not the private sector should be involved in civil society.

> *Ik denk dat de expertise van het werkveld moet gevalideerd worden, absoluut, maar dan moet je ook een zeker mandaat hebben, een gelijkwaardige stem eventueel in dat debat. Je kan heel veel vergaderen, en ik denk dat wij er als groep veel sneller dan de politiek zouden uitkomen met een gezamenlijk standpunt, maar als dat standpunt elke keer wordt weggeveegd omwille van politieke of morele overwegingen, dan ben je ook een excuustruus.*
>
> *(…)*
>
> *Euhm, is niet zo eenvoudig vind ik om dat te operationaliseren, want bij maatschappelijk middenveld wordt snel gedacht aan de preventie en de drughulpverlening, maar voor vele beleidsmakers is dat natuurlijk veel breder dan dat, en dat begint het. Dus je hebt ziekenhuizen, centra GGZ, eerstelijnsgezondheidszorg, OCMW's, en dan heb je het alleen nog maar over de gezondheidssector, er is ook de sociale sector, maar sommigen gaan er ook de privésector aan toevoegen. Dus, dat is niet zo een gemakkelijk begrip, maatschappelijk middenveld*
>
> *(FG_RC)*

Lastly, there are some respondents that emphasise the voice of people who use drugs and involving lived experiences. People who use drugs are subjected to the drug policy, and are therefore experts by experience. That fact that they are not heard in the current drug policy, is described as a lost opportunity.

Ik mis de stem van de gebruiker soms toch wel. Ja dus ja, zo trekken een drug users union kan absoluut meerwaarde geven. Daar dat ook hier in België nog geen sprake van is. (NL_2)

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following need:

- On all policy levels:
  - Involve civil society (in its broad interpretation) and people with lived experiences in the development of drug policy. In doing so, civil society should be operationalised.

b. Cooperation is too often individual-related

Most respondents refer to the fact that cooperation with other policy domains or policy levels, often depends on the available network and existing connections between individuals from different policy domains and levels. If it weren't for the voluntary initiatives of a few, there would be much less cooperation across policy levels and policy domains, respondents describe. Some respondents regret this, as established cooperation dependent on the actions of some individuals. Whenever these persons leave a certain organisation, the acquired expertise, established trust and cooperation initiatives might be jeopardised. Respondents refer to examples within police, customs, epidemiology, prevention, and FAGG.

B. Barriers and bottlenecks related to the objective 'to coordinate an integral and integrated drug policy'

Several respondents mention barriers and bottlenecks with the coordination of an integral and integrated drug policy.

a. Unclarity about the operationalisation of the concept 'an integral and integrated drug policy'

A comprehensive and integrated approach to the drugs phenomenon is the central concept of Belgian drugs policy. Respondents describe, however, that the concept lacks a concrete operationalisation in practice and describe the concept 'integral and integrated' as a container concept. In 2007, the DODONBEL Belspo project defined both concepts as follows: Integral'' refers to all-encompassing, which means that all aspects of the multidimensional drug phenomenon are addressed, and thus implies cooperation between different policy sectors. Thus, welfare and health, harm reduction, prevention, treatment and supply reduction are all included in drug policy. Integrated' logically follows an integral approach, in the sense that multidisciplinary cooperation requires the involvement of all relevant actors and policy levels (De Ruyver, 2009; Vandam et al., 2010; Vander Laenen et al., 2010). Cooperation between those actors and levels is essential within an integrated approach.

Despite this theoretical clarification, our respondents stress how difficult it remains to implement this concept in practice. They clarify that the different policy levels do not know how to cooperate in an integrated way, especially at the federal and state level. Examples of integrated cooperation are often related to well- defined projects that are rather situated at the local level. For example, respondents refer to a good understanding and cooperation, and close communication between the different partners, within the context of the drug consumption room in Liège between police and health care workers, to the drafting of a concrete festival policy between local police and prevention workers, or to the cooperation between the justice and treatment sector in the Judicial Alternative Measures projects.

R3: Alors, je rejoins tout à fait ce qui vient d'être dit, une politique intégrale et intégrée ne peut pas se faire sans une vision commune. J'entends dire depuis des décennies que le mot d'ordre

en Belgique c'est politique intégrale et intégrée, mais c'est une espèce d'incantation qui ne repose sur rien, parce qu'il n'y a aucune vision unique, ni au niveau politique, ni au niveau social.

R1: (…) en ik begrijp eigenlijk wel de frustratie, die ik voor een stuk deel, namelijk dat over dat concept globaal en geïntegreerd dat eigenlijk heel snel verworven is, zonder er een grondige politieke discussie over te hebben over wat dat precies betekent. (FG_RC)

b. General Drug Policy Cell lacks clout

Although respondents praise the existence of the general drug policy (cf. supra), they mention that it lacks clout for several reasons.

A first bottleneck that respondents describe, concerns the members of the general drug policy cell. Many respondents mention that there is a lack of continuity of the members of the drug policy cell. Since the composition technically comprises of representatives of the cabinets, apart from some permanent experts, stability is sometimes jeopardised, for instance when there was only a government of general management and when the formation of the federal government took a very long time. No meeting of the general drug policy cell was organised during this period, while in the meantime, of course, the drug phenomenon continues to be an issue.

Le problème, c'est que ce sont des représentants de cabinets. Donc, il y a problème de continuité. A part quelques fonctionnaires qui sont invités permanents, le reste sont des membres de cabinets et ils changent en fonction de la situation politique. (FR_5)

Additionally, respondents often mention that the members who participate in the General Drug Policy Cell are not always politically mandated, even though they have a great knowledge of the cases. However, when it comes down to making a decision, it is imperative to include politicians, as they have the final say. Including them in the preparatory phases organised at the General Drug Policy Cell is therefore necessary.

Another barrier described by most respondents, is that the number of members of the General Drug Policy Cell can act a barrier. The competences of the Belgian drug policy are fragmented across many different policy domains and policy levels (cf. supra), so to have a representation of all relevant competences, there is a large group of participants. Respondents describe that the larger the group of members, the more difficult to get the compromise. Moreover, this requires a great deal of coordination between all stakeholders, which in turn is very time-consuming, respondents describe.

The result of this fragmentation of competences across different policy domains and policy levels, is that a compromise has to be sought between al lot of different stakeholders. These stakeholders often do not have the same priorities, nor do they share the same vision.

Mais c'est vrai que parfois les priorités ne sont pas les mêmes selon les niveaux de pouvoir. (…) Parfois la cellule générale, c'est l'obstacle… Plus on a de gens autour de la table et plus c'est difficile d'avoir quelque chose qui fait consensus. A la cellule générale, je pense qu'il y a 22 ministres représentés, avec des Régions qui ont une certaine orientation politique et le Fédéral qui en a une autre, ce n'est pas facile. (FR_1)

Oui, je pense que la lasagne belge fait que, de toute façon, on ne peut pas imposer des positions. Il n'y aura jamais de position belge forcément uniforme. (FR_5)

The difficulty in finding compromises can also be seen in legislative or policy documents, respondents mention. When there is no real compromise, very different points of view are united in one document, often resulting in a vague text. Some respondents refer to this as a "compromis à la belge". Respondents describe that this is sometimes reflected in policy initiatives that the General Drug Policy Cell has taken. Two respondents refer for example to the Joint Declaration, and state that the policy document is formulated so broadly that everyone can read in it what they want.

Ge kunt er vanalles in lezen, hè, iedereen komt er zo een beetje aan bod met zijn eigen visies en met zijn eigen projecten en regelgevingen. Maar om nu te zeggen dat dat één duidelijk standpunt is, euh ja, dat gaat niet, denk ik. (NL_1)

La Déclaration Conjointe (...) c'est essentiellement un inventaire, un état des lieux, en 2010, de ce qui se fait et des voies dans lesquelles on envisage de poursuivre. Au niveau prospectif pour le développement, pour les années futures, (...) c'est relativement maigre (...) Alors, à la cellule générale, on doit travailler par consensus et c'est encore beaucoup plus compliqué parce que les gens ne sont pas souvent d'accord sur grand chose. (FR_4)

Respondents indicate that this is problematic, especially for the field, where some discussions are waiting for clear policy lines.

Wat dat we gezien hebben de afgelopen jaren en dat is ongelooflijk kwetsend, is dat het lokale beleid zit te schreeuwen om nodige hulp en ga zo maar door, uhm, en dat federaal gewoon geen uitspraak over is he. (NL_8)

Still, policymakers have to rely on each other to achieve an integrated approach to a certain phenomenon. Because the competences are fragmented across different policy areas and policy domains, policy makers are sometimes dependent on each other to achieve an approach, as the respondent below demonstrates with an example:

Het is trouwens, ik zeg niet op alles, maar in de meeste dingen heeft dat eigenlijk geen zin dat de ene minister iets doet als de andere niet mee is. Of, euh, allé bijvoorbeeld als federaal een terugbetaling voorziet van de psycholoog, dan is er een federaal kader daarvoor, maar moeten de specifieke normen toch bepaald worden, of elk geval de erkenning van die norm moet bepaald worden door de deelstaten. Dus ge kunt dat eigenlijk niet op poten zetten als je niet samenwerkt. (NL_1)

Additionally, it happens from time to time, when no compromise is reached, that each government takes its own measures within their domain without any coordination. This has been the case, for example, after the discussion on the alcohol plan. Sometimes, however, this leads to actions that are diametrically opposed to each other. An example of this is the drug consumption rooms. In Wallonia and Brussels, drug consumption rooms have been set up, whereas the federal legislation does not allow this. This leads to tension between both policy levels. Moreover, on an international level, Belgium cannot report on these practices, because there is not unanimous point of view.

Ah ja, natuurlijk. De druggebruikersruimtes is er eentje van. Dus, euh, op federaal niveau was er gezegd 'Wij willen de wetgeving niet veranderen, dus wij zijn tegen druggebruikersruimtes'. En Wallonië, en Brussel ook denk ik hé, hebben gezegd… Hebben dan toch zo'n druggebruikersruimte opgestart, of gaan ze opstarten, dus ja, dat geeft verschillen, ja. Maar dat geeft niet echt, euh, fricties tussen de regio's. Dat gaf wel fricties tussen het Waalse gewest natuurlijk en federaal. (NL_1)

Respecting each other's competences is a common thread throughout the interviews, and is often emphasised by respondents. This fragile balance sometimes leads to tension when respondents judge that their competences are not being respected.

Si, en fait, c'est quelque chose qui existe depuis toujours et dans laquelle la cellule, honnêtement, n'a pas grand chose à avoir, donc je tiens à respecter les compétences respectives, justement. (NL_5)

Lastly, many respondents mention a few barriers with the coordination of the general drug policy cell. The role of the president has been mentioned as an important facilitator for a good operation of the General Drug Policy Cell (cf. supra). Respondents indicate that this person should be chosen with care, keeping in mind the aforementioned characteristics such as affinity with the scientific world, the field of practice and politics, have insight into the social relevance of themes and have a strategic overview of

Belgian drug policy, but also have sufficient authority to lead the General Drug Policy Cell. If this president lacks these qualities, this role acts in fact as a barrier

There is also one bottleneck suggested with the role of the secretariat. Some respondents mention that the secretariat, which is situated with the administration within Public Health, lacks some sensitivity related to the security and judicial perspective of the drug phenomenon. Respondents describe how they perceive that the perspective of enforcement is not fully considered, an describe that enforcement measures are less prominent in the General Drug Policy Cell.

> *De algemene cel drugsbeleid werkt met een secretariaat en, dat is gewoon mijn persoonlijke mening he, ik heb de indruk dat binnen dat secretariaat van de algemene cel drugsbeleid, dat we toch wel de sensitiviteit van de repressie missen. (NL_7)*

> *Il faut faire une distinction entre la cellule comme telle, les membres de la cellule et le secrétariat. Ils sont quand même plusieurs à être pratiquement 'Full Time' là-dessus (...) Je pense qu'il fait respecter les compétences respectives. (FR_5)*

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following need:

- Identified needs regarding the general drug policy cell:
  - A clear mandate for the General Drug Policy Cell and its members.
  - Develop drug policy starting from the needs in the field and the evidence base.
  - Choose a strong president to coordinate the general drug policy cell.
  - Clarify the division of competences, roles and responsabilities.

c. The lack of a drug strategy in order to have an up to date, central vision on the Belgian drug policy

Furthermore, nearly all respondents denounced the fact that there is no overall drug strategy in Belgium. The current policy documents, the Federal Drug Note and Joint Declaration, are outdated, and there is no up to date, central vision in the current initiatives. By setting a number of priorities at the beginning of the legislature, the General Drug Policy Cell wanted to address this bottleneck, however according to the respondents more is needed to develop a Belgian drug policy's vision. At both policy and practice levels, respondents stressed the need for an overarching strategy.

> *Euh, maar allé, het is niet dat er achter alles een gedragen en gecoördineerde visie zit. Dus we hebben een druggebruikersruimte, we doen piltesting, euh, enzovoort. Maar ja, het is niet dat België een standpunt heeft rond piltesting of rond druggebruikersruimte, nee. Maar dat heeft dat heeft ook te maken met het eerste dat ik zei, dat er zo veel ministers bevoegd zijn. Nu iedereen effectief, jah, zijn eigen ding mag doen. Dat is nu eenmaal zo. (NL_1)*

In addition, respondents stress that the Federal Drug Note and Joint Declaration are outdated policy documents. Apart from being almost 20 years old, respondents for example emphasise that both policy documents focus solely on illegal drugs, alcohol, tobacco and psychoactive medication, whereas today, behavioural addictions such as gaming and gambling must also be taken into account. Additionally, some respondents note that both policy documents focus proportionally more on illegal drugs than on the other substances, such as alcohol, tobacco and psychoactive medication.

Lastly, one respondent mentions that the many existing policy documents relevant for the drug policy, are often not synchronised in terms of timing, making it difficult to organise a coherent policy approach

> *Als dat allemaal op een andere timing wordt gezet, dan kun je moeilijk afstemming doen, mekaar regelen he. (NL_8)*

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following need:

- On all policy levels:
  - An integral and integrated drug strategy, with a long-term and unambiguous approach towards the drug phenomenon.
  - Establish a clear, overarching coordination and follow-up of the drug strategy and action plans.
  - A clear communication about the drug strategy, and the action taken to each sector, to civil society and the wider public.

C. Barriers and bottlenecks related to the objective 'To engage in international treaties and policy plans'

The respondents mention a few barriers and bottlenecks that are related to the objective 'To engage in international treaties and policy plans'.

First of all, the lack of a pronounced position towards central discussions, for example the cannabis discussion, is mentioned as a barrier. For example, one respondent describes that sensitive topics within Belgium are often not discussed at the EU level, let alone a Belgian vision on the topic being drafted into policy documents. Especially at the UN level, a clear position from Belgium would be required, because, according to one respondent, there is always a balance to be struck as to which position will be adopted. This clashes with the approach of countries that are much more organised, such as Russia, Iran and China. One respondent refers to the fragile balance between member states as an explanation. The visions between progressive and conservative countries are constantly growing further apart, and some countries are heading in a very different direction, yet still a common vision has to be found.

Second, one respondent notes the need to review cost-efficiency of intensively participating in policy-making at the EU level. There are many meetings, and individual member states, as well as the EU, invest a lot of time in these meetings. Although the added value of the EU is still stressed, for example at the international level and as a defender of human rights, cost efficiency cannot be overlooked according to the respondent.

Lastly, respondents mention that when the position of Belgium is discussed at the international level, it is not always clear where that position has taken shape. Here too, respondents pointed out that the lack of a coordinated vision can cause problems. After all, how can the Belgian position be explained when there is no unanimity within the country on certain initiatives (as is the case for example with drug checking and the drug consumption rooms). Also, one respondent mentions that there is a need for a contact person at Foreign Affairs for everything that concerns an international drug policy.

Il faudrait un Monsieur drogue au niveau Affaires étrangères, tous les niveaux sont liés. (FR_5)

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following need:

- On an international level:
  - Move towards a clear position of the EU in sensitive discussions.

7.1.2.3 Challenges with regard to the realisation of an 'Integral and integrated approach'

Finally, we asked respondents what they identified as a challenge for their work related to 'Integral and integrated approach'. Unlike the bottlenecks and barriers described by the respondents, these challenges are not identified as a problem *an sich*, but issues that hinder the realisation of and integral and integrated approach. In this section, we list three challenges raised by the respondents.

A. Prioritising drugs on policy maker's agendas

First of all, many respondents mention that prioritising the drug theme on the agenda of policy makers in Belgium, is a challenge. According to the respondents, the drug phenomenon is rarely a priority for policy makers. The challenge, therefore, is to get their attention to the problem areas in drug policy alongside all the other issues. An additional obstacle, is that in many administrations or cabinets, there is no personnel appointed full-time on drug policy.

> *Uhm, plus ook, denk ik, je hebt sommige diensten waar je effectief geen mensen hebt die quasi fulltime met alcohol en drugsbeleid bezig zijn. Bij de federale politie heb je dat. Euh, bij heb je dat. Maar in vele andere administraties of kabinetten is dat niet zo. Dat is dat één van de dingen. Euh, en om er dan voor te zorgen dat dat toch ergens bovenaan de prioriteitenlijst komt, dat is ook niet eenvoudig. (NL_1)*

Respondents refer, for example, to the fact that there is no unit in the Justice department or in Foreign Affairs to deal specifically with all cases related to drug policy. Furthermore, one respondent indicates that not all actors are represented in the General Drug Policy Cell which might lead to these topics being less highlighted.

> *Maar de lokale politie is er niet [in de algemene cel drugs], daar is niemand die vertegenwoordigd is voor de lokale politie. (…) ik denk dat dat een probleem is. Gezien dat de lokale politie echt moet worden ingezet voor het bestrijden van de vraag, he, en van de kleinhandel. (NL_7)*

B. Stress the relevance of the EU drug policy agenda at a national level

Many respondents refer to the challenge to make EU drug policy discussions relevant for the national, regional and local level. Some respondents, for example, describe that they have given input for the EU country reports, but describe that they rarely see a return of what happens with that input. This lack of return is especially apparent at the EU level:

> *Bijvoorbeeld de vergadering met de nationale drugcoördinatoren. Wat is de outcome daarvan geweest van België in de afgelopen jaren. Ik zou het niet weten. Ik zou niet eens weten of dat er documentatie van is. (NL_8)*

C. Different views on various drug policy themes between criminal justice actors and health care workers

The differences in point of view between actors, active in enforcement on the one hand, and actors within health care on the other hand, is a recurring challenge. On different themes, these actors often seem to have opposite views on several drug-related topics. Examples that occurred during the interviews are drug checking, drug consumption rooms, etc. (cf. supra).

Within the different contested themes, respondents within enforcement often emphasise the ambiguous message offered by the Belgian drug policy. They indicate that on the one hand legislation prohibits the possession of illegal substances, but on the other hand a space could be set up where those illegal substances can be used freely, making it an irreconcilable contradiction to them.

> *On a connu la vague d'ouverture des salles de consommation et là, on reste dans la même hypocrisie, dans la même schizophrénie. Venez consommer ici, on va vous soigner, mais on ne veut pas savoir si vous avez arraché un sac pour acheter la drogue. On ne veut pas savoir ce qu'il y a dans votre seringue. Qu'est-ce que c'est que ça pour une politique de santé? (FR_4)*

Respondents within health care, on the other hand, put the health of the client at the centre. In that sense, they focus on strategies that promote health, and reduce the risks of people who use drugs to the greatest extent. They refer to the existing evidence-base to underpin these initiatives.

> *Bijvoorbeeld met het feit van de methodiek van drugs checking op festivals, (…), het analyseren van drugs voor cliënten om hen meer verantwoorde keuzes te laten nemen. Dat is iets dat al jarenlang, dat we al jarenlang proberen, en dat ook al evenveel jaren ettelijk wordt tegengehouden. (…) Er is ook steeds meer en meer evidentie dat dat de methode is om preventief te werken. (NL_15)*

The challenge within an integral and integrated approach is to reconcile those different points of view, according to respondents, to get to a shared approach.

7.1.2.4 Perceived unintended consequences

When respondents were asked to identify possible positive or negative unintended consequences of initiatives within the 'Integral and integrated approach', none of the respondents identified unintended consequences.

7.1.2.5 Conclusion of the context to the stage of realisation

The semi-structured interviews and the focus group with practitioners, civil servants and experts gave insight in how the Belgian drug policy is shaped in daily practice, and how "policy in the books" is translated into "policy in practice".

First of all, respondents described how the integral and integrated approach of the drug phenomenon reaches its limits, especially on a federal and state level. Respondents describe how the container concept 'integral and integrated' is hardly operationalised on a federal and state level, as opposed to the integral and integrated approach of some well-defined initiatives on a more local level. At the local level, a needs-based approach is applied. There are several examples of this integral and integrated approach for well-defined initiatives on a more local level, for example the drug consumption room in Liège, the cocaine problem in the port of Antwerp, drug policy at festivals, etc. This needs-based approach generates integral and integrated cooperation, be it locally or regionally. Often, these collaborations are not institutionalised or structural, but initiated by individuals or specific organisations. This makes cooperation dependent on the available network of individuals and/or organisations and on the existing contacts between people from different policy areas and levels. Consequently, these integral and integrated cooperations differ per region. Taking into account the fact that an integral and integrated approach is especially fuelled and shaped bottom-up, respondents denounce the fact that both practitioners and people with lived experiences are not involved in the policy development at the different policy levels.

Apart from the difficulties operationalising the concept and the cooperation being dependant on the initiative of individuals or organisations, respondents refer to barriers with coordination. The General Drug Policy Cell is mentioned within this context. Respondents acknowledge this Cell as an open forum for discussion where new drug phenomena as well a recent research results are brought to the attention of all policy. Although it is described as an open forum for discussion where new drug phenomena as well a recent research results are brought to the attention of all policy levels and discussed, the lack of continuity in its members, the lack of political mandate for some of the members, the number of members, the difficulties to reach a compromise between the different policy domains and levels, and

the need for a strong president are defined as barriers for a more decisive General Drug Policy Cell. It also remains a challenge to try to reconcile opposing visions of drug policy, for example between health and criminal justice, especially in contested debates such as drug checking services and, drug consumption rooms., etc.

According to respondents, the lack of a clear vision and direction in Belgian drug policy is an additional obstacle in the integral and integrated approach of Belgian drug policy. The current policy documents are outdated, and recent policy documents are not overarching. This while practice clearly indicates a need for an updated strategy. This is even expressed at the international level, where participation in, for example, the CND makes it difficult for Belgium to take a clear position.

Additionally, some respondents highlight the benefits of participating in the international drug policy to facilitate the relationship between the different member states. At these international gatherings, the practical and scientific branches are present, as well as civil society leading to exchanging knowledge and good practices. However, they also describe difficulties translating these European discussions and demonstrating its relevance on a national, regional and local level.

Respondents further describe the challenge of making the drug phenomenon relevant to policymakers, as the topic is often not high on the political agenda.

Finally, respondents seem to be less aware of unintended (positive or negative) consequences, as they were not able to identify any positive or negative unintended consequence.

7.2 Lessons learned

The transversal theme 'Integral and integrated approach is an essential part of the Belgian drug policy. To develop the three pillars 'Prevention', 'Care, risk-reduction and reintegration' and 'Repression', a coordination and cooperation is indispensable. These are the 'lessons learned' from a process evaluation of this transversal theme.

POLICY INTENTIONS:

A critical appraisal of the policy logic found that:

- ⇨ The transversal theme 'Integral and integrated approach' is generally **explicit on its objectives and central actions, but often remains vague about the concrete intended outputs**.
- ⇨ The transversal theme 'Integral and integrated approach' is not explicitly based on a situation analysis.
- ⇨ The transversal theme ''Integral and integrated approach' **does not distinguish between short-term, medium-term and long-term outcomes.**
- ⇨ The transversal theme 'Integral and integrated approach' is **mostly logical,** with two smaller exceptions.
- ⇨ The transversal theme 'Integral and integrated approach' is **not explicit about the processes through which change is achieved**. It mostly focuses on the policy design.

MEASUREMENT OF POLICY INTENTIONS:

With regards to the extent of realisation, we found that:

- ⇨ First of all, the document review reveals that there is little structural follow-up of the implementation of the Federal Drug Note and Joint Declaration, nor of other developments in the transversal pillar 'Integral and integrated approach'. There are several reports and

publications that help to get an overview on specific parts of an integral and integrated approach, however, it paints a very fragmented and anecdotical picture.

- ⇨ Second, the document review shows that there have been many developments for an integral and integrated approach, especially for the actions related to the drug policy coordination and the international policy participation
- ⇨ Third, the survey learns that there are a lot of discrepancies in the level of perceived realisation (only three actions had a unanimous answer). These discrepancies could be explained by local differences, e.g. locally implemented in one place, but not in another. As there is no complete overview of the realisations, this could indicate that experts and practice are encountering the same barrier of fragmentation as the researchers of this research have.
- ⇨ And lastly, when we compare the results of the document review with the survey, we learn that for most objectives, there are discrepancies between the actual and perceived realisation. This shows that actions may be implemented (cf. document review), but they do not necessarily operate in the best possible way and improvement is necessary (cf. survey).

With regards to the context to the stage of realisation, practitioners and civil servants perceived that:

- ⇨ First of all, respondents described how the integral and integrated approach of the drug phenomenon reaches its limits, especially on a federal and state level. Respondents describe how the container concept 'integral and integrated' is hardly operationalised on a federal and state level, as opposed to the integral and integrated approach of some well-defined initiatives on a more local level.
- ⇨ Apart from the difficulties operationalising the concept and the cooperation being dependant on the initiative of individuals or organisations, respondents refer to barriers with coordination. Respondents acknowledge the General Drug Policy Cell as an open forum for discussion where new drug phenomena as well a recent research results are brought to the attention of all policy. Nevertheless, they mention a lack of continuity in its members, a lack of political mandate for some of the members, problems with the number of members, the difficulties to reach a compromise between the different policy domains and levels, and the need for a strong president are defined as barriers for a more decisive General Drug Policy Cell.
- ⇨ According to respondents, the lack of a clear vision and direction in Belgian drug policy is an additional obstacle in the integral and integrated approach of Belgian drug policy. The current policy documents are outdated, and recent policy documents are not overarching.
- ⇨ Additionally, some respondents highlight the benefits of participating in the international drug policy to facilitate the relationship between the different member states. However, they also describe difficulties translating these European discussions and demonstrating its relevance on a national, regional and local level.
- ⇨ Respondents further describe the challenge of making the drug phenomenon relevant to policymakers, as the topic is often not high on the political agenda.

CHAPTER 8

TRANSVERSAL THEME 2: EPIDEMIOLOGY, RESEARCH AND EVALUATION

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8 TRANSVERSAL THEME 2: EPIDEMIOLOGY, RESEARCH AND EVALUATION

This chapter evaluates the transversal theme 'Epidemiology, research and evaluation' of the Belgian drug policy.

The development of monitoring- and evaluation tools is indispensable in a drug policy. A (high-quality) evidence-base can guide policy responses and even policy reform (Reuter, 2001). It assists policy makers to make well-informed decisions about policies, projects and programs (Davies, 2004a). The emphasis on 'research evidence' in policy-making, is often referred to as 'evidence-based policy', indicating that a policy is based on scientific knowledge. This approach gathers and assesses (high quality) research evidence and uses this evidence to inform and develop policy decisions. Both epidemiology and scientific research contribute significantly to policy in this approach. Evidence-based policy is particularly common in the drug policy field: questions about *what works* are commonplace and drug policy documents often refer to scientific knowledge (EMCDDA, 2008; Lancaster & Ritter, 2014). Recently, however, researchers increasingly started to use the concept 'evidence-informed policy', acknowledging that there are other factors that influence policy making (e.g. values, resources, etc.) and that research evidence is just one aspect taken into account during the policy-making process (Davies, 2004a; Nutley et al., 2007).

In Belgium, the Parliamentary Working Group on Drugs (1996-1997) was the first political body to stress the importance of epidemiology and research. Up until then, data on the nature, scale and distribution of (illicit) drugs were scarce. Official statistics only roughly informed about the number of drug seizures and population surveys were fragmentary. In particular, there appeared to be multiple issues with the registration of clients in drug treatment services (Parliament Working group). Financing research and evaluation studies only occurred on an ad hoc basis and research projects were of variable quality.

It wasn't until 2001 that Belgian policymakers addressed this gap. The Federal Drug Note (2001) introduced an entire chapter on epidemiology, research and evaluation, prioritizing an evidence-based strategy. The importance of this transversal theme was confirmed in 2010 with the Joint Declaration of the Interministerial Conference Drugs: here too, epidemiology, research and evaluation were considered as a corner stone of the Belgian drug policy.

This chapter evaluates the transversal theme 'Epidemiology, research and evaluation'. To do so, we first explain the policy logic (i.e. the logic model) behind the transversal theme: how does the transversal theme 'Epidemiology, research and evaluation' intent to achieve its goals. Second, we conduct a critical analysis of the logic model. This way, discrepancies, inconsistencies and omissions in the policy's theory are raised and discussed. In a last step, we measure the implementation and evaluate whether the aims and actions are still relevant to the current issues and needs within the Belgian drug field.

8.1 A logic model of the transversal theme 'Epidemiology, Research and Evaluation'

In this section, we address the first research question 'What are the identified aims, action points, intended outputs and intended outcomes of the Belgian drug policy?'. To do so, we rely on logic models as an evaluation framework, as explained in the methodological chapter (cf. supra). Logic models are a systematic and coherent description of a policy that identify the aims, actions, resources, intended outputs and intended outcomes underpinning a certain policy (EMCDDA, 2017a). The logic models make the underlying assumptions of how a policy aims to achieve change, explicit. Logic models identify and describe how a policy fits together in a simple sequence. The policy's theory is described in a logical, linear depiction of how policy makers intend to achieve change.

Policy makers did not explicate how the transversal theme 'Epidemiology, Research and Evaluation' would contribute to the central aims of the Belgian drug policy. Therefore, we reconstructed this logic model in retrospect. To estabish a logic model for the transversal theme 'Epidemiology, Research and Evaluation', we conducted a document analysis of the two central and overarching policy documents of the Belgian drug policy: the Federal Drug Note of 2001 and the Joint Declaration of the Interministerial Conference of Drugs of 2010. We extracted the aims, the actions, the inputs, the intended outputs and the intended outcomes (where possible) word for word from these documents, and rearanged them in a logical sequence (shown by *Figure 10. Summary of logic model for the transversal theme 'Epidemiology, research and evaluation*). We additionally analysed the report of the Parliamentary Working Group on Drugs (1997) to further contextualize these aims and actions (e.g. problem description, unclear actions).

The logic model on 'Epidemiology, Research and Evaluation' shown by *Figure 19. Summary of logic model for the transversal theme 'Epidemiology, research and evaluation'*, thus describes how the aims and actions under 'Epidemiology, Research and Evaluation – according to the Belgian drug policy makers - contribute to the central aims of the Belgian drug policy.

Since the description of the logic model is a representation of the central policy documents, we adopt the terminology mentioned in the policy documents to describe the actions, inputs, intended outputs and intended outcomes. That means that sometimes stigmatising language is used, or old names of institutions that have since changed names are used. For the latter, we added the current name between brackets.

8.1.1 Two central aims, a range of actions

The Federal Drug Note (2001) and the Joint Declaration of the Interministerial Conference Drugs (2010) described two central aims for this pillar:

1. To gain a global insight into all aspects of the drug problem;
2. To develop and mobilize scientific knowledge in function of an integral and integrated drug policy;

8.1.1.1 Actions to gain a global insight into all aspects of the drug problem

To gain a global insight into all aspects of the drug problem, policy makers established a range of actions that we clustered into four groups.

The **first group** consists of actions that are aimed at gaining insight into the drug use in the general and specific populations. Specifically, they suggest to conduct systematic drug surveys, both in the general population (e.g. by adding a chapter on substance use in the Health survey), as well as specific at-risk target groups (youth, night life, sex workers, detainees). Furthermore, they want to map both general drug use as well as problematic drug use. Additionally, policy makers emphasise the mapping of drug-related deaths and drug-related infectious diseases. Lastly, they state that epidemiological research would have to comply with the EMCDDA standards and that gender-specific variables should be taken into account in epidemiological and research initiatives.

The **second group** of actions consists of actions that aimed for a uniform registration of clinical treatment data. One of these actions refer to the implementation of a registration system in all treatment services so that clinical treatment data would be recorded uniformly. A second action, linked to the previous one, intends to map the demand for treatment for the use of drugs and alcohol.

A **third group** of actions aims to identify new synthetic drugs, to map their use and to inform all relevant partners of this information. Actions in this groups are first of all to complete an 'Early Warning System' (EWS) by transforming the Belgian National Focal Point into a Belgian Monitoring Centre for Drugs and

Drug Addiction (BMCDDA). Second, they want to communicate product analyses to all relevant partners (e.g. EMCDDA, prevention sector, telephone info lines, care services, judicial and police services, etc.) and to make an inventory of recent trends. Lastly, they want to monitor the composition of new and dangerous substances on the market, both on the level of drug users as on the level of drug trade.

A **forth group** relates to the coordination of the epidemiological effort. These actions aim to keep track of epidemiological research and results, to indicate blind spots and to purposefully introduce new research. The central action in this group is the transformation of the Belgian National Focal Point to a BMCDDA. This newly formed BMCDDA would then install a communication network between all relevant partners concerning the drug phenomenon, they would harmonize registration with the European standards, they would analyse and improve the quality of data concerning the drug phenomenon, they would valorise this knowledge and build expertise concerning epidemiology. Lastly, they would be the responsible partly to fulfil the Belgian obligations of the EMCDDA. A second action emphasises the cooperation between the newly formed BMCDDA and the Belgian Information Reitox Network (between the National Focal Point and the four sub focal points: VAD, CCAD (now Eurotox), ASL and CTB-ODB).

8.1.1.2 Actions to develop and mobilize scientific knowledge in function of an integral and integrated drug policy

To develop and mobilise scientific knowledge in function of an integral and integrated drug policy a range of actions were developed. Three distinct groups of actions could be identified.

The **first group** of actions consisted of actions that continuously and scientifically evaluate aspects of the demand and supply side. The actions state that the DWTC (now Federal Science Policy) should order research to the effectiveness of several substance use treatment options and to the organisation of the substance use treatment. These actions are either specifically aimed at a certain type of service (e.g. the medical-social treatment centres), at certain treatment methods (innovative treatment methods), a certain target group (e.g. double diagnosis) or at substance use treatment in general. The evaluation of prevention-initiatives is mentioned too, and this evaluation should be in accordance to the guidelines of the EMCDDA. Two actions refer to scientific knowledge on the supply side: One action encourages the mapping of certain aspects like price, production, availability and the criminal drug chain, and another action emphasises the importance of mapping the changes on drug policy of the neighbouring countries and their impact on drug supply and nuisance in Belgium.

A second group of actions aims to finance research projects on a yearly basis. To do so, the federal government wants to establish a research program Drugs within the Federal Science Policy. This research program should ensure scientific eminence in research to the drug phenomenon, it should gather all relevant research questions to ensure coherence in research to the drug phenomenon and it should offer a range of financing options. Therefore, the Federal Science Policy should work together with the WIV (*now Sciensano*) and her partners. The General Drug Policy Cell would advise on the research priorities.

Lastly, **a third group** of actions is aimed at taking into account scientific knowledge when developing Belgian drug policy. The three actions to achieve this goal, are: 1) the General Drug Policy Cell should consult experts through ad-hoc working groups, 2) the General Drug Policy Cell should support scientific research and 3) the General Drug Policy Cell should formulate changes to the drug policy based on evaluation research.

All these actions are summarised in *Figure 19. Summary of logic model for the transversal theme 'Epidemiology, research and evaluation'*, under ‘Activities’.

8.1.2 Inputs

The inputs displayed in *Figure 19. Summary of logic model for the transversal theme 'Epidemiology, research and evaluation'*, present the human, financial, organizational, and community resources that are needed to implement the actions under the transversal theme 'Integral and integrated approach'. The inputs are not always clearly defined in the policy documents. Therefore, not every action was allocated a specific input. Only the Federal Drug Note (2001) mentions budget allocations.

For the first objective, there are only two actions with an identified input: the establishment of the BMCDDA and the EWS. A feasibility study estimated the cost for the establishment of the **BMCDDA** on BEF 34 million for 2001, BEF 32 million for 2002 and BEF 29 million for 2003. The EMCDDA would pay BEF 2 million of this amount every year. The federal government intends to come to an agreement with the Communities on the remaining funding, but there is no further mention of the exact funding. The (sub)Focal Points will be financed by the Communities. The feasibility study took into account the costs of the actions mentioned in table 5.

Table 10 Estimates of the funding of a BMCDDA in Belgian francs (Federal Drug Note, 2001)

Action	2001	2002	2003
Coordination	2 216 000	2 216 000	2 216 000
Network and communication	2 998 000	2 548 000	2 548 000
Prevalence of drug use in general population	1333 000	1446 000	0
Treatment demand Indicator	3 302 000	2 739 000	2 739 000
Local prevalence of problematic drug use	1 783 000	1 783 000	1 333 000
National prevalence of problematic drug use	3 358 000	1 671 000	1 671 000
Incidence of problematic drug use	1 108 000	1 108 000	1 108 000
Mortality	2 036 000	2 711 000	2 036 000
Drug induced infectious diseases	1 108 000	1 108 000	1 108 000
Analysis of drugs in circulation	1 851 000	1 851 000	1 671 000
Total	**21 094 000**	**19 181 000**	**16 431 000**
Reitox	**12 431 000**	**12 319 000**	**12 319 000**

The Federal Drug Note (2001) further mentions that the Minister of Public Health would draw up a reimbursement scheme for the laboratory who analyse the samples on assignment of the EWS.

The second objective almost never mentions any input. Only the action regarding the evaluation of substance use treatment, is allocated BEF 16,5 million by the Federal Government to the DWTC (now Federal Science Policy). For the other actions, relating to the aim 'To develop and mobilize scientific knowledge in function of a global and integrated drug policy', no specific budget allocations are mentioned.

8.1.3 Intended outputs

The outputs displayed in *Figure 19. Summary of logic model for the transversal theme 'Epidemiology, research and evaluation'*, show the immediate outputs (deliverables) that result from the implementation of the actions under the transversal theme 'Epidemiology, research and evaluation'. Outputs in grey are implicit outputs (not word for word in the policy documents, but deduced from the context). The policy documents often do not mention a direct result of the action. Therefore, some of the described actions do not have a clear output.

The outputs of the actions aimed at "**Gaining a global insight into all aspects of the drug problem** are various. The outputs of the first group, the actions aimed at gaining insight into drug use in the general population, are mostly **surveys and reports** on (problematic) drug use in the general population, as well as in specific target groups. The outputs also consist of reports on drug-related

infectious diseases and drug-related deaths, and of a module on drug use in the health survey. Lastly, outputs consist of the **implementation of the requirements of the EMCDDA** regarding epidemiology and research.
The outputs of the second group, the uniform registration of treatment data, are twofold: a **central registration system** for treatment data and reports on treatment demand for both alcohol and drugs. The immediate result of the actions of the third group, to identify new synthetic drugs and map their use, is the **Early Warning System**. More specifically, the number of **lab analyses**, the inventory of new drug trends, the number of **early warning alerts** that have been send out and the **collaboration** with the Flemish and French Community, the federal police and all specialized laboratories are considered outputs here. The outputs of the actions of the fourth group – the actions that intend to keep track of epidemiological research results and to indicate blind spots and to purposefully introduce new research – are: a **communication network** between all relevant partners involved in the drug phenomenon; **initiatives to collect, analyse and disseminate knowledge** and insights in all disciplines interested in the drug phenomenon; **expertise** in epidemiological research; **initiatives to stimulate epidemiological research**; **(annual) reports** on drugs and drug addiction in Belgium; implementation of the **Belgian obligations to the EMCDDA** and the **uniform registration** based on EU variables and definitions by means of a unique code.

The outputs of the actions aimed at "**Developing and mobilizing scientific knowledge in function of a global and integrated drug policy"** are also numerous. The first group, the implementation of standard, continuous and scientific evaluation of aspects of the demand and supply side, resulted in **(a call for) research reports** on the evaluation of the effectiveness and organization of substance use treatment, research reports on mapping aspects of the supply side, research report on the evaluation of the MSOC and on new innovative treatment techniques, on the experiments with double diagnosis, international research report on the evaluation of controlled heroine supply, a registration system for traffic offences related to drugs, the implementation of EU directives for evaluation research towards prevention initiatives and research reports on the evaluation of actions to help drug users or reduced risks and their effect on drug supply.
The second group – to finance research projects on a yearly basis – has the following outputs: implementation of the Federal Science Policy should result in an **overview of all studies** relevant for the Belgian drug policy, a **compilation of all relevant questions** and themes for research to the Belgian drug policy, a uniform and **centralized funding**, recognized **expertise**, the **mapping** of existing evidence in collaboration with Sciensano and sub focal points and lastly, **advice** on research priorities towards the General Drug Policy Cell.
The last group, the implementation of the actions that take scientific knowledge into account in determining the Belgian drug policy, should result in the establishment of **ad hoc working groups** that consult with researchers and experts, **support** for scientific research and **proposals** to adjust the drug policy based on research reports.
All these outputs are summarized in *Figure 10. Summary of logic model for the transversal theme 'Epidemiology, research and evaluation* under 'Outputs'.

8.1.4 Intended outcomes

The summary depictured in *Figure 10. Summary of logic model for the transversal theme 'Epidemiology, research and evaluation,* shows the outcomes of the actions under the transversal theme 'Epidemiology, research and evaluation'. These outcomes demonstrate the mid- and long-term effect the policy makers sought to achieve by implementing the actions above. The intended outcomes are not always clearly defined in the policy documents. Some outputs were not literally described, but could be deduced from (parts of) the text of the policy documents. These outputs are indicated in grey. Sometimes, there was not output defined (not literally, not deducible). In these cases, we left the spaces blank.

The outcomes of the actions aimed at **gaining a global insight into all aspects of the drug problem** are various. The outcome of the first group of actions, the actions aimed at gaining insight into drug use in the general population, is twofold: (1) insight into the drug use in Belgium and (2) that Belgian epidemiology will have been brought up to standards.
The outcome of the second group of actions, the uniform registration of treatment data, is not explicitly defined. From the context, it is clear that this action should result in access to clinical treatment data. We therefore marked this outcome grey.

There are no explicit outcomes for the actions of the third group of actions 'to identify new synthetic drugs and map their use'.

The outcomes of the actions of the fourth group of actions – the actions that intend to keep track of epidemiological research results and to indicate blind spots and to purposefully introduce new research – are: (1) that the Belgian epidemiology will have been brought up to standards, (2) that the Belgian epidemiology is in line with the European requirements, and (3) that the scientific knowledge is informing drug policy.

The outcomes of the actions aimed at **developing and mobilizing scientific knowledge in function of a global and integrated drug policy** are more straightforward.
The first group of actions, the implementation of standard, continuous and scientific evaluation of aspects of the demand and supply side, should result in uniform, permanent scientific evaluation so that drug users looking for treatment receive the most efficient and effective treatment. The action related to 'mapping the supply side' should lead to 'a structural approach towards the drug phenomenon'. No other outcomes were defined.
The second group of actions, to finance research projects on a yearly basis, should result in (1) complementarity in research and (2) in scientific knowledge is taken into account in drug policy.
The last group of actions, the implementation of the actions that take scientific knowledge into account in determining the Belgian drug policy, should eventually result in increased mobilisation of scientific knowledge in the Belgian drug policy.

All these outcomes are summarized in *Figure 10. Summary of logic model for the transversal theme 'Epidemiology, research and evaluation* under 'Outcomes'.

grey = implicit
= from 'epidemiology'
= from 'Integral/integrated'
= from 'prevention'
= from 'care'
= from 'enforcement'

Epidemiology, research and evaluation

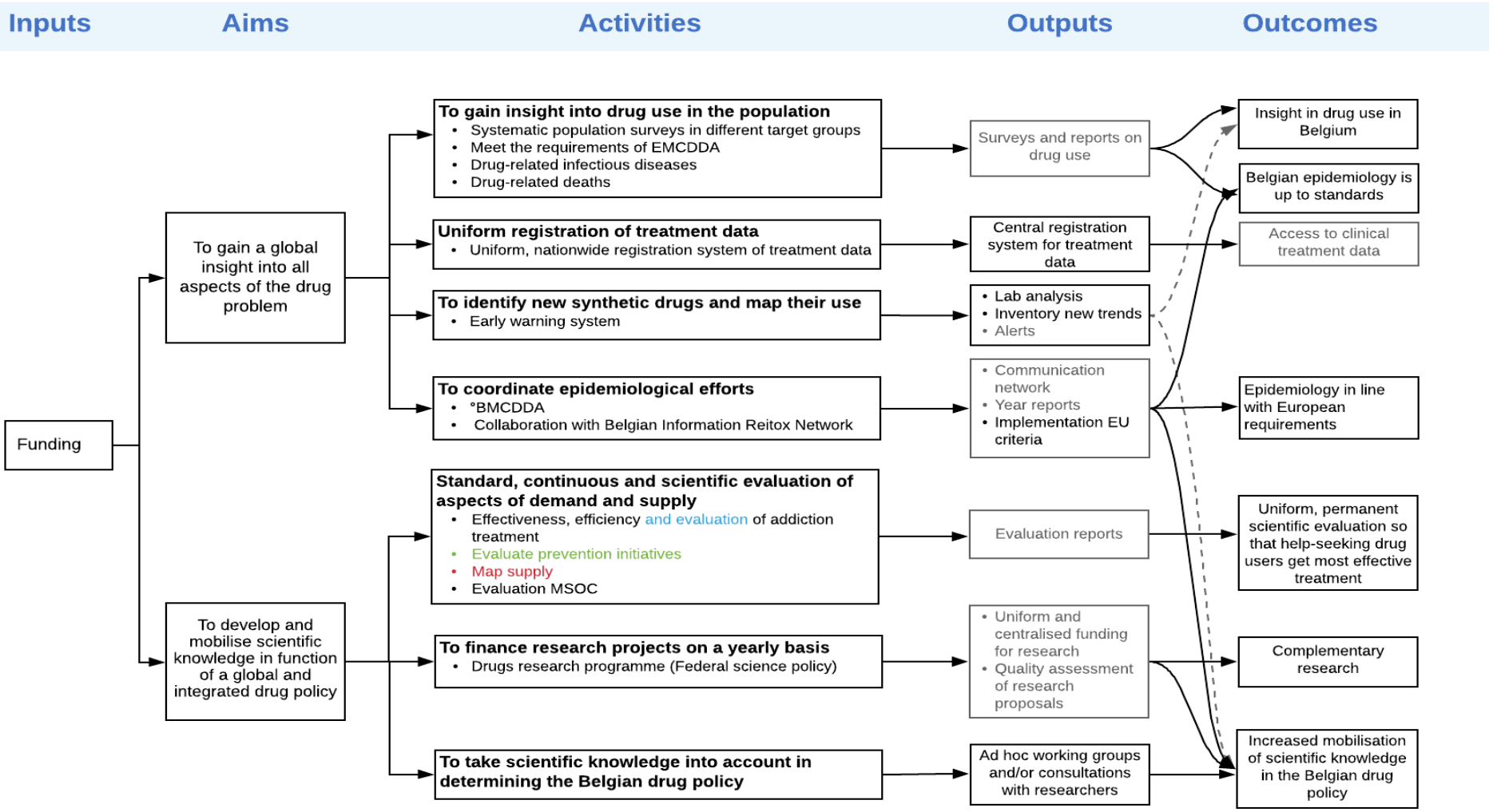

Figure 19. Summary of logic model for the transversal theme 'Epidemiology, research and evaluation'

8.2 Critical appraisal of the logic models

In this section, we address the research question 'To what extent are the logic models of the pillars and transversal themes consistent, coherent and logical?'. This critical appraisal of the logic model is a first step of the process evaluation, in the sense that it allows us to verify whether possible policy issues are attributable to a poor policy theory or not.

Building further on the document analysis of the central policy documents, we critically analyse the logic models, relying on indicators of internal validity (Funnell & Rogers, 2011). This way, discrepancies, inconsistencies and omissions in the policy's theory are raised and discussed.

The internal validity of the policy theory shows to what extent the policy theory is clear, realistic and logical about what the policy wants to achieve, and how the policy wants to achieve these outcomes (Funnell & Rogers, 2011). In this section, we assess this internal validity based on five indicators: Clarity of description, the outcome chain, demonstration of how the outcomes are related to the problem, the logical argument of the policy theory, and the articulation of mechanisms for change.

8.2.1 Clarity of description

A first measure of internal validity is 'clarity of description'. It assesses whether the logic model describes the policy with enough detail.

In general, the transversal theme 'Epidemiology, research and evaluation' is only clear on specific elements of the logic model. First of all, there is a clear definition of the problem the policy wants to address. The report of the Parliamentary Working Group on Drugs includes a thorough description of the issues related to cooperation and coordination in the Belgian drug policy (cf. supra). Both the Federal Drug Note and the Joint Declaration refer to the thorough and comprehensive problem description in the report, and build their policy objectives and actions around it. Yet, the question remains to what extent this problem description of the late nineties is still relevant, especially because the Joint Declaration was established more than 10 years later. The Federal Drug Note presents a one-page-long 'state of affairs', however mostly focuses on the extent of the implementation of the recommendations of the Parliamentary Working Group and provides only limited additions to the problem description. The Joint Declaration on the other hand, only lists the accomplishments per authority and policy level at the time. Neither policy document gives a proper description of the drug problems it wants to address. The policy documents (especially the Joint Declaration) therefore seemingly **relying on problem description** dating back from the 1990's

The transversal there 'Epidemiology, research and evaluation' mentions clear objectives and actions. These objectives are often described in detail. Even more, some actions not only describe what the action does, but also expand on specific subtasks of the actions (this was the case for the action on the establishment of the BMCDDA, or the establishment of the Federal Science Policy). There are a few exceptions though. Some actions do **not** provide **enough detail** about the actions. An example is 'the role the Federal Science Policy will be in providing recognised expertise in the management of programmes'. The actions emphasise 'the role of', but do not clearly specify how this should be done. Second, some actions are **formulated in a very non-binding way**, (i.e. 'Ask the General Drug Policy Cell to follow-up on the results of international research towards innovative treatment techniques'), which understates the relevance of the action.

Although the transversal theme 'Epidemiology, research and evaluation' is generally explicit on its objectives and central actions, it often remains vague about the concrete intended outputs and outcomes. In contrast to the clarity on the objectives and actions, the policy documents are **much less clear about the outputs and outcomes**. The direct output of the actions can often be deduced from the actions themselves, but are in about half of the cases not explicitly specified, leaving the researchers

with vague output-descriptions deduced from the context, like 'initiatives that ensure that research towards supply and epidemiology are in line with the requirements of the EMCDDA' or 'initiatives that regularly gather relevant information'. Vague or implied outputs could raise difficulties for the implementation.

The same applies to the outcomes. **More than half of the actions lack an explicit outcome**. For example, the action 'the implementation of registration systems in addiction treatment that which should bind the entire healthcare sector' never explicitly mentions 'access to clinical treatment data' as an outcome, although that is what seems implied by the introduction of the action: 'Up until now, we do not have access to complete clinical treatment data'. Moreover, sometimes outcomes are not mentioned at all, like for the actions 'complete the EWS by transforming the Belgian NFP into a BMCDDA' or 'The General Drug Policy Cell will advise on research priorities after deliberation with research institutions and services involved in prevention and treatment'. One could logically reason that the outcome here would be 'insight in new synthetic drugs and their trends' or 'better insight in effective methods, techniques and projects', however, there is no mention or implication of these outcomes in the policy documents, so these spaces remain blank (implied outcomes are coloured in grey). This is problematic, because outcomes are the changes a policy maker wants to achieve, and when this is omitted, you can question the relevance of the actions altogether. The lack of defined outcomes is especially clear on the group of actions aimed at 'Standard, continuous and scientific evaluation of aspects of demand and supply'. This group should result in 'Uniform, permanent scientific evaluation so that help-seeking drug users get most effective treatment'. This outcome only counts for the demand side of the actions. The supply side has no defined outcome.

And lastly, there is not a lot of information available on the input except for the action on the establishment of the BMCDDA, no clear budget or other inputs were defined. This does not mean that there was no budget allocated, it just seems like it was not agreed upon at the time. This leaves a fair amount of actions with no clearly defined input, and thus a lot of uncertainties.

8.2.2 The outcome chain

A second measure of internal validity is whether the logic model is built around the outcomes it wants to achieve. Are the outcomes central to the logic model, or are other elements accentuated?

The policy documents **do not distinguish between short-term, medium-term and long-term outcomes**, although several described outcomes in the logic model can be located on both short-, the medium as well as the long-term spectrum. The best example to illustrate this, is the outcome 'uniform, permanent scientific evaluation so that help-seeking drug users get most effective treatment'. This outcome illustrates a short-term outcome (Uniform, permanent scientific evaluation) and a long-term outcome (help-seeking drug users get most effective treatment), however policy makers define it as one outcome. The lack of making this distinction could also be made for other outcomes. For example, 'access to clinical treatment data' eventually helps to get 'insight in (problematic) drug use in the Belgian population'. In this case, 'access to clinical treatment data' is a short-term outcome, whereas 'insight in (problematic) drug use in the Belgian population' is a middle-term outcome. A long-term outcome could possibly be 'the increased mobilization of scientific knowledge in the Belgian drug policy'. However, the policy documents do not define the outcomes on a spectrum, and outcomes like 'Epidemiology is in line with the European requirements' or 'Belgian epidemiology is up to standards' are described as an end-point of the drug policy, limiting the policy logic. Although these short-term outcomes are essential to understand the policy logic, they do not illustrate the long-term changes the policy makers want to

achieve. These long-term changes should be made explicit, all the more, because these long-term outcomes explain how the actions contribute to the three central outcomes of the Belgian drug policy[101].

To summarise, we could state that the emphasis of the logic model on 'Integral and Integrated approach' seems to be on the aims and the objectives, and less on the outputs and outcomes.

8.2.3 The demonstration of how the outcomes are related to the problem

A third measure of internal validity questions whether the logic model indicates how the outcomes address the problem(s) that the policy is to address. This means that we assess if and how the problem(s) that gave rise to the establishment of the policy, are linked to the intended outcomes.

We previously established that the problem description is elaborate and thorough, though dates back to the 1990's (Parliamentary Working Group on Drugs; to a limited extent the Federal Drug Note). The objectives and actions described in the logic model 'Epidemiology, research and evaluation' address to a large extent the problems described in the Parliamentary Working Group, as we illustrate below.

The report of the Parliamentary Working Group on Drugs describes the problems with epidemiology, evaluation and research in 1997 Up until then, data on the nature, scale and distribution of (illicit) drugs were scarce. A first problem d**escribe problems** with the **official statistics** that only roughly informed about the number of drug seizures and that the data on drug-related deaths were a serious underestimation because only police officers could determine drug-related deaths. Moreover, the lack of refined judicial statistics prevented gaining insight into the population entering the Belgian criminal justice system for drug-related offences other than those provided for in the Drugs Law of 1921. A second problem indicated that **population surveys on drug use in Belgium were fragmented** - partly for budgetary reasons - and were usually limited to certain subgroups (often school-age students) or to territorially limited areas (a city, a province). The comparison of the results obtained from these different surveys was problematic, given the difference in methodology. Therefore, the existing epidemiology could only outline an incomplete picture. A third problem described that both the prevention sector and the treatment sector already registered a large amount of data, yet in very different ways and for very different reasons. There appeared to be multiple issues with the **registration of clients in drug treatment services**. A uniform, national registration system that could verify double counting, was absent. Fourth, the **financing of research and evaluation** only occurred on an ad hoc basis and research projects were of variable quality. The limited information that was present, was fragmented.

In 2001, the Federal Drug Note provided a brief update of the problem description regarding an integral and integrated approach (which mostly consisted of an update on the implementation of the recommendations of the report of the Parliamentary Working Group on Drugs). In 2001, there were still few research initiatives taken to gain insight into the use of illicit drugs. The Scientific institute public health (now Sciensano) was appointed as NFP, but funding for research was still ad hoc, uniform registration was still in its infancy and epidemiological data were still not bundled (Federal Drug Note, 2001).

Three trends are thoroughly addressed by the transversal theme 'Epidemiology, research and evaluation'. There are objectives, actions and particular outcomes that (1) get systematic insight into drug use in different target populations, (2) that implements a uniform registration system of treatment data, and (3) to stimulate and finance research of the drug policy (cf. logic model). Specific actions were implemented to eliminate specific parts of the problem description (e.g. the Drug research programme of the Federal Science Policy).

[101] Defined by the Federal Drug Note (2001) as: (1) a reductions of the number of dependent drug users, (2) a reductions of the physical and psychosocial damage caused by drug use, and (3) a reductions of the negative impact of the drug phenomenon on society.

Not all problems addressed in the first trend, were explicitly addressed. One action mentioned mapping drug-related deaths in both the general population and amongst problematic drug users. But no action addressed the problems with the drug seizures. The lack of refined judicial statistics on drug-related crimes was not addressed in this transversal theme, although one action under the pillar 'Enforcement' seems to refer to this ('A circular on the development of an effective, simple and uniform measuring instrument (registration and statistics).').

We can conclude that the Belgian drug policy makers oriented their 'Epidemiology, research and evaluation' towards the problems as described by the Parliamentary Working Group on Drugs, thereby making sure that the policy addresses the situations it wished to see changed. The main issue though, is that – although the Federal Drug Note gave an update (to some extent) of the problem description – this problem description is still mainly based on the situation of the 1990's.

8.2.4 The logical argument of the policy theory

A fourth measure of internal validity is 'the strength of the logical argument'. This means that we measure the extent to which the logic model is 'logic' in terms of coherence, sequence and completeness.

The logic model on 'Epidemiology, research and evaluation' is **mostly logical**. – In general, the actions logically follow from the central objectives, the intended outputs (when they are defined) logically follow from the actions, and the intended outcomes logically result from the intended outputs (Culley et al., 2012). Furthermore, the logic model is **coherent across substances**. Actions formulated in this transversal theme are nearly all aimed at both licit and illicit substances. There is also **coherency in target groups**: the actions focus both on the general population, as well as on specific populations at risk (like youth, sex workers, detainees, nightlife). Also, there is **no contradiction between the Federal Drug Note and the Joint Declaration**. Although the Federal Drug Note is more elaborate and addresses more themes than the Joint Declaration, the overlapping objectives and actions show no inconsistencies. And lastly, unlike previous pillars, policy makers are consistent in the terminology they use in this transversal theme i.e. they consistently use the terms 'drug use' and 'problematic drug use', and do not use these concepts interchangeably with 'substance use' or 'addiction'.

We could however mention some flaws in the policy logic. First of all, it is not possible to verify the 'logic' of some actions because these particular actions do not have a clear, explicit output and in a few occasions not even a clear outcome. In these cases, the policy logic is simply incomplete.

Furthermore, we found that the actions in the transversal theme 'Epidemiology, research and evaluation' **focus mainly on the demand side**. Sixteen actions aim to map, evaluate or measure aspects of the demand side, whereas only four actions specifically focus on the supply side. The Federal Drug Note (2001) completely lacks actions that measure, map or evaluate (interventions against) drug supply chain. The Joint Declaration (2010) addresses this gap: Four actions concerning the supply side are prioritized, focussing on mapping certain aspects of the supply side like market price, retail market and the criminal drug chain (1) (2); evaluating the actions that help drug users or reduce their risks in terms of their impact on the supply market (3); measuring changes of drug policies in neighbouring countries in terms of their impact on the supply of illicit drugs (4). Only two of those actions intend to evaluate an intervention, method or policy, of which one action is again aimed at the demand side (people who use drugs). In contrast, seven actions mention to evaluate the effectiveness of substance use treatment and prevention. It seems that initiatives on the demand side have to be efficient, effective or show some added value, whereas the initiatives on the supply side do not (as much). However, an evolution can be seen through time: mapping (and partially evaluating) the supply side was not a priority in 2001, but was eventually also prioritized in 2010.

The transversal theme 'Epidemiology, research and evaluation' thus appears globally 'logic' in terms of coherence, sequence and completeness, however displays a few gaps, specifically in division of actions between the supply side and the demand side.

8.2.5 The articulation of mechanisms for change

The last measure of internal validity is 'the articulation of the mechanisms for change'. This entails the question 'Does the logic model clearly identify the assumed mechanisms of change that underpin its selection of outcomes and activities'. Funnell et al. (2011) describe these mechanisms for change as the 'because' statements: if A happens, then it will result in B, because of C. 'C' is the mechanism for change in this case.

In this area we can be brief. Almost none of the actions explicitly mention the mechanisms for change that lead to their outcome. This means that whereas for most actions a sequence of 'if-then' statements can be made; these sequences are often not accompanied with a 'because'. However, in the policy logic outlined by the policy makers, some general directions can be distinguished. Additionally, the Parliamentary Working group provides a number of nodes - although these remain fairly general. The mechanism for change explicitly described by the Parliamentary Working group, and suggested by the outcomes 'insight into the drug use of the Belgian population' on the one hand, and 'mobilization of scientific knowledge in the Belgian drug policy' and '(Uniform, permanent scientific evaluation so that) help-seeking drug users get most effective treatment' on the other hand, is:

> In general, epidemiological research, population surveys, official statistics and other (evaluation) research should give insight in the drug phenomenon and the factors associated with it. This insight is necessary to react in an appropriate way to the drug phenomenon. To do so, policy makers on every level should take this insight into account when drafting a drug policy. This will eventually result in a more effective drug policy.

Apart from questioning whether these assumptions are valid (or rather: are they valid in every context, for all target audiences, and under every circumstance[102]), an important observation, is that the policy logic does not (explicitly) reflect this assumption.

It is essential for a policy to explain how the intended outcomes and impact will be achieved, not only through how a policy is designed and set up (and so focus on the sequence of actions, deliverables and inputs). It is also crucial to describe the processes through which change comes about (and so focus on the relation between outcomes and eventual impact). This is not entirely (at least not explicitly) the case for the transversal theme 'Epidemiology, research and evaluation', which primarily focuses on the first aspect (policy design).

8.2.6 Conclusion of the policy intentions

In terms of shape of the Belgian drug policy, we first of all see that the policy documents were often explicit about the objectives and actions, and thus about what the policymakers intent to undertake. Objectives and actions are mostly described with a lot of detail. There are a few exceptions, but they are limited.

Second, although most actions and objectives were clearly defined, the policy documents were less concrete about the expected changes that an action should bring about. Vague or implied outputs and outcomes cannot show how the objectives and actions are related to the intended changes in practice. This might produce problems with accountability. If it is not clear what change a certain action has to produce, then why is the action introduced? It also hinders the monitoring and evaluation of the policy plans. If it is not clear what change an action should bring about, how can we measure whether this change has occurred at all?

[102] To measure this, we are focusing on effect, and that it not the intention of this evaluation.

Third, whenever the outcomes are defined, there is no differentiation between short-term, medium-term and long-term outcomes. This makes it seem as if the short-term outcomes are the final destination of the drug policy, which they are not.

In terms of what the policy makers implicitly or explicitly emphasised, the critical analysis showed consistency between the Federal Drug Note and the Joint Declaration. There are no contradictions between both policy documents and they show similar priorities, and the policy documents address both licit and illicit substances, as well a different target group. Yet, the actions in the transversal theme 'Epidemiology, research and evaluation' predominantly focus on the demand side. There were no actions focusing on the supply side in the Federal Drug Note, and only a few actions (mostly aimed at 'mapping' the supply side) in the Joint Declaration. The premise of an evidence-based drug policy seems to only apply to the demand side.

8.3 Have the policy intentions been realised: a measurement

In this chapter, we describe whether the policy intentions for the transversal theme 'Epidemiology, research and evaluation', summarised in the logic models, were actually realised. We discuss the results in two steps. First of all, we examine to what extent and how the policy intentions were realised. Second, we measure how the realisation of the policy intentions is perceived by different stakeholders and experts in drug policy. This way, we get a view on facilitators, barriers, bottlenecks, challenges and needs in the field.

To examine to what extent and how the policy intention were realised, we rely on two methods: a document review and an online survey. The results are discussed in the section 'traffic light assessment'.

To measure how the realisation of the policy intentions is perceived by different stakeholders and experts in drug policy, we rely on semi-structured interviews. The results are discussed in the section 'Providing context to the stage of realisation'.

8.3.1 Extent of realisation

In this section, we map the extent to which the policy intentions, summarised in the logic models, are actually realised. We map this out in two ways[103].

We start with an analysis **of the main developments** in the field within the various objectives of the transversal theme 'Epidemiology, research and evaluation'. We do this through a **rapid document review** of the websites, reports and other publications from various institutions with a role in the Belgian drug policy. In this section, we describe the major developments in the field for each objective. We refrain from presenting a full inventory of all actions that have been realised in micro detail, because it is not feasible to do so. The Belgian drug policy field is fragmented among many different competences and many different policy levels (cf. infra and supra). The follow-up of the realisations of the Federal Drug Note and the Joint Declaration was not centralised in one institution. Therefore, piecing together the puzzle in retrospect for all actions in all policy levels and domains, scattered over reports from different institutions, is not only virtually impossible, it is also not the core objective of this research. This section rather seeks to summarise the key developments within the different objectives, as they feed into the overall performance in transversal theme 'Epidemiology, research and evaluation'.

We therefore opted to list some of the major developments within the various objectives. We have mapped out these developments with a rapid document review, using the websites, reports and other publications from various institutions, such as the General Drug Policy Cell, Belspo, VAD, Fedito, Eurotox, Sciensano, many different addiction care institutions, the public prosecutor's office, federal and local police, NGO's, etc.

The results of this section are limited to an overview of the realisations within each objective, but does not reveal whether or not the realisations work as intended, whether they sufficiently meet the needs in the field, nor whether they are executed in a good way. Moreover, many of the realisations from the rapid document review are not necessarily a direct result of the Federal Drug Note or the Joint Declaration. Often, realisations fit as if coincidentally into the framework outlined by the Federal Drug Note and the Joint Declaration, but were no direct implementations of the two policy documents.

Second, we map the **perceived realisation** through **an online survey** amongst practitioners working within one or more domains related to the drug policy. The survey gained an explorative insight into the perceived realisation of the different actions defined by the Federal Drug Note and the Joint Declaration from a large number of experts at all policy levels (federal, regions and communities, local level) and

[103] For a more elaborate description of the methods used in this project, we refer to Chapter 2 'Methodology'.

across the different policy domains (integral and integrated approach; epidemiology, research and evaluation; prevention; care, risk-reduction and re-integration; enforcement)[104]. The survey thus provides a first insight into how the work field evaluates the realisation of the policy intentions. The online survey was distributed amongst practitioners working within one or more domains related to the drug policy.

Ten respondents completed the section on 'Epidemiology, research and evaluation'. The respondents represented different domains and policy levels.

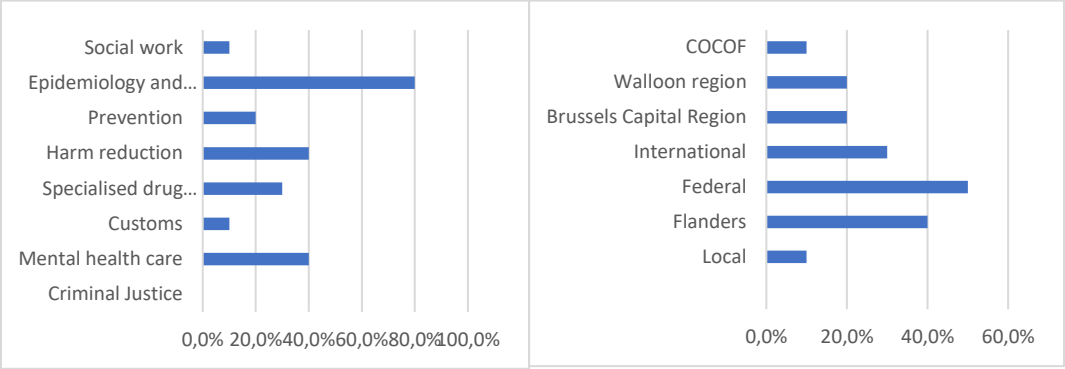

Figure 20 Policy domains and policy levels that respondents of the pillar 'Epidemiology, research and evaluation' represent

The respondents have experience in the drug field. One respondent has worked in the field for 3-5 years. All other respondents have been working in the drug field for more than 5 years.

Lastly, it is important to consider the limitations of the survey when interpreting the results. Respondents were encouraged to answer only those questions they were aware of, so the number of responses per action varied between 10 responses for the most answered action ('Ensure scientific excellence'), and 1 response for the least answered actions ('Evaluate legislation for driving under influence'). In addition, it remains a reality that the actions already date from 2001 and 2010, and that respondents were asked to reflect on actions that were already formulated a while ago. Finally, as was also highlighted in the critical appraisal of the logic models, some actions are very broadly formulated or difficult to measure. This causes differences in interpretation amongst respondents.

8.3.1.1 Results

First, we will present a summary of the results before we will elaborate on the realisations of each objective more in detail.

Summary of the 'extent of realisation'

With regards to the **extent of realisations**, we found that:

- ⇨ The document review reveals that there is **little structural follow-up of the implementation of the Federal Drug Note and Joint Declaration**, nor of other developments in the transversal pillar 'Epidemiology, research and evaluation', resulting in a fragmented overview of the implementation of both policy documents.
- ⇨ The document review shows that there have been **many epidemiological and research developments**. With regards to evaluation actions, the realisations remain more limited, especially for the actions on the supply side.

[104] For more information about the methodology, we refer to chapter 2 'Methodology'

- ⇨ The survey learns that there are **a lot of discrepancies in the level of perceived realisation**.
- ⇨ For most objectives, there are **discrepancies between the actual and perceived realisation**. In most cases, we see that, although the document review identifies certain actions as realised, there are survey respondents indicating them as partially or even not realised. This shows that actions may be implemented (cf. document review), but they do not necessarily operate in the best possible way, and improvement is necessary (cf. survey).

A. Realisation objective 'To gain insight into all aspects of the drug problem'

a. Extent of realisation: a document review

There is **no centralised overview of the realisations** for the objective 'to gain insight into all aspects of the drug problem', although there are some sources that summarise the most important developments. The information on the various achievements of the objective is summarised on the Sciensano website and in the Belgian Drug Country Reports for EMCDDA (but only until 2019), but information was also found in the Health Survey of Sciensano, the VAD website and reports, the Eurotox website and reports, and some scientific publications. The realisations are thus fragmented throughout different websites, reports and other publications. As such, it is not easy to get an overview on the realisation, and as a result this section presents **an anecdotal overview** of the achievements within the objective rather than a complete representation of the field which is not the goal of this study.

The document review reveals that **several actions** intended by the Federal Drug Note and the Joint Declaration for the objective 'to gain insight into all aspects of the drug problem' **were fully implemented.** The document review clarified that for the first group of actions, there has indeed been a section on both illegal drugs, alcohol and tobacco in the Health survey since 2004 under the heading lifestyle' (Gisle & Demarest, 2013; Gisle & Drieskens, 2019). Through this survey, there is some data on the use of these substances in the general population. Another look at drug use in the general population, we get from the Global Drug Survey, which conducted annually, runs in 10 languages, and is hosted by partners in over 20 countries (Global Drug Survey, z.d.). While not a representative sample, the Global Drug Survey does provide a picture to inform policy and practice of emerging trends. The GDS has only been done once in Belgium, afterwards only in Flanders.

Apart from the initiatives towards the general population, there are also initiatives to get insight into the drug use of specific target groups. For example, from 2006 to 2012, the use of drugs and related health risks was monitored in Belgian prisons (Van Malderen, 2012). In 2017, the survey was only conducted in the region North. In 2016, a study amongst a sample of 1326 offenders incarcerated in 15 prisons throughout Flanders, also measured the drug use in prisons (Favril & Vander Laenen, 2018). Both studies gave some insight in drug use among the prison population. There is also an ongoing research project for representative Belgian regults by Sciensano (PRS-20). Also, since 2017, Sciensano has ran multiple web surveys on the Belgian population which have provided more reports and infoflux towards policy makers (for example in parliamentary questions), mostly aimed at recreational drug use.

In Flanders for example, there is also epidemiological data on the target group of students, pupils, and persons in the nightlife. VAD organizes a continuous student survey. This is used to study substance use in the living environment of young people at the school level and at the Flemish level. A prevention component is also linked to this student survey (cf. supra) (VAD, 2020). In addition, VAD organizes a similar survey with students from colleges and universities. Every four years, a survey is distributed among student to gain insight into different forms of substance use, such as excessive alcohol consumption, experimenting with illegal drugs and the use of stimulant medication. During the most recent edition of the survey, all Dutch-speaking higher education institutions in Flanders and Brussels

were involved (Van Damme et al., 2018). Finally, every three years VAD also organizes a survey on alcohol and drug use among visitors of clubs, dance events and festivals (Rosiers, 2016).

Epidemiological data on drug-related infectious diseases and drug-related deaths is available in Belgium, although both indicators have shortcomings. For the data on drug-related infectious diseases, the Sciensano relies on the data of the syringe exchange project, as well as on recent projects on injection drug use and HCV. The survey of the syringe exchange project in Flanders asks people who inject drugs whether they have been tested for blood-borne diseases, such as HIV and hepatitis B and C, but also for tuberculosis (TB). In other words, self-reporting is used for this data, since it is not feasible to subject all clients to a blood test. Consequently, this gives a biased picture (Windelinckx, 2019). Additionally, since 2019, the PUSH project by Sciensano which estimated the number of people injecting drugs, high risk opiod users and HCV among those groups in Brussels. Drug-related deaths are measured based on the National Mortality Register (Selection B) (Sciensano, z.d.). However, this mortality rate is an underestimate of actual drug-related deaths because it only looks at direct deaths. However, there are also people who die who are indirectly related to drug use, for example infectious diseases, suicide, or a "natural death" after long-term drug use (De Donder, 2020a). Also, according the Belgium Drug Country Report (2019), the latest data from the National Mortality Register at the national level dates from 2014. The interviews clarified that the latest data from the National Mortality Register today dates from 2017.

An overview of these indicators is, together with other information on the drug phenomenon in Belgium, annually assembled by the BMCDDA and used to be reported in an annual country report to the EMCDDA (EMCDDA, 2020), and is now reported through an internal report system.

For the second group of actions, ‘uniform registration’, the document review clarified that a uniform registration platform for treatment data was set up in the form of a Belgian Treatment Demand Indicator (TDI) by the Federal government in 2011. Before 2011, there were also initiatives that measured treatment data (e.g. the registration by the VVBV in specialized drug treatment facilities in Flanders), however, they were not compatible with one another (Antoine et al., 2020). Belgium could finally get an overview on the number of treatment requests related to both drug and alcohol-related problems across the whole country. The registration of the TDI consists of registering the treatment requests related to a drug problem. According to EMCDDA, only the requests related to illegal drugs have to be registered, but Belgium has added, at the request of the CGD, the treatment requests related to legal drugs (specifically alcohol) too (Antoine et al., 2020). Treatment facilities are tasked with registration. By implementing TDI, Belgium also committed itself to the EU's requirements towards monitoring. Following the introduction of the new TDI protocol agreement between the ministers responsible for health in Belgium on October 19, 2015, which included a (modified) funding allocation key, hospitals were now also required to systematically register treatment demand (Antoine et al., 2020). The survey indicates that practitioners are well informed about this realisation in both parts of the country, which we deduce from the unanimity of the responses. Despite this success, there are a number of bottlenecks, mostly technical in nature. The overall coverage of the specialized centres (ambulatory and residential) is above 97%, that of the hospitals is around 95%, but that for the Mental Health Centers is much lower, around 75% (realizations ACD). The TDI does not yet include all treatment providers (e.g. no GP) in the registration, and certain settings are not taken into account (e.g. prison). The necessary workload and the lack of available resources are the main obstacles thereto (Algemene Cel Drugs, 2019).

For the third group of actions, to identify and map new synthetic drugs, we found that the EWS is still fully operational. The Belgian Early Warning System Drugs (BEWSD) service of the Sciensano provides communication at the federal level, based in part on information from the Drugline and Eurotox, customs services, police, the prosecutor's office and mostly on the input of a small number of laboratories mainly located in the upper part of the country (EMCDDA, 2020). The law of 7 February 2014 adds the obligation for all Belgian laboratories to automatically transmit analysis results to the BEWSD, even if they are part of a judicial investigation. The sub-focal points (VAD, Eurotox, PFCSM-OPGG and SPZ)

are in turn responsible for communicating EWS messages to and from the network of professional intermediaries (Sciensano, z.d.).

Lastly, for the last group of actions, to coordinate epidemiological efforts, we can confirm that the BMCDDA was indeed established. Sciensano (formerly: Scientific Institute of Public Health (WIV-ISP)) was appointed as the BMCDDA. One of the missions of Sciensano, is the collection and analysis of available information regarding all aspects of drugs and drug addiction in Belgium. This is carried out by the Drugs Program specifically, and for that reason used to be referred to as the BMCDDA. This is not longer the case in 2021 because the name caused too much confusion. As its main objective, the Program Drugs supports professionals, national and international policy makers in the development, implementation and evaluation of a global and integrated drug policy (Sciensano, z.d.).The main mission of the Program Drugs consists of two tasks: (1) as a national information hub, to collect and analyse drug-related information in Belgium within the European Union, and (2) to conduct more detailed analyses within the framework of scientific research. The Program Drugs is therefore also the national focal point within the European Reitox network, , within which data and methodological information are exchanged in order to gain insight into the drugs phenomenon across national borders. The Program Drugs therefore cooperates with its regional partners and sub-focal points VAD, Eurotox, PFCSM-OPGG and SPZ, to collect the epidemiological information (although the latter two to a limited extent).

We did not find evidence of a European monitoring system for legislation and practices concerning drugs in the document review, although the EMCDDA has taken some initiatives to inventory good practices within the prevention field. For example, Xchange is an online registry of evaluated prevention interventions, that rate the beneficial outcome, according to European evaluation studies (EMCDDA, z.d.-a). A similar example is the Healthy Nightlife Toolbox, which comprises of a database of evaluated interventions within the field of nightlife alcohol and drug prevention (EMCDDA, z.d.-b).

From the document review it is clear that **most of the actions** mentioned by the Federal Drug Note and the Joint Declaration **are addressed, and fully implemented.** There are few exceptions, for example with getting insight in the drug use of specific target groups and the European monitoring system for legislation and practices.

b. Perceived realisation: a survey amongst experts

According to the survey respondents most of the actions within this objective, are partially to fully realised. However, for most actions, there are also respondents indicating that the action was not realised, revealing inconsistencies in the level of perceived realisation.

For the first subgroup of actions, to gain insight into drug use in the population, responses are the most consistent. According to the respondents, the actions to map problematic use in specific target groups are partially to not realised, as well as the mapping of drug-related deaths. On the other hand, the actions ‘to add a section on drug use in the health survey’, ‘map the drug use of the general population’ and ‘comply with EMCDDA standards’, are partially to fully realised. Only the ‘mapping of drug-related infectious diseases’ shows clear inconsistency in the answers. For this action, regional differences are apparent: Flemish respondents indicate that this is not or partially realised, whereas Walloon and Brussels respondents indicate this is fully to partially realised.

For the second group of actions, the uniform registration of treatment data, most respondents agree that these actions have been partially to fully realised, although for each action, there is also one respondent who does not agree. These differences appear both within a region (e.g. implement a registration system in addiction treatment), and between regions (e.g. map treatment demand).

For the third group of actions, to identify and map new synthetic drugs, most respondents indicated that this was fully or partially realised. For two actions (to complete BMCDDA with more laboratories and more socio-cultural information; to communicate recurrent product analyses and the inventory of new trends to the several partners), there was one respondent that indicated that the actions were not

realised. These actions were partially to fully realised according to Flemish respondents, and partially to not realised according to Walloon and Brussels region respondents. Respondents unanimously agreed that there is a cooperation between the BMCDDA and the sub focal points.

And for the last group of actions, to coordinate epidemiological efforts, most respondents indicate a full to partial realisation, although, as with the previous actions, one, two or three respondents indicate that some actions are not realised. These discrepancies appear both within a region or policy level (more specifically for 'install, develop and retain a communication network', 'fulfil Belgian obligations towards EMCDDA'), as well as between regions (more specifically for 'transform national focal point to a BMCDDA').

The many discrepancies could indicate either local and/or regional differences in realisation of the actions, but also often show a lack of overview amongst the respondents about the realisations.

The survey responses demonstrate **little consistency in the perceived realisations** for the objective 'to gain insight into all aspects of the drug problem'. Discrepancies between the regions suggest a different application of the action between the regions. Discrepancies that cannot be explained by regional differences, suggest that there is **a limited overview of the epidemiological efforts** amongst practitioners. Some smaller discrepancies may also be explained by differences in appreciation of implementation.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **a number of discrepancies between the actual realisation and the perceived realisation**. Although the document review found an implementation of most actions relating to 'to gain insight into all aspects of the drug problem', there are respondents who mention that the same actions are not realised. For example, although a BMCDDA has been established (cf. document review), there is still a respondent who indicates this is not the case (cf. survey).

These discrepancies could indicate two things. First, this could indicate that different respondents interpret the same action in a different way and thus **show different appreciation levels,** although this mainly explains small discrepancies (e.g. between partial and full implementation/realisation)**.** Second, it could suggest that, **although the actions are implemented** (cf. document review), the actions do not necessarily operate in the best possible way and **improvement is needed** according to the experts (cf. survey).

B. Realisation of the objective 'To develop and mobilize scientific knowledge in function of a global and integrated drug policy'

a. Extent of realisation: a document review

In contrast to the aforementioned objective, there is **centralised overview available of the realisations** for the objective 'to develop and mobilize scientific knowledge in function of a global and integrated drug policy'. The information on the various achievements of the objective is summarised on the BELSPO website, that lists all BELSPO publications, as well as how the Science Policy Program was established.

The document review reveals that **several actions** intended by the Federal Drug Note and the Joint Declaration for the objective 'to develop and mobilize scientific knowledge in function of a global and integrated drug policy' **were partially to fully implemented.** The document review for example clarified that the Federal Government Service Science Policy has established a research program on drugs (the Federal Research Program on Drugs, also called the Program on Drugs) in 2001, in accordance with the decision by the Council of Ministers on 19 January 2001. The Science Policy Unit was allocated an annual budget of BEF 36.472 million (approximately EUR 940 000) to set up a scientific research program on Drugs. Since then, every year (or in recent years, every two years), a call for research

proposals is launched by BELSPO's Drugs Research Program. Thematic priorities are defined by the sub-cell "scientific research and information" (Cell SRI) within the General Drug Policy Cell. This sub-cell thus the annual working program on which the BELSPO call of proposals is based (Belspo, z.d.). BELSPO requires the following compliance principles:

- *"Scientific excellence and international integration;*
- *Concentration around key questions covering multiple competences and offering a coherent framework in which fragmentation is minimized. The themes should support the strategic orientations of the Belgian drug policy as adopted by the Interministerial Conferences on Drugs ;*
- *Collaboration with other entities are preferred (authorities at the federal, regional, community, international level) and flexible funding mechanisms involving these levels should be sought."*

BELSPO further specifies the selection procedure consisting of three phases: (1) eligibility check, (2) review by external reviewers, and (3) ranking based on the consensus report. Afterwards, the consensus reports are discussed in a committee consisting of the members of the Working group "Research and Scientific information" of the General Cell Drug Policy. The eventual decision is made by the Minister in charge of the Federal Science Policy, based on the scientific evaluation by the external reviewers and the strategic advice of the committee (Belspo, z.d.). Except for the meetings with the guidance committee, there is no other quality control.

A list of all the previously financed BELSPO projects can be found on their website[105]. Up to 2021, there have been 89 projects financed by the BELSPO Program Drugs.

Most of the research projects funded by BELSPO are aimed at the demand side, only a minority of the projects maps (aspects of) the supply side (#18, according to the BELSPO website). Most projects fit within the BELSPO category 'Responses to the drug situation', and include studies on demand reduction interventions such as the evaluation of interventions (treatment, prevention, etc.), the implementation of policies and laws, estimates of public expenditure and other economic topics. Additionally, the research projects within the categories 'Determinants of drug use' and 'Mechanisms of drug use and effects', focus on demand too.

Results of the research projects are often presented to the General Drug Policy Cell, and the General Drug Policy Cell often refers to previous (national and international) research projects when establishing a vision note, synthesis note or report. Yet, the survey indicates that taking scientific knowledge into account in policy is not sufficiently done. A possible explanation is mentioned by the VAD Memorandum and the VVBV Memorandum (De Vlaamse revalidatiecentra voor drugverslaafden, 2019), that clarify that many pilot projects are not structurally embedded despite positive evaluations (e.g. drug treatment court, Proefzorg, crisis units, projects on double diagnosis, etc.), or that some policy initiatives are not implemented despite the scientific evidence (e.g. the alcohol policy). The survey respondents further clarify that consultation with the field on possible research topics for the BELSPO call is not done systematically, although it does occur (e.g. for ERANID).

We could not find information on the implementation of the following actions: develop a monitoring system and evaluate the legislation for driving under influence, research towards the organisation of the treatment offer.

From the document review it is clear that **most of the actions** mentioned by the Federal Drug Note and the Joint Declaration **were at least partially addressed.** Instead of focusing predominantly on evaluation, BELSPO projects often focus on mapping new phenomena, and exploratory research.

[105] http://www.belspo.be/belspo/drugs/project_year_nl.stm

b. Perceived realisation: a survey amongst experts

First of all, for some actions, only a few answers have been provided. For example, for the evaluation of the legislation of driving under influence, the monitoring of research towards innovative methods, or expertise in research management, responses are limited to one or two respondents.

Most responses from the first group of actions 'standard, continuous and scientific evaluation of aspects of supply and demand', are more or less consistent. Most actions are perceived as partially or not realised, except for the evaluation of de MSOC/MASS, the evaluation of the double diagnosis experiments and evaluation of international research on controlled heroin distribution. There are four actions where respondents answered all answer categories: 'research on the organisation of addiction treatment', 'research on the effectivity of addiction treatment', 'research towards aspects of supply', and 'research towards the demand of illegal drugs'. The discrepancies appear both within a region (e.g. 'research on the effectivity of addiction treatment' was both realised and not realised according to Flemish respondents), as well as between regions (e.g. 'research towards aspects of supply' was realised according to Flemish respondents, but not realised according to Walloon and Brussels respondents.

For the second group of actions, the survey respondents agree that the actions are partially to fully realised. For three actions, there is always one respondent that indicates the action is not realised: 'expertise in research management', 'provide a flexible funding scheme', and 'ensure scientific excellence'. The discrepancies in answer categories appear between regions and policy levels.

For the last group of actions, most respondents agree that there is only a limited or a lack of realisation. There is only partial or no consultation through ad hoc working groups, and policy changes are only partially or not based on effect research, according to the survey respondents. Furthermore, one federal respondent indicates that research priorities are defined after consultation with the field. Respondents from the regions (Flemish, Walloon, and Brussels region) indicate that this is only partially the case.

The many discrepancies could indicate either regional differences in realisation of the actions, or show a lack of overview on the realisations of the actions in the field, especially the ones across the borders of the regions and the communities.

The survey responses demonstrate **some consistency in the perceived realisations** for the objective 'to develop and mobilize scientific knowledge in function of a global and integrated drug policy'. Discrepancies between the regions suggest a different application of the action between the regions. Discrepancies that cannot be explained by regional differences, suggest that there is **a limited overview of the existing research projects** amongst practitioners. Some smaller discrepancies may also be explained by differences in appreciation of realisation.

c. Comparison of the actual realisation with the perceived realisation

A comparison of the results of the document review and the survey reveal **a number of discrepancies between the actual realisation and the perceived realisation**. Although the document review found a (partial) implementation of several actions relating to 'develop and mobilize scientific knowledge in function of a global and integrated drug policy', there are respondents who mention that the same actions are not realised, or the other way around. For example, although is some research aimed at mapping the supply side (cf. document review), there is still a respondent who indicates this is not the case (cf. survey). And although we did not find evidence of the realisation of the evaluation of the treatment offer (cf. document review), some respondents indicated this action was fully realised (cf. survey).

These discrepancies could indicate two things. First, this could indicate that different respondents interpret the same action in a different way and thus **show different appreciation levels,** although this mainly explains small discrepancies (e.g. between partial and full implementation/realisation)**.** Second, it could mean that, there are more initiatives in practice than the document review could identify. Third,

it could suggest that, **although the actions are implemented** (cf. document review), the actions do not necessarily operate in the best possible way and **improvement is needed** according to the experts (cf. survey).

8.3.1.2 Conclusion of the extent of realisation

First of all, the document review reveals that there is little structural follow-up of the implementation of the Federal Drug Note and Joint Declaration, nor of other additional developments in the transversal pillar 'Epidemiology, research and evaluation'. There are many annual reports and other publications that list provide a structured overview of the developments for the transversal theme. Instead, they always mostly focus on specific parts of the transversal theme, for example the loss of epidemiological indicators or a list of BELSPO research studies. All of these reports and publications help to get an overview on specific parts of an integral and integrated approach this pillar, however, it paints a rather fragmented and anecdotical picture of the realisation of the actions of the Federal Drug Note and the Joint Declaration within this pillar. As a result, this fragmentation is reflected in this evaluation too.

Second, the document review shows that there have been many developments within the field of epidemiology and research. With regards to evaluation, the realisations remain more limited, especially for the actions on the supply side. For both objectives, most actions have been- at least- partially realised. There are a few exceptions, for example with getting insight in the drug use of specific target groups and the European monitoring system for legislation and goof practices of the member states.

Third, the online survey learns that there are a lot of discrepancies in the level of perceived realisation. These discrepancies could be explained by regional differences, e.g. the actions have been implemented in one region, but not in another. As there is no complete overview of the realisations, this could indicate that experts and people from practice experience a lack of overview due to fragmentation. Experts and practice are encountering the same barrier of fragmentation as the researchers of this research have: a lack of overview on 'what's out there'. Another explanation could be that some actions are formulated very broad, so respondents could have interpreted the action in a different way. Depending on how the action is interpreted by the respondent, replies may vary. Another explanation lies in the fact that some actions are difficult to quantify or measure, so what is 'fully realised' for one respondent, might only be 'partially realised' for another respondent because this is not specified clearly. However, some actions were very clear, and still discrepancies remained, which suggest that even practitioners do not have a clear view on the realisations.

And lastly, when we compare the results of the document review with the survey, we learn that for most objectives, there are discrepancies between the actual and perceived realisation. In most cases, we see that, although the document review identifies certain actions as realised, there are survey respondents indicating them as partially or even not realised. This shows that actions may be implemented (cf. document review), but it is not known or that they do not necessarily operate in the best possible way, and improvement might be necessary (cf. survey).

8.3.2 Providing context to the stage of realisation: interviews and a focus group with stakeholders

A third method used in the EVADRUG evaluation, are semi-structured interviews and a focus group with civil servants and practitioners that have an expertise in one or more domains related to the Belgian drug policy. These semi-structured interviews aim to provide an explorative insight into the facilitators, barriers, bottlenecks, challenges and needs for the Belgian drug policy. The semi-structured interviews were conducted amongst 39 civil servants and practitioners at all policy levels (federal, regions and communities) and across the different policy domains (Integral and integrated approach; Epidemiology, research and evaluation; Prevention; Treatment, risk-reduction and reintegration; Enforcement).

This section summarises their views on the realisation of the objectives across the transversal theme of ''Epidemiology, research and evaluation'. The interviews and the focus group are aimed at obtaining and understanding how Belgian drug policy is experienced by respondents. We examined how they shape the Belgian drug policy in daily practice, giving insight in how they translate "policy in practice", as opposed to "policy in the books".

It is important to note that semi-structured interviews are a qualitative method to gain an explorative and more in-depth insight into the drug policy. Therefore, this method does not give a representative view of all opinions in the field. The qualitative semi-structured interviews intended to report on recurrent perceptions, opinions and experiences that are prevalent in the drug field, to help explain why the realisation of certain objectives within the pillar of 'Epidemiology, research and evaluation' is hindered or facilitated, but also to record new barriers and bottlenecks, and to map what the field deems necessary for this pillar. Additionally, it is important to consider that the Belgian drug policy covers a very broad field of topics. Because of that, we were not able to describe every bottleneck in detail. In this section, each topic is touched upon briefly.

In this section, we describe the results of the semi-structured interviews and the focus group for the pillar 'Epidemiology, research and evaluation'.

First, we will present a summary of the results before we will elaborate on the facilitators and barriers more in detail.

Summary of the 'context to the extent of realisation'

With regard to the **context to the stage of realisation**, practitioners, (scientific) experts and civil servants perceived that:

- ⇨ Although the epidemiological monitoring and research field has made **an importance evolution** since the establishment of the Federal Drug Note, there are s**till barriers and bottlenecks** to a thorough and transparent monitoring and evaluation of the drug phenomenon and drug policy (initiatives), as well as a decisive coordination.
- ⇨ Research towards the drug phenomenon show **a lack of geographical and thematic diversity** in the research projects, and remain **limited in the valorisation** of research results towards the field or towards policy.
- ⇨ Despite the **predominant focus on "what works"**, the **value of qualitative research** and the **input of practice** and **lived experiences** is emphasised.
- ⇨ The premise of an **evidence-based drug policy clashes with its limits** in practice, for example because research results seemingly barely result in policy change.

8.3.2.1 Facilitators with regard to the realisation of the 'Epidemiology, research and evaluation'- theme's objectives

We asked the respondents what they identified as facilitators for epidemiology, research and/or evaluation. Four facilitators were identified.

A. Sciensano as a coordinator of epidemiology-related issues in Belgium

Many respondents praise the role of the section Drugs within Sciensano to collect and coordinate the development and collection of the epidemiological data in Belgium and to act as the Belgian National Focal Point. Respondents for example emphasise the good cooperation, refer to the initiatives that Sciensano undertakes, such as their involvement of European projects in research, and also their scientific output including scientific publications. Some respondents also refer to their strong and broad

network, connections and cooperation with the EU, which in turn ameliorates the operation of the national focal point.

> *La coordination au niveau de Sciensano, honnêtement, elle est bonne: de bons contacts, il y a des évolutions très positives. L'équipe est chouette, productive dans son ensemble. On essaye de collaborer à la mission européenne de manière très efficace, je pense. (FR_14)*

B. Federal Science Policy (Belspo) ensures conducting drug research on a regular basis

Many respondents emphasise that the funding provided by BELSPO has enabled the field of epidemiology, evaluation and (other) scientific research to develop further throughout the years. One respondent mentions that without that funding, the epidemiological field would not be where it is today.

> *De grote troef van het programma ligt er in om toch goed onderzoek te kunnen financieren zonder dat er getwijfeld wordt aan de wetenschappelijke kwaliteit van de projecten, van aanbevelingen en van de achterliggende studies. (NL_5)*

Furthermore, respondents mentioned that in Belgium different research groups exist having specific expertise related to diverse drug-related themes. As such, it is possible to rely on lots of scientific evidence and expertise. Yet, a few respondents emphasise that there are still research groups with a specific expertise in a sub-domain, such as with a focus on the gambling issue, or academics of public administration, but do not know they can finance their research with the BELSPO budgets (cf. infra).

C. Evolutions in monitoring and technical advancements broaden epidemiological and research possibilities

One respondent refers to the evolutions in monitoring, such as facilitated online data collection, linking of different datasets, making it possible to reach different, hidden and wider populations for epidemiological research. Opportunities like online surveys have also enabled to reduce the budget costs for epidemiological research over the years. In addition, new ways of linking datasets have opened new doors for more in-depth analysis. These extensions of research opportunities allow for more, better quality and further in-depth research.

Another respondent specifically refers to new lab technology, such as infrared spectrograph that fastens product identification and make it more mobile.

> *Des nouveaux outils aussi en développement, comme la spectrographie infrarouge que possède Modus Vivendi et qu'utilise aussi l'Institut National de Criminologie et de Criminalistique. C'est encore assez expérimental, mais ça va permettre de faire évoluer aussi l'identification des produits en le rendant plus mobile et plus rapide. (FR_14)*

Given that funding remains limited, respondents emphasise the importance of these developments. One respondent also stresses the strong commitment in the sub focal points to make the most of the limited resources.

> *Het is zeer positief omdat er zeel veel engagement is voor eigenlijk de weinige middelen die er maar zijn en die steeds minder worden. (NL_8)*

D. Strong EU commitment for certain indicators

Whenever there is a strong commitment in the EU regarding a certain epidemiological indicator, it can act as a facilitator on the national level. A strong support of the indicator by the EU, e.g. through international regulations, facilitates the implementation of the indicator at national level. This is the case, for example, with the Early Warning System and the analysis of threats.

Dat ook bijvoorbeeld in de nieuwe drugsstrategie 2021-2025 opnieuw early-warning en het analyseren van threats dat die, dat dat blijft een prioriteit. Dat blijft eigenlijk een luik dat zeer sterk ondersteund wordt door internationale regulations. (NL_8)

8.3.2.2 Barriers and bottlenecks with regard to the realisation of the pillar of the 'Epidemiology, research and evaluation'- pillar's objectives

We asked our respondents what they identified as a barrier or a bottleneck for the pillar 'Epidemiology, research and evaluation'. Bottlenecks and barriers are problems that prevent or obstruct a successful realisation. In this section, we list all barriers and bottlenecks related to the specific objectives of the pillar 'Integral and integrated approach'.

A. Barriers and bottlenecks related to the objective 'To gain insight into all aspects of the drug problem'

a. Coordination of epidemiology between the National Focal Point and the Sub focal Points

Although respondents emphasise a good cooperation with Sciensano as National Focal Point, they also identified some barriers and bottlenecks in the coordination of the epidemiological data.

One respondent describes that, until a few years ago, the (former) WIV/ISP (now Sciensano) has struggled with instability. Today, they believe that Sciensano is working successfully as a National Focal Point with its sub-focal points in the regions, although a number of bottlenecks remain.

A first bottleneck linked to the sub-focal points, is that only two of the four sub-focal points are officially endorsed in the State Gazette and perform their task as they should: VAD and Eurotox. The lack of a framework and proper funding limits the opportunities with the other two focal points. For instance, these two sub-focal points are primarily healthcare institutions, so their core business is not collecting data. This different mandate means that they cannot always fulfil their tasks as they should in an ideal situation. For example, they contribute to the TDI, but they are not able to provide much information for other indicators. As a result, there are differences between the more established sub-focal points in Flanders and Wallonia and the other two sub-focal points in Brussels and Ostbelgien. Even more, as they are regional sub-focal points, their tasks are also implemented within the regions. In this sense, there is often no harmonisation of the sub-focal points. They differ from each other and have their own priorities.

One respondent also refers to funding. The two more established sub-focal points are partially funded through the National Focal Point by the European Funding system. This funding allows for an official mandate and imposes contact and cooperation between the National Focal Point and these two sub-focal points, one respondent notes. This in turn ensures a good performance. The two smaller sub-focal points that are less established, are often unable to deliver what they are asked for, although the respondent stresses a good relationship with the Consultation platform for Mental Healthcare (PFCSM-OPGG). In that sense, the respondent emphasises that there is more to gain from the sub-focal system, than is currently being practiced. But then, in the first place, something has to happen to the lack of funding.

Ici, pour le volet épidémiologique, on est financé pour 0,3 ETP pour la Wallonie et un peu plus de 0,375 pour la CoCoF. C'est bien sûr insuffisant. Je ne peux pas faire des miracles avec ce financement. Heureusement, il y a d'autres niveaux qui sont tout à fait utiles et complémentaires au travail que nous on fait. Mais assurément, il y a des données et des focus qu'on ne peut pas exploiter par ce manque de financement. J'imagine que je ne suis pas le seul dans le cas. (FR_14)

Another respondent refers to the fact that too often, the different partners start from what is expected of them within their responsibility. A lack of an overarching strategy and vision, as well as the lack of harmonisation between the regions and priorities is therefore identified as a barrier. Also, the fact that there is not enough visibility of the results of the epidemiological data, is identified as a barrier. One respondent refers to the great deal of work in data collection, -analysis and drafting of reports, that often remains invisible, and in turn results in a lack of recognition. As a consequence, the motivation to perform these tasks also decreases.

> *Uhm, en opnieuw de visibiliteit van het werk is te laag. Er wordt heel veel werk verzet, maar het is heel weinig visibel, waardoor dat de credits heel vaak niet gegeven worden naar mensen die het aanbelangt en dus ook de motivatie om te blijven deelnemen in het systeem daardoor in gedrang komt. (NL_8)*

The sub focal points point to some barriers and bottlenecks in the cooperation with the National Focal Point too. For example, some respondents mention that access to Belgian data, is not automatically dispersed to the wider public anymore. On demand, aggregated datasets are always available, and respondents describe that they are happily shared when asked for. Yet, to some respondents, they feel that this method is less transparent than it was. Moreover, it could create a return for the delivered data.

> *Wat ik daar wel kan van zeggen is dat vroeger, wat betreft de dataverzameling, altijd wel een nationaal rapport voor België werd gemaakt waarin dat alle cijfers werden verzameld. Dat werd opgestuurd naar Europa en daar leverden alle regio's data voor aan om dat rapport samen te stellen. Die datalevering gebeurt nog altijd. (…), maar zij maken daar nu geen rapport meer van. Dat is wel iets wat intern nog wel gebeurt, maar dit staat niet ter beschikking voor het publiek. (…) Wij moeten die telkens opvragen omdat die niet publiek beschikbaar zijn bij hen. Tot nu toe krijgen we die wel altijd, dat is geen probleem, maar het is niet zo transparant of niet meer zo publiek beschikbaar, tegenover vroeger.(NL_18)*

> *Je pense qu'il y aurait moyen de rendre cela public sans risque de mauvaise utilisation, mais on pourrait se demander si c'est vraiment nécessaire, dans la mesure où on peut aller sur le site de l'Observatoire Européen et chercher les informations spécifiques à la Belgique. Mais ces informations sont refiltrées et standardisées. Et donc, il y a une richesse qui se perd par rapport à ce qui est initialement formulé (FR_14)*

Other issues with coordination and communications are mentioned. One respondent for example regrets that the sub focal points are not always consulted on new epidemiological initiatives, where they believe could have added an interesting and more regional perspective. Especially when they are informed of these epidemiological initiatives through the grapevine, they regret the fact that there is no formal communication about the new epidemiological initiative.

> *Sciensano ne fait pas suffisamment appel aux points focaux pour certaines initiatives. Pour prendre un exemple, l'enquête Covid qu'ils ont mené était très chouette, une belle opportunité... Mais je trouve regrettable que nous et le VAD n'avons pas été impliqués dans cette enquête, dans la mesure où on avait certainement des choses intéressantes à apporter tant au niveau de la construction de l'outil qu'en termes d'analyse. (FR_14)*

One respondent also refers to a bottleneck with the EWS coordination. Communication between the national coordination and the sub-focal points does not always run smoothly in this regard. They refer to delayed warnings, and the lack of warnings for the French-speaking part of the country, which suggests that there are problems with some laboratories. The difficulties in communication with the sub-focal points means that little has been done to address these problems, although they are raised every year.

Lastly, one French-speaking respondent indicates that the sixth state reform acted as a barrier for established cooperations with other institutions, that had to be rebuilt after the reform:

La réforme n'a pas aidé, les connexions parfois se sont dissolues, alors qu'on a une bonne connexion avec la communauté française. Il a fallu reconstruire de nouveaux liens avec de nouvelles personnes du cabinet qui, malheureusement, se renouvellent continuellement. Au niveau de l'AVIQ notamment, c'est parfois difficile de construire sur le long terme, dans la mesure où il y a ce renouvellement et ces problèmes organisationnels internes qui font qu'un travail de proximité n'est pas toujours facile à établir. (FR_14)

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- Identified needs on all policy levels:
  - Define clear expectations and tasks for the National Focal Point, and to provide the focal point with a clear mandate.
- Identified needs on a regional level:
  - Develop and finance the sub-focal points further in its connection to the National Focal Point.

b. Limits to existing epidemiological indicators

Although nearly all respondents refer to the importance of epidemiological data, they also acknowledge that each epidemiological indicator has its limits.

Die vind ik heel waardevol. Maar dat is weer, dan denk ik, ja, die cijfertjes zijn ook maar cijfertjes. (…)Ik zeg niet dat cijfers niet belangrijk zijn, zeker niet. Maar ik vind de input van mensen op het terrein en zeker ook kwalitatief onderzoek, dat dat wel, dat die zeker moeten worden meegenomen. (NL_1)

We list the limits of the different indicators, mentioned by the respondents, below.

First of all, respondents denounce the fact that there are barely data available to gain insight in the drug supply side. Regarding supply, there are only a few indicators, and many of the existing indicators are not well monitored. For example, one respondent describes that there is only good data on the drug-related crime in the sense of code "60" files. Several respondents indicate, however, that this does not provide a realistic picture of drug-related crime, because it goes far beyond the infringements of the drug law. One respondent points out that the supply side indicators are still fairly recent compared to the demand indicators. These supply indicators are therefore still in development. Finally, one respondent points out that the European framework of the five key indicators (i.e. Prevalence and patterns of drug use, Problem drug use, Treatment demand indicator, Drug-related deaths and mortality, Drug-related infectious diseases), is outdated.

Het probleem ligt erin dat Europees kader dat er voor gehaald was, was vijf key indicators, en daar moeten ze ook van afstappen, want uiteindelijk zijn we al veel verder gegroeid en zijn er veel meer indicatoren en gaan ze dan evenzeer zoals dat eigenlijk toekomt op de, de indicatoren van de vraagzijde, moeten die van de aanbodzijde ook ontwikkeld worden, geïnstalleerd worden en geïmplementeerd worden. (NL_8)

Second, the respondents identify limits to the different drug demand side indicators. Above all, most respondents refer to TDI as a good practice. Throughout the last ten year, TDI has evolved to one of the most detailed indicators in Belgium and especially the uniform registration is praised by the respondents. However, every respondent also lists the limits of TDI. For example, respondents indicate that the number of treatment requests is registered, which does not allow to follow treatment trajectories nor does it give an overview of all treatment episodes within that year. Additionally, not every treatment request is registered, as for example general practitioners or emergency care are not part of the

registration, nor outreach initiatives or several registered harm reduction initiatives. Also, one respondent indicates that the TDI data are often analysed on a national level, although there appear to be significant regional differences.

When looking at the broader healthcare landscape, some respondents particularly note the lack of coordination between the various epidemiological initiatives to map the treatment demand. For example, one respondent describes a discrepancy between the TDI figures and the psychiatric figures because they measure in a different way (diagnoses vs. client's treatment indication):

> *Je hebt dan de TDI-cijfers, en opeens verschijnt dan over de verslavingszorg de minimale psychiatrische gegevens, waar je dan ook cijfers hebt over de verslavingsproblematiek, maar dan zie je grote verschillen, aangezien de ene eigenlijk diagnoses zijn en in de TDI zie je alleen hetgeen de cliënt aangeeft wat dat hij zelf zijn belangrijkste probleemmiddel vindt. Ook op dat vlak is er in België toch nog verbetering mogelijk is. (NL_16)*

Other respondents denounce the differences in registration systems. For example, one respondent mentions that to get insight into drug-related diseases, one must unravel hospital data Different organisations, collecting diverse information regarding a similar topic complicates the interpretation of the data for the field.

> *Voor ons is dat ook belangrijk om daar een goed zicht op te hebben. Daarvoor moeten wij vooral gaan kijken naar ziekenhuisgegevens over de diagnoses. Het is soms dus wat moeilijk om de verhouding van al die verschillende registratiesystemen die er nog altijd zijn en naast mekaar bestaan, de weg in te vinden en om die op een goede manier te vertalen naar het werkveld.(NL_18)*

> *Parce que actuellement, chaque service a son propre outil, ils ne sont pas standardisés. C'est difficile de retirer une information globale sur cette base là. Et ça me paraît important. (FR_14)*

Third, respondents describe that, although there has been an evolution throughout the years, we still do not possess a clear insight into the prevalence of drug use. The Health Survey of Sciensano is mentioned as an indicator of drug use in the general population, as it has a fixed section on alcohol, tobacco and illegal drugs. Although this gives a certain insight into the prevalence of drug use in Belgium, the results remain rather limited. First of all, there are problems with the sample size. The use of illegal drugs is relatively rare at the population level. As a result, it becomes difficult to make statements, for example about age or gender, because the group analysed becomes very small. Nor is there a completely reliable representation of the target group. For instance, a respondent mentioned that a comparison of the student survey in Flanders showed very different results from the health survey for the same age group. The health survey is based on the population registers, and measures a household. A number of groups are not represented, because they are not in the population registers, for example the prison population, people without a national registry number, ... Lastly, one respondent states that the underlying reasons for use should not be forgotten, and that today there is very little insight into this.

Apart from drug use in the general population, some respondents indicate there is still no clear insight into drug use in prison. Yet respondents indicate that it could support prisons in drafting and adapting their drug policies.

A fourth indicator with limits, is the number of drug-related deaths. The current registration is an underestimation of the actual number of drug-related deaths. Often the exact cause of death is not clear, and a toxicological analysis is only done in judicial investigations.

> *Pour la mortalité, actuellement, on se base essentiellement sur le registre de mortalité pour évaluer l'impact létal des drogues. Malheureusement, le registre n'est pas vraiment adapté pour cela, même si ça se fait classiquement au niveau européen, c'est un des axes pour évaluer la mortalité, mais ce n'est pas le seul et on pense que le registre sous estime la mortalité. (FR_14)*

Depending on the definition of drug-related deaths, there are differences between for example a direct and indirect link with drug use as a cause of death. One respondent explains that 'drug-related' can be interpreted differently. The operationalisation of this indicator is high on the European agenda to clear out some of these ambiguities.

> *Een arts is verantwoordelijk om op het overlijdensformulier te zetten dat het gelinkt was aan middelengebruik. Maar dan kom je al: gelinkt aan middelengebruik. Wilt dat dan zeggen dat die overleden is daaraan? Of was dat gewoon van: hij was onder invloed? (NL_8)*

Fifth, a respondent clarifies that for some drug-related infectious diseases, such as hepatitis C, we only have a limited view.

> *Mais en revanche, pour l'hépatite C, je parle pour la partie francophone du pays, on est encore dans le flou, ce serait peut être utile d'avoir un registre tel qu'on le fait pour le VIH, avec un système de laboratoire vigie avec des médecins… (FR_14)*

Sixth, respondents refer to the various student surveys in Belgium. Respondents praise the initiatives towards school students, although there are some epidemiological limits. The most pertinent limit, is that none of the studies are aligned with one another, nor do they fit within the European ESPAD studies (for international comparability), mostly because of different aims and uses. There is for example the school student survey of VAD; This is often mentioned as a good practice because the data is used to develop a prevention offer tailored to the school that participate. However, since it has a different objective than purely an epidemiological one, it is not a perfect fit with ESPAD, for example.

> *Als je kijkt naar ESPAD zijn specifieke vragen rond meer dan illegale drugs, daar zit alcohol ook bij, er zit ook een stuk bij rond andere gezondheidsaspecten die gelinkt kunnen worden en, en ja hoe sluiten die daarbij aan die leerlingenbevraging, dat zijn niet dezelfde vragen, maar dat is geen perfecte fit. (NL_8)*

According to some of the respondents, a problem with the HBSC study, which is conducted in both Flanders and Wallonia, is that it is conducted differently in both parts of the country. Also, the part on alcohol and drugs is very limited. And lastly, there have been ESPAD studies in Belgium (specifically in Flanders), but due to lack of funding, these have ceased to exist.

Seventh, the nightlife survey in Flanders has great value, yet one respondent highlights that each time the survey is conducted, it is not comparable with the previous ones, because the populations differ too much. This is however inherent to the methodology of the survey, which voluntarily cooperates with certain events, which do not necessarily take place systematically or in similar circumstances every year. Additionally, the respondent refers to the fact that the way the survey is conducted, is time consuming.

> *Zeker bij het uitgaansonderzoek is het wel een uitdaging om het onderzoek op die manier te blijven doen, omdat het tijdsintensief is om zelf naar de locaties te gaan en daar een steekproef van mensen te bevragen. Daar zijn we soms al over aan het nadenken geweest over hoe we het mogelijks anders zouden kunnen aanpakken of bijvoorbeeld online - zoals de Global Drugs Survey die via een online vragenlijst werkt - maar dan zit je ineens wel met een heel andere methodologie die ook dan zijn eigen knelpunten heeft. (NL_18)*

Lastly regarding the early warning system, two respondents indicate that there seems to be a misconnection with some laboratories. According to them improvements in cooperation and communication are needed. Also, as the following respondent indicates, there might be issues with the secrecy of the investigation when justice is involved.

> *Certains juges d'instruction ont tendance toujours à éluder, ne pas donner des informations assez rapidement, alors qu'il y a un texte légal qui fait qu'ils ne peuvent plus se retrancher derrière le secret de l'instruction pour donner des informations sur des intoxications ou des décès. (FR_14)*

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- Identified needs on all policy levels:
  - A further development of existing indicators
    - Treatment demand indicator, for example by including non-specialised treatment, crisis care and general practitioners, to present real-time data, or to include behavioural addictions.
    - Drug related infectious diseases in Wallonia, for example by implementing a similar register like for HIV.
    - Indicators for supply.
    - Early warning system, for example by checking the collaboration with the laboratories, but also by allowing drug checking as a market monitoring system.
    - Drug use, for example by triangulation of data
  - Get a better insight into:
    - The context and motivation to use drugs.
    - Regional differences in drug use, and in treatment demand.
    - The drug use of specific populations, like people in prison, the sport sector or people at work, for example, through a periodical survey.
    - Other drug-related diseases, for example, liver failure.
  - Coordination and alignment of the different indicators on the supply side and on the demand side.

c. Fragmentation of existing data

Some respondents identify the hesitance to share data as a barrier. One respondent for example refers to some sort of competition in the field to create and disperse information. The respondents link this perception to the lack of a proper mandate of the national focal point. According to this respondent, an overarching vision regarding a shared mapping of the drug phenomenon might help.

> *En dat is denk ik wat dat mij ontbreekt daarin, is dat het precies een competitiviteit is in het landschap in België voor het creëren of voor het afgeven van informatie en dat is opnieuw gewoon een gebrek aan een structurele manier van werken, een structureel mandaat. (..) ik denk dat nu dat het veel te hard gaat over pakketjes, alle zo het feit van jij bent verantwoordelijk voor dit, je bent verantwoordelijk voor dat, terwijl dat er geen gemeenschappelijke visie of missie dan eigenlijk aanhangt. (NL_8)*

Today, there is a lot of relevant epidemiological research and quality data available. However, many respondents describe a fragmentation of the data. There is not always a good overview available of what is already out there, which hinders the use and dissemination of that data. Respondents mention that there are points of improvements for the harmonisation of the available data.

> *Ik denk dat het belangrijk is dat data beschikbaar zijn en dat dat ook wel het moeilijke is. Dat is vaak (…) om die (…) data samen te brengen een hele zoektocht. Niet veel dingen zijn goed zichtbaar of worden goed gerapporteerd. Dat zou wel een meerwaarde zijn, mocht daar meer worden in geïnvesteerd op verschillende domeinen. Ook een coördinatie daarbinnen zou goed zijn, al wordt dat nu wel opgenomen door BMCDDA, maar wat zeker - als ik voor mezelf spreek - niet altijd zo duidelijk is of niet altijd zo publiek is. (NL_18)*

> *Het verspreiden van die kennis, het harmoniseren van die kennis, het gebruiken van de best practices, uhm, want iedereen draait een beetje op zijn eigen omdat er geen push komt van boven, dan gaat iedereen gewoon door hé. (NL_5)*

B. Barriers and bottlenecks related to the objective 'To develop and mobilise scientific knowledge in function of a global and integrated drug policy'

a. An often limited degree of diversity in BELSPO projects

Although the BELSPO program is praised by many respondents, respondents also mention a few barriers and bottlenecks with the program and related projects.

First of all, some respondents refer to the often narrowly defined projects without a specific link to a broader strategy, and the often short duration of the projects.

> *Er zijn dus heel veel onderzoeken geweest, maar die zijn soms vrij kort durend of op, dat is denk ik goed dat ze op iets heel specifieks gericht zijn, maar er zou wel denk ik, wat meer strategie en planning achter kunnen zitten. (NL_22)*

Second, many respondents mention the underrepresentation of French-speaking researchers, and the overrepresentation of Dutch-speaking ones, especially from certain universities. Respondents explain this underrepresentation by less motivation of French-speaking universities to submit Belspo projects, but also refer to community barriers and language barriers. This underrepresentation could lead to less attention towards Walloon and Brussels projects and initiatives, and that there is therefore less insight into the Walloon or Brussels region.

> *Parfois, j'ai l'impression que dans certains projets (et le vôtre est fort heureusement une exception, et prouve que le contraire existe), il y a parfois une sous-représentation de la partie francophone, pour des raisons pratiques. La première étant qu'il y a moins, je pense, de participation, ou de motivation à participer des universités francophones que flamandes, et des difficultés communautaires et linguistiques aussi. Mais quand les projets sont entièrement menés par une université flamande, c'est plus compliqué de venir au contact et récolter de l'information auprès de la population francophone. C'est un aspect qui est parfois regrettable dans les études Belspo. On remarque de manière générale que les francophones sont difficiles à mobiliser, que ce soit les usagers ou les services. (FR_14)*

A Dutch-speaking respondent furthermore refers to the fact that Flemish researchers and Walloon or Brussels respondents have few contacts with each other, nor are they familiar with each other's context (e.g. organisation of treatment offer) which explains why cooperation is less likely.

Some respondents mention that the recurrence of the same research teams in the BELSPO projects might be a bottleneck. Respondents note that, because research projects are often executed by the same research teams, they feel that some phenomena are extensively studied, whereas other phenomena remain understudied, depending on the background of the research(er) (team). For example, one respondent indicated that clinical practice or gambling have been rarely addressed. Reference is made to the Netherlands, where clinical practice is often evaluated, and research results of what works are validated to practitioners through a yearly valorisation congress. Two respondents also question the independence of certain researchers who are also more directly involved in drug policy.

> *Je kunt echter toch vaststellen dat er iedere keer wel zowat dezelfde groepen aan die BELSPO-onderzoeken werken wat bepaalde zaken in een bepaalde richting kan doen uitgaan of dat er zo bepaalde dingen gemist worden. (NL_18)*

Third, some respondents note the overrepresentation of projects on illegal drugs, although this has evolved during the past few years, with more projects on alcohol and psychoactive medication in recent years. Still, according to one respondent topics like gaming remain understudied. According to one respondent this could be related to a non-familiarity with the Drugs Research Programme.

Fourth, one respondent emphasises that most BELSPO research projects are focusing on the demand side, and projects regarding the supply side are less present. The respondent describes that this limitation is apparent when drafting the call for proposals, but also when research teams are asked to propose a blue sky project. When input is requested for possible research topics, the supply-related topics are often limited, or focus on a renewal of a previously performed study.

A fifth bottleneck focuses on the valorisation of BELSPO projects, although respondents mention that this bottleneck could be extended to other research projects outside the BELSPO program. Almost all respondents mention that there has been a lot of high-quality research projects within the BELSPO program, however, after a research project is finished, often little is done with the results. Respondents refer to the fact that often seminars are organised but no real return to the field, who are often in need for this. Another respondent indicates that valorisation usually takes place after the project has ended, and that therefore this research phase depends on the goodwill, time and availability of the researchers involved. Yet, another respondent mentions that this has recently been included as a specific criterion in the BELSPO assessment.

> *Il manque parfois une dernière forme d'output, comme simplement l'organisation d'un événement tel qu'il se fait généralement initialement, on a un événement plus scientifique souvent au début, ce serait bien que ce soit obligatoire d'avoir un retour plus public, ... Ou alors que l'institution fournirait un digest de l'information de l'année à travers les projets. (FR_14)*

> *Meestal op een klassieke manier he, meestal een studiedag. Waarbij dat je dan de uitdaging hebt dat je het in de twee landstalen moet doen, dat je tolken moet inhuren. Maar eigenlijk denk ik bij elk project dat wij al gedaan hadden zit die valorisatie er al in. Maar dan op een klassieke manier, dat dat dan voldoende doorstroomt naar beleid, naar de praktijk toe, dat is nog een ander paar mouwen (…) ik weet niet of dat de verdienste is van Belspo, maar in alle geval door de relatief beperkte budgetten, de korte tijdsframes, hebben ze volgens mij, toch zeker in onderzoek waar ik in betrokken ben geweest, altijd value for money gehad. Ik denk euhm, ja dat je in al die projecten, dat de onderzoekers zich dubbel geplooid hebben om alles tijdig rond te krijgen en dikwijls er nog een stuk langer aan gewerkt hebben. (NL_22)*

However, apart from the valorisation activities performed by the researchers themselves, the results of the project are often not translating into (new) drug policy. Many respondents describe that research is often not taken into account to redirect drug policy. In that sense, respondents mention that there is no real evidence-based policy in Belgium.

> *Dan stopt daar, dan zie je van kijk, we hebben nu een eerste fase in dat onderzoek, hebben we kwaliteitsindicatoren ontwikkeld die geïmplementeerd worden. Maar wie doet dat dan? Wie krijgt daar dan geld voor? Daar stopt het. (NL_16)*

> *Verder blijft het natuurlijk projecten die heel beperkt en afgebakend zijn binnen die BELSPO-oproepen, en nadien belandt het toch wel vaak in de kast. (NL_18)*

> *Soms gebeurt het onderzoek wel, maar dan stopt het daarmee. En soms gebeurt er helemaal geen onderzoek ook. (NL_3)*

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- Identified needs on all policy levels:
  - More strategy and structure into how research can support drug policy.
  - More longitudinal research and follow-up research, in order to get insight into treatment trajectories, but also into drug use and context throughout time, etc. by relying on both quantitative and qualitative methods.
  - A balance between quantitative and qualitative research.

- More diversity in the BELSPO projects, both in terms of regional diversity, as in thematic diversity.

b. The lack of an evidence-based policy

Almost all respondents acknowledge there is **no "real" evidence-based policy in Belgium**. At best, research results are used by practitioners in the field, but only seldomly, the research results are taken into account to develop or adapt policy.

> *C'est qu'on a parfois l'impression que de produire du savoir qui dort dans des rapports, qui n'est finalement exploité que par les spécialistes du secteur et pas tellement par les politiques. (FR_14)*

> *ik kan niet zeggen dat dat, ik denk dat dat altijd al zo geweest is, als je dan vraagt van wat is de impact geweest op beleid, dan denk ik dat dat al bij al vrij beperkt is. (NL_22)*

Respondents support this observation by for example referring to the fact that, although many pilot projects have been evaluated positively, many of these projects remain pilot projects after the evaluation. There is seldom structural implementation of the pilot projects (cf. supra), or the structural implementation drags on for several years (e.g. Drug Treatment Court).

> *Evidence based initiatieven ondersteunen, dat evaluatie onderzoek. Daar zie ik toch niet veel van op de werkvloer. En als het dan toch gebeurt... We hebben bijvoorbeeld zo'n project gehad (…) binnen de gevangenissen. (…) Da's geëvalueerd geweest, als positief bevonden, maar goed, dat is het dan hè. Daar gebeurt daar niks verder.(NL_3)*

Furthermore, one respondent describes that research is taken into account as context for policy making, as a "good to know".

> *Ze nemen dat meer als contextinformatie. Ze doen verder met hun beleid. We zitten niet in een Covid-crisis waarbij dat je echt een mening moet vragen van een onderzoeker of een specialist of een wetenschappelijk expert, die je eigenlijk volgt. (NL_5)*

Another respondent refers to the fact that sometimes, when an evaluation is carried out, and the results are published, there is a different minister responsible for the subject, or (after the sixth state reform), even a different policy level. As a result, little is done with the research results. Moreover, as the respondent below also points out, research is often used in an opportunistic way for drug policy. What fits into the current framework is included, what does not fit into that framework is ignored.

> *Het onderzoek vaak na de implementatie, bijvoorbeeld van een bepaalde beleidsmaatregel die er kwam, waardoor dat dat dan al een andere minister was, of een ander kabinet dat de bevoegdheid had over dat domein. Dus ja, dat denk ik dat de euhm, de echt impact van die onderzoeken, dat die ja, niet zo groot is en als hij al euhm, ja, als het onderzoek al gebruikt is dat het toch vaak ook eerder uit opportunistische dan fundamentele overwegingen is geweest. (NL_22)*

> *En niet zoals de Vlaamse overheid zegt, ge moet evidence based werken en dan eigenlijk zelf hun goesting doen en dingen naast hun neerleggen. (NL_15)*

As such, one respondent refers to the division of competences leading to a certain tension to developing an evidence-based policy.

> *Il y a la particularité de Bruxelles, avec la CoCom qui a ses connexions, avec des visions à long terme aussi, mais qui peuvent faire en sorte que la CoCoF puisse se sentir en position plus faible sur ces questions... et avec des positions bi-communautaires dans certaines compétences qui sont pourtant allouées à la CoCoF, cette complexité fait qu'au-delà des*

> *connexions qu'on peut entretenir et développer avec différents niveaux de pouvoir, il y a des problèmes de positionnement stratégique ou parfois de rivalités. (FR_14)*

One respondent also indicates that the drugs domain is still an ideological domain, where negative associations are easily made with the phenomenon. And that also influences a policy maker, so that perhaps less attention is paid to scientific results.

> *Mais je pense qu'un des grands freins, c'est que cette thématique des drogues génère encore tout un ensemble de représentations sociales négatives qui font que les politiques ont parfois du mal à prendre leurs responsabilités, par rapport aux différents moyens qu'ils pourraient mettre en place pour améliorer la santé de manière générale et le bien être des personnes concernées par ces comportements. (FR_14)*

Some respondents therefore promote an evidence-informed drug policy, rather than an evidence-based drug policy.

> *Ik bedoel de evidence based policy dat bestaat niet eh, evidence informed policy, wij moeten ook nooit een evidence based policy hebben dan, dat dan is het geen policy of politiek meer dan heb je gewoon experts. (NL_5)*

All the more so because there are limits to evidence-based research. For example, the research conducted is often not in line with what practice encounters. Moreover, it deals with very complex problems in which cause and effect are difficult to distinguish.

> *"Dat is, dat laat zich echt allemaal niet zo gemakkelijk meten in RCT, en in dat soort dingen he. Ik bedoel allee ja, die RCT's en dan meestal monodiagnoses, want het gaat over alcohol. Hoeveel keer komen we dat tegen in de praktijk? Dat kom je bijna nooit tegen." (NL_16)*

Another identified bottleneck is the lack of outcome evaluations. Many respondents refer to the need of an evidence-based policy, explaining that an evidence-based policy means evidence on 'what works'. Respondents refer to effect evaluations, and the need for 'hard evidence' on what works, and what does not work. One respondent explicitly highlights research that quantifies a problem, such as SOCOST, YIELCAN and Drugs in figures, in order to get an 'objective' insight into the drug field.

> *Maar doe dan iets dat meer evidence based is, dat je kunt zeggen dit is de causaliteit die daarachter ligt (NL_5)*

> *En ja, als je geen duidelijke cijfers hebt, in veel gevallen, dan pakt dat ook niet politiek. Ge moet goeie cijfers hebben, bijvoorbeeld de SOCOST studie was heel goed omdat dat een impact geeft, zo van die dingen, maar zo zijn er niet veel van die dingen. (NL_1)*

At the same time, respondents emphasise the barriers to conducting a quality outcome evaluation. For example, there is a need for a decent registration and monitoring from the beginning of a project, in order to be able to evaluate it properly. Most of the time, an evaluation is ordered post hoc. So, measurement from the past, have to be reconstructed afterwards, which often results in evaluation projects that are perceived as lower quality projects. Or as one respondent states: "quality outcome evaluations, need quality data" (NL_22) Often, however, a picture must be formed in retrospect.

Yet, not all respondents share this holy believe in 'hard evidence', and emphasise the importance of qualitative research, besides a quantitative approach.

> *C'est bien beau le quantitatif, mais il faut donner du sens à tout ça et pour donner du sens à tout ça il faut le relier à du qualitatif, à du vécu. Et c'est important aussi de financer des études qualitatives à côté du quantitatif. Je pense que les deux sont indissociables. (FR_14)*

Respondents also refer to the importance of input from the professional field. The field of work, as well as people with lived experiences, are in touch with the field of work and therefore not only know what is going on in practice, but also what works in a certain context and what does not.

Ik denk dat dat absoluut een goed idee is om evidence based of evidence informed uit te voeren, en daarnaast ook veel meer het middenveld, civil society organisations te betrekken, omdat wij op zijn minst practice based werken en heel veel voelen van wat er op het werkveld leeft, maar wat er ook werkt, en ook voelen wij wat er niet werkt. (FG_RC_R2)

In line with some of the abovementioned barriers and bottlenecks, the respondents mention the following needs:

- Identified needs on a national level:
  - Evaluation should be part of a project from the start, in order to enable outcome evaluation. Monitoring and clear registration should be built in from the start.
  - Attention to valorisation of research.
  - A drug policy informed by research, and evidence-based decisions.

8.3.2.3 Challenges

We asked the respondents what they identified as a challenge for the realisation of the policy intentions for the pillar 'Epidemiology, research and evaluation'. Unlike the bottlenecks and barriers described by the respondents, these challenges are not identified as a problem *an sich*, but issues that hinder the realisation of and integral and integrated approach. In this section, we list three challenges raised by the respondents

A. Administrative caseload with the registration of indicators

Some respondents refer to the hesitation in the field towards the administrative caseload that might come with the registration of certain indicators. Everyone agrees on the importance of evaluation, respondents admit. However, when it comes to adequate registration, which is essential for evaluation research, a hesitant attitude is often adopted, because it includes a workload for the practice field and registration systems are often not adapted to the registration of certain indicators.

Bij registraties moeten ze altijd rekenen, niemand ziet u graag komen, registratie is altijd extra werk en in geen systeem past dat eigenlijk goed thuis.(NL_8)

Ja ik kan dat alleen maar onderschrijven, ik geloof enorm in datacollectie, maar ik wil ook wel meegeven dat de meeste hulpverleningsdiensten daar geen tijd voor hebben, of geen mankracht voor hebben, om dat fatsoenlijk te doen. De meeste datacollectie gebeurt tussen de soep en de patatten, bij wijze van spreken. (FG_RC_R10)

Respondents thus identify the balance between a good evaluation versus good registration in the field, as a challenge. An important prerequisite for respondents is that sound investments are made, for example in the range of tasks, to make registration possible.

B. Providing real time data

One respondent mentions that epidemiological data always gives a view of the (recent) past, because data collection, data management and data analysis take time. The data flow, as well as analysis often take too long, so that the results always say something about the previous year, but not the present. For some phenomena this is not really a problem (e.g. the use of cannabis amongst 15/16-year-olds), but for other phenomena an up-to-date view is essential (e.g. to develop policy recommendations), such as a view on new drug trends.

Maar we zitten wel heel hard vast in een gegeven waarbij dat we gegevens verzamelen en met een zekere vertraging die gegevens verkrijgen en analyse erop doen. Dus tegen de tijd dat je

er een aanbeveling op doet, spreken we vaak over een situatie die sowieso al iets wat verder in het verleden ligt. Hé, bijvoorbeeld over de behandelingsdata is dat zo. (..) Maar meer en meer gaan we moeten werken naar meer real time data, uhm, real time analyses die veel korter op de bal spelen en die veel meer kunnen gaan zeggen van, dit is de situatie. Omdat uiteindelijk, dat is wat dat het is, als we spreken over, wat zijn de trends, dan willen we graag weten wat dat er nu gaand is en wat dat er nu moet gebeuren. Als je spreekt over wetenschappelijke data die gebruikt wordt voor beleidsaanbeveling, willen we graag iets dat de actualiteit zo goed mogelijk benaderd om daar iets op te doen. (NL_8)

To keep up with the rapid changes in the drug phenomenon, it is therefore essential to work with the most recent data on new trends. This obviously creates a number of practical challenges, not in the very least, technical ones (e.g. dataflow after registration). However, as some respondents indicate, if it is possible to have daily updates on the number of infections, hospitalisations and deaths of corona, it is not impossible to extend this practice to these drug-related phenomena.

C. Balance between blue sky projects and needs in the field

The respondents indicate that one of the challenges of the BELSPO projects is to find a balance between the blue sky projects, where researcher can propose a topic themselves, and research projects that respond to the needs in the field. Blue Sky projects allow researchers to develop their own projects independently of policy priorities. At the same time the research must remain policy-relevant and contribute to policy and/or practice.

Ik denk dat het best (…) opengetrokken wordt. De blue sky is, denk ik, een element waar dat de [onderzoeksteams] een beetje ruimte krijgen om hun eigen project uit te werken dat niet beantwoordt aan het één of ander prioriteit, maar dat het wel belangrijk is. (NL_5)

On the other hand, some respondents identify concrete needs in the field that need to be studied, for example to focus on the evaluation of the clinical practise, but which are often insufficiently addressed in the current BELSPO projects. One respondent expresses the need for an overview of what the current evidence base has shown about (certain aspects of) the treatment offer or specific treatment methods.

Dan denk ik, dat is het zo een beetje en als je dan ziet van wat komt daar van terug, wat heeft de gemiddelde hulpverlener daar aan? Ik ben soms een beetje jaloers op de Nederlanders, ik weet wel, je kunt dat niet vergelijken, Nederland met Vlaanderen. Maar als ik zo, ik ga jaarlijks naar Amsterdam, dat jaarsymposium Verslaving. En altijd krijg je daar bij wijze van spreken overzichten op vlak van, als behandelaar van dat en dat kun je doen en dat en dat is onderzocht. (…) En dan krijgt het weinig, euhm, ingang of wordt weinig geïmplementeerd in de brede verslavingszorg. Ik heb altijd, ik vind dat echt wel spijtig. (NL_16)

8.3.2.4 Perceived unintended consequences

When respondents were asked to identify possible positive or negative unintended consequences of initiatives within the 'Epidemiology, research and evaluation', none of the respondents identified unintended consequences.

8.3.2.5 Conclusion of the context to the stage of realisation

The semi-structured interviews and the focus group with practitioners, civil servants and experts gave insight in how the Belgian drug policy is shaped in daily practice, and how "policy in the books" is translated to "policy in practice". The results show that there are limits to the "policy in the books" intention for an evidence-based drug policy. Respondents emphasise that monitoring and research have evolved over the years, in which Sciensano, as the Belgian National Focal Point, and the Federal

Science Policy play an important role. This has resulted in a solid evidence base alongside the already existing international evidence base.

Nevertheless, both in the monitoring of epidemiological indicators, as well as the research towards the drug phenomenon, barriers remain. For the monitoring of the epidemiological indicators, barriers include the fact that each of the current epidemiological indicators has its limits, problems with funding and a streamlined mandate in the coordination between the National Focal Point and the sub focal points remain, and the limited visibility of the current epidemiological work, which in turn results in lack of recognition. Furthermore, respondents mention a fragmentation of epidemiological research and quality research data. This confirms the observations in the previous pillars, as well as the results of the document review.

With regards to the existing research towards the drug phenomenon, coordinated by the Federal Science Policy, respondents describe a lack of regional and thematic diversity in the research projects, as well as the limited valorisation of the research results, both in terms of translating the results to actual policy, as well as the lack of accustomed valorisations of the research results to the different stakeholders from the researchers themselves.

However, the respondents still put the focus of an evidence-based policy predominantly on a 'what works' evaluations, where 'causality' and 'hard evidence' are emphasised, although several respondents also highlight the importance of (qualitative) input of practitioners and lived experiences. Despite this emphasis on effect evaluation research, researchers often come up against barriers to conducting a proper evaluation. Current evaluation studies, for example, have to work with limited registration and limited monitoring of new projects, which prevents high-quality evaluation.

The results also indicate that the premise of an evidence-based drug policy clashes with its limits. Current monitoring initiatives and research projects are more often focused on getting insight or evaluating the demand side than getting insight or evaluating the supply side. Additionally, despite positive evaluations, many pilot projects do not appear to be structurally implemented. Lastly, respondents also indicate that research results are at best translated into changes in practice, but research results rarely lead to policy changes.

8.4 Lessons learned

The transversal theme ‘Epidemiology, research and evaluation’ is an essential part of the Belgian drug policy. To develop the three pillars ‘Prevention’, ‘Care, risk-reduction and reintegration’ and ‘Enforcement’, an epidemiological and evaluation instrumentation is indispensable. These are the ‘lessons learned’ of a process evaluation of this transversal theme.

POLICY INTENTIONS:

A **critical appraisal** of the policy intentions of the Federal Drug Note and the Joint Declaration found that:

- ⇨ The transversal theme ‘Epidemiology, research and evaluation’ is generally **explicit on its objectives and central actions, but often remains vague about the concrete intended outputs and outcomes**.
- ⇨ The transversal theme ‘Epidemiology, research and evaluation’ **does not distinguish between short-term, medium-term and long-term outcomes.**
- ⇨ The transversal theme ‘Epidemiology, research and evaluation’ is not explicitly based on a recent situation analysis.

- ⇨ The transversal theme 'Epidemiology, research and evaluation' is **mostly logical,** but the actions in 'Epidemiology, research and evaluation' **focus mainly on the demand side**, both for the monitoring of indicators, as for evaluation research.

MEASUREMENT OF POLICY INTENTIONS:

With regards to the **extent of realisations**, we found that:

- ⇨ The document review reveals that there is **little structural follow-up of the implementation of the Federal Drug Note and Joint Declaration**, nor of other developments in the transversal pillar 'Epidemiology, research and evaluation', resulting in a fragmented overview of the implementation of both policy documents.
- ⇨ The document review shows that there have been **many epidemiological and research developments**. With regards to evaluation actions, the realisations remain more limited, especially for the actions on the supply side.
- ⇨ The survey learns that there are **a lot of discrepancies in the level of perceived realisation**.
- ⇨ For most objectives, there are **discrepancies between the actual and perceived realisation**. In most cases, we see that, although the document review identifies certain actions as realised, there are survey respondents indicating them as partially or even not realised. This shows that actions may be implemented (cf. document review), but they do not necessarily operate in the best possible way, and improvement is necessary (cf. survey).

With regard to the **context to the stage of realisation**, practitioners and civil servants perceived that:

- ⇨ Although the epidemiological monitoring and research field has made **an importance evolution** since the establishment of the Federal Drug Note, there are s**till barriers and bottlenecks** to a thorough and transparent monitoring and evaluation of the drug phenomenon and drug policy (initiatives), as well as a decisive coordination.
- ⇨ Research towards the drug phenomenon **a lack of geographical and thematic diversity** in the research projects, and remain **limited in the valorisation** of research results towards the field or towards policy.
- ⇨ Despite the **predominant focus on "what works"**, the **value of qualitative research** and the **input of practice** and **lived experiences** is emphasised.
- ⇨ The premise of an **evidence-based drug policy clashes with its limits** in practice, for example because research results seemingly barely result in policy change.

CHAPTER 9

EVALUATION BY PEOPLE WHO USE DRUGS AND PEOPLE IN RECOVERY

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9 EVALUATION BY PEOPLE WHO USE DRUGS AND PEOPLE IN RECOVERY

Engaging people with a lived experience of usingdrugs - in drug policy is essential. After all, they are the people affected by drug policy (Lancaster et al., 2017; Ti et al., 2012). Within a drug policy, peers can leverage their personal knowledge and skills to collaborate and consult, ensuring that their priorities and needs are addressed (Ahmed & Palermo, 2010). Moreover, it reflects a broader trend towards inclusive democratic participation and pluralisation of knowledge (Gaventa & Cornwall, 2008). We therefore engaged people with lived experience in the evaluation. The purpose of engaging them in our EVADRUG research, was to actively process the experiences and perspective of people who use drugs/who are in recovery regarding the Belgian drug policy and to map out how people they evaluate the current drug policy.

Three focus groups were organised in Ghent, Antwerp and Brussels and a total of 23 respondents were reached through the different focus groups. During the focus groups, different aspects of drug policy were discussed. The script of the focus group can be found in annex. All focus groups were subsequently transcribed, before they were coded and analysed through NVivo. As with the semi-structured interviews, the analysis consisted of a thematic analysis in a first step, and a more in-depth analysis in a second step (cf. supra). In this chapter, the results of the three focus groups with people with lived experiences are discussed.

In this chapter, the results of the focus groups with people with lived experiences are discussed. The chapter summarises different themes that consistently came up during the focus groups. As explained in chapter 2, the final sample of the different focus groups consisted of a group of respondents with a fairly similar profile, which explains why the diversity in the answers remains relatively limited.

9.1 People with lived experiences face a lot of stigma regarding their (former) drug use

During the different focus groups, nearly all respondents referred to stigma in different forms. This section explores how the respondents are confronted with stigma and how they relate such experiences to the Belgian drug policy.

9.1.1 Public stigmatisation, especially towards people who use illegal drugs

Most respondents describe several negative stereotypes about people who use drugs held by the wider public. Many respondents indicate that the wider public views people who use drugs as marginalised people, homeless or “with a needle in their arm “. The negative stereotype often refers to the use of illegal drugs but to a lesser extent to, for example, alcohol.

> *Dus ik vind wat dat betreft het beeld ook heel erg eenzijdig van verslaving. Het is meteen een marginale, terwijl het komt in alle lagen van de bevolking voor. En dat mag ook wel benoemd worden vind ik en dat mag zeker al beginnen bij drank.* (NL2_R1)

The respondents emphasise that this negative stereotyping is a very narrow interpretation of drug use and drug addiction. It does not recognise drug use that does not fit this stereotype, for instance recreational drug use. Moreover, it stigmatises a very large group of people and lumps everyone who uses drugs or suffers from addiction together. People who use drugs are often portrayed as criminalsor looked down upon. To them, also the law considers them as criminals– as the participants will later also stress. In effect and by law, they are criminals too – as the participants will later also stress. Respondents describe how the wider public wants to avoid association with people who use drugs in all possible ways. For example, some respondents described that there are often protests when a treatment centre for

people with addiction is set up in their neighbourhood. Another respondent describes that harm reduction initiatives like drug consumption rooms are sometimes marketed to the wider public as "removing drug users out of the street scene", as if they were giving up on people who use drugs by keeping them inside, rather than trying to help them.

> *R4: Gewoon, mensen willen dat niet. Oh drugsverslaafden. Je moet maar eens proberen om een illegalencentrum in uw buurt te krijgen, dat is precies hetzelfde.*
> *R2: Plus ook drugsverslaafden= criminelen.*
> *R4: Dat is allemaal een pot nat volgens hen.*
> (NL2)

> *La première chose à faire, c'est déstigmatiser. Les gens n'auraient plus honte et ça diminuerait les problèmes. Une fois qu'on part de là, on peut prendre différents chemins, mais on peut enlever la culpabilité, et ça passe par la levée de l'interdiction (FR_R1).*

Several respondents emphasise that this stigma is especially the case towards people who use illegal drugs. Several respondents note that alcohol is generally accepted by the wider public. People who drink alcohol are perceived as sociable and pleasant people, respondents notice. As a legal substance, alcohol is also ubiquitous in daily life. Unlike people who use alcohol, people who use illegal drugs are considered as marginalised, respondents emphasise. They have to buy their drug in an illegal setting , and are therefore portrayed as criminals. As a result, they feel like looked down upon and more stigmatised than people who use alcohol.

> *Iedereen drinkt, allé of vele mensen drinken. En als het gaat over een jointje roken of zelfs coke of bruin, daarvan kan je in de gevangenis geraken, voor coke of zelfs voor iets op zak, dus dan ben je crimineel. (NL2_R3)*

> *Pour les usagers de drogues, tout est à la répression, quand c'est illégal. Maintenant, quand c'est légal, je parle de cigarettes, je parle d'alcool, il y a l'absence de prévention, parce qu'on en parle pas, ça n'existe pas, et quand ça existe, on te colle une étiquette et on cache ce qu'on ne saurait voir, et voilà... (FR_R1)*

> *L'alcool, c'est très mauvais pour la santé, mais on trouve ça normal, on ne dit rien. Quelqu'un qui fume un petit joint dans la rue ou dans un petit parc, c'est commissariat, perquisition, ça te fait des problèmes personnels, familiaux, voisinage, pour juste un petit pétard, alors qu'on autorise l'alcool dans les pompes à essence, or que sur l'autoroute on n'est pas censé s'arrêter à la pompe à essence et boire des bières... c'est de l'hypocrisie totale (FR_R5).*

Even within the treatment services, respondents describe this difference between people who use alcohol, and people who use illegal drugs. In a sense that within the group of people with lived the respondents experience inter group stigma, for instance when people who misuse alcohol look down on people who misuse illegal drugs.

> *Maar het is he, ik weet nog in de tijd dat ik in (…) binnenkwam, hadden ze twee groepen he. Dat waren de alcoholverslaafden en de drugsverslaafden (..). En de alcoholverslaafden die keken echt neer op de drugsverslaafden, echt he. (NL2_R4)*

9.1.2 Stigmatisation by the police

Many respondents have been in contact with the police. During these contacts, they have been confronted with stigmatisation from the police. According to the respondents, the stigma associated with drug use causes the police to treat people who use drugs differently: the police acts less respectful and correct towards people who use drugs, in comparison to non-users. For example, one respondent described being laughed at and being made fun of when he was locked up by police officers who had arrested him. Another respondent described being stopped by the police when he was out for a walk

with his son. Despite the fact that his last drug offences dated 10 years back, they stopped and searched him in front of his son, a minor. Many other respondents acknowledge the incidents and indicate that they have been confronted with similar situations.

> *En ook als ze u tegenhouden zijn ze efkes vriendelijk en ze roepen u dan op wat dat je gedaan hebt en ze horen dan: "Ah, ja, druggebruiker," en dan verandert hun gedrag ook. (NL1_R8)*

> *R14: Ze beschouwen u eigenlijk als... Ik vraag mij af als wat dat ze u beschouwen. Ik weet het niet. Beschouwen ze u als een crimineel, als uitschot, of wat is dat met die gasten? Je weet het niet meer op den duur.*
> *R4: Nog slechter, een hond.*
> *(NL1)*

Most respondents conclude that their drug use and previous convictions remain a label they have to deal with when they interact with police.

9.1.3 Shame and self-stigmatisation of people who use drugs

Lastly, even respondents refer to feelings of shame and guilt because of their use, and describe themselves as being unwanted, as people that need to be removed from the streets. It seems that the stigma that is propagated by the wider public, is echoed by (some) of the respondents too.

> *(…) dat jullie niet om ons hebben gevraagd, want we hebben zelfs niet om onszelf gevraagd* (NL1_R14)

> *Terwijl, als ze ons allemaal in deze ruimte duwen, gaat de rest van de wereld ons niet zien hé.* (NL1_R6)

Not all respondents agree. Some respondents oppose the internalisation of such negative stereotyping. For example, when one respondent described himself as having a past of being a “junkie”, other respondents reacted affronted by that. They emphasised that the negative stereotypical category of “junkies” is very different from who they are, and explicitly differentiate themselves from that category.

Some respondents mention that these feelings of guilt for the fact that they use illegal drugs, results from the fact that illegal drugs are prohibited. One respondent further notes that the focus should not be that drugs are prohibited, it should be that using drugs is not a healthy choice.

> *Veel mensen die gebruiken voelen [zich] heel schuldig. Dat helpt niet, vind ik. Het is dat ding van het niet mogen.* (NL1_R3)

Key messages of people who use drugs and people in recovery emphasised during the focus groups:

- Decriminalise the use of drugs (drug possession), so that the use (possession) of drugs is taken out of illegality.
- Work towards a comprehensive image of drug use and addiction.

9.2 An evaluation of prevention

When the respondents are asked how they evaluate drug prevention in Belgium, most respondents acknowledge the importance of prevention, especially towards young people. Many respondents mention that it is important to paint a comprehensive picture of drug use and addiction stressing the diversity, which is not always the case at the moment. They, for instance, indicate that people should be informed about the impact of drug use, including alcohol and tobacco.

La prévention, c'est compliqué parce que faut pas que ce soit de l'incitation (FR_R2)

On peut pas dire ça, je suis désolé. Moi je pense que, faire de la prévention, c'est aussi dire qu'il y a du plaisir, prévenir c'est être juste dans ce qu'on raconte, et pas essayer de diaboliser, l'incitation il n'y en a pas (FR_R4)

C'est pas parce que tu vas pas parler de sexualité que tu vas pas avoir des relations sexuelles. Et donc c'est pas parce que tu vas pas parler de drogues que tu vas pas être confronté à la drogue. Dans la même optique qu'on parle de sexualité aux enfants au moment où on se cherche, où on se pose des questions, il faut aussi faire de la prévention, et aussi auprès des parents, de l'ensemble des acteurs sociaux, que ce soit les professeurs, le PMS... il y en a plein qui ne savent pas ce que c'est et qui font n'importe quoi (FR_R1).

They also highlight to talk more about the subject (for example at schools). When talking about it in public, , the taboo might decrease. Many respondents suggest to stimulate the involvement of experts by experience during this kind of prevention, to set an authentic and diversified tone of the prevention messages.

Maar om terug te komen op die preventie, (…) dat werkt niet uit 'het mag niet, het kan niet', maar meer vanuit ervaringsdeskundigen. We gaan niet zeggen dat alcohol niet slecht is, want alcohol is legaal. Is het slecht? Ik mag geen alcohol drinken, maar heeft iedereen verslavingsproblematiek? Neen. Er zijn mensen die dat gezond kunnen pakken, maar wij vertellen wat de consequenties kunnen zijn. Ik denk dat op die manier die preventie wel goed lukt. (…) Het zou beter zijn geweest moesten ze het bij mij zo gedaan hadden. (NL1_R5)

Moi je trouve que c'est fondamentalement aux usagers de faire passer le message de la prévention, c'est eux qui peuvent parler le mieux de leur parcours, leurs plaisirs comme leurs erreurs (FR_R4)

When focusing on the prevention of alcohol, some respondents stress that there is a lack of a clear alcohol prevention policy . Alcohol is not only widely accepted, it is also closely linked to everyday life. Respondents describe that drinking at work is accepted, and give examples that, when they were young, their teachers drank a beer every afternoon, or that people at work drink beer during noon. They also describe how alcohol is available almost everywhere 24/7, with no real restrictions, compared to for example the Netherlands. Alcohol is even promoted during football games and on TV. There is no real prevention, nor are people well aware of the impact of alcohol. Again, respondents emphasise the importance of informing the general public as profoundly and honestly as possible about the impact of alcohol.

En dat is zo euhm, gebagatelliseerd het gebruik van alcohol. Dat ik nu pas sinds ik clean ben dat ik om me heen zie hoe de hele maatschappij er rond gebaseerd is. Cafés die pas om drie-vier open gaat waar je ook kan eten, wat echt gericht is op het gebruik van alcohol. (…) maar gewoon ik ben nooit voorgelicht over alcohol, verslaving bijvoorbeeld, ik zei ook altijd dat ik clean was terwijl ik elke dag dronk. En het is ook redelijk geaccepteerd, er wordt ook niet heel erg problematisch over gedaan. Het is voor het eerst dat ik ook gestopt ben met alcohol en nu pas merk dat het wel heel erg verweven is met samenleving. (NL2_R1)

Almost all respondents stress the importance of prevention among young people (especially in schools, in youth clubs). Respondents often state that, for them, an intervention came too late, and they therefore emphasise the importance of early intervention, especially towards young people.

A few respondents also mention more structural safety nets as a prevention strategy for drug use and addiction. They describe how the lack of connection to society relates to the use of drugs as a way of coping with the societal apathy. One respondent for example explains that the lack of connection between people today, further encourages problems, including drug use. Prevention should therefore be focused on these structural root causes too.

Lastly, some respondents in the French-speaking focus group point to the fact that prevention was not always sufficiently inclusive towards the ethnic and socio-economic groups in the population.

> *Ils ont un bon programme mais ils visent une population bourgeoise blanche, je dis les choses comme elles sont, ils parlent de produits comme l'ecstasy qui sont vraiment consommés par une catégorie spécifique de la population, mais pour d'autres populations c'est moins accessible, alors que c'est ces populations là qui sont plus susceptibles d'avoir des problèmes, ils sont moins visés, il y a une partie de la population qui est oubliée, et c'est à cause de cette approche par produits (FR_R3)*

9.3 An evaluation of harm reduction

When the respondents are asked about their evaluation of harm reduction in Belgium, they are generally positive about the existing harm reduction initiatives, and expressed their wish for the further development of other harm reduction initiatives like drug consumption rooms, drug checking and the provision of Naloxone.

9.3.1 Existing harm reduction initiatives are perceived as positive

First of all, several respondents have experiences with using methadone. They highlight the importance of methadone treatment, and evaluate it positively. They mention that methadone helped them in different ways. Some respondents highlight that because of methadone, they would move less into illegality, and being off side vis-à-vis society. Other respondents highlight that it helped them in their recovery process.

Second, many respondents refer to syringe exchange as an important harm reduction initiative. Most respondents evaluate syringe exchange in a positive way because it reduces the risk factors for blood-borne diseases such as HIV/AIDS and hepatitis, and it is very low-threshold. They highlight the importance of having different places where they could exchange their syringes. Some respondents prefer the pharmacy, others day centres or other places, depending on personal reasons (e.g. wanting to avoid contact with friends who use or wanting to avoid condemning looks). Nevertheless, respondents mention that there are still many peers who are not familiar with the practice of syringe exchange. Respondents also highlight that syringe exchange is especially aimed at people who inject drugs. Harm reduction for other drug use should be promoted too according to them.

9.3.2 New harm reduction initiatives are cheered on

Apart from a positive evaluation of some existing harm reduction initiatives, respondents underline that some harm reduction initiatives are not yet implemented (mostly in Flanders). Most respondents mention the implementation of drug consumption rooms in all big cities, also in Flanders. Respondents explain that drug consumption rooms could provide a place to use drugs in a safer and more controlled way, in particular for homeless people. Several respondents also emphasise that it is a way of removing the nuisance associated with drug use, which again confirms how respondents have internalised stigma. However, some respondents also say that, if a drug consumption room was set up in Ghent, they would not immediately make use of it, whereas respondents in Brussels, who are aware that such a facility is announced to open by the end of 2021, report a positive view about it.

> *Welja, da's ook daarstraks gezegd: een plaats waar dat je proper kan gebruiken. Dat vind ik al niet slecht. Ik zou het zelf ook niet echt doen, maar ik zou het wel goed vinden moest het bestaan. (NL1_R11)*

> *Heureusement, il paraît qu'ils vont ouvrir la salle de consommation. Moi je suis dans un trajet de soins pour arrêter parce que j'ai 20 ans de consommation... Mais s'il y avait une salle de*

consommation il y a quelques années, avec des produits propres, avec du matériel propre, un endroit sécurisé, et pas consommer dans la rue parce que moi je suis passé par la rue, on se met dans le métro, dans des squats, c'est très dangereux (FR_R5).

Also drug checking is emphasised by some respondents. They explain that this encourages the safe(r) use of drugs, when someone does not know what the substance exactly consists of. The respondents refer to the Netherlands, where drug checking can be done completely anonymously, for example at festivals.

Lastly, one respondent also notifies to make Naloxone available, as a strategy to reduce the immediate dangers associated with an opioid overdose.

Key messages that people with lived experiences emphasised during the focus groups:

- Harm reduction and safe use are important for people who use drugs and people in recovery. These initiatives should be supported and expanded.

9.4 An evaluation of treatment

The evaluation of treatment is elaborately discussed during the focus groups. Respondents refer to the lack of an overview of the treatment offer, a gap in the current treatment offer, and the impact of covid-19 on their access to treatment.

9.4.1 The availability of a diverse treatment offer, but a lack of overview

A first gap mentioned by many respondents, is the lack of overview of the treatment offer. Although the respondents have experience with various treatment initiatives, there are many respondents that are not aware of the many existing treatment initiatives and the broad treatment offer. Often, respondents mention certain shortcomings or gaps in the current treatment provision, while other respondents replicated that these . initiatives do exist

As such, some respondents explicitly mention that there are many treatment initiatives, but that there's a lack of overview on the existing treatment offer.

They also mention that once people have finished a programme, they often receive little guidance on the wide range of other options they have for further support or aftercare.

Ik denk dat er enorm veel zijn, maar dat het overzicht er niet is. (…) ik weet dat er enorm veel zijn, maar de mensen (…) weten niet waar ze moeten gaan zoeken en online is er te veel. Er is niets gecentraliseerd (..). Er zijn enorm veel werkingen, er zijn enorm veel vzw's die helpen met reïntegratie. Het probleem dat wij zien, is dat de professionele hulpverlening daar niet altijd van op de hoogte is. Dus na een traject van 6 maanden, een jaar in een TG, whatever, worden de mensen eigenlijk 'gedropt', tussen aanhalingstekens, zonder meer informatie van: Nu kun je daar naartoe gaan, je kunt daar voor een lotgenoot, je kunt daar voor vzw, daar kan je naartoe gaan voor bepaalde activiteiten. (NL1_R5)

Les compétences sont explosées, et on ne sait pas qui fait quoi. Moi si je cherche un centre, je sais pas où aller (FR_R3)

Furthermore, they mention that even some treatment providers cannot help them to provide this overview.

R4: Dat vind ik dan ook een stuk van de straathoekwerkers voor u daarin te begeleiden, maar dat gebeurt niet.

R5: Ze weten het zelf niet. Je wordt van het kastje naar de muur gestuurd. (NL1)

Le manque d'information, même entre structures, pour savoir diriger les personnes... moi y a des trucs que j'ai appris, mais plus tard... Chaque personne est différente, il faut que les acteurs collaborent ensemble pour s'adapter à tous les besoins (FR_R2)

One respondent explicitly refers to the division of competences between the Federal level and the Regions (in this case Flanders) as an extra barrier. Communication between these policy levels does not always work well, and respondents indicate that they eventually bear the consequences.

"Ah ja, maar dat is op gewestelijk niveau, ahnee da's op federaal niveau, ah maar nee, da's op dat niveau." Ze sturen u van het kastje naar de muur, terwijl dat eigenlijk het zitten, het moet eigenlijk een beetje meer in kaart gebracht worden. (NL1_R5)

Key messages that people with lived experiences emphasised during the focus groups:

- Need for an accessible overview of the treatment offer, so that people who want help, know where they can find it
- Need for more collaboration between professionals and services.

9.4.2 Gaps in current treatment offer

Nearly all respondents emphasise the importance of a comprehensive and diverse treatment offer. They explain that what works for one person, does not necessarily work for another. Respondents stress that everyone is different and that therefore the treatment options should be diverse and individualised too, ranging from low-threshold care to specialised treatment. Most respondents acknowledge that the current treatment offer is diverse. However, they highlight several gaps.

Dat is het ding dat R3 juist zegt. Je moet het een beetje individueel bekijken. Bij de ene past dit beter, bij de ander dat, maar er zijn zoveel verschillende soorten karakters en problematiek van soorten drugs dat ze meebrengen in het sociaal leven, dat het heel moeilijk is om alle problemen apart aan te pakken. (NL1_R4)

A first gap mentioned by many of the respondents, are the long waiting lists in several treatment facilities. Several respondents were confronted with long waiting list before they could enter a treatment program that fits them. Respondents describe waiting periods up to 12 months. One respondent said that he was admitted to a crisis intervention centre, but that after those 11 days there was no place in a subsequent programme. After 11 days he ended up back on the street.

Ja, op dit moment zijn de wachtlijsten tot 12 maanden. Ik heb geluk gehad, want het was echt niet te doen eigenlijk, allee 12 maanden. Als je op dat moment hulp nodig hebt, kan je geen 12 maanden overbruggen, dat gaat niet. (NL2_R1)

Moi dans mon parcours, j'ai été dans plusieurs centres, de bas-seuil, de cure, de post-cure, etc. mais chaque fois, là où j'allais, c'est parce qu'il y avait de la place. C'est pas parce que ce qu'ils offraient, c'était ce que j'avais besoin, mais juste parce qu'il y avait de la place. Je ne savais pas ce qu'ils offraient. Si j'avais pu savoir ce qu'ils offraient à ce moment là, ça m'aurait fait gagner beaucoup de temps... Ca manque vraiment, savoir où tu vas et prendre le temps de comprendre (FR_R3).

Another gap, connected to the previous one, is the fact that the treatment offer is limited or even non-existing in certain cities. For example, respondents describe that there are no therapeutic communities in Western-Flanders. Or they describe that for outpatient centres, they sometimes have to travel far.

Respondents therefore emphasise that the capacity and some types of treatment centers, such as outpatient centres, may be expanded, brought closer to their homes.

> *R3: Ja, wachtlijsten wegwerken he, en meer ambulante centra of wat is het daar allemaal. (…) En dat ze capaciteit van drughulpcentra echt wel mogen nog verder verhogen.*
> *R2: Dat de mensen die dat willen geholpen worden echt snel geholpen kunnen worden. (NL2)*

A third gap in the treatment offer is that certain target groups are less addressed than others. Respondents point out that some target groups such as the elderly user population, women with dual diagnosis, people with poly drug use and parents who use drugs, have trouble getting access to treatment facilities.

> *Veertigplussers, vijftigers, zoals de meesten van ons hier bijna, voor ons is er veel minder kans om ergens opgenomen te kunnen worden. Ge moogt gij nog bellen, je gaat minder kans hebben of een twintiger hé. Dat vind ik ook fout, want ik denk dat ik nu als vijftiger toch ook nog een kans verdien. (NL1_R11)*

Another example is given by a respondent with poly drug use. The respondent indicates that she had been looking for a place for a long time where she could be admitted for polydrug use, but that she often failed to get in because her situation was too complex for existing programs.

> *Maar het is natuurlijk ook heel erg gericht, heel veel programma's zijn gericht op mensen die één hoofdgebruik hebben, één middel gebruiken. En daar viel ik al bij heel veel aanmeldingen buiten de boot omdat ik meerdere vlakken verslaafd was. (...) Te complex voor hen om te behandelen. Dus ik vind dat voor polygebruik het aanbod zeer beperkt is. En daar ben ik ook echt tegenaan gelopen, ik heb drie maanden gezocht en allemaal aanmeldingen gevolgd, ja, en heel veel afwijzingen gewoon, daar word je ook niet vrolijker van. Als je een beetje in het afvoerputje terecht komt en iedereen zegt dat het een beetje onbehandelbaar is. (NL2_R1)*

Several respondents describe that facilities are becoming more selective about who they admit, and the free spots go to people with minor problems. Sometimes, respondents were confronted with very strict eligibility criteria. One respondent described how he could not get into a particular addiction treatment facility, unless he could prove that he was not using. Respondents explain how the most vulnerable people often do not receive the help they need.

> *Da's een ander probleem. De overheid vraagt meer en meer dat we bepaalde cijfers gebruiken. Dus hoe dat mensen slagen en dat willen meten. En dat betekent dat veel instellingen selectief zijn over wie ze aanvaarden. En de plekken gaan allemaal naar de mensen met lichtere problemen. Dezelfde mensen vallen weer uit de boot. (NL1_R3)*

To conclude, many respondents emphasise the importance of aftercare. The transition from a very protected environment to the "big outside world" is not easy. Respondents indicate that aftercare is very important, but that the current options for aftercare are too limited. Too often, aftercare is limited or even non-existentMany respondents indicate community centres or leisure facilities can play a significant role in this aftercare.

Key messages that people with lived experiences emphasised during the focus groups:

- Increase the capacity of day centres, in order to eliminate waiting lists.
- Pay attention to certain target groups in the treatment offer, especially to older people who use drugs, people with multiple and complex problems, women with double diagnosis, etc.
- Better regional distribution of inpatient and outpatient treatment facilities.
- Expand the aftercare offer and stimulate its accessibility

9.4.3 Uneven quality of professionals and services

Treatment services and the professionals working in the services are very different from one another. French-speaking respondents had diverse experiences concerning contacts with professionals and admission to residential care. They acknowledge that most professionals are doing the best they can, and that it is important to have a variety of services and approaches. However, French-speaking respondents feel that most professionals are not well trained, and trying to deepen the expertise is mainly a personal choice.

> *Ils essaient, et je vois que les choses changent petit à petit... mais c'est ceux qui vont sur le terrain, ceux qui restent derrière leur bureau, ils donnent des médicaments, mais ça ne suffit pas (FR_R2).*
>
> *Les pratiques des soignants ne s'adaptent pas assez vite aux changements de pratique sur le terrain (FR_R4).*

9.4.4 Impact of covid-19 on access to treatment offer

Several respondents also highlighted that covid-19 and its subsequent restrictions have had an impact on the treatment offer and the organisation of treatment. Some respondents describe that because of the restrictions, the waiting list became even longer. Treatment facilities had to comply with the restriction of the "bubbles", etc., and allowed less people to participate in the programs. Some respondents also describe a feeling of loneliness and extended isolation, because they were hardly allowed to have visitors. In that sense, respondents indicate that the covid-19 restrictions negatively impacted their recovery process. Respondents describe how fragile the existing service provisions is and how existing problems become amplified due to covid-19.

9.5 An evaluation of enforcement

When the respondents are asked about their evaluation of enforcement in Belgium, they highlight distrust towards the police and other law enforcement actors, they mention the sentences for drug-related crime and to the fact that enforcement is mostly focused at the lower levels of the drug chain.

9.5.1 Law enforcement is too much focused at the lower levels of the drug chain

Many respondents emphasise that enforcement is still too much focused towards the lower levels of the drug chain. Especially during the focus group in Antwerp, it was emphasised that the local policy is aimed at low-level dealers, but that they never catch the 'big fish'. Of course, there is an important impact of local policy.

> *R2: Maar dat is enkel maar op de kleine viskes aan het azen zijn. En ze halen die van het straat, maar uiteindelijk, de grote vis blijft er wel en die vindt wel andere loperkes dus...*
> *R4: Nee, en die grote garnalen pakken ze nooit hé.*
> *(NL2)*

Respondents describe that these low-level dealers are easily replaced, because there is so much money to be made in drug trafficking. Respondents doubt whether this model actually works, and claim that in the current war on drugs, "*drugs are winning*" (NL2_R4).

9.5.2 Distrust towards police

,Several Dutch-speaking respondents express their distrust towards the police and other law enforcement actors. Respondents indicate that they suspect police and other enforcement actors of corruption. According to the respondents, it seems impossible to them that the police are razor clean, especially considering the astronomical amounts of money being made from drug trafficking. Respondents say they were further confirmed in their suspicion after the Sky-ECC operation, where people from the police, prosecutors and lawyers were found to be helping members of a criminal network.

> *Plus ik denk dat er ook veel corruptie is. De een tegenover de ander. (…) Ja, dat die er zelf tussen zat inderdaad ja. Ik heb er heel weinig vertrouwen in. (NL2_R2).*

If we add the fact that people who use drugs do not always have a good experience with the police (cf. supra, “Stigmatisation by the police”), it is clear that respondents distrust the police and other law enforcement actors.

French-speaking respondents had a different view about the relationship with the police. Several participants had a long-term experience with using drugs and told about several interactions they had with the police in the past. Yet, they considered that things changed in the last years.

> *Maintenant, quand quelqu’un est pris, même avec des grosses quantités, et que c’est un usager, c’est obligation de faire un trajet de soins, un truc fermé, un an, mais c’est une bonne évolution, ils sont pas en prison (FR_R5).*

> *Quand il n’y a pas de délit connexe, en général ça se passe bien, ils nous laissent tranquille, les flics de terrain, ils nous disent « c’est pas vous qui nous intéressez, on sait que vous êtes des victimes » mais seulement ils ont besoin de nous pour remonter les filières, alors il y a des enquêtes de téléphonie, ça se passe plutôt bien à condition que tu collabores... Ils savent qu’ils ont intérêt à être plutôt souples avec nous (FR_R3)*

9.5.3 Sentences for drug-related crime are too high

There are a few aspects related to the sentencing of drug-related crime that respondents raised during the focus groups.

First of all, some respondents question what exactly is considered as drug-related crime. Many respondents indicate that they do not consider the use and possession of small number of illegal drugs as a form of drug-related crime. They underline that this should be treated as a medical or social problem, but not as a criminal problem.

That aside, there are quite a few respondents who indicate that the current penalties for drug-related offences are too high, especially compared to other criminal offences.

> *En ik vind dat nu de straffen voor drugs hoger zijn dan de straffen voor aanranding of wat dan ook. Dan denk ik van ja, daar moet ook al naar gekeken worden. Ik denk niet dat het in verhouding staat met andere criminele feiten en ja, daar ben ik het gewoon absoluut niet mee eens. (NL2_R4)*

Additionally, respondents **denounce the (high) fines imposed for drug-related offences**. They explain that when it comes to high-level dealers, these dealers have earned enough money through drug trafficking to pay those high fines. When it comes to low-level dealers, these fines could cause additional (financial) problems. To be able to pay the fines, or to make sure that they have enough money to support themselves, respondents mention that one would be tempted to start dealing again.

> *R8: Da's ook zo dubbel hé. Als je dan buiten komt en je hebt zo'n grote boete en je kan ze niet betalen, dan kan je ook gaan zeggen: "Ze pakken mij hier alles af van mijn geld, van wat moet ik nu leven?" En 'k ga weer beginnen dealen! Dat gebeurt ook veel.*
> *R5: Als je goed verkocht hebt, kun je de boete betalen, als je geen geld meer hebt… good money is terug gaan dealen.*
> (NL1)

Furthermore, respondents discuss **judicial referral to treatment**. Many respondents acknowledge the importance of judicial referral to treatment. Considering the 'label' of a criminal record, respondents emphasise that these alternatives are better than prison. Two respondents refer to a good experience with the Drug Treatment Chamber in Ghent and Charleroi.

> *Want anders staat dat ineens direct op uw strafblad en dat achtervolgt u. (NL1_R5)*

> *Ils ambitionnent de ne pas intervenir quand il n'y a pas d'usage problématique, ils ont créé une chambre spécialisée pour réprimer les usages problématiques, ce qui sous-entend qu'on reconnait qu'il y a des usages non-problématiques, c'est la première étape, et c'est validé (FR_R3)*

However, some respondents also highlight that when someone is referred from criminal justice to participate in a treatment program, this can sometimes hinder other voluntary participants during the programme. After all, the respondents describe that someone who participates in the programme under judicial coercion is not necessarily motivated, and so can also hamper the programme for others.

> *R4: En dan heb je dikwijls mensen die niet willen. Ik heb met zo'n gasten gezeten he, begin die maar te confronteren...*
> *R2: Plus ook, ik denk dat er ook veel gewoon in opname gaan omdat ze niet in de bak willen zijn. Dat het niet is omdat ze gemotiveerd zijn, maar omdat het beter is dan...*
> (NL2)

Lastly, one respondent mentions that alternative or smaller-scale prison project, with a specific programme aimed at detainees convicted for drug offences and having problems with addiction, like B.Leave, could encourage detainees to do something about their drug use while they are in prison.

9.6 An evaluation of policy and legislation

Lastly, several respondents refer to policy and legislation when evaluating the Belgian drug policy. Recurring themes that the respondents referred to, are the unclarities in the legislation, and opinions about legalisation and regulation of illicit drugs.

9.6.1 Unclarity about the drug law

Several respondents referred to what legislation did or did not allow, but often their claims were not (entirely) correct. For example, they referred to "legal highs" as legal substances, substances that are always one step ahead of legislation, whereas there is a generic legislation in Belgian since 2017 that criminalises the groups of psychoactive substances instead of listing each individual substance. Other respondents explain that the possession of drugs is not criminalised in Belgium. This indicates that the current legislation is not always clear or widely known within the wider public, even amongst people with lived experiences.

Furthermore, several respondents indicated that the legislative division regarding cannabis "for personal use" and "for profit" is not only confusing, but is also an artificial distinction that insufficiently takes other criteria into account, such as context of drug use, nor the reality in which the dealing of cannabis takes place. One respondent for example refers to the fact that exchanging a couple grams of cannabis, even

in a private setting, is considered as drug trade, a very serious offense for a seemingly "innocent" action. It creates the impression that all offenses are lumped together. This respondent therefore emphasises to not only consider the quantity, but also the context in which dealing happens.

> *Maar is die context niet, om dat te bestempelen als dealen, is dat niet een beetje te vergaand? Want ik zit in de privésfeer en ik deel een aantal gram uit, maar gaan we daar niet dat gaan bestempelen als handel, maar verkeerdelijk? (R2_NL1)*

9.6.2 Differences in ideology in the current drug policy

Regarding the current drug policy, several respondents referred to the discrepancy between their own experience and the political ideology towards drugs. Respondents clarify that conservative politicians keep the debate focused on criminalszing drug use and prioritising a punitive reaction to the drug phenomenon, whereas the respondents with lived experiences emphasise that this does not stop people from indulging in drug trade nor from using drugs, because the lucrative business model behind drug trade profits too much. They explain that penalizing drugs only further increases the street value of drugs, contributes to violence within the drug trade, and how criminalisation of drug use (possession) further stigmatises people who use drugs.

> *Als dat nog een bedrijfsmodel is dat zich kan permitteren van 10 ton per jaar kwijt te geraken, per maand zelfs al... Ik bedoel dan weet je toch er zoveel mensen zijn met coke bezig. Dat kun je u niet voorstellen. (…) Ik moest er [locatie waar regelmatig gedeald wordt] gisteren per toeval zijn en je ziet gewoon van alles gebeuren, (…) Maar dat ik denk, met wat zijn ze hier allemaal bezig, dat helpt niet met war on drugs. Alleen de prijs gaat omhoog.(NL2_R4)*

Respondents are therefore sceptical about the current political climate. They emphasise that there is little room for improvement within this political discourse and political practice. They describe that there is too little political gain from the drug debate.

> *Volgens mij zit er in België geen politieke wil in. Omdat er geen stemmen mee te verdienen zijn. (NL2_R4)*

Additionally, some respondents describe how drug policy differs between cities. They clarify that the mayor, and more broadly local politics, has an influence on a local drug policy, which amplifies differences between cities.

> *Ik vind dat dat tussen steden heel verschillend ligt. Hoe het beleid is, wie dat er de burgemeester is, of het een linkse of een rechtse regering is – of midden – ik denk dat dat een verschil uitmaakt. Ik hoor dat wel van mensen van West-Vlaanderen, mensen van Antwerpen, mensen van Gent dat dat toch een verschil uitmaakt. (NL1_R11)*

Key messages that people with lived experiences emphasised during the focus groups:

- Involve lived experiences in drug policy, to help better understand the reasons and contexts of drug use. Keep participation accessible, avoid barriers such as requirements like a certain level of qualification (e.g. A1 education) to be eligible.

9.6.3 Legalisation and regulation of illicit drugs

Several respondents emphasise that drugs are part of society, and that a drug-free society is simply impossible. Starting from that reality, several respondents resonate that, in order to protect people who use illicit drugs, it is better to move away from the criminalisation of illegal drugs. Several respondents mention that the status of illegality hinders prevention, which would be (partly) resolved by

decriminalisation. Other respondents go a step further and indicate that legalisation with (strict) regulation of (certain) illicit substances is appropriate.

> *Le truc qui serait important à faire, c'est la légalisation, ou au moins la dépénalisation de toutes les substances (FR_R3).*

Personal experience has an influence on how respondents perceive the current drug policy and legalisation and regulation options. Some respondents describe for example how the use of cannabis has helped them in their recovery, and therefore explain that they are in favour or legalising of cannabis so they (and other people in recovery) are able to purchase this in a legal way. Throughout all the focus groups, it was however emphasised that drugs use and being in recovery is highly individual and what works for one person, does not necessarily work for someone else. Based on these personal experiences, their views on drugs policy and alternative policy models differ too. Some respondents emphasise that it is important to differ between substances, explaining that legalising drugs like cannabis, is different from legalising other drugs like heroin, in which case the risks and harms of usage is estimated to be heightened.

When respondents were asked what regulation model they prefer, opinions differed even further. Some respondents refer to commercialising drugs, other mention to keep access and quantities limited, to limit access through pharmacies, or to develop a framework where there is cooperation with or access to health professionals. Several respondents refer to alcohol as a bad example, and stress that regulation should differ from the approach that was taken to alcohol.

> *La légalisation, ce serait que les drogues soient accessibles comme l'alcool, ça je crois pas que ce soit la bonne manière de faire. Par contre, ce serait bien qu'on puisse distribuer les produits dans des lieux comme les pharmacies, avec des produits de qualité et des quantités contrôlées... Et qu'il y ait des lieux de consommation (FR_R4).*
>
> *Un accès limité et une quantité limitée (FR_R5)*
>
> *...Encadré avec des professionnels, pour que les usagers, quand ils ont envie, ils puissent demander de l'aide pour changer (FR_R2).*
>
> *Voila, apothekers van die toestanden. Dat je wel nog een stap moet zetten maar een veilige stap. (NL2_R3)*

While discussing regulation, several respondents refer to the Dutch model, where cannabis is separated from other substances. In the Netherlands, the possession and trade is illegal, but is not prosecuted in practice (i.e. de facto depenalisation). Within this model, cannabis is commercialised through a coffee shop distribution model. However, some respondents refer to the Dutch model as a bad example, because within the model there is a lot of discretion and little (if any) regulation of substances that are still harmful (e.g. respondents refer to psychosis).

> *Ik zou niet willen dat het zoals Amsterdam wordt, want ze zijn ook gevaarlijk (…). (NL1_R3)*

Yet, not all respondents agree with a legalisation of some or all illegal substances, and emphasise that they are not in favour of legalisation or regulation of (some) illicit substances. They refer, for example, to a fear of a further derailment of drug use. In this sense, they make a comparison with alcohol xxxxxxxx

Apart from avoiding that people have to get involved into illegal activities, respondents also explain that there can be a better control on quality of the product.

Recurring narratives within the context of legalisation and regulation, are references to health i.e. reducing harms (e.g. quality control, preventing the exposure to the danger of not knowing what you take) and reducing addiction problems (e.g. prevention of addiction problems), reducing stigma related to criminalisation, as well as economic advantages (e.g. the creation of revenue for the state by means of taxes).

9.1 Conclusion of the evaluation of people with lived experiences

In general, people with lived experiences evaluate the Belgian drug policy tentatively positive. They stress that there is a broad and diverse range of treatment possibilities, with both low-threshold options, as well as inpatient treatment. Several harm reduction initiatives are praised, and respondents are generally positive towards initiatives to involve experts with lived experiences in prevention.

Yet, they highlight a few barriers and bottlenecks within the current drug policy.

One main theme that respondents emphasised throughout the different focus groups, is the different policy approach towards illegal drugs and alcohol. To them, starting from a harm perspective, alcohol could do as much or even more harm than (some) illegal drugs.

Another main theme, is the reference to stigma through the negative perceptions of illicit drugs and those who consume them, which has been described by previous studies too (Askew & Bone, 2019). This is especially emphasised towards people who use illicit drugs, rather than people who use alcohol, although international literature also suggests that people who experience problems with alcohol, or who are addicted to alcohol, are also one of the more stigmatised conditions by the wider public (Room et al., 2001). Some respondents show an internalisation of this stigma, and refer to feelings of shame or guilt because of their drug use.

Furthermore, respondents seem to have a limited view of what prevention can entail, and mostly focus on the education of a comprehensive picture of drug use that depicts diversity and addiction towards young people. They emphasise the importance of sharing information on the effects of all drugs (breaking away from the distinction between legal and illegal drugs) and to improve discussion and knowledge about both licit and illicit substances.

Additionally, respondents refer to bottlenecks in the current treatment offer, like the lack of overview on the treatment offer, as well as certain gaps in the current treatment offer (e.g. the long waiting lists, limited or non-existing geographical allocation of the treatment offer, less attention to certain target groups, limits of aftercare, etc.).

Respondents also refer to negative experiences with law enforcement. They describe how law enforcement is very focused on the lower levels of the drug chain (e.g. low-level dealers), and discussthe (high) fines imposed for drug-related offenses and theirdistrust towards the police because of previous experiences. Yet, the emphasise the importance of judicial referral to treatment and smaller-scale prison projects focusing on drug treatment in prison.

Lastly, whereas most respondents were in favour of changes in the current policy, the opinions on what this policy change should look like, differ. Some respondents emphasise concrete changes within a specific pillar, for example a need for involvement of lived experiences in prevention and treatment or the expansion of aftercare, whereas other respondents are in favour of legalisation and regulation of cannabis, and propose several regulation models starting from a health approach including the reduction of harm and addiction problems, stigma related to criminalisation, as well as economic advantages.

In short, in line with previous research, we found that personal experience has an influence on how respondents perceive the current drug policy, legalisation and regulation options (Askew & Bone, 2019; Leonard & Windle, 2020). Our results also acknowledge that people with lived experiences hold a diverse range of opinions and perspectives about the current drug policy, which is in line with previous research studies (Askew & Bone, 2019; Lancaster et al., 2018; Lancaster et al., 2013; Leonard & Windle, 2020; Ritter et al., 2018). According to the respondents, this diversity is absent within the political discourse – which primarily reflects a conservative ideological position wherein moral arguments might surpass empirical evidence (Bone, 2019). Nevertheless, most respondents held favourable views on harm reduction initiatives, and emphasised the importance of implementing initiatives like drug

consumption rooms and drug testing. Even so, respondents likewise realised that such initiatives will unlikely solve every existing and complex problem.

9.2 Lessons learned

PEOPLE WITH LIVED EXPERIENCES EVALUATE THE DRUG POLICY

From the focus groups with people with lived experiences, we can conclude that:

- In general, people with lived experiences evaluate the Belgian drug policy tentatively positive (broad and diverse range of treatment, several harm reduction initiatives, initiatives to involve experts by experience in prevention).
- Yet, barriers and bottlenecks remain. Respondents for example refer to the difference in policy approach towards illegal drugs and alcohol, to stigma through the negative perceptions of illicit drugs and those who consume them (especially towards people who use illicit drugs), to a limited view of what prevention can entail, to bottlenecks in the current treatment offer (like the lack of overview on the treatment offer, as well as certain gaps in the current treatment offer), and to negative experiences when they were in contact with law enforcement.
- Whereas most respondents were in favour of changes in the current policy, the opinions on what this policy change should look like, differ from concrete changes within a specific pillar to reflections on legalisation and regulation of cannabis centralising health, reducing stigma and economic advantages.
- Personal experience has an influence on how respondents perceive the current drug policy, legalisation and regulation options, which results in a diverse range of opinions and perspectives on the current drug policy. Nevertheless, most respondents held favourable views on harm reduction initiatives, and emphasised the importance of implementing initiatives like drug consumption rooms and drug testing, although they also felt that these policy options are limited given the societal complexity of the drug phenomenon. Nevertheless, this diversity in opinions and perspectives on drug policy in not necessarily reflected within the political discourse that primarily hold ideological positions that moralise the use of drugs.

The following key messages were voiced by the respondents with lived experiences:

- Decriminalise the use of drugs (drug possession), so that the use of drugs (possession) is undone from its illegal status.
- To work towards a diversified and comprehensive image of drug use and addiction.
- Harm reduction and safe use are important for people who use drugs and people in recovery. These initiatives should be supported and expanded.
- Need for an accessible overview of the treatment offer, so that people who want help, know where they can find it.
- Need for an accessible overview of the treatment offer, so that people who want help, know where they can find it
- Involve lived experiences in drug policy, to help better understand the reasons and contexts of drug use. Keep participation accessible, avoid barriers such as requirements like a certain level of qualification (e.g. A1 education) to be eligible.

CHAPTER 10

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

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10 CONCLUSION AND RECOMMENDATIONS

In this chapter we present the main conclusion and related recommendations of the process evaluation of the Belgian drug policy.

10.1 Conclusion

This section formulates a concluding answer to the central research questions of this evaluation. Based on the findings of the previous chapters, the following questions will be answered:

- What were the policy intentions for the Belgian drug policy?
- Have the policy intentions of the Belgian drugs policy been realised?
- Is the Belgian drug policy still relevant in light of current needs?
- What do we learn from this evaluation?

These questions have been addressed based on a document analysis of the two central policy documents of the Belgian drug policy (Federal Drug Note and the Joint Declaration), a document review to describe previous realisations of Belgian drug policy, a survey to measure the perceived implementation of the policy intentions, semi-structured interviews to assess the context in which the realisations took place, and focus groups comprising people with lived experiences and stakeholders from practice and administration.

10.1.1 What can we conclude from this process evaluation?

This research has aimed to gain insight into the policy intentions of the Belgian drug policy and its subsequent implementation through a thorough process evaluation. Process evaluations are an essential part of the evaluation process, as they help to understand how the results of a policy have been achieved, whether the policy was fully and properly implemented and what the limitations of a policy strategy are.

This evaluation, therefore, focuses on process, rather than outcome and does not examine whether the policy has worked or not. Effect evaluations are extremely difficult to conduct for large scale policies like a national drug policy (Ritter et al., 2018; Sanderson, 2003), which are often too complex to disentangle direct and indirect effects, synergies and interactions. They, therefore, require an evaluation design that is equally complex, acknowledges differences between communities, and assesses implementation as well as adaption over time (Komro et al., 2016). Ideally, we should be able to ascertain what would have happened if the intervention had not taken place. Only then can the observed changes be attributed to the intervention, and we can speak of an ‘effect’. However, an experimental design in which a 'treatment group' is compared to a 'control group' (minimum conditions according to the Maryland Scientific Methods Scale to measure effect) is not feasible on such a large scale (an entire country). The absence of a baseline measurement, a control group, or other possibilities to check for interfering variables, hinder a thorough effect evaluation of our national drug policy (Farrington et al., 2002).

To gain insight into the policy intentions and their subsequent implementation, we relied predominantly on qualitative research methods. These methods were aimed at obtaining and understanding how Belgian drug policy is experienced by respondents, practitioners, administrators, (scientific) experts, and experts by experience. We examined how these stakeholders shape the Belgian drug policy in daily practice, giving insight into “policy in practice”, as opposed to “policy in the books”. In other words, we mapped out what practitioners, administrators and people with lived experiences are confronted with, and what needs they identify for future drugs policy.

In this conclusion, we emphasise what the various results show us about Belgian drugs policy, rather than listing what has or has not been achieved. So, rather than inventorying what we did in the past, the focus of this conclusion lies on what the past can tell us about the future.

Lastly, this evaluation focuses on the entire drug policy, and thus deals with a wide range of topics related to both the demand and supply sides, but also on cross-cutting themes such as policy coordination, epidemiology and research. As a result, the thrust of this report is on a broad overviewness of drug policy, rather than its depth. Although various themes are discussed, they are not necessarily analysed in depth. To do the latter would distract too much from the scope of the evaluation, which is to gain insight into the Belgian drugs policy in its entirety.

10.1.2 What were the policy intentions of the Belgian drug policy?

We started the evaluation by mapping the policy intentions of the Belgian drug policy, based on a content analysis of the central drug policy documents. This provides us with insights about the past from 2001 to 2010.

A. Challenges in defining 'the' Belgian drug policy

The first task of this process evaluation was to define what is understood by 'the Belgian drug policy'. Internationally, this is defined by the Federal Drug Note (2001) and the Joint Declaration of the Interministerial Conference on Drugs (2010) as its backbone (EMCDDA, 2020). These official sources comprise the Belgian approach to drugs, and consider the different policy domains and (for the Joint Declaration) different policy levels.

The evaluation analysed the policy intentions of the Federal Drug Note and the Joint Declaration by applying logic models mapping objectives, actions, outputs and outcomes. That exercise provided robust insights into Belgian policy intentions in tackling the drug problem. It also revealed how Belgian drug policy has been shaped and what policy makers implicitly or explicitly emphasised in 2001 and 2010.

We found that both policy documents are outdated. They were drafted eleven and 20 years ago respectively, during which period, Belgium was subjected to a state reform process that led to a delegation of several prevention and treatment policy competences to the federated entities. As a result, some of the objectives set out in the two documents eventually had to be endorsed and implemented by the regions.

On top of these outdated policies, since 2010, several additional policy documents have been published, relevant to the Belgian drug policy none of which are drug-specific, nor do they encompass_different policy domains and policy levels as the Federal Drug Note and the Joint Declaration do. This adds to the scattered nature of a national agenda and drug policy(-making). For example, some policies focused on a single policy level and/or on a single policy domain (e.g. Concept Note Addiction in Flanders), or were cross-domain, but not drug-specific (e.g. Framework Note on Integral Security 2016-2019). As such, these documents do not provide sufficient data to observe an overarching vision (which was of course not their intention) behind Belgian drug policy[106]. Therefore, one of the main challenges in mapping the overarching intentions of a Belgian drug policy was to rely on the outdated and scattered sources of the Federal Drug Note and Joint Declaration. We consider the discovery of this out-datedness

[106] We included additional policy documents when measuring the implementation of the policy intentions of the Federal Drug Note and the Joint Declaration (see infra), such as the Framework Note on Integral Security, the Flemish Concept Note on Addiction, etc.

and scattered nature of those written sources as “law in the books” a first and important finding of this study.

B. The structure of drug policy documents provide insufficient tools for their implementation

a. No coherent policy-analysis approach

Regarding the structure of the Belgian drug policy, we made several key observations. First of all, for a drug policy to adequately address a drug problem, there has to be a clear overview of the nature, scope, and the extent of what the policy aims to address (Funnell & Rogers, 2011). Such a situation analysis should describe the various features of the problem, including who is (in)directly affected, what the existing evidence says about the size of the problem and how this is changing over time (Funnell & Rogers, 2011). The Parliamentary Working Group on Drugs conducted an extensive situation analysis in 1996-1997 which four years later has led to the Federal Drug Note in 2001. It is not clear whether the Joint Declaration of 2010 was preceded by a (similar) situation analysis, because the policy document does not refer to it. It is therefore difficult to assess whether the Joint Declaration sufficiently addressed the drug situation at the time, and if it did, it is not clear how it was addressed. The lack of a sound situation analysis can be considered another sign and symptom of the scattered landscape that is the Belgian drug policy.

b. Lack of detail and guidelines

We discovered that the policy documents often lack detail and guidance for implementation of both the **policy aims and actions and also** (registered) **outputs and outcomes**. For most pillars, the policy documents were explicit and detailed about the objectives and actions, and thus about what the policy makers intended to aim for. Objectives and actions were clearly defined and specific. There are some good examples in the pillar ‘Treatment, risk reduction and re-integration’ and the transversal theme ‘Integral and integrated approach’, especially in the Federal Drug Note, for example ‘to evaluate three pilot projects of crisis psychiatry in Brussels, Antwerp and Charleroi’.

However, there are two exceptions where the objectives and actions remain vague.

First, the actions referred to in the Joint Declaration are often very vague due to abstract, non-measurable formulations. Almost all pillars and transversal themes are affected by this abstract language. The objectives and actions are often formulated in such a general and broad way that they do not lead to actionable and practical guidance on how to realise them. Instead, the Joint Declaration gives rather vague, and to an extent counter-productive, guidelines on how the Belgian drug policy should develop e.g. “*Attention should be paid to better and renewed communication with the population* [concerning enforcement]” (p. 77)). As a result of this vagueness, the Belgian drug policy continues to be mostly defined by the Federal Drug Note.

Second, for the pillar ‘Prevention’, we see that several actions outlined by the Federal Drug Note (relating to competences of the communities and the regions) also consistently tend to be vague or lacking in detail. They seem to be formulated as broadly as possible so that various visions could be included in one policy document, with the unintended consequence of a lack of coherent vision. Given these observations on the lack detail and guidance, we conclude that the objectives for actions are difficult to implement as they were intended by the policy makers, especially because that 'intention' was not clear to begin with.

A lack of detail and guidance for implementation can, however, specifically be found when looking for **output and outcome**. Both policy documents were less specific about the expected changes that an action should and could bring about. Vague or implied outputs and outcomes cannot show how the objectives and actions are related to changes in practice. This causes problems for accountability and

raises several questions: If it is not clear what effect a certain action aims to achieve, why it would be worth implementing the action at all (and who should feel encouraged to implement it). Additionally, vagueness hinders the monitoring and evaluation of policy plans: If it is not clear what has to be implemented, what changes are aimed for or how one measures the effect of those changes. Exceptional, but especially problematic especially, is that the pillar 'Prevention' does not explicitly define outputs and outcomes at all. For the other pillars, there are often outputs or outcomes defined, but they remain vague, nor is it clear how particular actions link to particular outcomes. Together with the fact that these policy pillars were also vague about most of the objectives and actions in the first place, these shortcomings can be considered to be a result of two conflicting intentions installed in both documents. On the one hand, they aim to define a generic, integrated framework for drug policies that would be consistent throughout all pillars and authority levels. On the other hand, however, there is the standard policy practice in Belgium that builds in 'discretion' to compromise, but in effect leaves room for coexisting interpretations of policy (intentions).

Fourth, the policy documents almost never differentiated between short term, medium term and long-term outcomes. There were several initiatives to distinguish between the long, medium- and short-term objectives across the various pillars and transversal themes, but none of the actions managed to connect them to short, medium- and long-term outcomes in an actual cause-and-effect chain. This gives the impression that short-term outcomes are the final destination of the drug policy, which presumably they are not.

C. The implicit emphasis differs from the explicit emphasis

We were able to make several observations regarding the components that policy makers wanted to explicitly or implicitly emphasise in the policy documents of 2001 and 2010. To begin with, both explicitly emphasise a number of consistent messages. According to both, Belgian drug policy focuses on legal and illegal psychoactive substances, including tobacco and alcohol and psychoactive medication. It starts from the premise that the drug problem is primarily a public health problem, and applies a policy of normalisation aimed at rational risk management. The policy documents set out three goals:

1. A decrease in the number of dependent citizens;
2. A decrease in the physical and psychosocial harm that can be caused by drug abuse; and
3. A reduction of the negative impact of the drug phenomenon on society (including social nuisance).

Both policy documents emphasise the importance of addressing both the drug supply side and the drug demand side. This is pursued through a policy based on three pillars:

4. Prevention for non-user(s) and non-problematic user(s);
5. Treatment, risk reduction and (re)integration for problem users;
6. Repression of drug production and drug trade.

These three pillars are accompanied by two transversal priorities:

C. increased cooperation between the various policy areas concerned; and
D. the development of an epidemiological and evaluation toolbox.

However, we found that certain topics and groups are implicitly emphasised more than others. This is demonstrated below.

First, within the pillar 'Prevention' for example, the objective related to alcohol i.e. 'to develop an alcohol policy' is formulated in such vague terms that actors are not committed (enough) to implement them, ("*as far as they are compatible with the tradition, the culture and public opinions on the subject*" (Federal Drug Note, p.40)). However, actions within prevention objectives related to other substances such as 'to implement strategic measures specifically targeted at psychoactive drugs' and 'tobacco policy', do

have more concrete actions listed. This, once more, leads to the observations of an inherent and problematic contradiction in drug policy documents: although policy makers aspired 'to prevent the use of alcohol', they did not perceive the objective as a priority requiring concrete and decisive actions. Furthermore, most objectives and actions do not explicitly define a specific setting where actions should take place. Even when a setting is identified, only the setting of school and education is defined as a prevention setting; other domains (e.g. work, health) were less emphasised, and domains such as 'Leisure' and 'Wellbeing' are not even mentioned. Lastly, for the prevention actions relating to the competences of regions and communities, policy documents often remained vague too, especially in comparison to actions set for federal level competences. It therefore seems that policy makers attempted to define a broad-as-possible vision so as to leave discretion for implementation to regions and communities. However, the result is that the overarching drug policy plan lacks a concrete, overarching, vision for the 'Prevention' pillar. Once more we see how the intention of policy to create discretionary space for regional drug policy implementation (e.g. through vague language, objectives and actions), has the unintended outcome of producing/worsening a scattered landscape.

Second, within the pillar 'Treatment, risk reduction and re-integration', we see a similar trend. Although the Federal Drug Note and Joint Declaration are aimed at both legal and illegal drugs, the actions for risk reduction all refer to intravenous illicit drug use and the use of opiates. So, although, the Federal Drug Note and the Joint Declaration avowedly focus on 'Treatment, risk reduction and re-integration' of "problem users", they define a narrow target group of such "problem users". Risk reduction thus seems to be narrowly defined by the Federal Drug Note and Joint Declaration, and adds an explicit (and presumably intended) focus on the policy being "evidence-based", although (unintendedly) leading to no explicit health outcomes being defined. Additionally, there seems to be a slight difference between the Federal Drug Note where there is an explicit focus on harm reduction, and the Joint Declaration, where the focus on harm reduction is only implicit, because the general goal is "an integral and integrated policy of prevention, early detection, treatment including risk reduction, and repression" (Vander Laenen, 2012). In contrast to risk reduction, the actions concerning treatment are coherent and consistent with the explicit emphasis of treatment focusing on problem users.

Third, within the pillar 'Enforcement', we notice an inconsistency between the actions related to 'Reinforced repressive response towards drug trade' and the actions related to 'Differentiated penal response towards drug use'. Whereas the actions of the latter are clearly defined, and the policy documents mention specific outputs and outcomes for many of the actions, the opposite holds true with respect to the actions of the former related to drug supply. As such, there seems to be a clear vision on the judicial response toward drug use and possession, but not so much towards drug trade[107].

Fourth, the actions in the transversal theme 'Epidemiology, research and evaluation' predominantly focus on the demand side and rather neglect the supply side. The documents, for example, outline that initiatives concerning the demand side should be *systematically* evaluated , providing evidence-based insights, while they merely mention that supply side initiatives need to be '*mapped'* and '*monitored'*, without emphasising an evidence-based approach. There were no actions outlined focusing on the supply side in the Federal Drug Note (compared to eight actions to evaluate the demand side), and only four in the Joint Declaration (mostly aimed at 'mapping' the supply side, instead of evaluating them). Hence, the premise of an evidence-based drug policy and the requirement to prove effect seems to be implicit but mostly relevant to the demand side.

Lastly, there are no pronounced differences in the explicit and implicit emphase in the pillar "Integral and integrated approach", meaning that the actions for this transversal theme are coherent with the intention to increase cooperation between the various policy areas concerned.

[107] The latter was clarified with more detail in the Framework Note on Integral Security, and the consequent National Security Plan, although this focus is not drug specifc.

WHAT DO WE LEARN FROM THE ANALYSIS OF THE POLICY INTENTIONS OF THE BELGIAN DRUG POLICY?

We can conclude that there are several shortcomings in the way the Federal Drug Note and the Joint Declaration are formulated, which provide limited guidance for the actual implementation of the drug policy objectives and actions. Moreover, although the policy explicitly starts from clear and logical premises, the list of objectives and actions shows a number of imbalances, both within and between the diverse pillars.

10.1.3 Have the policy intentions of the Belgian drug policy been realised?

Having to work with unintended, and sometimes contradicting outcomes, it is imperative to assess whether these intentions ("law in the books") of the Belgian drug policy have actually been realised ("law in action"). We empirically explored the extent of realisation) by executing a thorough document review, conducting an online survey, holding semi-structured interviews with practitioners and administrative personnel, and consulting focus groups comprisingh (1) people with lived experiences and (2) key practitioners, (scientific) experts and civil servants. Based on the empirical findings retrieved from the different sources in the field, we concisely discuss our main conclusions below so as to answer the research questions of this section.

10.1.3.1 Extent of realisation

Measuring the extent of realisation means that we verified whether the actions outlined in the Federal Drug Note and the Joint Declaration have been realised based on a document review and an online survey. As such, we have an overview of both the actual (based on the document review) and perceived (based on the online survey) realisation of these actions. We summarise the results in an overview of both policy and practice initiatives. We list the main conclusions here.

A. Fragmentation and lack of overview of the Belgian drug policy realisations

First of all, the document review revealed that there is no structural follow-up of the implementation of the objectives and actions outlined in the Federal Drug Note and Joint Declaration, nor of other developments in the drug prevention field, the treatment field, the enforcement field or the transversal theme 'Epidemiology, research and evaluation'. For the pillar 'Integral and integrated approach', there is some follow-up for the objectives relating to cooperation and international engagement by the General Drug policy Cell because these are tasks they provide, but they do not provide an overview of the entire transversal theme. This structural follow-up does not exist on a federal level, nor within the Communities or the Regions. There are, it is true, many annual reports that list the realisations of specific subsections or reports from specific actors or organisations regarding the drug policy approach. For example, the General Drug Policy Cell yearly reports on its activities, thus giving a general overview of important realisations within the different policy domains and policy levels. Another example is VAD which centralises information about the Flemish prevention and treatment field. Likewise, Eurotox publishes an annual dashboard summarising the state of the art of drug use and related activities in the French-speaking community. However, there is a lack of centralisation and overview across different domains and policy levels, and even across different (policy and practice) actors. Together, all these reports and publications help us to get a grasp of specific realisations within the drug policy field. However, they paint a rather fragmented and anecdotical picture, making a full, extensive and overarching overview difficult.

This fragmentation and lack of overview was also confirmed by the practitioners during the online survey and the semi-structured interviews. Although the document analysis indicated that certain actions were (partially) implemented, some respondents indicated that these actions were not (fully) realised. This divergence between actual implementation and perceived realisation indicate that practitioners encounter fragmentation too, as well as a lack of overview regarding the realisation of several drug policy objectives and actions.

B. Whether the intended actions have been realised, differs per pillar and per objective

Focusing on the different pillars and transversal themes, our study indicated that several actions intended by the Federal Drug Note and the Joint Declaration, are fully implemented, although there are differences in implementation within the pillars (and the several intended actions across the distinct objectives) and between the different pillars.

For the 'Prevention' pillar, a lot of initiatives have been realised relating to the objectives 'strategic measures specifically targeted at psychoactive drugs', 'discourage driving under the influence of legal and illegal drugs' and 'tobacco policy'. The initiatives for implementation of 'prevent drug-related nuisance' and 'alcohol policy' are much more modest. Initiatives were taken, but got stranded along the way, or were given another interpretation within the Regions and Communities. Some actions were never implemented, which was especially the case for several actions related to drug-related nuisance.

The pillar 'Enforcement' has been very active in the field of international cooperation and the development of security policy plans. Several of the actions intended by the Federal Drug Note and the Joint Declaration for enforcement, are fully implemented, especially the actions in support of the objectives 'control drug supply through international cooperation' and 'control drug supply by creating synergy between the policy plans of the different department'. There were also several partial implementations, for example for the subgroup 'a differentiated penal response towards drug use' of the objective 'to respond proportionately to criminal offences', but they were often not fully seen through, or were implemented differently from that intended by the Federal Drug Note and the Joint Declaration, for example because there were issues with the legality of the central concepts. Lastly, there was little evidence of implementation of the actions regarding a penitentiary drug policy.

For the transversal theme 'An integral and integrated approach', many actions regarding coordination and international engagement are fully implemented. There were also several partial implementations. For example, the transversal theme did implement initiatives to 'establish clear agreements between the criminal justice system and the treatment sector', but not necessarily the ones mentioned by the Federal Drug Note and the Joint Declaration. Similarly, this pillar showed little evidence of the implementation of the intended actions regarding 'eliminate specific problems with the 'Drugs' section of the Global Plan', even though there were several realisations that fit within this objective.

For the transversal theme 'Epidemiology, research and evaluation', there are several actions regarding the objectives 'uniform registration of treatment data', 'the coordination of epidemiological data' and 'the finance of research projects on an annual basis' which are fully implemented. There were partial implementations of the transversal theme relating to 'gain insight into drug use in the population' (e.g. the Health Survey of Sciensano) and for a 'standard, continuous and scientific evaluation of aspects of demand and supply', where there are initiative, but again not necessarily implemented as mentioned by the Federal Drug Note and the Joint Declaration. Lastly, the actions relating to 'take scientific knowledge into account in policy' were often not implemented or implemented in a limited way.

In comparison to the other pillars, fully realised actions were more difficult to find for the pillar 'Treatment, risk reduction and reintegration'. This can partly be explained by the fact that, compared to the other pillars, the objectives and actions are more specifically defined and described in more detail. So, although there have been several developments in drug treatment and harm reduction, they do not necessarily fit within the detailed and delineated intended actions. For most objectives, the actions were partially rather than fully implemented. Sometimes, there were implementation initiatives for an action,

but they were not fully seen through (e.g. they were only implemented as pilot projects, but never structurally established). That was, for example, the case for the actions centred around the objectives 'to create a treatment offer for drugs users with a dual diagnosis' and 'to organise an emergency and crisis response network'. For other objectives, there have been implementation initiatives, but the actions have not been implemented in the way foreseen by the Federal Drug Note and the Joint Declaration, for example with the actions regarding care circuits and case management. These actions were implemented, yet differently from how it was initially intended because the central concepts had evolved since 2001 or the action was given a broader interpretation (e.g. as part of the wider mental health field, instead of focused specifically in the specialised drug treatment field). The actions regarding aftercare, minors and funding for the care circuits were mostly not implemented.

We want to emphasise that the actions in the different pillars and transversal themes, **were not always implemented because they were listed by the Federal Drug Note and the Joint Declaration**. In many cases, the realisations were initiated by specific institutions or organisations, and were the effect of different policy processes than those put forward in the documents. As mentioned abbove, there was no structural follow-up of the implementation of the Federal Drug Note or Joint Declaration. So rather than meticulously implementing the actions prescribed by the policy documents, the common thread of the policy was upheld within new initiatives.

Moreover, the fact that we found evidence of the implementation of an action, does not provide insight into the performance or the difficulties that were encountered with the realisation of that action. There was a need for contextualisation of the actions, and to address this need, we conducted additional semi-structured interviews and focus groups with practitioners, civil servants, (scientific) experts and people with lived experiences (see 10.1.2.2).

C. Several additional realisations within some pillars and some objectives

realisations not included in the Federal Drug Note or the Joint Declaration. have come to light.The number of these additional realisations as well as their extent differs per pillar. Pillars where the competences are divided between the Regions/Communities and the federal level (i.e. 'Prevention' and 'Treatment, risk reduction and reintegration') have a lot of more additional realisations than the other pillars or transversal themes. These additional realisations are often, but not always, fuelled by local initiatives or initiatives of the regional government.

For example, the pillar 'Prevention', has several realised actions, not includedin the Federal Drug Note or the Joint Declaration. These additional actions are especially linked to the included objectives 'to develop a prevention policy', 'to apply a policy of discouragement' and 'a tobacco policy'. For the pillar 'Treatment, risk reduction and reintegration' the additional realisations are particularly relevant to the objective 'to further develop risk reduction' (e.g. harm reduction projects in nightlife settings), but also for the objective 'to create a comprehensive and integrated treatment offer' (e.g. focus on a broad interpretation of recovery in Flanders). These additional realisations are almost always fuelled by practice. Those for the other pillars are much more modest.

The additional realisations mostly fit within the general framework set out by the Federal Drug Note and the Joint Declaration. So, although some of the actions might be outdated today (they are not relevant anymore because the context has changed (e.g. sixth state reform)), most policy objectives formulated in 2001 and 2010 are still relevant today. The objectives relate to active domains which are addressed by practice on a daily basis. However, additional realisations concerning risk reduction are not entirely in line with this general framework. The pilot project of controlled heroin distribution, for instance, could be seen as running counter to it.. The Federal Drug Note emphasised that the results of controlled heroin distribution projects abroad were to be monitored, but should not be implemented in Belgium ("*The federal government will not set up nor pay for experiments in controlled heroin distribution*" (p. 49)). Drug consumption rooms do fit within leading principles of the policy intentions (encouragement of development of harm reduction initiatives to reduce the negative consequences of excessive drug use),

but they do not seem compatible with the Drug Law of 1921 (prohibiting the facilitation or incitement of drug use and unlawful possession, see also Vander Laenen et al., 2018). Furthermore, the additional actions have broadened the focus of harm reduction. Instead of restricting harm reduction towards problematic injecting drug use (which was how harm reduction was shaped in the Federal Drug Note and Joint Declaration), harm reduction initiatives nowadays also target harms related to recreational drug use and the use of legal substances like alcohol.

These additional realisations are often developed by practitioners, individual (local) policy makers and sometimes even an individual region, and show that these actors are important in further fuelling the Belgian drug policy (especially for the pillars 'Prevention' and 'Treatment, risk reduction and re-integration') without an overarching and crosscutting drug plan to give direction.

WHAT DO WE LEARN FROM THE EXTENT OF REALISATION OF THE DRUG POLICY INTENTIONS?

To conclude, we see that there have been several implementation initiatives for the pillars 'Prevention' and 'Enforcement', but to a lesser extent for the pillar 'Treatment, risk reduction and re-integration'. Considering the policy intentions, this can partly be explained by the comparative specificity and detail of policy intentions for this latter pillar. So, although there have been several developments in drug treatment and harm reduction, they do not necessarily fit within the detailed and delineated intended policy intentions. This contrasts with the broadly and generally formulated actions and objectives of the other pillars, which may be implemented in many different ways and thus can be implemented more easily. It can therefore be deduced that the level of implementation of the Federal Drug Note and the Joint Declaration is mostly achieved because both policy documents set relatively broad agendas for the pillars 'Prevention' and 'Enforcement'. The realisations for the pillar 'Treatment, risk reduction and reintegration' are much more modest, but then this pillar also defines the most detailed actions.

Furthermore, examination of the extent of realisation has shown that there have been several additional realisations not intended by the Federal Drug Note or Joint Declaration, and that these actions, with a few (limited) exceptions involving risk reduction, are in line with the general guidelines that both policy documents put forward,. The risk reduction field has evolved a lot in the last twenty years, which in turn supports the need for an updated policy framework.

10.1.3.2 Context to realisation

As mentioned above, we are mainly interested in obtaining data on and understanding how Belgian drug policy is experienced by respondents, practitioners, administrators, experts and experts-by-experience. We examined how they shape the Belgian drug policy in daily practice, thereby gaining insight into how the policy works in practice. In other words, we mapped out what the practitioners, administrators, (scientific) experts and people with lived experiences perceive as obstacles.

This conclusion summarises the overarching results of the semi-structured interviews and the focus groups, and does not include the detailed conclusions of each separate pillar or transversal theme. For more detailed conclusions, we refer to the intermediate conclusions in the results sections. In this section, we try to present the overarching theme in a straightforward way, in order to discuss the core of the problems that practice, administration and people with lived experiences encounter. For more contextualisation and depth on these conclusions, we again refer to the intermediate conclusions in the results sections.

A. The 'Integral and integrated approach' reaches its limits

The evaluation shows that the integral and integrated approach, one of the central principles of the Belgian drug policy, encounters many obstacles. First, many respondents find it difficult to define what an 'integral and integrated approach' entails. They describe the concept as a catch-all concept that is hardly operationalised on federal and regional level. Although there is a definition of what 'an integral and integrated approach' is (De Ruyver, 2009), there is no proper operationalisation athigher policy levels, as opposed to the integral and integrated approach of some well-defined initiatives at a more local level. Respondents described various well-defined initiatives at the local level where an 'integral and integrated' approach was applied. Reference is made to (local) multidisciplinary cooperation centred around concrete needs or problems, such as a festival policy, drug consumption rooms and the cocaine problem in the port of Antwerp. This needs-based approach generates integral and integrated cooperation both locally and regionally. Often, these collaborations are not institutionalised or structural, but rather initiated by individuals or specific organisations. This makes cooperation dependent on the available network of individuals and/or organisations and on the existing contacts between people from different policy areas and levels (see also Vander Laenen (2010)). Consequently, these integral and integrated cooperations differ per region: They take place in one location, but not in another. An integral and integrated approach is thus interpreted as a cooperation at the local level between actors from different domains, but not necessarily in a structural way.

This integral and integrated way of cooperation is much less common at the (higher) policy level. Several respondents refer to the lack of political consensus and agreement between different policy actors in discussions such as the development of an alcohol policy, the implementation of drug consumption rooms or other risk-reduction initiatives. For these initiatives, a compromise has to be found between many different stakeholders, each within its specific policy level and -domain. After all, after the sixth state reform, most competences regarding prevention and many competences concerning drug treatment were regionalized, whereas the competences regarding enforcement and penal law remain a federal competence. Since they often do not share the same priorities or the same vision, a compromise is difficult to achieve. This is reinforced by the lack of a mandatory bounding framework such as a drug policy that concretizes the objectives. The underlying ideological paradigms that dominate the drug debate too often paralyse the necessary decisive policy initiatives or result in a lack of a coherent vision. The result is that policies are developed within one's own competence, often lacking an overarching or coherent vision. And yet, as described above, at the local level there are many good examples of excellent integration, showing that the lack of political consensus at the national level has left room for local leadership and autonomy with initiatives (Smith et al., 2019).

According to the respondents, the lack of a clear policy vision is also an obstacle to an integral and integrated drug policy. The Federal Drug Note and the Joint Declaration are outdated and more recent policy documents are not overarching. Moreover, the existing (yet outdated) overarching policy vision, for example as described by the Joint Declaration, is formulated in very broad terms in order to reunite very different policy approaches, resulting in a vague policy text. Respondents describe this as "a compromis à la belge". As confirmed by our critical analysis of the policy intentions, the Joint Declaration consists of rather broad and vague actions without defining a clear outcome. This can lead to policy (a.k.a. policy in the books) and practice (a.k.a. policy in practice) growing further and further apart. Policy makers do not take a clear stance while practitioners make their own interpretation of the broad policy vision. This is evident, for example, in the installation of drug consumption rooms in Wallonia and Brussels (Smith et al., 2019; Vander Laenen et al., 2018), but also in the drug prevention field in Flanders, which focuses on a broad range of prevention, early intervention and harm reduction, without the outspoken support of the Flemish Government. Against this background, practice and administration continue to voice their need for an overarching, shared and concrete vision regarding the Belgian drug policy. . However, because of this "standstill" and culture of compromise in policy and the lack of proper cooperation transcending policy domains and levels, practitioners and administrators seem to be losing trust in the possibility of an overarching integral and integrated drug policy altogether.

The General Drug Policy Cell and the Interministerial Conference (Thematic Meeting on Drugs) were set up to facilitate an integral and integrated drugs policy. Since various competences within Belgian drug policy are spread across the federal government and the regional governments (cf. supra), this consultation forum (the General Drug Policy Cell) was needed and established in 2009. This study highlights the important role of the General Drug Policy Cell as an open forum for discussion. Yet, it has shown that respondents believe the current Cell not to have sufficient clout to promote the necessary integral and integrated coordination. Several factors such as the lack of continuity in its members, the large number of members, the fragile balance between competences and a lack of clear management, jeopardise a stable and sustainable drug policy.

B. The importance of the bottom-up approach

Throughout the different pillars, there are many examples of policy initiatives that were established bottom-up: initiatives or cooperations that were introduced by organisations or institutions, often at a local level, (sometimes) being structurally implemented and expanded through policy plans afterwards. Several pilot projects can be mentioned in this context, across different pillars, for instance a number of risk reduction initiatives (expanding risk reduction to include recreational drug use and legal drugs) and treatment initiatives (e.g. crisis units in hospitals). Within enforcement too, there are examples of bottom-up initiatives being consolidated in policy afterwards (e.g. the Drug Treatment Chamber), as well as informal cooperation initiated by individual actors (e.g. informal consultation between Sciensano, federal police, federal agency for medicins and food safety (FAGG), the National institute for criminology and criminalistics and customs). Practice thus appears to play an important role in responding to the ever-changing challenges of the drugs phenomenon, and bringing innovation to the Belgian drug policy (De Ruyver et al., 2012).The downside is often that when these local initiatives are not structurally expanded, differences between regions or municipalities might grow. Moreover, these initiatives and cooperations often remain dependent on the available network of individuals and/or organisations and on the existing contacts between people from different policy areas and levels. When these individuals leave the organisation, or when an organisation is not able to sustain the initiative, the cooperation and initiatives might also cease to exist. The respondents pointed to the example of the drug coordinator in East-Flanders and that ofa treatment offer in prison.

C. A limited evidence-based drug policy

Although the Federal Drug Note and the Joint Declaration highlight an evidence-based drug policy, the respondents state otherwise. Both research and monitoring have evolved over the years, creating a solid evidence base alongside the extensive international evidence base. However, research results and recommendations only occasionally result in effective development or adjustments in Belgian drug policy. Too often, research results are taken note of as'nice to know', without translation into (new) drug policy or adaptation to existing policy lines. The same is true of evaluation research on several pilot projects. Pilot projects are developed, often closely monitored and evaluated (as demanded by policy), their continuation often being contingent on a positive evaluation. However, despite positive evaluated projects, an extention or structured implementation is rarely granted.

Additionally, there were gaps for the monitoring of the epidemiological indicators on the demand and on the supply side. Barriers include the limitations of the current epidemiological indicators, problems with funding and a streamlined mandate in the coordination between the National Focal Point and the sub focal points remain, and the limited visibility of the current epidemiological work, which in turn results in lack of recognition. Furthermore, respondents mention a fragmentation of epidemiological research and quality research data.

An evidence-based approach also seems to apply mainly to the demand side, rather than the supply side. Evaluation research focuses mainly on (parts of) the former. In addition, monitoring of the supply side is still in its infancy compared to the indicators (structurally) monitored on the demand side. This

imbalance means that there is more insight into the different aspects of "what works" on the demand side than the supply side.

Nevertheless, respondents do not put the emphasis on a mere 'what works' belief, with high-standard evaluation research providing the necessary insights. There should be room for qualitative interpretation and appreciation too. Furthermore, the importance of experiences, perceptions and the input of practice as well as the input of people with lived experiences are often referred to as necessary, but so far rarely heard in the development of Belgian drug policy.

D. Stigma as a perceived unintended consequence of the Belgian drug policy

In general, the study indicated that there is little attention given to or knowledge about possible (perceived) unintended consequences that certain objectives/actions entail. Respondents often appear to confuse unintended consequences with (secondary) objectives (and thus intended objectives) of policy initiatives. In other words, there is little insight into the unintended consequences resulting from the various policy initiatives.

The main unintended consequence mentioned by the respondents i.e. during the focus groups with people with lived experiences as well as during the interviews with practitioners, was that due to the fact that the possession of drugs is illegal, they believe that people who use these drugs are often stigmatised by the wider public or by specific actors such as the police. Whereas alcohol is generally accepted by the wider public, illegal drugs are linked with stereotypes of criminals and highly marginalised people (Copes, 2016; Corrigan et al., 2017; Fraser et al., 2017; Lancaster et al., 2015; Lloyd, 2013; Willis, 2016; Yang et al., 2017). Respondents emphasise how people who use drugs have to venture into illegality to be able to use drugs, and are therefore portrayed as criminals. As a result, they are looked down upon and more stigmatised than people who, for example, use alcohol, a finding that is supported by previous studies (Kelly & Westerhoff, 2010; McGinty & Barry, 2020; Nieweglowski et al., 2018; Nieweglowski et al., 2019; Van Impe et al., 2021).

E. International participation

Several respondents described how Belgian actors are active in international cooperation and participation in international drugs policy. This is especially the case in terms of international drug policy (e.g. active at EU level and on CND) as well as within the pillar enforcement (ad hoc or structural cooperation with different law enforcement actors). Although respondents highlight the benefits of participating in the international drug policy, they also describe difficulties translating these European discussions and demonstrating its relevance on a national, regional and local level. On the level of international participation of enforcement, they describe a high-performing international network, as well as international cooperation among the police, customs and judiciary. Nevertheless, they still perceive barriers and bottlenecks within this international cooperation, as well within national cooperation between enforcement partners. They refer, for example, to the lack of shared priorities, differences in judicial and administrative procedures which prevent or delay cooperation and information exchange and a lack of coordination of the initiatives or problems with structural cooperation, especially with source countries.

F. A narrow vision on prevention and risk reduction amongst policy makers and enforcement partners

Throughout the study, it became clear that different actors had different visions about what ‘Prevention’ and ‘Risk reduction’ should entail. While prevention entails a broad range of types of prevention, partners in the police and criminal justice field, as well as (some) policy makers focus on the discouragement of the general population or specific target groups, mostly young people, from using drugs, for example by warning them about the harmful consequences. The respondents with lived experiences also had a narrow perception of what prevention should entail, primarily focused on education (“educate young

people"), although this vision already differs from the proscriptive vision that (some) policy makers and law enforcement actors apply (Geirnaert, 2002). This narrow view on prevention does not acknowledge the importance of safe use messages and harm reduction initiatives, nor does it support early intervention. This view stands in the way of a structural expansion of risk reduction and early intervention, so that numerous possibilities remain underutilised. Harm reduction prevention initiatives (e.g. safe 'n sound) often clash with these narrow views, resulting in a rift between the direction taken by prevention partners in practice and the government's prevention policy.

In addition, the lack of funding of this pillar is a common thread through the evaluation study. This lack has already been highlighted by several studies measuring public expenditure and social cost (SOCOST; DIC I; II; III; Algemene Cel Drugs, 2015). 75% of total public direct costs are spent on treatment, and about one quarter on safety (24%). Prevention (0.5%), harm reduction (0.1%) and other activities such as coordination and research (0.24%) are only small parts of the direct cost category (Lievens et al., 2016). Because of the limited financial resources invested in prevention, this pillar faces many limitations. The limited budgets force prevention workers to provide a demand-driven rather than a proactive service. They also create internal competition with the result that one setting is prioritised over another. Due to the uncertainty about funding, there are also few opportunities for structural expansion.

G. Lack of a clear policy vision for the development of treatment provision

There is a lack of a clear vision and an approach to the growing needs regarding the treatment offer. There are many blind spots in the current treatment offer, an observation that is emphasised by both practitioners and people with lived experiences. Several issues were highlighted. For instance, the provision of treatment is concentrated around the bigger cities and there is a need for the expansion and better geographical distribution of (mainly) outpatient centres to fill the gaps. Another example is that access to treatment is jeopardised by long waiting lists (which increased during covid-19) or a lack of treatment offer for some specific target groups (e.g. people with poly drug use, older people, people with dual diagnosis, etc.). Deficits are also reported for the development of aftercare, as well as in crisis and emergency treatment. In addition, respondents bemoan the fact that the many different network structures are often not aligned, which means that networking with ever new actors requires a large investment of time and effort. Finally, the people with lived experiences also mention that there is already a large, diverse and extensive treatment offer, but that a proper overview of the treatment offer for the wider public is lacking.

H. No clear delineation of tasks between different enforcement actors as a barrier of cooperation

Several examples show how different enforcement actors work well together. And yet, barriers can be found.. These barriers to cooperation are often related to the delineation of tasks not being entirely clear. Different actors have different roles, but when these roles are not clearly or structurally attuned to each other, problems can arise. For example: federal police and the federal public prosecutor work across borders, while local police and local public prosecutors focus on the local level. When these boundaries are blurred, and actors enter into each other's territory, cooperation can be compromised, as has also been confirmed by previous studies (e.g. Colman et al., 2020). Problems in access to information (no shared databases), capacity shortages and technological deficiencies contribute to this danger. Throughout the study, several examples were listed. Considering that every actor has priorities which are not necessarily shared with other actors (e.g. because, even though there is a Framework Note Integral Security, respondents mention there are no real shared actions plans between all different enforcement actors to facilitate sufficient cooperation and common goals), structural cooperation is even more challenged.

I. Perceived inconsistencies and pleas for change in the legal framework

Several respondents note a dichotomy between Belgian laws and its prosecution policy. The legal framework proclaims two different messages: on the one hand, there is legislation prohibiting the possession of all illegal drugs, but on the other hand, there is a ministerial directive (2015, updated 2018) saying that the possession of cannabis for personal use incurs no (or hardly any) consequences(quantified at 3g or 1 plant). Starting from a legal perspective, prosecution and police are confronted with an incoherent prosecution policy, which in turns confuses the general public (Gelders & Vander Laenen, 2009). This dichotomy is the cause of much frustration, as well as confusion, amongst police and judiciary. The respondents with lived experiences also atttested to some extent to these incongruences in the legal framework. Likewise, several respondents from the prevention and harm reduction sector propose adapting the legal framework to allow for the elaboration of the current harm reduction initiatives, but the current legal framework limits what they can do, for example concerning drug consumption rooms and drug testing (Vander Laenen & Favril, 2018).

We thus see that a range of respondents agree that the current legislative framework needs an update, although the direction of that update is still a source of disagreement (with law enforcement respondents pleading for clarity in the legal framework towards cannabis and the need for diversification of sentences, whereas respondents within healthcare plead for an extended legal framework that allows for a broader application of harm reduction initiatives).

J. Perceived challenges in the ever-changing drug field are diverse

Both within the prevention field and the treatment field as well as within enforcement, respondents mentioned that they were confronted with the challenge of an ever-changing drug-phenomenon. The emergence of new trends is a characteristic of the phenomenon that challenges the different actors involved. Prevention actors, for example, refer to new trends in drugs use and how to adapt prevention methods to react in an effective and efficient way, to the division of competences in a field with great interdependence, to the difficulty of reaching hard-to-reach target groups in prevention and convincing local government of the importance of the drug theme in a setting-oriented prevention perspective. Treatment actors, on the other hand, refer to challenges with the recovery approach in tackling addiction, for example involving those different life domains and the various actors involved, with the organisation of an accessible treatment offer, with differentiation in the treatment offer, with the involvement of experience experts in the functioning of treatment, with serving rural areas and with waiting lists (Bellaert et al., 2021). Actors from law enforcement are different again. The challenges theyy mention are the resilience of organised crime groups, the displacement of trafficking to smaller ports and recreational craft, the extreme violence in drug trafficking, the infiltration of organised crime into legal structures, poly-criminal organisations and the increasing production and trafficking of synthetic drugs.

These challenges are not expected to change over time, and practice will keep on facing an ever-changing drug-phenomenon. Therefore, practice voices the need for a framework in which all actors can further develop (amongst others in terms of collaboration) and anticipate on the next trends.

10.1.4 Is the Belgian drug policy still relevant in light of the current needs?

Our study finds that the current policy framework provided by the Federal Drug Note and the Joint Declaration is not adapted to current needs. Although some of the objectives are still relevant today, (parts of) the vision, as well as the actions set out in the Federal Drug Note and the Joint Declaration are outdated. This is not surprising given the fact that these documents were drafted over a decade ago and there are several observations supporting this finding.

First of all, since the Sixth State reform, treatment competences, as well as some aspects of enforcement competences have defederalized. Since then, the communities and regions have set

specific priorities within the different pillars of the drug policy. The framework, which largely dates from the 2001 Federal Drugs Policy Document, does not reflect this development.

Second, the document review has identified several additional actions and realisations within the different objectives that were not intended by the Federal Drug Note or the Joint Declaration. These additional realisations are often fuelled by practice or initiated by a certain region or community. They indicate that the drug field has already evolved extensively since the establishment of the Federal Drug Note, even without an overarching and cross-cutting drug plan giving direction.

Third, the interviews with practitioners and experts-by-experience have revealed several new challenges and needs that are not addressed by the current policy. For example, prevention faces constant new trends in drug use for which there is seldom evidence available regarding which prevention approach works best (e.g. regarding behavioural addictions, but also new trends like laughing gas). Treatment faces the same challenge. Enforcement lists a whole list of challenges related to the evolving phenomena at the supply side, comprising resilient organised crime groups, the displacement of drug trafficking to smaller ports and general aviation, extreme violence in drug trafficking, the infiltration of organised crime into legal structures, poly-criminal organisations and the rapidly expanding production and trafficking of synthetic drugs. Epidemiology is challenged by the need to provide real-time data regarding the central indicators of temporal change, and within research, the ever-growing importance of recognisable social impact is described as a challenge.

10.2 Recommendations

The results above lead to some lessons learned to inspire when drafting new policies, strategies or interventions. Based on the results of this study, a number of recommendations are formulated. We make a distinction between general recommendations that apply to Belgian drug policy as a whole, and recommendations that apply to the individual pillars of our Belgian drug policy. When presenting the recommendations, we will include some good practices or examples from other countries to inspire the translation of our recommendations into practice.

10.2.1 General recommendations

FIVE GENERAL RECOMMENDATIONS

- Draft a new Drug Strategy, accompanied by an action plan
- Develop an evidence-informed Drug Strategy
- Rethink the organisation and tasks of the General Drug Policy Cell
- Create opportunities for innovative projects to respond to the ever-changing reality of the drug phenomenon
- Support the development of structural and sustainable forms of cooperation (including financial support)

10.2.1.1 Draft a new Drug Strategy, accompanied by an action plan

A first recommendation relates to the development of a new Drug Strategy, accompanied by an action plan. This study clearly showed that the current Belgian drug policy, shaped by the Federal Drug Note and the Joint Declaration, is outdated. Not only have there been many new developments in both policy and practice since the last policy document (2010), but policy and practice are also confronted with new challenges that were not on the radar more than 10 years ago. We therefore recommend the development of a new Drug Strategy, involving all the different policy levels and including all relevant policy domains, and a corresponding action plan, as part of a broader policy cycle. This was the case with the policy drafting process in 1997-2001, and is even more complex today because the policy competences are more divided than they were twenty years ago. We therefore recommend a development process which coincides with the term of office of the federal government and that of the regional governments. More precisely, we recommend that a Drug Strategy is developed every five years and concretised in an action plan over the same time span. Inspired by the EU Drug Strategy approach, a Drug Strategy clarifying the overarching vision and goals, should be accompanied by an action plan that concretise this vision and provide tools for implementation. Considering the distribution of competences in Belgium, it is important that in addition to the federal level, the communities and regions are actively involved so that the Strategy is comprehensive. Political will remains a precondition for the further development of a comprehensive and integrated drug policy.

Lastly, it is important that the overall vision and framework is shaped at the national level by means of a strategy, which can be given further substance by means of a concrete action plan. When drafting the Drug Strategy, attention should be paid to finding a balance, coherency and consistency in the framework between the national, regional and local drug policy. The national Drug Strategy will be a leading framework, and will include the need to implement a local integral and integrated drug policy, as is also highlighted in the Framework Note Integral Security. However, there should be room to adapt it to local needs. In other words, the framework should not lay down every detail in order to leave sufficient room for a local drugs policy.

Table 11 Building blocks of the new drug policy

Clear vision Clear strategy Evidence-informed: include expertise from academia, civil society, practice, people with lived experiences	A transparent, fixed and recurrent policy cycle	Involving all levels Involving all policy domains Involving all substances Involving behavioural addictions	Establishment of the Drug Strategy and action plan must go hand in hand with structural funding	SMART objectives, actions, outputs and outcomes

A. Need for a clear vision: (re)define the core premises of the Belgian Drug Strategy

From our study, it became clear that ideological differences can paralyse the development of a concrete action plan or even concrete actions (e.g. alcohol plan, drug consumption rooms). Various initiatives are impeded by (political) ideological debates and too often this prevents a decisive policy response or results in fragmentation. At the same time, practice and administration voice the need for a clear and concrete vision on how to address the drug phenomenon.

In order to break through these clashing ideological viewpoints, it is necessary to create awareness about them, and to name and frame them in an open discussion. We therefore recommend to establish a situation analysis[108] in order to (re)define and (re)affirm the core premises of the Belgian Drug Strategy.

This situation analysis should comprise of an accurate analysis of the existing situation, discussing the nature, extent and various features of the drug phenomenon, as well as a needs assessment across the different stakeholders (i.e. policy makers, practitioners and civil servants, people with lived experiences, academics). Questions to include should be: What is the size, nature and extent of the drug phenomenon and its consequences? Who is affected by the drug phenomenon (directly, indirectly)? What are the challenges administration, practice and people with lived experiences encounter and what needs do they voice? How is the current policy experienced by the different stakeholders? What are possible approaches to address the issues revealed by the situation analysis? Part of this analysis should also provide a conceptual clarification of how "an integrated and integrated approach" should be operationalised. The situation analysis should also include a horizon scanning and try to have a foresight on upcoming aspects when talking about creating or finetuning a vision. In line with the EU Drug Strategy 2020-2025, there is a need to develop strategic foresight and a future-oriented approach to increase preparedness to identify and respond to potential future challenges. This also addresses the challenge identified in this study to face the ever-changing drug phenomenon. The situation analysis should thus consist of both data on the current evidence base and a foresight exercise.

This situation analysis can in turn be the basis for (re)defining and (re)affirming the core principles for the Belgian Drug Strategy, for setting clear objectives and to set priorities for the Belgian drug policy. There is a large body of international research and experiences abroad that can guide our efforts in conducting a situation analysis as a basis for a new policy strategy (Bartram et al., 1999; CICAD, 2009; Rajan, 2016; WHO, 2003).

Although this type of exercise has been conducted in the past by means of a Parliamentary Working Group, several practitioners and civil servants are reluctant to support the establishment of a new one. Notwithstanding the fact that a Parliamentary Working Group has the advantage of a relatively stable political base, as it is the parliament that decides on its creation, they fear the political jousting. In addition, a Parliamentary Working Group results in a number of challenges, such as the fact that the central competences relevant to drug policy are divided amongst the different policy levels, and thus, in addition to the federal government, the communities and regions are also involved, creating an unwieldy and slow process.

[108] The results of EVADRUG could be included in this situation analysis

Alternatively, there are international examples where a small team of experts (academia, practice, civil society and people with lived experiences) are brought together to systematically summarise the situation at stake in a report, that in turn is used as a basis for selecting the appropriate strategies (Rajan, 2016; WHO, 2003). A core team of experts managing thematic working groups, can avoid the challenges intrinsic to a ponderous and elaborate parliamentary working group. This core team of experts has to ensure effective coordination of the thematic working groups, and should be tasked with preparing the situation analysis, constituting working groups, informing and sensitizing relevant stakeholders, and organising, managing and supporting the working groups (Rajan, 2016). It is recommended that the core team consists of academics, practitioners, civil society and people with lived experiences (Rajan, 2016), acting as impartial advisers are involved as well (WHO, 2003). Additionally, this core team could assure continuity throughout the different policy cycles, as well as provide senior knowledge to the execution of the procedure. The 'Expert advisory panel' (cf. infra, Recommendation 3.2) could play a role to that regard.

Regardless of format or constitution, the need for an exhaustive situation analysis is imperative. This analysis could be executed internally by the administration(s) or externally by experts. In any case, we would advise consulting and engaging academics, practitioners, civil society and experts-by-experience. Academics can provide an overview of the current evidence base, practitioners and civil society can outline how the policy actually works in practice and people with lived experiences can in turn provide insight into how existing policy initiatives are experienced.

Example: the roadmap for the establishment of the EU Drug Strategy 2020-2025:
Following the expiry of the EU Drugs Strategy 2013-2020 and its two associated Action Plans, an evaluation was carried out by an external evaluator. In July 2020, the European Commission presented this evaluation, and additionally presented the new priorities for the future EU drug policy. An EU drugs agenda for 2021-2025 was simultaneously proposed. The Horizontal Working Party on Drugs (HDG), which is the coordination body for leading and managing the Council's work on drugs, was responsible for approving and validating the final version of the Strategy. Against that background, the various bodies of the Council developed the EU Drugs Strategy 2021-2025. The new strategy is thus based on the input from the Commission Communication "EU agenda and Action Plan on Drugs 2021-2025'[109], and the external 'Evaluation of the EU Drugs Strategy 2013-2020 and EU Action Plan on Drugs 2017-2020'[110], as well as continuous analysis of the current drug situation by EMCDDA and Europol, and information from civil society. On 21 June, the Council of the EU approved the EU Drugs Action Plan for 2021–2025 (EMCDDA, z.d.).

B. Drug Strategy and action plan as part of a policy cycle

The Federal Drug Note and the Joint Declaration are not bound in time. This leads, among other things, to the situation where a policy document drafted twenty years ago forms the basis for Belgian drug policy. As such, the basic policy documents are no longer adapted to the current situation and to the current challenges that policy and practice are facing. Taking into account that the EU Drug Strategy has changed three times since the Joint Declaration, introducing a policy cycle would also allow to take the changes in the European Drug Strategy into account.

A new policy strategy is not only an update of that policy plan to address the evolving circumstances and challenges, but also an opportunity to introduce the Drug Strategy to a new policy cycle.

[109] Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, EU Agenda and Action Plan on Drugs 2021-2025
[110] Commission Working Staff Document- "Evaluation of the EU Drugs Strategy 2013-2020 and EU Action Plan on Drugs 2017-2020", July 2020, SWD(2020) 150 final

We therefore recommend a new Drug Strategy, to be introduced as part of a policy cycle, consisting of four elements: (1) policy development, (2) endorsement of the Drug Strategy, (3) policy implementation and (4) policy evaluation. The coordinating actor could be the General Drug Policy Cell, together with the support and input of the inter-administrative working group and the expert advisory panel (cf. infra).

(1) **Policy development**. As mentioned earlier, we advise drafting a situation analysis (cf. A) in order to arrive at a proper agenda setting for the development of a Drug Strategy. Based on this situation analysis (including an exercise on strategy foresight), and (re)defining and (re)affirming the core principles, objectives and priorities, a draft policy strategy should be developed. This draft Drug Strategy should stipulate the global, generic principles, should take feasibility into account, and should– ideally- be accompanied by a feasibility analysis. Once a draft Drug Strategy has been developed, consultation and consideration of conflicting viewpoints with all stakeholders should be done. Here again, academics, practitioners, people with lived experiences and civil society can be involved to finetune the Drug Strategy in co-creation, which is inherent for the foresight part of the situation analysis. This consultation process enables validation of a support base, stimulates commitment in the field and increases the knowledge of proven strategies (evidence) (Vander Laenen et al., 2010). It is not only beneficial for gaining legitimacy, but also ensures that the Drug Strategy is attuned to the needs and challenges of all the stakeholders. After all, a successful implementation of the Drug Strategy also depends on their support. Also, as this is a policy cycle, it is important to take previous evaluation into account, as is explained in the fourth step.

(2) The second step in the policy cycle comprises **the official endorsement of the Drug Strategy** by all relevant policy domains and levels. A draft strategy could be discussed and adopted at the level of the Interministerial Conference of Public Health, Thematic Meeting on Drugs, after a wider discussion with all relevant stakeholders.

(3) The third step in the policy cycle comprises **policy implementation**. A policy without an implementation plan is destined to fail (WHO, 2003; World Health Organization, 2001). As a first move towards policy implementation, the Strategy should be translated into a concrete action plan that explains how the strategy will be implemented (translated into actions), defines targeted implementation measures and allocates financial and human resources. Within this action plan, there is a need for an implementation roadmap that details how the different actions will be implemented. This should define implementation priorities, as well as outline approaches and activities for each component of the Drug Strategy and should incorporate flexibility so as to take into account variation in local needs (Singleton & Rubin, 2014). This step of the policy cycle should also be accompanied by a framework for systematic monitoring of the implementation of the different actions in order to avoid fragmentation, for example by defining specific evidence-based indicators. For this, a specific monitoring system should be developed, for example at the federal level[111], to follow-up on the extent of implementation and enables a continuous assessment of progress (WHO, 2003; World Health Organization, 2001). It is recommended that a coordinating body oversees the coordination and monitoring of the implementation. An option could be for Sciensano to play a leading role in that regard, possibly assisted by the inter-administrative working group (cf. recommendation 3 "rethink the organisation and tasks of the General Drug Policy Cell"). Here again, other stakeholders - academics, administrators, practitioners, people with lived experiences and civil society should be involved to oversee implementation and in order to maintain support for the policy approach.

(4) Evaluation can comprise both the *ex nunc* monitoring of, for example, the implementation process (process evaluation), and also *ex post* evaluation at the end of the policy cycle. The *ex nunc* evaluation (also referred to as mid-term evaluation) allows for temporal adjustment where necessary and a quick response to obstacles encountered, and can be seen as a continuous review of the Drug Strategy and action plan. The results of the *ex post* evaluation in turn address the overall performance of the Drug Strategy and action plan and can feed into the development of the following Drug Strategy. This

[111] This system could for example be coordinated by Sciensano

evaluation could be conducted by an internal (e.g. the different administrations) or external (e.g. academics or research institute) evaluation team. In any case, there is a need for an independent evaluation by a party with the necessary expertise for evaluation. There should also be adequate resourcing to allow for a thorough evaluation (EMCDDA, 2017a). Lastly, it is important to have an experienced evaluation team with expertise in conducting an evaluation on such large scale.

The policy cycle should be limited in time, so that it provides sufficient stability to develop a decisive drug policy, but also allows for timely adjustments according to the ever-changing drug phenomenon. We therefore recommend have the Drug Strategy coincide with the term of office of the federal government and the term of office of the regional governments. More concretely, a Drug Strategy should be developed every five years and concretised in an action plan over the same time span.

C. Be consistent and coherent: include distinct target groups, demand as well as supply actions, all substances as well as behavioural addictions

The Federal Drug Note and the Joint Declaration focus on alcohol, tobacco, psychoactive medicine and illegal substances. Nevertheless, this evaluation has shown that the emphasis of existing policy plans still primarily remains on illegal substances. Throughout the years, behavioural addictions such as gambling and gaming have also gained the attention of drug policy initiatives. Other substances like performance enhancing drugs were barely addressed during the study, although the use of these drugs has changed from being a problem restricted to sports to one of public-health concern, and so it seems warranted to include them as well in policy initiatives (Hardyns et al., 2020). And yet this has not been adequately reflected in a Drug Strategy.

Additionally, the research results have shown that the Federal Drug Note and the Joint Declaration emphasise certain target groups more than others. For example, they prioritise target groups of young people and people with addiction problems. We also found that there is not always a balance between actions addressing the demand side and those addressing the supply side. For example, evaluation and monitoring is mostly aimed at mapping the demand side and proving the effectiveness of methods trying to influence the demand side, whereas the mapping of the supply side is far less developed, and evaluation studies of the supply side remain limited.

It is therefore important that in a new Drug Strategy, attention is paid to consistency and coherence involving all substances and behavioural addictions and all different target groups, and balancing actions between the supply side and the demand side. Lastly, we highlight the importance of avoiding the use of stigmatising language, for example when referring to people who use drugs.

Example: the coherency markers of the Pompidou Group:
Based on six indicators, the Pompidou Group introduced a method for measuring coherence between licit and illicit substances of a drug strategy. It focuses on coherence between conceptualisation, policy context, legislative and regulatory frameworks, strategic frameworks, responses and interventions, and structure and resources (Muscat & Pike, 2014).

D. Secure budget to implement policy priorities

Throughout the evaluation, it became clear that many projects (across the different pillars) faced inadequate funding, had been discontinued due to lack of funding, or had an uncertain existence due to lack of structural funding. It is therefore important to secure a budget for policy actions. Additionally, a budget should be reserved for the monitoring and evaluation of the Drug Strategy (cf. C), which has to be calculated separately from the budget to implement the action related to the Strategy.

E. Beware of the structure of the strategy: define SMART objectives, actions and outcomes and tools for implementation

When conducting this study (i.e. the measurement of the logic models based on the Federal Drug Note and the Joint Declaration), it became clear that there are several flaws in the way the Federal Drug Note and the Joint Declaration are formulated and structured. Both policy documents proved difficult to implement. When drafting a new Drug Strategy, it is therefore important to identify SMART objectives, actions and outcomes. There are many possibilities to draft objectives, actions and outcomes. We propose to work with SMART objectives making it easier to measure and monitor them.

SMART objectives/actions/outcomes are specific, measurable, achievable, relevant and timebound. Specific means that they are clear with respect to who, what, where and when. Measurable refers to concrete criteria for measuring the progress. Achievable relates to feasibility and attainability. Relevant means that they are adapted to the concrete needs of the stakeholders and useful in achieving the eventual outcomes. Lastly, timebound refers to the fact that a time period has to be stipulated (EMCDDA, 2017a).

Apart from a SMART defining of its different components, the Drug Strategy and action plan should also be structured in a 'cause-and-effect' chain, explaining which actions should lead to what change. In order to do so, logic models can be a useful tool. The logic models were used in this study as a tool to assess the policy theory spelled out by the Federal Drug Note and the Joint Declaration, but they could also be used *ex ante*, to draft your Drug Strategy. They allow a clear overview of how the objectives are concretised in actions, and how these actions lead to change in the short, medium and long terms. They can also be the starting point of an implementation monitoring tool if, when the objectives/actions/outcomes are drafted, indicators are identified to measure them at the same time.

Table 12 Example of how a logic model can assist in developing a Drug Strategy.

Objectives	Actions	Intended outcomes		
		Short term	Middle term	Long term
What do you want to achieve with the Drug Strategy?	What actions will you take to achieve the objective?	• Intended results and short-term changes • Lead • Timing • Indicators	• Intended results and middle-term changes • Lead • Timing • Indicators	• Intended results and long-term changes • Lead • Timing • Indicators

Lastly, it is essential for the new Drug Strategy to provide tools for implementation. This means that the Drug Strategy and action plan should clearly describe who takes the lead in the implementation, define the roles and responsibilities of partners and stakeholders and provide a roadmap for implementation. There is a large body of international research and experiments and experiences that can guide our efforts in drafting and shaping our Belgian Drug Strategy and action plan (CICAD, 2009; Culley et al., 2012; Vaslie et al., 2020; WHO, 2003).

Example: the European Drug Strategy 2013-2020 and its related Action Plans (2013-2016; 2017-2020):

The European Drug Strategy 2013-2020 and its related Action Plans (2013-2016; 2017-2020) rely on a logic model structure to describe their drug action plans. The action plans contain a schematic overview of the objectives with their corresponding actions. For each action, a timetable, responsible party, indicator for monitoring and sources of data collection or assessment mechanisms are defined. By defining these during the drafting of the drug action plan, monitoring and evaluation is facilitated, which in turn support the creation of a monitoring and evaluation culture.

Figure 21 Example of one of the actions of the EU Drug Action Plan 2017-2020 (p.215/23)

Objective	Action	Timetable	Responsible party	Indicator(s)	Data collection/assessment mechanisms
1. Prevent drug use and, secondly, delay the onset of drug use	1. Improve the availability and effectiveness of evidence-based [1] prevention measures that take account of risk and protective factors as outlined below a. population factors such as age; gender; education, cultural and social factors;	Ongoing	MS	— Over-arching indicators 1, 11, 12 — Availability and level of provision at MS level of evidence-based universal and environmental prevention measures	EMCDDA Reporting/ Reitox network national reporting package MS reporting on results of measures

10.2.1.2 An evidence-informed policy taking into account scientific knowledge, practice-based knowledge and lived experiences

A second recommendation relates to the importance of an evidence-informed policy. The research results have revealed a number of good developments when striving for an evidence-based drug policy, but have also pointed to a number of challenges when implementing such a policy. Examples are problems with the coordination of epidemiological data, limits to the existing indicators, a limited use of the existing data, a limited degree of diversity in BELSPO research projects and (the perception that) limited account is taken of research results in policy development. Moreover, the research results clearly show that there is a lack of evidence based on personal experiences and practice-based evidence in the policy process, despite the fact that involving lived experiences and practice-based evidence, next to scientific knowledge, promotes greater legitimacy, embodied by the slogan “nothing about us without us”. It also reflects a pluralisation of knowledge by not only relying on evidence within a scientific context, but also evidence based on personal experiences as well as practice-based evidence (Lancaster et al., 2017; valentine et al., 2020). We therefore recommend the development of an evidence-informed policy, rather than an evidence-based policy, where a drug policy is informed about the best available evidence taking into account the different sources of information, i.e. lived experiences, practice-based evidence and scientific evidence (Bowen & Zwi, 2005; Lancaster et al., 2017). The inclusion of the voice of people who are affected by drug policy and practice-based voices acknowledges the consideration of drug using subjectivities as multiple and emergent, and counterbalances the privileging of “objective” scientific knowledge within evidence-based policy (Lancaster et al., 2017; Ritter, 2015; Van Impe et al., 2021).

A. Involve civil society and people with lived experiences in different stages of the policy cycle

There should be an ongoing dialogue between policy makers and civil society stakeholders to involve the latter in the policymaking process. Using the slogan ‘Nothing about us, without us’, civil society and experts-by-experience are more and more often involved in the policymaking process. The importance of engaging these stakeholders at all levels of policymaking is widely recognised. As (un)intended impacts of a drug policy affects them, there is great value in engaging them in evidence-informed policy development (Oxman et al., 2009). By involving civil society in the policymaking process, expert knowledge shaped by professional experiences, as well as personal experiences, can provide proper connection with the practice field. It allows light to be shed on how policy is translated into practice, and can also provide insight into (perceived) unintended consequences (Bardell, 2020). This is not only beneficial for gaining legitimacy for a drug policy approach, but also for attuning the Drug Strategy to the needs and challenges of the different stakeholders. After all, a successful implementation of the

Drug Strategy also depends on the support of those who implement it or of those who will be subjected to it.

We therefore recommend to involving civil society and people with lived experiences, next to scientific evidence, at every stage of the policy cycle. Civil society should be defined in a broad way, referring to the associational life operating in the space between the state and market, including individual participation, and the activities of non-governmental, voluntary and community organisations (European Commission, 2006). Civil society and people with lived experiences should be consulted in the situation analysis. They should also be consulted when a draft Drug Strategy is developed. They should be engaged in the Drug Strategy's implementation, as well as in its evaluation.

There are many degrees of citizen participation in policy, ranging from complete non-participation, through 'tokenism' to genuine citizen power (Arnstein, 1969; Oxman et al., 2009), as is shown in Table 13. To avoid 'tokenism', mere symbolic involvement without a proper role or opportunity to have an actual impact, civil society and experts-by-experience should get a proper mandate. Limiting the involvement of civil society to the lower level of the table (i.e. "Information") should therefore be avoided. There could be structured consultation on decisions, advisory committees or forums that engage a range of civil society organizations in discussion of policy (WHO, 2021). There is a large body of international research and experiments and experiences abroad that can guide our efforts to involve civil society and people with lived experiences in the Belgian drug policy (Council of Europe, 2009; Lancaster et al., 2018; Lancaster et al., 2013; Oxman et al., 2009).

Table 13 Mechanisms of civil society involvement in drug policy (Council of Europe, 2009).

PARTNERSHIP	• Working group or committee	• Co-drafting	• Joint decision-making • Co-decision making	• Strategic partnerships	• Working groups or committee	• Working groups or committee
DIALOGUE	• Hearings and public forums • Citizens' forums and future councils • Key government contact	• Hearings and Q&A panels • Expert seminars • Multi-stakeholder committees and advisory bodies	• Open plenary or committee sessions	• Capacity-building seminars • Training seminars	• Working groups or committee	• Seminars and deliberative forums
CONSULTATION	• Petitioning • Consultation online or other techniques	• Hearings and Q&A panels • Expert seminars • Multi-stakeholder committees and advisory bodies	• Open plenary or committee sessions	• Events • Conferences • Forums • Seminars	• Feedback mechanisms	• Conferences or meetings • Online consultation
INFORMATION	• Easy and open information access • Research • Campaigning and lobbying • Website for key documents	• Open and free access to policy documents • Website for key documents • Campaigns and lobbying • Web casts • Research input	• Campaigning and lobbying	• Open access to information • Website for information access • E-mail alerts • FAQ • Public tendering • Procedures	• Open access to information • Evidence gathering • Evaluations • Research studies	• Open access to information
Steps in the political decision making process	AGENDA SETTING	DRAFTING	DECISION	IMPLEMENTATION	MONITORING	REFORMULATION

This recommendation is strongly supported by the different respondent groups involved in this study. Expert centres and member organisations (like Fedito, VAD) should keep investing in their role as representatives of specialized organisations and practitioners and as such, should be given a specific role in the different stages of the policy process.

Example from Finland:

Finland has always had close relationship between the state and civil society. An example of this connection can be found in the fact that they have several online platforms where citizens can launch initiatives and collect statements of support for these initiatives (propose, withdraw or change a new law), but also enable different forms of public consultation and participation (European Center for Not-for-profit Law, 2016). The involvement of civil society is also apparent in the country's drugs policy. The previous evaluation of the EU Drug Strategy revealed some more clarity on this matter. For example, non-state actors were consulted in the development of the future drugs strategy (around 2017), especially to give their input in the fields of prevention, treatment and harm reduction. Their specialisation and proximity to local conditions and actors, as well as relative ease of access to drug users, acted as a facilitator in delivering a wide range of services. However, the fragmented responsibility for drug policy implementation, in particular for demand reduction, brought up some difficulties to coordinate amongst actors and ensure uniform standards according to stakeholders, similar to the issues that we encounter in Belgium (Balbirnie et al., 2016).

B. Strive for quality and transparent data

Qualitative monitoring of key indicators forms the basis of monitoring the drug phenomenon in Belgium. However, this evaluation has reported on several issues with the current monitoring. While there is also room for improvement in the monitoring of the demand side, the monitoring of the supply side is clearly lagging behind. The monitoring of the supply sides relies on police and judicial statistics, but also includes partners such as customs, FAGG, Sciensano and the National Institute for Criminalistics and Criminology (NICC) in order to get a better overview. However, among other things, problems with misclassification during registration often appear and skew the data.

We therefore firstly recommend that monitoring be strengthened, especially of supply-side indicators (Vaslie et al., 2020). We need an overview of the drug phenomenon, which includes both health, security and lifestyle/wellbeing. An important precondition for adequate monitoring, however, is the willingness of all partners involved to contribute to it. Monitoring is based on the information input and proper registration from different government agencies, organisations and practitioners. These actors often indicate that registration 'takes a back seat to all the other work'. Efforts should therefore be made to find a win-win to increase willingness for registration, and convince actors of its added value (Lievens et al., 2016; World Health Organization, 2001). Registration and monitoring take time and this requires that means are ear-marked within the budget specifically for these tasks (Lievens et al., 2016; World Health Organization, 2001).

Apart from further developing and supportting the monitoring of both the demand and the supply sides, attention should also be paid to the transparency of data results, not only for practice but also for the wider public. Summaries, overviews and analyses that describe the results as well as give detailed descriptive information about the context should be publicly available, and adapt it to all the different audiences. Creating a return for monitoring is important, as well as an attractive format tailored to the target audience. Good example are for instance the website of the Trimbos Institute, that summarises an up-to-date picture of the use of drugs, alcohol and tobacco in the Netherlands, adapted to the wider public (https://www.nationaledrugmonitor.nl/) or working with an interactive platform to to focus on societal impact creation.

Timely information provision is key here, as the compilation of annual drug reports can take up some time. Centralising the available data is crucial for this, as well as centralising the best practices, following the example of the EMCDDA best practice portal. For this, a clear mandate for Sciensano must be established.

C. Shared responsibilities between academics and policy makers

The results of this research have shown that research results in general are often used as 'nice to know' by policy makers, but not translated into decisive policy change. Linked to this, several practitioners and administrators voiced the need for more and better valorisation and translation to policy and practice of

research results. Scientific information is after all but one source of information in policy making (Bardell, 2020).

We therefore recommend that both academics and policy makers facilitate mutual exchange of evidence. First of all, valorisation can be expanded by making it an indispensable and structural part of BELSPO projects. Implementing valorisation as the last work package of a research project would present it as an integral part of the research, rather than an option after the research report is published.

Next, although societal valorisation is already happening alongside scientific valorisation, academics should invest more in valorising their research results tailored to the specific target groups they are approaching. To tailor the output to the target group, there is no one size fits all. It is therefore advisable to build in a communication plan , which includes when and how the research results will be communicated, as part of a research proposal. This plan should also specify the different target groups, and what messages will be conveyed to which group. This way, summaries of the research project are translated to the audience (Benneworth & Jongbloed, 2010; Hladchenko, 2016). Other examples of dissemination could be providing a TED talk, designing interactive dashboards, fact sheets or short report overviews , writing blogs, sharing expert opinions through newspapers or podcasts to disseminate research results to a broader audience. In addition, the idea of an annual national conference on 'drugs', or a conference which brings together all domains, regions, political levels and experts (incl. debate) has also been mooted. These conferences have been organised in the past, coordinated by Brice De Ruyver, and might ensure that recent research into the drugs phenomenon can be further disseminated. These initiatives should be organized independent from specific funding organisations or a specific university, as this could limit an integral and integrated view. The organisation could be coordinated by the expert advisory panel (cf. infra).

Lastly, by introducing evaluation as part of the policy cycle, research and policy are more strongly interlinked. On the one hand, this ensures that even when designing a Drug Strategy, policymakers already take future evaluation into account, and thus pay attention to setting up monitoring indicators from the outset. On the other hand, it challenges evaluators to summarise research results more concisely so that they are accessible and ready to use to properly inform new policy initiatives.

D. Structural implementation of positively evaluated pilot projects

The results of this study have shown that many pilot projects remain as mere pilot projects for several years, even after a positive evaluation. Well-functioning pilots thus continue to operate for years under uncertain resource conditions, and their expansion to regions with similar needs often fails to take place.

We therefore recommend that a procedure is devised whereby pilot projects are closely monitored and evaluated after a specific period of time. The evaluation framework of logic models can be used as a means to monitor and evaluae process, output and outcome of the pilot projects, in a similar manner as has been applied in this study (cf. infra). If the pilot project is evaluated positively, the pilot project should be linked to long-term structural funding.

10.2.1.3 Rethink the organisation and tasks of the General Drug Policy Cell

This study revealed a number of barriers. In the General Drug Policy Cell, for example, there is a lack of continuity of its members that might lead to a lack of continuity and expertise. Its members also sometimes lack a political mandate. Its large number of participants and ideological fragmentation were highlighted as barriers, while the need for a strong President and Secretariat were cited as important preconditions for good functioning. Political will remains a precondition for the further development of a comprehensive and integrated drug policy.

We therefore recommend that the organisation and tasks of the General Drug Policy Cell be rethought in such a way as facilitate more integral and integrated cooperation. Integral and integrated cooperation

and coordination is, after all, essential in a federated state like Belgium, where diverse and shared interest should be balanced, taking into account the competences of the federal government and regional/community governments and their high level of interdependence. We can draw upon the experiences of other federated states like Germany, Austria or Switzerland to strengthen the Belgian General Drug Policy Cell. There is also a large body of international research that could guide our own efforts.

A. The role of the President as coordinator, liaison, and initiator of the Belgian drug policy

The results of the research have shown a need for a strong president of the General Drug Policy Cell as the key person to coordinate the policy efforts related to drugs. The president should take the role of coordinator, intermediary and catalyst for the Belgian drug policy. S/he should oversee the consistency and transparency of drug policy initiatives, while taking the initiative in pressing for the prioritisation of central issues in need of coordination. Second, the president should facilitate contact between different policy domains and policy levels and mediate between the different parties in order to seek consensus and cross-departmental support (Singleton & Rubin, 2014; Tieberghien, 2015), therefore strengthening the link between the General Drug Policy Cell and the Interministerial Conference on Public Health, Thematic Meeting on Drugs. Third, the president should act as an initiator for the further development and coordination of the Belgian drug policy. The president has, in that sense, also a symbolic value in creating visibility for the drug issue (Stolz, 1995).

As such, the president of the Drug Policy Cell must have a strong connection with the political domain as well as those of practice and science. S/he is therefore preferably familiar with scientific research or has a close link to the scientific community, in order to facilitate interaction between drug policy development and the existing evidence base. In addition, it is important that the president has a good understanding of, and connection with, the field of practice, and can call on a broad network of practitioners in the field of demand and supply. Finally, it is also important for this person to also have experience of the political context in which policy development takes place. This feeling for the field, the scientific community and the political context will ensure closer connections and therefore more harmonisation in drug policy initiatives, and also facilitate the bringing together of different perspectives on specific problems.

Lastly, the president has an important role in strengthening the link between the General Drug Policy Cell and the Interministerial Conference on Public Health (Thematic Meeting on Drugs).

As it is difficult to combine all these characteristics in one person, it may also be interesting to appoint a co-president who complements the profile of the president. In this way, the president and co-president together fulfil the necessary roles of a strong president.

B. Multidisciplinary working groups in support of the General Drug Policy Cell

The General Drug Policy Cell has been installed to facilitate coordination in the Belgian drug policy. However, this study identified a number of bottlenecks in this coordination. As indicated before, several respondents referred to the lack of continuity of the Cell's members, sometimes a lack of political mandate too, and the ideological fragmentation that often leads to a drug policy that is not developed in an integral and integrated way. Another bottleneck cited in the research was the limited room for input of practice and lived experiences. In addition, the division of competences between the federal government and the regions/communities, together with their elaborate interdependence, makes policy development and implementation all the more challenging.

When the different respondents involved in this research were asked how these issues should be addressed, there was a general consensus about a reorganisation of the General Drug Policy Cell. However, when respondents were asked to spell out the shape of this reorganisation and how to translate it into practice, some ideas were put forward but no concrete proposals were articulated, and

some disagreement occurred regarding the elaboration of these ideas. An example of a widely accepted idea among respondents was that the General Drug Policy Cell should take a more active role in preparing and developing policy, taking into account multidisciplinarity and with an eye to decisive coordination.

A first group of respondents proposed the idea of setting up an inter-administrative working group in support of the General Drug Policy Cell which would to prepare its meetings and develop concrete proposals to be discussed during the meetings. Other respondents emphasised that this working group should include not just members from administration but also stakeholders from outside government, to include advisers from diverse information sources (i.e. practice, research, lived experiences). This idea echoes the recommendation to include practice-based evidence and lived experiences made earlier (cf. recommendation “develop an evidence-informed drug policy”, sub recommendation A). Another group of respondents emphasised the importance of involving policy makers in the preparation and development of policy.

Overall, the replies have in common that a redefinition of the structure and/or tasks of the General Drug Policy Cell is needed in order to deliver better outcomes and ‘good governance’ (Singleton & Rubin, 2014).

Based on an analysis of literature and good practices in other countries, we propose the following reconstitution of the General Drug Policy Cell (see figure 14).

An **expert advisory panel** could be appointed. It would consist of people with expertise in (specific domains of) the drug phenomenon, as well as practitioners and people with lived experiences, and function in support of the General Drug Policy Cell. This is in line with what our respondents proposed during the focus group. A number of temporal working groups could be established from this expert advisory panel to provide expert advice or identify the necessary information needed for the development of specific aspects of drug policy. Halligan (2008) argued that working groups or topic-specific taskforces aimed to resolve particular issues can provide more innovative answers to divisive issues (Hughes et al., 2010). With a multidisciplinary composition, such groups allow for the involvement of stakeholders outside of government, and thus provide specific insider/outsider perspectives. Moreover, they allow for accountability and transparency.

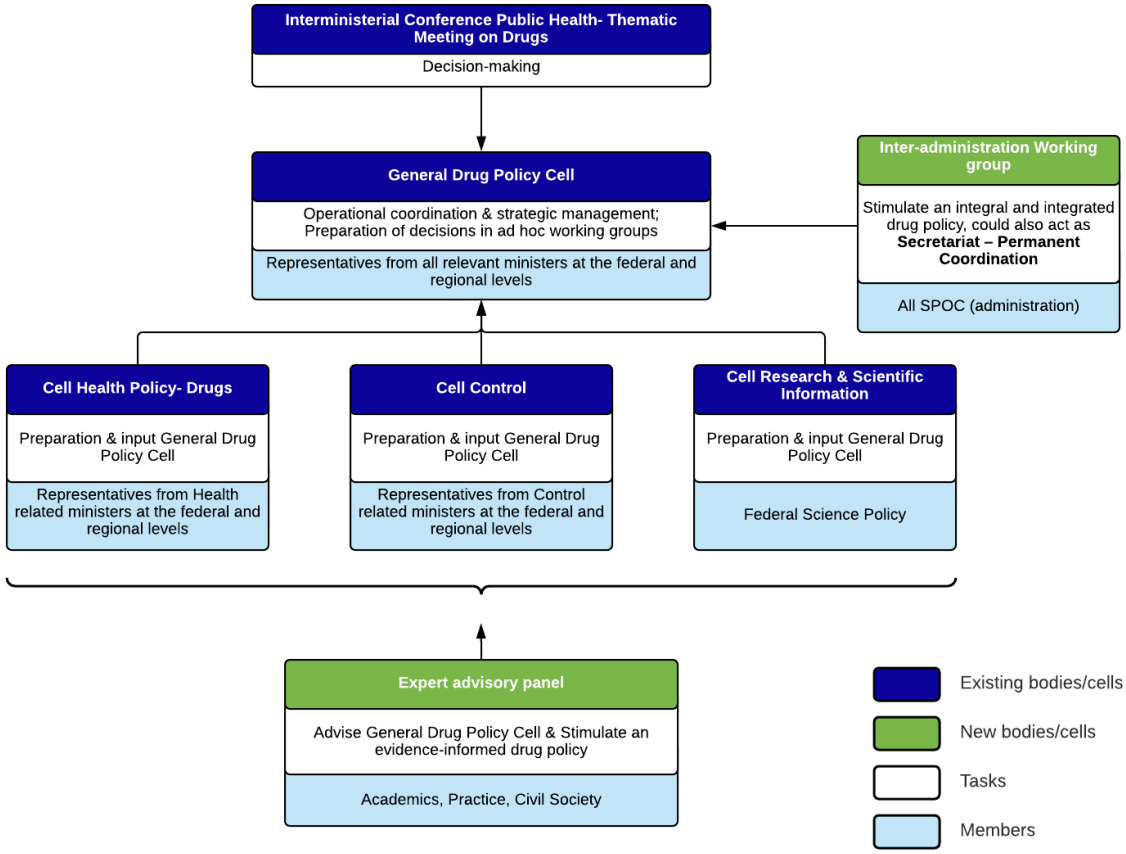
Additionally, an **inter-administration working group** (including both the Federal level and the Regions and Communities), comprising health and law enforcement civil servants, could oversee the implementation of the Drug Strategy as well as liaising with other governmental actors and the non-government sector. This idea was mentioned by our respondents during the focus group. The inter-administration working group could facilitate information exchange too. This way, the General Drug Policy Cell can be focused on strategic, controversial and long term issues, whereas more technical issues can be handled by the inter-administration working group (Hughes et al., 2013; World Health Organization, 2001). The inter-administration working group could also act as the secretariat of the General Drug Policy Cell (i.e. an extension of the current secretariat with all SPOC), in order to further stimulate an integral and integrated drug policy (cf. Figure 14).

It remains important that the various stakeholders are informed about their specific roles and that clear expectations for the different structures are defined. A clear demarcation of responsibilities would in turn facilitate responsiveness (Hughes et al., 2013).

Within the context of the Belgian state structure, as well as the different perspectives and logics inherent in the drug debate, there will always be a need for improvement of coordination. The reconstitution of the General Drug Policy Cell should therefore consider the way in which better coordination is achievable given its context. And there is certainly room for improvement there.

As such, the organisation of the general drug policy cell could be summarised as follows:

Table 14 Overview of supporting working groups to the General Drug Policy Cell



Example of policy coordination: Austria:

Austria has, like Belgium, a ederalized government, competences being divided between a federal government and the nine provinces. Each province has its own government and parliament. The coordination of drug policy is shared between the two levels. Similar to the Belgian situation, the regional authorities play a central role in the healthcare system, while the federal government is responsible for justice, internal affairs and crime investigation issues. Provincial drug policies differ in scope and approach, but they all share some basic principles, such as the 'balanced approach' between health policy measures to achieve drug demand reduction, and law enforcement measures to reduce drug supply.

Coordination of the overall drug policy is led by the Federal Ministry of Health, which is responsible for the operational coordination of the federal drug policy, including the other ministries and the nine provinces. There are three other coordinating bodies. First, the Federal Ministry of Health chairs the **Federal Drug Coordination**, which gathers together permanent members from the Ministry of Health, the Ministry of the Interior and the Ministry of Justice, and ad hoc participants from other Ministries. Second, the **Federal Drug Forum (Bundesdrogenforum),** also chaired by the Ministry of Health, includes representatives from the Federal Ministries, the Provincial Governments, the associations of cities and municipalities and the Austrian National Focal Point (Gesundeit Österreich Gmbh). Individual experts and scientists also participate on invitation in this coordinating body. Third, the **Provincial Drug Coordinators Conference** (on the provincial level) allows cooperation and coordination between Austria's nine provinces, iincluding the drafting ofjoint positions and statements. Furthermore, each of Austria's nine provinces nominates representatives who are referred to as Addiction Coordinators, Addiction Representatives, Drug Coordinators or Drug Representatives. They are responsible for coordinating actions in the drugs area and the actions of federal authorities' direct partners. In addition, there are both Provincial Drug or Addiction Coordination Offices, and

Provincial Addiction Prevention Units in all Austrian provinces. There are thus several coordination and cooperation bodies at both national and provincial levels. This illustrates the greater need for coordination related to issues such as the clarification of responsibilities of the federal and the provincial levels and cooperation among provinces in federalized countries. While this profusionmay be demanding and complicated, it can also provide an opportunity for more regular information exchange. This 'soft ' coordination can also be pragmatic in its contents, focusing more on practical issues and compromises than on ideological debates and conflicts (EMCDDA, 2014).

C. Strengthen the administration of the General Drug Policy Cell with SPOC's

Lastly, we recommend that the public services behind the central policy domains, which are responsible for preparing and implementing policy within their respective policy areas, be strengthened and specialised. Specifically, we recommend that an attaché or Single Point of Contact (SPOC) be appointed in each administration (federal and regional) with a central role in preparing and implementing (parts of) the Belgian drug policy. There are already SPOC's in some of the central administrations, but not in a systematic way. This SPOC can lobby to put a drugs theme on the political agenda within their policy domain, and thus build towards more political commitment for developing a coherent drug policy. Previous research has consistently stressed the importance of political commitment to the effective coordination of a drug policy (EMCDDA, 2003, 2017b; Hughes et al., 2010; Singleton & Rubin, 2014; Vandam et al., 2010; Vander Laenen et al., 2010). At the same time, a SPOC allows for a specialised drug theme within each administration. This way, one does not have to start from scratch during each discussion, and it is possible to build on a long-term plan.

These SPOC's would thus have a central liaison function, by connecting expertise between the different policy levels and policy domains, liaising not only between governmental actors, but also with the non-governmental sectors. They could also play a role in the day-to-day coordination of the implementation of the Drug Strategy within their domain. These SPOC would form the inter-administration working group, and could act as the secretariat of the General Drug Policy Cell (cf. B). It is important that there is consistency in these SPOC's. Given their central liaison role, it is important to limit turnover to avoid loss of expertise. For example, it is advisable to appoint more than one SPOC within an administration, or to organise a significant overlap period for the transfer of expertise when there is a change of personnel. And lastly, taking into account the need for clear roles, tasks and responsibilities mentioned in the conclusion, specific attention should be paid to a clear definition of tasks, and communication of the mandate of each member. Meaning that, if these SPOCS are implemented, attention must be paid to defining their tasks and responsibilities related to other partners, including the General Drug Policy Cell and the proposed Expert advisory panel.

10.2.1.4 Create opportunities for innovative projects to respond to the ever-changing reality of the drug phenomenon

In order to support bottom-up innovation, opportunities should be created to develop innovative projects. This was the case in the past with the former Addiction Fund (established in 2006, discontinued in 2014 after defederalization). This Fund should be revived and expanded to address not only innovative projects on the demand side but also those on the supply side. After all, each of the pillars indicates that there is a need for innovation. Innovative projects allow for natural experiments adapted to the local context or addressing specific phenomena. In line with the importance of evidence-informed policy and considering that evaluation should be part of the policy process, monitoring and evaluation must be integrated into these projects, embedded from the start of the process, to allow for a baseline measurement, as well as proper monitoring of the project. This will facilitate the early identification of problems so that the project can be adjusted in time, but also facilitates the overall assessment of the projects. The evaluation framework of logic models can be used as a means to monitor and evaluate

process, output and outcome of these innovative projects, in a similar manner to that applied in this study (cf. infra).

Attention should also be paid to securing a budget for these innovative projects. Additionally, a budget should be reserved for their monitoring and evaluation, which has to be calculated separately from the budget of the Drug Strategy or specific intervention

10.2.1.1 Support the development of structural and sustainable forms of cooperation (including financial support)

The evaluation has shown that there are a lot of 'integral and integrated' cooperation initiatives throughout all the pillars. This cooperation is often located at a local level, and at the initiatives of organisations, institutions or sometimes even individuals. The downside, however, is that these initiatives are not structural, and fragmentation occurs as these cooperations exist in one place but not in the other. It is therefore recommended to support the development of structural and sustainable forms of cooperation, including and starting with financial support. A balance must be found between securing the freedom and flexibility to take initiatives for cooperation on the one hand and looking for formalised cooperation with no room for initiative on the other hand. We therefore recommend that these initiatives be structurally supported by guaranteeing continuity. So, instead of merely cheering on the consultation between different actors of different domains, which limits cooperation to a mutual understanding between the particular actors and domains involved, cooperation should be structurally supported, for example by introducing a structure for the funding of the organisations or actors for their cooperation.

10.2.2 Recommendations for the specific pillars

Although the main aim of this research was to present a broad overview of the general Belgian drug policy rather than to go into detail, we may also formulate some recommendations aimed at each of the four specific pillars.

RECOMMENDATIONS FOR THE SPECIFIC PILLARS

- Structurally fund prevention and early intervention
- Implement a legislative framework to support risk reduction initiatives
- Increase access to diverse and quality treatment, both geographically and by eliminating barriers
- Implement an overarching coordinating framework between the different enforcement partners to facilitate infoflux and to promote cooperation
- Rely on a theory-based framework to evaluate targeted interventions

10.2.2.1 Prevention and early intervention: structurally fund prevention and early intervention

In order to develop a long-term vision and structural approach towards prevention, there is a need for funding. This need has been raised by various research reports over the years (Algemene Cel Drugs, 2015; De Ruyver, Pelc, et al., 2007; Lievens et al., 2016; Vander Laenen et al., 2011), and by practitioners from the sector, but has remained unaddressed so far. Although the sector has proved to be innovative with its limited resources, there are many unresolved bottlenecks related to this issue of underfunding. Since the pillar is put forward as the first and most important pillar in drug policy, its proper financing is appropriate. Structural funding is needed to develop not only a demand-oriented but also a proactive prevention offer, without having to compromise on quality. In this way, continuity of prevention,

but also early detection and intervention is guaranteed for the various target groups. Structural financing also makes it possible for prevention initiatives to monitor quality better and to focus on quality standards (Vaslie et al., 2020).

10.2.2.2 Risk reduction: Strengthen the legislative framework to further support risk reduction initiatives

Although risk reduction is not a separate pillar in the Belgian drug policy, we discuss this matter separately from the 'Prevention' and 'Treatment' pillar so that we can emphasise the theme of reducing harms associated with drug use. Like with the final evaluation of the EU Drug Strategy, this general process evaluation has shown the increasingly key role of harm reduction in drug policy (Vaslie et al., 2020).

Strengthening the legal framework is a fundamental precondition for the elaboration and structural expansion of harm reduction initiatives. Several risk reduction initiatives run up against the current legislative framework, which limits what they can do. This is not only the case regarding drug consumption rooms, but also for syringe exchange, substitution treatment and drug testing. An adaptation of the legislative framework remains politically sensitive (Smith et al., 2019). During this general process evaluation, respondents stressed the (purported) moral ambiguity that harm reduction might entail (Zampini, 2018). There is a need for a fundamental and open debate regarding this theme, allowing input from research, practice and lived experiences to increase policy legitimacy and outcomes. In order to break through these ideological positions, it is necessary to name and frame them in an open debate. After all, the expansion of various existing and new risk reduction initiatives requires a legal framework that clearly expresses the focus on the health and welfare of people who use drugs, a need that is raised by both practitioners, (scientific) experts (Alistar et al., 2011; Marlatt & Witkiewitz, 2010; Ritter & Cameron, 2006) and people with lived experiences (Leonard & Windle, 2020). This would allow for innovation in the field of harm reduction, and could facilitate structural funding (Vaslie et al., 2020). One suggestion could be to allow experimental frameworks, possibly transcending the legal framework, when initiatives have been taken and are supported by evidence elsewhere, as was previously the case with TADAM (Van Caillie, 2013).

10.2.2.3 Treatment: Increase access to diverse and quality treatment, both geographically and by eliminating barriers

Based on the research results, we recommend increasing access to diverse and quality treatment.

We suggest that the treatment offer be expanded geographically by tailoring it to the setting and needs of both the geographical region and the clients. Urban areas have different needs from rural areas and the treatment offer must be adjusted accordingly.

We also propose the elimination of identified barriers in the area of access to (evidence-based) treatment (e.g. waiting lists, eligibility criteria, cultural sensitivity, continuity of treatment). The research results have shown a lack of a clear responce to the growing needs regarding the treatment demand. Additionally, there are many blind spots in the provision of treatment for certain target groups (e.g. older people, people with poly drug use, people with double diagnosis,) and in the treatment offer in more rural areas and various obstacles in the current treatment offer, an observation made by both practitioners and people with lived experiences. The accessibility of treatment should also be addressed. The current barriers must be tackled in order to make the treatment offer more accessible. For instance, increasingly strict inclusion criteria mean that certain target groups (older population of people with drug and addiction problems, people with children, people with a migration background, people with poly drug use, etc.) are increasingly excluded. Attention should also be paid to the supply of services for the ageing population of clients. Stigmatisation of people with drug problems (especially illegal drugs) in the provision of treatment and financial accessibility are two major themes within the context of treatment.

Furthermore, we also recommend further development and broader promotion of aftercare and the crisis care services. Lastly, although our findings do not specifically refer to the involvement of direct social environment and contacts and their experience as partners in mental health care, the current literature does recommend their involvement (Vander Laenen, (in press)). The emphasis throughout these recommendations should be on the continuity of care and developing an integrated approach..

10.2.2.4 Enforcement: Implement an overarching coordinating framework action between the different enforcement partners, to facilitate infoflux and to promote cooperation

The research results have shown several obstacles in the coordination between different enforcement partners, amongst others with the infloflux, as well as with cooperation. Today, tackling drug supply and the especially high-level of drug production and drug trafficking requires (international) coordination, harmonisation, information sharing and the necessary capacity – qualities in which the current security architecture does not always excel, as this general process evaluation has shown us. We therefore recommend more coordination between the different enforcement partners in order to bring them closer together and facilitate cooperation.

For example, today, the Framework Note on Integral Security is the engine of the broader security policy which is the competence of the Ministers of the Interior and Justice. However, the drafting of the Framework Note Integral Security is done with input from various actors, including other Federal Ministries, the National Security Council (NVR), the Board of Procurators General, and since the Cooperation Agreement of 2014 also that of the Communities and Regions. In addition, the chairmen of the Council of Mayors, the Federal Police Council and the Permanent Commission for Local Police, and a representative of the Federal Police have been involved (Colman et al., 2020). In its implementation, it is the police and judiciary that play the dominant role. In other words, the link from the Framework Note to the local security policy is largely made by the police and the judiciary, with other actors, such as inspection services or customs, not playing a significant role (Colman et al., 2020). We therefore recommend involving all enforcement actors in the translation into practice of the Framework Note on Integral Security but also as much as possible in other necessary policy frameworks and working groups. Shared priorities across domains and a clear definition of responsibilities and tasks can contribute to closer cooperation and allow different domains to tackle the phenomenon together. In other words, this recommendation emphasises a more pronounced and operationalised 'common direction'.

Parallel to the establishment of this 'common direction', one must develop the will to cooperate and tackle illicit drug trafficking in close cooperation and in a complementary manner. In this way, joint monitoring of illicit drug trafficking can also be built up, in order to acquire a good mapping of the various crime phenomena (Colman et al., 2018). There is less agreement on how this improvement should be concretised. Whereas most respondents supported the need for a shared approach and shared priorities towards drug supply in order to facilitate infoflux and promote cooperation, there was no consensus regarding how to operationalise it. There was agreement about the fact that information must be shared but not about what kind (and how much and how). There is, for example, a European trend towards shared workspaces among actors from different law enforcement domains, as a way of increasing multidisciplinarity and information sharing. This idea, proposed by some law enforcement partners, is strongly opposed by others, due to perceived legal obstacles and the sensitivity of confidential information.

Additionally, there needs to be a clear demarcation of responsibilities regarding the various enforcement partners. An overlap in tasks now causes actors to enter on each other's operational domain, which can jeopardise cooperation and trust between different enforcement partners.

10.2.2.5 Epidemiology, research and evaluation: Rely on a theory-based framework to evaluate interventions (cf. targeted evaluations)

Based on the results of the evaluations of the two targeted interventions, it is recommended that drug interventions are consistently evaluated and that the evaluation relies on theory, such as the logic model theory. An evaluation promotes programme and service improvement, quality assessment and administrative control, but it also helps to understand whether novel (treatment) approaches or methods are effective and who benefits by the interventions (EMCDDA, 2007). The logic model theory supports the identification of expected outcomes of the intervention and thus the development and implementation of monitoring and evaluation activities. But it should be borne in mind that the logic model theory assumes cooperation among all stakeholders to the intervention as an inherent feature of evaluation.

10.3 Lessons learned

We can summarise the key points of the conclusion and recommendations in this "lessons learned" section.

CONCLUSION

The evaluation of the Belgian drug policy has shown that the policy in its current form is to a large extent scattered and fragmented. Both policy intentions ("policy in the books") and their measurement ("policy in practice") exhibit these features. Concerning "policy in the books", we found that the overarching drug policy framework is outdated and current drug policy initiatives are taken within a specific policy level or domain. Regarding actions related to the competences of the regions, the policy vision remains vague and hardly concrete. Concerning fragmentation in "policy in practice", we found a lack of follow-up of implementation of the drug policy, resulting in a list of realisations that are scattered across many policy domains and levels without proper overview. Another lack here concerns decisive integral and integrated cooperation (except for some examples at a local level). Even within the specific pillars, practitioners, administrators, experts and people with lived experiences all refer to scatteredness and fragmentation. Practitioners and experts, for example, cite no clear delineation of tasks amongst law enforcement partners, and the lack of financing of prevention leading to further fragmentation of the prevention field. People with lived experiences cite the lack of overview of the treatment offer. This scatteredness and fragmentation is one of the core findings of this evaluation. Therefore, the creation of cohesion should be the starting point of a future Belgian Drug Strategy.

Nevertheless, from a historical perspective, we do see an evolution in the attitude towards an integral and integrated approach. Before the establishment of the Federal Drug Note, the main focus of the Belgian drug policy was enforcement, with an instrumental use of prevention and treatment. The shift in policy perception with the Federal Drug Note, inspired by the Parliamentary Working Group on Drugs (and later acknowledged by the Joint Declaration), emphasised the drug phenomenon primarily as a public health issue. And although we cannot speak of an integral and integrated drug policy in Belgium, most (policy) actors today agree that the drug phenomenon is first and foremost a public health issue, and that prevention, treatment, and enforcement have a role to play in drug policy.

RECOMMENDATIONS

Based on the conclusions of the evaluation, we have made five main recommendations and five recommendations related to specific pillars.

The five general recommendations based on the evaluation are:

1. Draft a new Drug Strategy and action plan
2. Develop an evidence-informed drug policy cycle, combining lived experiences, practice-based evidence and scientific evidence
3. Rethink the organisation and tasks of the General Drug Policy Cell
4. Create opportunities and funding for innovative projects to respond to the ever-changing reality of the drug phenomenon
5. Support the development of structural and sustainable forms of cooperation (including financial support)

The five specific recommendations based on the evaluation are:

1. Structurally fund prevention and early intervention
2. Strengthen the legislative framework to support risk reduction initiatives
3. Increase access to diverse and quality treatment, both geographically and by eliminating barriers
4. Implement an overarching coordinating framework between the different enforcement partners to facilitate infoflux and to promote cooperation
5. Rely on a theory-based framework to evaluate targeted interventions

Budgetary implications are hard to estimate as this was not the aim of this evaluation. However, a rough estimation of the overarching recommendations, suggests that the reorganisation of the General Drug Policy Cell and the drafting of a new Drug Strategy do not have large budget costs, except for time (and the personnel cost linked with it). For a more accurate estimation of the budget, additional research is required.

11 REFERENCES

Aga, N., Vander Laenen, F., & Vanderplasschen. (2020). Recovery of Persons Labelled "Not Criminally Responsible": Recommendations Grounded in Lived Experiences. In F. Focquaert, E. Shaw, & B. N. Waller (Eds.), *Routledge Handbook of the Philosophy and Science of Punishment* Routledge.

Agentschap Zorg & Gezondheid. (2019). *Decreet van 5 april 2019 betreffende de organisatie en ondersteuning van het geestelijke gezondheidsaanbod*. Retrieved 10/02/2021 from https://www.zorg-en-gezondheid.be/

Ahmed, S. M., & Palermo, A.-G. S. (2010). Community engagement in research: frameworks for education and peer review. *American journal of public health*, *100*(8), 1380-1387.

Algemene Cel Drugs. (2015). *Monitoring van overheidsuitgaven voor het drugsbeleid begrotingsjaren 29014 en 2015*.

Algemene Cel Drugs. (2019). *Realisaties 2014-2019 & aanbevelingen voor de volgende legislatuur*.

Algemene Cel Drugsbeleid. (2011). *Activiteitenrapport 2009-2011*.

Algemene Cel Drugsbeleid. (2019). *Realisaties 2014-2019 & aanbevelingen voor de volgende legislatuur*. Brussel Retrieved from https://overlegorganen.gezondheid.belgie.be/sites/default/files/documents/20190325_rapport_acd_2014-2019_nl_def.pdf

Alistar, S. S., Owens, D. K., & Brandeau, M. L. (2011). Effectiveness and cost effectiveness of expanding harm reduction and antiretroviral therapy in a mixed HIV epidemic: a modeling analysis for Ukraine. *PLOS Medicine*, *8*(3), e1000423.

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, *16*(4), 11-23. https://doi.org/10.1037/h0095655

Antoine, J., Plettinckx, E., van Baelen, L., & Gremeaux, L. (2020). *De TDI registratie in België: jaarlijks rapport registratiejaar 2019*.

Arnstein, S. R. (1969). A ladder of citizen participation. *Journal of the American Institute of planners*, *35*(4), 216-224.

Arrindell, W. A., & Ettema, J. H. M. (2005). Symptom checklist: handleiding bij multidimentionale psychopathologie-indicator. In. Amsterdam: Pearson Assessment and Information B.V.

Arthur, S., & Nazroo, J. (2003). Designing fieldwork strategies and materials. *Qualitative research practice: A guide for social science students and researchers*, *1*, 109-137.

Ashford, R. D., Brown, A. M., McDaniel, J., & Curtis, B. (2019). Biased labels: An experimental study of language and stigma among individuals in recovery and health professionals. *Substance Use & Misuse*, *54*(8), 1376-1384. https://doi.org/10.1080/10826084.2019.1581221

Askew, R., & Bone, M. (2019). Deconstructing prohibitionist ideology: A sociocognitive approach to understand opinions on UK drug policy and the law. *International journal of drug policy*, *74*, 33-40.

ASL. (2020). *Tätigkeitsbericht*. http://static.asl-eupen.be/wp-content/uploads/jahresbericht-2020.pdf

Astbury, B., & Leeuw, F. L. (2010). Unpacking black boxes: mechanisms and theory building in evaluation. *American journal of evaluation*, *31*(3), 363-381.

Autrique, M., Demarest, I., Goethals, I., De Maeyer, J., Ansseau, M., & Vanderplasschen, W. Consensusvorming over minimale en ideale kwaliteitsstandaarden voor preventie, behandeling en harm reduction van verslavingsproblemen (COMIQS. BE).

Babor, T., Caulkins, J., Edwards, G., Fischer, B., Foxcroft, D. R., Humphreys, K., Obot, I., Rehm, J., & Reuter, P. (2010). *Drugs policy and the public good*.

Balbirnie, E., Davies, M., Disley, E., Monsalve, C. G., Hartka, S., Hoorens, S., Kruithof, K., Sacher, M., & Taylor, J. (2016). Mid-Term Assessment of the EU Drugs Strategy 2013–2020 and Final Evaluation of the Action Plan on Drugs 2013–2016.

Bamberger, M., Tarsilla, M., & Hesse-Biber, S. (2016). Why so many “rigorous” evaluations fail to identify unintended consequences of development programs: How mixed methods can contribute. *Evaluation and program planning*, *55*, 155-162.

Barbour, R. (2008). *Doing focus groups*. Sage.

Bardell, H. (2020). *Drug policy and human rights in Europe: a baseline study*.

Bartram, M. B., Falconer, I. R., Jones, G., & Kuiper-Goodman, T. (1999). Situation assessment, planning and management.

Beaten, I., Claessens, J., & Vanmarcke, K. (2016). *Een drugbeleid in de bijzondere jeugdzorg*.

Bekkering, T., Lenaerts, E., Matthys, F., Zeeuws, D., Pas, L., Verstuyf, L., Aertgeerts, B., & Matheï, C. (2016). *Integrated Care of Alcohol USe disorders (ICArUS)*.

Belgian Psychotropics Experts Platform BelPEP. (2014). *Globale visienota en actieplan van de 3 werkgroepen*. https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/visienota_nl_april_2015.pdf

Bellaert, L., Martinelli, T. F., Vanderplasschen, W., Best, D., van de Mheen, D., & Vander Laenen, F. (2021). Chasing a pot of gold: an analysis of emerging recovery-oriented addiction policies in Flanders (Belgium) and The Netherlands. *Drugs: Education, Prevention and Policy*, 1-12.

Belspo. (z.d.). *Handbook for the applicant of a research proposal* Belspo. http://www.belspo.be/belspo/drugs/call_nl.stm

Benneworth, P., & Jongbloed, B. W. (2010). Who matters to universities? A stakeholder perspective on humanities, arts and social sciences valorisation. *Higher education*, *59*(5), 567-588.

Bewley-Taylor, D. R. (2002). *United States and international drug control, 1909-1997*. A&C Black.

Blamey, A., & Mackenzie, M. (2007). Theories of change and realistic evaluation: peas in a pod or apples and oranges? *Evaluation*, *13*(4), 439-455.

Bone, M. L. (2019). *Human rights and drug control: A new perspective*. Routledge.

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative research journal*, *9*(2), 27.

Bowen, S., & Zwi, A. B. (2005). Pathways to "Evidence-Informed" Policy and Practice: A Framework for Action. *PLOS Medicine*, *2*(7), e166. https://doi.org/10.1371/journal.pmed.0020166

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol. 2. Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 57–71). American Psychological Association.

Brosens, W. (1976). De Wet en Drugs. Rede uitgesproken door de advocaat-generaal W. BROSENS op de plechtige openingszitting van het Hof van Beroep te Antwerp en op 1 september 1976. *Rechtskundig Weekblad*, *40*(17-18), 1026-1112.

Brousselle, A., & Champagne, F. (2011). Program theory evaluation: Logic analysis. *Evaluation and program planning*, *34*(1), 69-78.

Bruffaerts, R., Vanderplasschen, W., Van Hal, G., & Demyttenaere, K. (2011). *Crisisopvang voor middelengebruikers in België: een formele evaluatie en aanbevelingen voor een duurzaam beleid/De Evaluatie van Crisis en Case Management (ECCAM)-studie*. Academia Press.

Casselman, J. (2019). *Van jeneverellende tot Tournée Minérale: 150 jaar aanpak van alcoholproblemen in Vlaanderen (1868-2018)*. Gompel&Svacina.

Chen, H. T., & Chen, H.-t. (2005). *Practical program evaluation: Assessing and improving planning, implementation, and effectiveness*. Sage.

CICAD. (2009). *How to develop a National Drug Policy: A guide for policymakers, practitioners and stakeholders*.

Clarke, V., Braun, V., & Hayfield, N. (2015). Thematic analysis. *Qualitative psychology: A practical guide to research methods*, 222-248.

Colman, C., Bronselaer, A., Devresse, M.-S., Slabbekoorn, G., Piron, S., & Timmerman, Y. (2020). *From the alley to the web. Belgian involvement on drug cryptomarkets*. Maklu.

Colman, C., De Middeleer, F., Spapens, A., Van Nimwegen, S., Ceulen, R., Gerbrands, S., … Roevens, E. (2018). De grens voorbij : Belgische en Nederlandse drugsmarkten in beweging. Den Haag: Boom.

Colman, C., Janssens, J., & Brusselmans, L. (2020). *Procesevaluatie Stroomplan*.

Colman, C. (2018). Naar een geïntegreerde aanpak van de invoer en doorvoer van cocaïne via de haven via Antwerpen. *Panopticon*, *39*(2), 130-140.

Colman, C., Vander Laenen, F., & De Ruyver, B. (2010). De samenwerking tussen justitie en de (drug) hulpverlening. Randvoorwaarden voor een optimale interactie. *Update in de Criminologie*, *2010*(5), 313.

Copes, H. (2016). A narrative approach to studying symbolic boundaries among drug users: A qualitative meta-synthesis. *Crime, Media, Culture*, *12*(2), 193-213.

Cornwall, A. (2008). Unpacking 'participation': models, meanings and practices. . *Community development journal*, *43*(3), 269-283.

Corrigan, P., Schomerus, G., & Smelson, D. (2017). Are some of the stigmas of addictions culturally sanctioned? *The British Journal of Psychiatry*, *210*(3), 180-181.

Coryn, C. L. S., Noakes, L. A., Westine, C. D., & Schroter, D. C. (2011). A Systematic Review of Theory-Driven Evaluation Practice From 1990 to 2009 [Review]. *American journal of evaluation*, *32*(2), 199-226. https://doi.org/10.1177/1098214010389321

Council of Europe. (2009). *Civil participation in the decision-making process. The code of good practice.* https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016802eede1

Council of the European Union. (2020). *EU Drugs Strategy 2021-2025*.

Creswell, J. W., & Clark, V. L. P. (2017). *Designing and conducting mixed methods research*. Sage publications.

Culley, D. M., Taylor, J., Rubin, J., Hoorens, S., Disley, E., & Rabinovich, L. (2012). Assessment of the implementation of the EU drugs strategy 2005–2012 and its action plans. *Rand health quarterly*, *2*(2).

Davies. (2004a). Is evidence based government possible? Jerry Lee Lecture, presented at the 4th annual Campbell Collaboration Colloquium. Washington DC, USA. In.

Davies. (2004b). Scale, complexity and the representation of theories of change. *Evaluation*, *10*(1), 101-121.

De Donder, E. (2020a). *Factsheet opioïden*.

De Donder, E. (2020b). *Factsheet psychoactieve medicatie*. Paul Van Deun Vanderlindenstraat 15 1030 Brussel. https://www.vad.be/assets/factsheet_medicatie_dec2020_final

De Kiem. (2020). Het gevangenisnummer. *Driemaandelijks tijdschrift van De Kiem vzw*, *27*(4).

De Kock, C., Mascia, C., Toyinbo, L., Laudens, F., Leclercq, S., Jacobs, D., & Decorte, T. (2020). Mapping & enhancing substance use treatment for migrants and ethnic minorities (MATREMI): Summary, conclusions & recommendations.

De Maeyer, J., Cole, S., Franssen, A., & Vanderplasschen, W. (2007). Kwalitatieve evaluatie van 10 jaar zorgcoördinatie en case management in de Oost-Vlaamse drughulpverlening: een rondvraag bij hulpverleners en cliënten. *Orthopedagogische Reeks Gent*, *29*, 1-73.

De Maeyer, J., Vander Laenen, F., Dewaele, C., Goethals, I., Joostens, P., Ponnet, E., & Windelinckx, T. (2017). Herstelondersteunend werken binnen de ambulante verslavingszorg. In W. Venderplasschen & F. Vander Laenen (Eds.), *Naar een herstelondersteunende verslavingszorg*. Acco.

De Ruyver, B. (2009). *Do's and don'ts in een integraal en geïntegreerd drugbeleid*. Academia Press.

De Ruyver, B., Colman, C., De Wree, E., Vander Laenen, F., Reynders, D., Van Liempt, A., & De Pauw, W. (2008). *Een brug tussen justitie en de drughulpverlening: Een evaluatie van het proefzorgproject*. Maklu.

De Ruyver, B., Macquet, C., & Ponsaers, P. (2007). *Effecten van alternatieve afhandeling voor druggebruikers*. Academia Press.

De Ruyver, B., Pelc, I., Casselman, J., Geenens, K., Nicaise, P., From, L., Vander Laenen, F., Meuwissen, K., & Van Dijck, A. (2004). *Drugbeleid in cijfers: een studie naar betrokken actoren, overheidsuitgaven en bereikte doelgroepen*. Academia Press.

De Ruyver, B., Pelc, I., De Graeve, D., Bucquoye, A., Cornelis, L., & Nicaise, P. (2007). *Drugs in cijfers II: studie naar betrokken actoren, overheidsuitgaven en bereikte doelgroepen: vervolg studie*. Academia Press.

De Ruyver, B., Vander Laenen, F., & Eelen, S. (2012). The long road to an integral and integrated policy in Belgium. In R. Muscat & B. Pike (Eds.), *Reflections on the concept of coherency for a policy on psychoactive substances and beyond* (Vol. 33). Council of Europe Publishing.

De Ruyver, B., Vander Laenen, F., Vanderplasschen, W., Colman, C., & Broekaert, E. (2010). *De drugbehandelingskamer, Kwalitatieve evaluatie van het pilootproject "Drugbehandelingskamer" Rechtbank Eerste Aanleg*. Universiteit Gent.

De Ruyver, B. U., Casselman, J., Meuwissen, K., Bullens, F., & Van Impe, K. (2000). Het Belgisch drugbeleid anno 2000: een stand van zaken drie jaar na de aanbevelingen van de parlementaire werkgroep drugs. In: Gent Onderzoeksgroep Drugbeleid.

De Vlaamse revalidatiecentra voor drugverslaafden. (2019). *Memorandum 2019. Speerpunten voor een doeltreffende en kwaliteitsvolle Vlaamse Verslaafdenzorg*.

Debaere, V., Schil, E., Vandevelde, S., Vander Laenen, F., Vanderplasschen, W., Colman, C., Maes, E., & Mine, B. (2020). *RECOvery in PRISon (RECO-PRIS): Evaluatie van het pilootproject in drie Belgische gevangenissen*.

Decorte, T., Kaminski, D., Muys, M., & Slingeneyer, T. (2005). *Problematisch gebruik'van (illegale) drugs. Onderzoek naar de operationalisering van het concept in een wettelijke context*. Academia Press.

Decorte, T., Kramer, R., Vlaemynck, M., De Donder, E., & de Duve, M. (2019). *Assessment of alternative models for regulation of alcohol marketing in Belgium: Final Report*.

Decorte, T., & Paoli, L. (2013). *Cannabisproductie in België: evaluatie van de aard en de schadelijkheid en de implicaties voor prioriteitsbepaling (CANMARKT)*.
Decoster, C. (2012). Geestelijke gezondheidszorg in België: Een nieuw model voor de toekomst. *Huisarts Nu*, *41*(1), 10-13.
Draucker, C. B., Martsolf, D. S., & Poole, C. (2009). Developing distress protocols for research on sensitive topics. *Archives of psychiatric nursing*, *23*(5), 343-350.
EMCDDA. (2003). Coordination: a key element of national and European drug policy. *Drugs in focus*.
EMCDDA. (2004). *Evaluation of national drug strategies in Europe* (Annual report on the state of the drugs problem in the European Union and Norway, Issue.
EMCDDA. (2008). *National drug-related research in Europe* (Selected issues, Issue. O. f. O. P. o. t. E. Communities.
EMCDDA. (2014). *Drug policy profile: Austria* (EMCDDA Papers, Issue. P. O. o. t. E. Union.
EMCDDA. (2017a). Evaluating drug policy: A seven-step guide to support the commissioning and managing of evaluations. In. Luxembourg: European Monitoring Centre for Drugs and Drug Addiction
EMCDDA. (2017b). *New developments in national drug strategies in Europe* (EMCDDA Papers, Issue.
EMCDDA. (2017c). Note on guidelines and tools for the evaluation of national drug policy. In.
EMCDDA. (2019). *Timeline of EU drug strategies and plans and their evaluation*. Retrieved 2/09/2019 from https://www.emcdda.europa.eu/publications/topic-overviews/policy-evaluation_en
EMCDDA. (2020). *Belgium Country Drug Report 2019*. https://www.emcdda.europa.eu/publications/country-drug-reports/2019/belgium_en
EMCDDA. (z.d.-a). *Best practice portal*. Retrieved 12/12/2020 from https://www.emcdda.europa.eu/best-practice_en
EMCDDA. (z.d.-b). *Healthy Nightlife Toolbox*. Retrieved 06/01/2021 from http://www.hntinfo.eu/
Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. *Science*, *196*(4286), 129-136. https://doi.org/10.1126/science.847460
EUCPN Secretariat. (2013). Practical guidelines for evaluating crime prevention initiatives. In EUCPN (Ed.), *EUCPN Toolbox Series* (Vol. 3). European Crime Preventions Network.
Eurocare. (2016). *European Report on Alcohol Policy: a review*.
European Center for Not-for-profit Law. (2016). *Civil participation in decision-making processes: An overview of Standards and Practices in Council of Europe Member States*.
European Commission. (2006). *Green Paper on the role of Civil Society in Drugs Policy in the European Union*. Brussels
European Monitoring Centre for Drugs and Drug Addiction. (2021a). *Implementing quality standards for drug services and systems: a six-step guide to support*

quality assurance.
European Monitoring Centre for Drugs and Drug Addiction. (2021b). *Prison and drugs in Europe: Current and future challenges*. Publications Office of the European Union.
Farrington, D. P., Gottfredson, D. C., Sherman, L. W., & Welsh, B. C. (2002). The Maryland scientific methods scale. *Evidence-based crime prevention*, 13-21.
Favril, L., Laenen, F. V., & Audenaert, K. (2017). Psychiatrische morbiditeit bij gedetineerden in Vlaanderen. *Panopticon*, *38*(4), , 231-245.
Favril, L., & Vander Laenen, F. (2013). Een geïntegreerd drugsbeleid in de gevangenis: zorgen voor morgen. *Fatik*, *31*(140), 15-20.
Favril, L., & Vander Laenen, F. (2018). Predictoren van druggebruik tijdens de detentieperiode: data van 1326 gedetineerden uit 15 Vlaamse gevangenissen. *Panopticon*, *39*(4), 296-312.
Favril, L., Vander Laenen, F., & Decorte, T. (2015). *Schadebeperkende maatregelen voor de stad Gent. Een onderzoek naar de lokale noden en prioriteiten*. Maklu.
FAVV. (2020). *Activiteitenverslag 2019: Globale controleresultaten*. Retrieved 22/02/2021 from http://www.afsca.be/activiteitenverslag/2019/inspecties/resultatencontroles/
Federaal Parket. (2019). *Jaarverslag 2018*. https://www.om-mp.be/
Federale Overheidsdienst Binnenlandse Zaken. (2020). *Strategische veiligheids- en preventieplannen (SVPP)*. Retrieved 21/02/2021 from https://www.besafe.be/nl/strategische-veiligheids-en-preventieplannen
Federale Politie. (2018). *Veiligheidsmonitor 2018*. Retrieved 22/02/2021 from http://www.moniteurdesecurite.policefederale.be/veiligheidsmonitor/
Fedito BXL, Fedito Wallonie, & VAD. (2020). *IDA – MEMORANDUM 2020*. https://feditobxl.be/site/wp-content/uploads/2020/05/iDA_Memorandum_2020_NL.pdf

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International journal of qualitative methods*, *5*(1), 80-92.

Fijnaut, C., & De Ruyver, B. (2014). *De derde weg: een pleidooi voor een evenwichtig cannabisbeleid*. Intersentia.

Fijnaut, C., & De Ruyver, B. (2015). *The third way: a plea for a balanced cannabis policy*. Intersentia.

FOD Justitie - DGWL, & Dienst voor het Strafrechtelijk beleid. (2019). *Kadernota Integrale Veiligheid 2016-2019: eindrapport*.

FOD Justitie. (2021). *Drugsbeleid in de gevangenis*. https://justitie.belgium.be/nl/themas_en_dossiers/gevangenissen/leven_in_de_gevangenis/drugsbeleid

FOD Volksgezondheid. (2021). *Blikvanger gezondheidszorg: Geestelijke gezondheidszorg*. https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/blikvanger_gezondheidszorg_ggz_nl.pdf

Fraser, S., Pienaar, K., Dilkes-Frayne, E., Moore, D., Kokanovic, R., Treloar, C., & Dunlop, A. (2017). Addiction stigma and the biopolitics of liberal modernity: A qualitative analysis. *International journal of drug policy*, *44*, 192-201.

Frechtling, J. (2007). *Logic modeling methods in Program Evaluation*. John Wiley & Sons, Inc.

Free Clinic vzw. (z.d.). *Free Clinic vzw in een notendop*. Retrieved 21/05/2021 from https://free-clinic.be/free-clinic-vzw-in-een-notedop/

Funnell, & Rogers. (2011). *Purposeful program theory: Effective use of theories of change and logic models* (Vol. 31). John Wiley & Sons.

Funnell, S. C., & Rogers, P. J. (2011). *Purposeful Program Theory: Effective Use of Theories of Change and Logic Models.* Jossey-Bass.

Galla, M., Gageldonk, A., Trautmann, F., & Verbaeck, H. (2006). *Evaluation of the implementation of the national strategy to combat drugs; A Hungarian - Dutch cooperation*. http://www.drugresearch.nl/media/41409-Evaluation%20of%20implementation%20strategy.pdf

Gaventa, J., & Cornwall, A. (2008). Power and knowledge. *The Sage handbook of action research: Participative inquiry and practice*, *2*, 172-189.

Geenens, K., Vanderplasschen, W., Broekaert, E., De Ruyver, B., & Alexandre, S. (2005). *Tussen droom en daad: implementatie van case management voor druggebruikers binnen de hulpverlening en justitie*. Academia Press.

Geirnaert, M. (Ed.). (2002). *Preventiestrategieën*. Kluwer.

Gelders, D. (2008). Communicatie over nieuwe gevaarlijke drugs: recent onderzoek over het Belgische Early Warning System. *AnD: Tijdschrift van de Vereniging voor Alcohol-en andere Drugproblemen*, 14-15.

Gelders, D., & Vander Laenen, F. (2009). 'Mr Police Officer, I thought cannabis was legal'—Introducing new policy regarding cannabis in Belgium: A story of good intentions and Babel. *Drugs: Education, Prevention, and Policy*, *14*, 103-116. https://doi.org/10.1080/09687630600935113

Gezond Leven. (2020). *Wetgeving over tabak: zo zit het in België*. Retrieved 5/04/2021 from https://www.gezondleven.be/themas/tabak/wet-en-beleid/wat-zegt-de-wet-over-roken

Gisle, L., & Demarest, I. (2013). *Gezondheidsenquête 2013*.

Gisle, L., & Drieskens. (2019). *Gezondheidsenquête 2018: Druggebruik*. www.gezondheidsenquête.be

Global Drug Survey. (z.d.). *Global Drug Survey (GDS) runs the worlds biggest drug survey*. Retrieved 2/02/2021 from https://www.globaldrugsurvey.com/about-us/

Griffiths, P., Strang, J., & Singleton, N. (2016). *Report of the rapid expert review of the National Drugs Stategy 2009-2016*.

Guillain, C. (2003). La politique pénale du gouvernement arc-en-ciel en matière de drogues. *Courrier hebdomadaire du CRISP*(11), 5-49.

Habraken, H., De Craene, S., Pas, L., DeCLerCq, T., Lannoy, J., & CHriSTiaenS, T. (2013). Niet-medicamenteuze aanpak van slapeloosheid in woonzorgcentra. *Een pilootproject. Huisarts Nu*, *42*, 281-285.

Halligan, J. (2008). The impact of horizontal coordination in Australia. Paper for the European Consortium on Political Research Regulation & Governance conference Utrecht University,

Hannes, P. (2014). Wat betekent de zesde staatshervorming voor de gezondheidszorgsector en de ouderenzorg? . In J. Velaers, J. Vanpraet, W. Vandenbruwaene, & Y. Peeters (Eds.), *De zesde staatshervorming: instellingen, bevoegdheden en middelen*. Intersentia.

Hardyns, W., Vander Laenen, F., Lambrechts, M.-C., Godderis, L., Fincoeur, B., Lambrechts, C., Boets, I., Mendes Fonseca, D., & Rullo, J. (2020). Prévalence et effets des drogues ameliorant la

performance dans différents groupes: enseignements pour une politique préventive et curative en Belgique.
Hebberecht, P. (2008). *De'verpaarsing'van de criminaliteitsbestrijding in België: kritische opstellen over misdaad en misdaadcontrole in de laatmoderniteit*. ASP/VUBPRESS/UPA.
Hennink, M., Hutter, I., & Bailey, A. (2020). *Qualitative research methods*. Sage.
Hladchenko, M. (2016). Knowledge valorisation: A route of knowledge that ends in surplus value (an example of the Netherlands). *International Journal of Educational Management*.
Holliday, L. R. (2014). Using logic model mapping to evaluate program fidelity. *Studies in Educational Evaluation*, *42*, 109-117. https://doi.org/https://doi.org/10.1016/j.stueduc.2014.04.001
Home Office Government. (2017). *An evaluation of the Government's Drug Strategy 2010*.
Housing First Belgium. (z.d.). *De strijd tegen dakloosheid winnen door goede huisvesting*. Retrieved 28/02/2021 from http://www.housingfirstbelgium.be/
Hughes, C., Lodge, M., & Ritter, A. (2010). Monograph No. 18: The coordination of Australian illicit drug policy: A governance perspective. . *DPMP Monograph Series*, *18*.
Hughes, C. E., Ritter, A., & Mabbitt, N. (2013). Drug policy coordination: Identifying and assessing dimensions of coordination. *International journal of drug policy*, *24*(3), 244-250. https://doi.org/https://doi.org/10.1016/j.drugpo.2012.08.004
Hughes, C. E., & Stevens, A. (2007). The effects of the decriminalization of drug use in Portugal.
InforDrogues. (2021). *Médicaments*. Retrieved 1/10/2021 from https://infordrogues.be/informations/produits/medicaments-depresseurs-stimulants/
Jelsma, M. (2011). *The development of international drug control: Lessons learned and strategic challenges of the future*. International Drug Policy Consortium.
Joe, G. W., Rowan-Szal, G. A., Greener, J. M., Simpson, D. D., & Vance, J. (2010). Male methamphetamine-user inmates in prison treatment: During-treatment outcomes. *Journal of substance abuse treatment*, *38*(2), 141-152. https://doi.org/https://doi.org/10.1016/j.jsat.2009.08.002
Kazadi Tshikala, T., & Vander Laenen, F. (2015). Het Belgisch penitentiair drugbeleid: Sleutelfiguren uit de top van de administratie kijken vooruit. *FATIK*, *146*(16-20).
Kelly, J. F., & Westerhoff, C. M. (2010). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *The International journal on drug policy*, *21*(3), 202-207. https://doi.org/10.1016/j.drugpo.2009.10.010
Komro, K. A., Flay, B. R., Biglan, A., & Wagenaar, A. C. (2016). Research design issues for evaluating complex multicomponent interventions in neighborhoods and communities. *Translational Behavioral Medicine*, *6*(1), 153-159.
Kools, J.-P., van der Gouwe, D., & Keizer, B. (2017). *Evaluation of the National Drug Strategy 2012-2017 of the Republic of Croatia: Analysing the accomplishments of the current National Drug Strategy and providing recommendations for the National Drug Strategy 2018-2025*.
Kramer, R., De Donder, E., De Duve, M., Van Havere, T., Geirnaert, M., Matthys, F., & Decorte, T. (2020). Naar een integraal alcoholbeleid in België. *TSG-Tijdschrift voor gezondheidswetenschappen*, *98*(3), 118-121.
Lancaster, K., & Ritter, A. (2014). Examining the construction and representation of drugs as a policy problem in Australia's National Drug Strategy documents 1985–2010. *International journal of drug policy*, *25*(1), 81-87.
Lancaster, K., Ritter, A., & Diprose, R. (2018). Recasting participation in drug policy. *Contemporary Drug Problems*, *45*(4), 351-365.
Lancaster, K., Ritter, A., & Stafford, J. (2013). Public opinion and drug policy in A ustralia: Engaging the 'affected community'. *Drug and Alcohol Review*, *32*(1), 60-66.
Lancaster, K., Santana, L., Madden, A., & Ritter, A. (2015). Stigma and subjectivities: Examining the textured relationship between lived experience and opinions about drug policy among people who inject drugs. *Drugs: Education, Prevention and Policy*, *22*(3), 224-231.
Lancaster, K., Seear, K., Treloar, C., & Ritter, A. (2017). The productive techniques and constitutive effects of 'evidence-based policy'and 'consumer participation'discourses in health policy processes. *Social Science & Medicine*, *176*, 60-68.
Lande, A. (1962). The Single Convention on Narcotic Drugs, 1961. *International Organization*, *16*(4), 776-797.
Leblud, J., Meesmann, U., Houwing, S., & Opdenakker, E. (2019). *Themadossier Verkeersveiligheid nr. 4: Drugs en geneesmiddelen*.
Leonard, J., & Windle, J. (2020). 'I could have went down a different path': Talking to people who used drugs problematically and service providers about irish drug policy alternatives. *International journal of drug policy*, *84*, 102891.

Lievens, Vander Laenen, F., Verhaeghe, N., Schils, N., Putman, K., Pauwels, L., Hardyns, W., & Annemans, L. (2016). *The social cost of legal and illegal drugs in Belgium* (Vol. 51). Maklu.

Lievens, D., Vander Laenen, F., Verhaeghe, N., Schils, N., Putman, K., Pauwels, L., Hardyns, W., & Annemans, L. (2016). *The social cost of legal and illegal drugs in Belgium*. Maklu.

Lloyd, C. (2013). The stigmatization of problem drug users: A narrative literature review. *Drugs: Education, Prevention and Policy*, *20*(2), 85-95.

Mackieson, P., Shlonsky, A., & Connolly, M. (2019). Increasing rigor and reducing bias in qualitative research: A document analysis of parliamentary debates using applied thematic analysis. *Qualitative Social Work*, *18*(6), 965-980.

Marlatt, G. A., & Witkiewitz, K. (2010). Update on harm-reduction policy and intervention research. *Annual Review of Clinical Psychology*, *6*, 591-606.

McAllister, W. B. (2002). *Drug diplomacy in the twentieth century*. Routledge.

McGinty, E. E., & Barry, C. L. (2020). Stigma reduction to combat the addiction crisis—developing an evidence base. *New England Journal of Medicine*, *382*(14), 1291-1292.

Mistiaen, P., Dauvrain, M., Eyssen, M., Roberfroid, D., Miguel, L. S., & Vinck, I. (2017). *Gezondheidszorg in Belgische gevangenissen: Huidige situatie en stockrooms scenario's*. https://kce.fgov.be/sites/default/files/atoms/files/KCE_293As_Gezondheidszorg_Belgische_gevangenissen_Synthese.pdf

Moernaut, J. (2019). *Wegwijzer voor beginnende preventiewerkers & Logomedewerkers alcohol en andere drugs, psychoactieve medicatie, gokken en gamen*.

Moreira, M., Trigueiros, F., & Antunes, C. (2007). The evaluation of the Portuguese drug policy 1999-2004: the process and the impact on the new policy. *Drugs and Alcohol Today*, *7*(2).

Morell, J. A. (2018). Systematic iteration between model and methodology: A proposed approach to evaluating unintended consequences. *Evaluation and program planning*, *68*, 243-252.

Mowbray, C. T., Holter, M. C., Teague, G. B., & Bybee, D. (2003). Fidelity criteria: Development, measurement, and validation. *American journal of evaluation*, *24*(3), 315-340.

Muscat, R., & Pike, B. (Eds.). (2014). *Coherence Policy Markers for Psychoactive Substances*. Council of Europe Publishing.

Nicaise, P., Dubois, V., & Lorant, V. (2014). Mental health care delivery system reform in Belgium: the challenge of achieving deinstitutionalisation whilst addressing fragmentation of care at the same time. *Health Policy*, *115*(2-3), 120-127.

Nieweglowski, K., Corrigan, P. W., Tyas, T., Tooley, A., Dubke, R., Lara, J., Washington, L., Sayer, J., Sheehan, L., & Team, A. S. R. (2018). Exploring the public stigma of substance use disorder through community-based participatory research. *Addiction Research & Theory*, *26*(4), 323-329.

Nieweglowski, K., Dubke, R., Mulfinger, N., Sheehan, L., & Corrigan, P. W. (2019). Understanding the factor structure of the public stigma of substance use disorder. *Addiction Research & Theory*, *27*(2), 156-161.

Nutley, S. M., Walter, I., & Davies, H. T. (2007). *Using evidence: How research can inform public services*. Policy press.

O'Donnell, C. L. (2008). Defining, conceptualizing, and measuring fidelity of implementation and its relationship to outcomes in K–12 curriculum intervention research. *Review of educational research*, *78*(1), 33-84.

Oxman, A. D., Lewin, S., Lavis, J. N., & Fretheim, A. (2009). SUPPORT Tools for evidence-informed health Policymaking (STP) 15: Engaging the public in evidence-informed policymaking. *Health research policy and systems*, *7*(1), 1-9.

Parsons, V. L. (2014). Stratified sampling. *Wiley StatsRef: Statistics Reference Online*, 1-11.

Pas, W. (2014). Algemene beschouwingen over de bevoegdheidsverdeling in het kader van de Zesde Staatshervorming. In A. Alen, B. Dalle, K. Muylle, W. Pas, J. Van Nieuwenhove, & W. Verrijdt (Eds.), *Het federale België na de Zesde Staatshervorming* (pp. 341-371). die Keure / la Charte.

Pauwels, L., Vander Laenen, F., Maes, E., De Kock, C., & Mine, B. (2017). *Sociale Preventie van Druggerelateerde Criminaliteit (SOCPREV)*

Pawson, R., Greenhalgh, T., Harvey, G., & Walshe, K. (2004). Realist synthesis: an introduction. *Manchester: ESRC Research Methods Programme, University of Manchester*.

Peyton, D. J., & Scicchitano, M. (2017). Devil is in the details: Using logic models to investigate program process. *Evaluation and program planning*, *65*, 156-162.

Pivovarova, E., & Stein, M. D. (2019). In their own words: language preferences of individuals who use heroin. *Addiction (Abingdon, England)*, *114*(10), 1785-1790. https://doi.org/10.1111/add.14699

Purdy, J., Cummins, H., & McAvoy, H. (2018). *Review of the New Strategic Direction for Alcohol and Drugs – Phase 2*.

Rajan, D. (2016). Chapter 3. Situation analysis of the health sector. In G. Schmets, D. Rajan, & S. Kadandale (Eds.), *Strategizing national health in the 21st century: a handbook*. World Health Organisation.

Reitox National Focal Point. (2019). *Belgium, Country Drug Report 2019*. https://www.emcdda.europa.eu/system/files/publications/11345/belgium-cdr-2019_0.pdf

Reuter, P. (2001). Why does research have so little impact on American drug policy? *Addiction*, *96*(3), 373-376.

Ritchie, J., Lewis, J., & Elam, R. G. (2013). Designing and selecting samples. *Qualitative research practice: A guide for social science students and researchers*, *111*.

Ritter, A. (2015). The privileged role of researchers in "evidence-based" policy: Implications and engagement of other voices. *Drugs and Alcohol Today*.

Ritter, A., & Cameron, J. (2006). A review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco and illicit drugs. *Drug and Alcohol Review*, *25*(6), 611-624.

Ritter, A., Lancaster, K., & Diprose, R. (2018). Improving drug policy: The potential of broader democratic participation. *International journal of drug policy*, *55*, 1-7.

RIZIV. (2020). *Statistieken over geneesmiddelen afgeleverd in openbare apotheken (Farmanet)*. Retrieved 05/04/2021 from https://www.riziv.fgov.be/nl/statistieken/geneesmiddel/Paginas/Statistieken-geneesmiddelen-apotheken-farmanet.aspx

Rogeberg, O., Bergsvik, D., Phillips, L. D., van Amsterdam, J., Eastwood, N., Henderson, G., Lynskey, M., Measham, F., Ponton, R., Rolles, S., Schlag, A. K., Taylor, P., & Nutt, D. (2018). A new approach to formulating and appraising drug policy: A multi-criterion decision analysis applied to alcohol and cannabis regulation. *International journal of drug policy*, *56*, 144-152. https://doi.org/https://doi.org/10.1016/j.drugpo.2018.01.019

Room, R., Rehm, J., Trotter II, R. T., Paglia, A., & Üstün, T. B. (2001). Cross-cultural views on stigma, valuation, parity, and societal values towards disability.

Rosiers, J. (2016). *Uitgaansonderzoek 2015*.

Rosiers, J., De Maeseneire, I., Geirnaert, M., & Moernaut, J. (2018). *Gingerrapport 2018: Monitoring van activiteiten*.

Rossignol, N., Bouvy, J., Jauniaux, L., Regueras, N., & Pauwelyn, K. (2019). Stand van zaken van de overdracht van bevoegdheden inzake gezondheid en bijstand aan personen na de zesde staatshervorming. *CM-Informatie*(275), 4-14.

Rousselet, M., Guerlais, M., Caillet, P., Le Geay, B., Mauillon, D., Serre, P., Chameau, P.-Y., Bleher, Y., Mounsande, S., Jolliet, P., & Victorri-Vigneau, C. (2019). Consumption of psychoactive substances in prison: Between initiation and improvement, what trajectories occur after incarceration? COSMOS study data. *PloS one*, *14*(12), e0225189-e0225189. https://doi.org/10.1371/journal.pone.0225189

Ruyver, B., Vermeulen, G., Vander Beken, T., Vander Laenen, F., & Geenens, K. (2002). *Multidisciplinary drug policies and the UN drug treaties*. Maklu.

Sabbe, B., Malone, M., Van Ham, S., & De Wilde, B. (2008). *Onderzoek naar de effectiviteit van de residentieel geïntegreerde behandeling voor patiënten met een dubbeldiagnose.*

Sanderson, I. (2002). Evaluation, policy learning and evidence-based policy making. *Public administration*, *80*(1), 1-22.

Sanderson, I. (2003). Is it 'what works' that matters? Evaluation and evidence-based policy-making. *Research Papers in Education*, *18*(4), 331-345. https://doi.org/10.1080/0267152032000176846

Schalast, N., & Tonkin, M. (2016). *Essen climate evaluation schema*.

Sciensano. (z.d.). *Drugs epidemiologie België*. Retrieved 12/02/2021 from https://drugs.wiv-isp.be/drugs-and-figures/Drug-related-mortality/Pages/default.aspx

Seys, A. (2017). *Inventaris van educatieve, preventieve en curatieve materialen over psychoactieve medicatie*. Paul Van Deun. https://www.vad.be/assets/inventaris-van-educatieve-preventieve-en-curatieve-materialen-over-psychoactieve-medicatie

Sholokhova, S. (2021). Visie, structuur en financiering van de preventie en gezondheidsbevordering in België. *CM informatie*(283), 42-57.

Sim, J., & Waterfield, J. (2019). Focus group methodology: some ethical challenges. *Quality & Quantity*, *53*(6), 3003-3022.

Singleton, N., & Rubin, J. (2014). What is good governance in the context of drug policy? *International journal of drug policy*, *25*(5), 935-941.

Sinha, J. (2001). *The history and development of the leading international drug control conventions*. Library of Parliament, Canada.

Smet, V., De Ruyver, B., Colman, C., Surmont, T., De Moor, A., Pauwels, L., & Vander Beken, T. (2013). *Het aanbod van illegale drugs in België: wat weten we? Een haalbaarheidstudie van betrouwbare indicatoren voor het drugsaanbod (SUPMAP): eindrapport*. Academia Press.

Smith, P., Favril, L., Delhauteur, D., Vander Laenen, F., & Nicaise, P. (2019). How to overcome political and legal barriers to the implementation of a drug consumption room: an application of the policy agenda framework to the Belgian situation. *Addiction Science & Clinical Practice*, *14*(1), 40. https://doi.org/10.1186/s13722-019-0169-x

Smith, P. A., & Dawber, J. (2019). Random probability vs quota sampling.

Sridharan, S., & Nakaima, A. (2012). Towards an evidence base of theory-driven evaluations: Some questions for proponents of theory-driven evaluation. *Evaluation*, *18*(3), 378-395.

Stewart, D. P. (1989). Internationalizing the war on drugs: The UN convention against illicit traffic in narcotic drugs and psychotropic substances. *Denv. J. Int'l L. & Pol'y*, *18*, 387.

Stolz, B. A. (1995). Creating a drug czar: A study of political rationality and symbolic politics. *Journal of Drug Issues*, *25*(1), 195-207.

Sys, O., Favril, L., & Vander Laenen, F. (2020). Needs assessment van druggebruikers in Gent: focus op niet-bereikte groepen.

Ti, L., Tzemis, D., & Buxton, J. A. (2012). Engaging people who use drugs in policy and program development: a review of the literature. *Substance abuse treatment, prevention, and policy*, *7*(1), 1-9.

Tieberghien, J. (2015). *The intersection between science and policy : the case of the development of Belgian drug policy between 1996 and 2003* 2015.]. http://lib.ugent.be/catalog/rug01:002299262

Trautmann, F., & Braam, R. (2014). *Evaluation of the Governmental Strategy and Action Plan 2010-2014 of Luxembourg regarding the fight against drugs and addictions*.

Trautmann, F., Braam, R., Keizer, B., & Lap, M. (2011). *Evaluation of the National Drug Strategy of the Republic of Croatia (2006-2012)*.

United Nations Office on Drugs and Crime. (2015). *Handbook on dynamic security and prison intelligence*.

UNODC. (2017). *Evaluation Handbook: guidance for designing, conducting and using independent evaluations at UNODC*.

VAD. (2015). *Samenwerken met de GGZ binnen de 107-ontwikkelingen*. Retrieved 10/02/2021 from https://www.vad.be/

VAD. (2017a). *Quality Nights: Gezondheidsservices voor clubs en dance-events*. Retrieved 21/05/2021 from https://www.vad.be/artikels/detail/quality-nights

VAD. (2017b). *TANDEM gestart*. VAD. Retrieved 7/06/2021 from https://www.vad.be/artikels/detail/tandem-gestart

VAD. (2018). *Memorandum over middelengebruik en verslavingsproblemen*. https://www.vad.be/artikels/detail/memorandum-over-middelengebruik-en-verslavingsproblemen

VAD. (2020). *De VAD-leerlingenbevraging*. Retrieved 22/02/2021 from https://www.vad.be/onderzoek/vad-leerlingenbevraging

valentine, k., Persson, A., Newman, C. E., Hamilton, M., Bryant, J., & Wallace, J. (2020). Experience as Evidence: The Prospects for Biographical Narratives in Drug Policy. *Contemporary Drug Problems*, *47*(3), 191-209.

Van Caillie, D. (2013). Analyse socioéconomique: analyse coûts-bénéfices comparée des traitements DAM et méthadone: l'expérience TADAM (2011-2012). In I. Demaret, G. Litran, C. Magoga, C. Deblire, J. De Roubaix, E. Quertemont, D. Van Caillie, N. Dubois, A. Lemaître, & M. Anseau (Eds.), *Projet TADAM: rapport final 2007-2013*. Université de Liège.

Van Damme, J., Thienpondt, A., Rosiers, J., De Bruyn, S., Soyez, V., Sisk, M., Van Hal, G., & Deforche, B. (2018). *In hogere sferen? Volume 4*.

Van Damme, P., Vanhove, W., Tytgat, J., & Cuypers, E. (2017). *Gevaren van de illegale binnenteelt van cannabis voor de omgeving en interventiepersoneel*.

Van Ham, S., & Sabbe, B. (2005). *Onderzoek naar de effectiviteit van de residentieel geïntegreerde behandeling voor patiënten met een dubbeldiagnose*. Academia Press.

Van Havere, T., Dirkx, N., Vander Laenen, F., De Clercq, B., Buijs, T., Mathys, C., van Praet, S., Deforche, B., El Houti, A., & Van Damme, J. (2018). *The law of 2009 concerning the selling and serving of alcohol to youths: from state of the art to assessment*.

Van Impe, M. R. E., Vander Laenen, F. p. R. E., & Petintseva, O. c. R. E. (2021). *Stigma through the eyes of people who use(d) illegal drugs : challenging boundaries through Participatory Action Research* Ghent]. http://lib.ugent.be/catalog/pug01:8722239

van Laar, & van Ooyen-Houben. (2009). *Evaluatie van het Nederlands Drugsbeleid*.
Van Malderen, S. (2012). *Drugs in de gevangenissen: een blik op het penitentiair drugsbeleid*. Retrieved 5/04/2021 from http://www.dekiem.be/documents/tekst/PL4Vanmalderen.pdf
Van Malderen, S., Pauwels, L., Walthoff-Born, C., Glibert, P., & Todts, S. (2011). Drug use in Belgian prisons: monitoring of drug related health risks 2010. *Brussels: Federal Departement of Justice*.
Van Tomme, N. (2017). *Psychofarmacabeleid in België: wat met slaap- en kalmeermiddelen?* FAGG. Retrieved 19/02/2021 from https://www.fagg.be/nl/presentaties
Vandam, L., Colman, C., Vander Laenen, F., & De Ruyver, B. (2010). Towards an integral and integrated drug policy: Pearls and pitfalls. *Safety, societal problems and citizens "perceptions": new empirical data, theories and analyses*, *3*, 239-262.
Vandenbruwaene, W. (2014). Hoofdstuk 10. Justitie: strafrechtelijk beleid, jeugdsanctierecht en justitiehuizen. In *De zesde staatshervorming: instellingen, bevoegdheden en middelen* (pp. 295-315). Intersentia. https://www.jurisquare.be/en/book/9789400004559/2/hoofdstuk-10-justitie-strafrechtelijk-beleid-jeugdsanctierecht-en-justitiehuizen/
Vander Laenen, F. (2012). Voordracht 'Harm Reduction and social inclusion in Belgium: a metaview and critical insight'. Harm reduction and social inclusion, Brussels.
Vander Laenen, F. (2015). Memorandum naar een volwaardige gezondheidszorg voor gedetineerden en geïnterneerden in België. *FATIK*, *145*, 28-30.
Vander Laenen, F. (2016). De communautarisering van de drughulpverlening: herstel centraal. *Panopticon*, *37*(4), 275-289.
Vander Laenen, F. ((in press)). *Gedwongen opname. Ervaringen van professionals en ervaringsdeskundigen*. Gompel & Svacina. .
Vander Laenen, F., De Ruyver, B., Christiaens, J., & Lievens, D. (2011). *Drugs in Cijfers III/Onderzoek naar de overheidsuitgaven voor het drugsbeleid in België*. Academia Press.
Vander Laenen, F., & Dhont, F. (2004). De drugwetgeving en de hulpverlening: een brug te ver. *ORDE VAN DE DAG: CRIMINALITEIT EN SAMENLEVING*, *26*(2), 35-44.
Vander Laenen, F., & Eechaudt, V. (2018). Gelijkwaardigheid van de gezondheidszorg in detentie: De wet is er, nu nog de toepassing. *FATIK*, *160*, 3-6.
Vander Laenen, F., & Favril, L. (2018). Druggebruiksruimtes nog niet voor morgen: Controversieel ondanks positieve onderzoeksresultaten. *Sociaal.net*. https://sociaal.net/achtergrond/druggebruiksruimtes-niet-voor-morgen/
Vander Laenen, F., Nicaise, P., Decorte, T., De Maeyer, J., De Ruyver, B., Smith, P., van Puyenbroeck, L., & Favril, L. (2018). Haalbaarheidsstudie van druggebruiksruimtes in België.
Vander Laenen, F., Remoortel, J., Boeck, M., Balthazar, T., & Opgenhaffen, T. (2020). Tien jaar forensische geestelijke gezondheidszorg in Vlaanderen. *Panopticon*, *40*(6), 450.
Vander Laenen, F., Van Remoortel, J., Hanoulle, K., De Boeck, M., Balthazar, T., & Opgenhaffen, T. (2019). Tien jaar forensische geestelijke gezondheidszorg in Vlaanderen: De trein is blijven rijden, zij het niet voor elke wagon met dezelfde snelheid. *Panopticon*, *40*(5), 450-469.
Vander Laenen, F., Vandam, L., & Colman, C. (2010). Met velen aan de tafel: goede voorbeelden van een integraal en geïntegreerd drugsbeleid. *Verslaving*, *6*(4), 54-71.
Vander Laenen, F., Vanderplasschen, W., & Smet, V. (2013). Analysis and optimization of substitution treatment in Belgium.
Vander Laenen, F., Vanderplasschen, W., Wittouck, C., Dekkers, A., De Ruyver, B., De Keulenaer, S., & Thomaes, S. (2013). *Het pilootproject drugbehandelingskamer te Gent: een uitkomstenevaluatie*. Academia Press.
Vanderplasschen, W., Lievens, K., Mostien, B., & Franssen, A. (2009). Tien jaar netwerkvorming en case management in de Oost-Vlaamse drughulpverlening: zorgen dat circuits net werken. *PSYCHIATRIE EN VERPLEGING*, *85*(4), 200-210.
Vandevelde, S., Debaere, V., Schils, E., Vander Laenen, F., Colman, C., Mine, B., Vanderplasschen, W., & Maes, E. (2021). De pilootprojecten drughulpverlening in de gevangenis: aanbevelingen op basis van het 'RECOvery in PRISon' – RECOPRIS project. *Panopticon*, *42*(2), 189-195.
Vandevelde, S., Vander Laenen, F., Mine, B., Maes, E., De Clercq, L., Deckers, L., & Vanderplasschen, W. (2020). Linkage and continuity of care after release from prison: an evaluation of central registration points for drug users in Belgium. *International Journal of Prisoner Health*.
Vandevelde, S., Vander Laenen, F., Vanderplasschen, W., Mine, B., & Maes, E. (2016). PRocess and Outcome Study of Prison-basEd Registration points (PROSPER).
Vaslie, R., van Nierop, P., Gounev, P., Fernandes, M., Ernia, N., Wildoer, E., Pradille, J., M, F., Sabev, M., Barendregt, C., & Martinelli, T. (2020). *Final Assessment of the EU Drugs Strategy 2013 - 2020 and the EU Action Plan on Drugs 2017 - 2020*.

Vlaamse Logo's. (2015). *Logo, gezondheid troef: jouw partner in gezondheidspromotie en ziektepreventie*. Hasselt: Frank Smeets Retrieved from https://issuu.com/vlaamselogos/docs/voorstellingsbrochurevlaamselogo_s

Vlaamse Overheid. (2018). *Penitentiair Landbouwcentrum Ruiselede: JAARVERSLAG 2018*.

Vlaamse Regering. (2013). *Groenboek Zesde Staatshervorming: Deel 2 - Gezondheidszorg, ouderenzorg en hulp aan personen*.

Vlaanderen. (2010). *Gids naar een betere geestelijke gezondheidszorg door de realisatie van zorgcircuits en zorgnetwerken*. Retrieved from http://www.psy107.be/

Vos, S., & Van Hal, G. (2017). Nazorg en continuïteit van zorg: complementaire kracht van ervaringsdeskundigheid en zelfhulp. In W. Vanderplasschen & F. Vander Laenen (Eds.), *Naar een herstelondersteunende verslavingszorg, Praktijk en Beleid*. Acco.

Vyncke, V., Hanssens, L., Steenberghs, E., & Willems, S. (2015). *Onderzoeksrapport 'Gezondheidsprofiel Gedetineerden'*. https://www.departementwvg.be/sites/default/files/media/Eindrapport_gezondheidsprofiel_gedetineerden_def.pdf

Walker, M., Beadman, K., Griffin, S., Beadman, M., & Treloar, C. (2019). Involving peers in research: the UNSW community reference panel. *Harm Reduction Journal*, *16*(1), 52. https://doi.org/10.1186/s12954-019-0325-3

Weiss, C. H. (2000). Which links in which theories shall we evaluate? *New directions for evaluation*, *2000*(87), 35-45.

WHO. (2003). How to develop and implement a national drug policy. *WHO Policy Perspectives on Medicines*, *6*.

WHO. (2021). *Primary health care*. Retrieved 30/09 from

Willis, L. L. (2016). *Deconstructing divergent constructions of illicit drug use and drug-using subjects: understanding enduring stigma and marginalisation* Curtin University].

Windelinckx, T. (2014). *Dossier Harm Reduction*.

Windelinckx, T. (2019). *Rapport Evaluatie Onderzoek Spuitenruil Vlaanderen 2019*.

Wittouck, C., & Vander Laenen, F. (2020). Na internering, tijd voor zorg voor gedetineerden en personen met een drugproblematiek. *Panopticon*, *41*(3), 313-319.

World Health Organization. (2001). *How to develop and implement a national drug policy*. World Health Organization.

Yang, L., Wong, L. Y., Grivel, M. M., & Hasin, D. S. (2017). Stigma and substance use disorders: an international phenomenon. *Current opinion in psychiatry*, *30*(5), 378.

Zampini, G. F. (2018). Evidence and morality in harm-reduction debates: can we use value-neutral arguments to achieve value-driven goals? *Palgrave Communications*, *4*(1), 62. https://doi.org/10.1057/s41599-018-0119-3

Zerrouk, E.-A., Schils, E., Vandevelde, S., Vander Laenen, F., Vanderplasschen, W., Colman, C., Maes, E., & & Mine, B. (2021). *Evaluatie van het pilootproject in drie Belgische gevangenissen: Uitbreiding van het RECO-PRIS onderzoek*.

12 ANNEXES

12.1 Topic list semi-structured interviews

Interview time: 1h30 (max. 2h)	
When contacting a respondent, we will send a simplified version of the logic model. This way, the respondent can read through these specific topics beforehand. Additionally, we will send the informed consent beforehand. • Information on and signing of the informed consent + recording (MS Teams + external recorder) • What is your role/title/job description? • Can you explain in what way your organization is involved in the Belgian drug policy? • Information about EVADRUG and goal of interview	

Context for traffic light
 	
(We chose to focus on the objectives instead of the actions to get more general context and not spend to much time in the past.)
	Explain logic model (*share screen*)
	
	• You can see (*fill in number*) objectives in this pillar. For which of these objectives can you tell us a little more?
	• How was (fill in objective) achieved?
	  ○ What were/are the most significant challenges with the realization of this objective?
	• How is the current operation of this objective going?
	  ○ From your point of view, what were the bottlenecks of the realization of this objective?
	  ○ From your point of view, what were the facilitators of the realization of this objective?
	  ○ Were there any unintended positive and/or negative consequences that resulted from the realization of this objective?

New orientations in the objectives of the Belgian drug policy	• From all these objectives, which one(s) is/are the most relevant in the current context, according to you?
	  ○ For which reason would you define these objectives as relevant?
	  ○ Please provide an example.
	• Are there other objectives that are currently missing here, but are relevant today, according to you?
	  ○ Why do these objectives matter?
	  ○ Please provide an example.

Current needs and problems in the different domains	• What are the current needs for an optimal (*pillar*)?
	  ○ Requirements concerning the different Regions and policy levels?
	  ○ Requirements in different target populations?
	  ○ Requirements towards different substances?
	  ○ Requirements in specific drug trends?
	  ○ Requirements regarding the policy evolutions (national drug policy ⇔ international drug policy evolutions)?
	  ○ Requirements concerning specific policy domains?
	• How are these needs currently addressed by (aspects of) the Belgian drug policy?

Clarification of concepts (not necessarily a separate question, could be a follow-up question)	• You've frequently mentioned the topic of 'addiction' during the interview. What do you mean by 'addiction'? ○ Could you elaborate also on what you mean by 'problematic drug use', 'Integral and integrated drug use', …

Focus on future outcomes
 	
(as we've already asked about the
	• What , would you say, are the priorities in terms of expected results (outcomes) of the Belgian drug Policy for the next 10 years?
	  ○ Priorities for the Federal level/ communities/ Regions?
	  ○ Priorities for certain substances/behavior?
	  ○ Priorities for specific target groups?
	  ○ Priorities for specific settings (work, prison, criminal justice system, nightlife, schools,…)

objectives in the previous questions)	○ Priorities for the coordination of a drug policy
Any extra information	• Undiscussed topics? • Ask for concrete documentation that could help us with the evaluation. • Mention that we have a few specific questions that remained unclear in the survey (doubts in traffic light exercise). Ask if we could send these specific question to them after the interview.

12.2 Script focus groups people with lived experiences

Elke deelnemer ontvangt een overzicht met informatie over het onderzoek, het informed consent formulier en contactinformatie van het onderzoeksteam.

Wat?	Timing?	Inhoud	Wie?
Welkom met koffie/thee en lunch + overzicht van informatie uitdelen			
Introductie van het EVADRUG onderzoek	+- 5 min	Ik ben (moderator) en ik zal dit gesprek begeleiden. Ik wil ook graag (observator) voorstellen die het gesprek zal meevolgen, zonder tussen te komen. We hebben jullie uitgenodigd om te spreken over het Belgisch drugsbeleid. Dat doen we omdat we een evaluatie uitvoeren naar het Belgisch drugsbeleid. In die evaluatie hebben we in kaart gebracht wat beleidsmakers of politici wilden bereiken met het drugsbeleid, een aantal jaren terug. En daarna zijn we gaan kijken of dat ook effectief gerealiseerd is. En het is met die laatste vraag dat we bij jullie terecht komen. Als je graag meer informatie krijgt over het onderzoek, dan geven we je dat graag mee, dus geef gerust een seintje. Dus, in deze evaluatie willen we ook het podium geven aan iedereen die betrokken is bij het Belgische drugbeleid. Daarom vinden we het ook zo belangrijk om te spreken met jullie, als ervaringsdeskundigen. We willen horen wat jullie ervaringen, verwachtingen en wensen zijn met en voor het Belgische drugbeleid. We willen vooral weten wat jullie mening is over het Belgische drugbeleid in al zijn vormen, en willen daarom ook ruimte laten voor een discussie van preventie, het beperken van schade, hulpverlening en politie en justitie. Voor we van start gaan, willen we kort enkele afspraken bespreken: • Om het gesprek vlot te laten verlopen, willen we vragen elkaar te laten uitspreken. • We zijn benieuwd naar jullie mening, en daar zijn uiteraard geen goeie of slecht antwoorden in. • Dit een vertrouwelijke discussie in die zin dat we jullie namen of wie wat gezegd heeft, aan niemand zullen doorgeven. We zullen wat hier besproken wordt volledig anoniem verwerken in de evaluatie. • Dit gesprek is vrijwillig. Je kan je op elk moment terugtrekken, en zonder een reden voor deze beslissing op te geven. Er zijn ook geen kosten of verplichtingen verbonden aan een deelname. • Tenslotte: dit gesprek wordt opgenomen. We zullen die opname alleen gebruiken om zo dicht mogelijk te blijven bij wat jullie hebben gezegd. We zullen jullie	

		namen niet vernoemen in het rapport. Nadat alles verwerkt is, worden de opnames verwijderd. Heeft iemand vragen of opmerkingen, of is er iemand niet akkoord?	
Start opname			
Introductie van de groep	+- 10 min.	Voor we starten, lijkt het ons fijn om elkaar te leren kennen. Ik stel voor om de tafel rond te gaan. Stel jezelf even voor met jouw naam of bijnaam. Ik zou ook willen vragen om aan te geven akkoord bent om deel te nemen aan het onderzoek.	
Kijk op het huidige drugsbeleid + Aanbevelingen	+- 10 min	ALGEMEEN: Als je kijkt naar het Belgisch drugsbeleid, hoe evalueer je dat? • Welke aanbevelingen zouden jullie willen meegeven aan beleidsmakers of politici voor het Belgische drugsbeleid?	
	+- 10 min	PREVENTIE: • Hoe kijk je naar preventie? • Preventie kan algemeen zijn (bv. gezond leven), maar kan ook specifiek gericht zijn op drugs (bv. minder roken, veilig gebruiken, ..). Hoe zou preventie volgens jullie moeten lopen? • Welke aanbevelingen zouden jullie willen meegeven aan beleidsmakers of politici voor het Belgische drugsbeleid en aanzien van preventie?	
	+- 10 min	SCHADE BEPERKEN: • Hoe kijk je naar de initiatieven om schade te beperken? • In het verleden hebben beleidsmakers en politici gezegd dat ze schadebeperking/harm reduction willen uitbreiden. Wat vind je daarvan? • Welke aanbevelingen zouden jullie willen meegeven aan beleidsmakers of politici voor het Belgische drugsbeleid ten aanzien van het beperken van schade?	
	+- 10 min	HULPVERLENING: • Hoe kijk je naar hulpverlening? • Beleidsmakers hebben een paar jaar geleden gezegd dat ze een breed en verschillend aanbod van hulpverlening willen hebben. Hoe zien jullie dat? • Welke aanbevelingen zouden jullie willen meegeven aan beleidsmakers of politici voor het Belgische drugsbeleid ten aanzien van hulpverlening?	
	+- 10 min	POLITIE EN JUSTITIE: • Hoe kijk je naar politie en justitie? • Beleidsmakers en politici hebben in het verleden aangegeven dat politie en justitie zich vooral moeten richten op illegale drugsproductie en -handel en dat mensen met drugsproblemen vooral moeten worden doorverwezen naar de hulpverlening. Hoe zien jullie dat? • Welke aanbevelingen zouden jullie willen meegeven aan beleidsmakers of politici voor het Belgische drugsbeleid ten aanzien van politie en justitie?	
	+- 10 min	ONDERZOEK: • Hoe kijk je naar onderzoek?	

		• Welke aanbevelingen zouden jullie willen meegeven aan beleidsmakers of politici voor het Belgische drugsbeleid ten aanzien van onderzoek?	
Nog te behandelen thema's?		Wil je nog iets kwijt waar we het nog niet over gehad hebben, en die voor jullie belangrijk zijn?	
Feedback over de aanpak		Wat vonden jullie van deze discussie?	
Afsluit		Een welgemeende dankjewel om tijd vrij te maken op een zaterdag als deze, en je mening met ons te willen delen. Je helpt ons en het onderzoek een heel stuk mee verder.	
Stop opname			
Incentive		**Moderator**: Verduidelijkt dat iedereen een ontvangstbewijs voor de incentive krijgt, en vraagt of dat kan worden ondertekend (kan anoniem worden ondertekend). Met dat papier kan je naar (observator) gaan, en daar krijg je de incentive. Wie busticketjes heeft, kan die afgeven aan (moderator), je krijgt opnieuw een briefje, en (observator) betaalt dat terug. **Observator**: Deelt de envelop met 10 EUR uit aan iedereen die het ontvangstbewijs heeft ingevuld. Ze geeft ook het geld terug voor de bus/tram/trein tickets.	

12.3 Script focus group practitioners and civil servants

Elke deelnemer ontvangt een overzicht met informatie over het onderzoek, het *informed consent* formulier en contactinformatie van het onderzoeksteam per mail enkele dagen voor de focusgroep plaatsvindt.

Wat?	Timing ?	Inhoud	Wie?
De vertaler/tolken zijn om 13u40 aanwezig in Zoom. De 'Host' voegt hen toe als 'interpreter' aan de meeting, zodat alles op voorhand kan worden getest.			
Vanaf 13u45 wordt een PPT geprojecteerd waarop de deelnemers worden verwelkomd (FR+NL) en waar staat aangegeven hoe ze kunnen kiezen voor simultaanvertaling. Wanneer de focusgroep begint, wordt de PowerPoint afgesloten.			
Introductie van het EVADRUG onderzoek	+- 5 min	Welkom. Voor we beginnen, wil ik u graag allemaal bedanken om vandaag aanwezig te zijn. We hebben inmiddels als enkele keren beroep gedaan op u, en dat doen we vandaag nog een laatste keer. We appreciëren het enorm dat u vandaag tijd hebt vrijgemaakt om hier aanwezig te zijn, ondanks uw drukke agenda's. Bedankt daarvoor. Over tot de orde van de dag. We hebben u uitgenodigd om input te geven voor aanbevelingen die we willen opstellen voor het Belgisch drugsbeleid. Zoals jullie ongetwijfeld weten, voert dit onderzoek een procesevaluatie uit van het Belgische drugsbeleid. In die procesevaluatie gaan we na wat de beleidsintenties waren van het Belgische drugsbeleid, hoe en in welke mate die beleidsintenties gerealiseerd werden, en in welke mate die nog in lijn liggen met de huidige noden en behoeften.	

		Het onderzoek bevindt zich in de laatste fase: het opmaken van beleidsaanbevelingen. Om concrete beleidsaanbevelingen voor het Belgisch drugsbeleid op te maken, organiseren we deze focusgroep. We werken vanmiddag met een aantal – soms uitgesproken – stellingen om de discussie op gang te brengen. Voor we van start gaan, willen we kort enkele afspraken bespreken: Om het gesprek vlot te laten verlopen, willen we vragen niet door elkaar te praten. We vragen dat iedereen zijn camera aansteekt, zodat iedereen op het scherm zichtbaar is, uw micro uit te zetten wanneer u niet aan het woord bent, en aan te schakelen als u het woord neemt. U hoeft geen hand op te steken om het woord te vragen. Dit is een vrijwillige en vertrouwelijke discussie. Het gesprek wordt opgenomen, zodat we in de rapportage zo dicht mogelijk blijven bij wat jullie hebben gezegd. Alles wordt echter anoniem verwerkt, jullie namen worden nergens vernoemd in het rapport. De afspraken die we zojuist hebben overlopen, zijn de zaken die ook in het informed consent terugkomen. We willen u vragen om ons een getekend exemplaar terug te bezorgen, of via mail te bevestigen dat u de informed heeft gelezen en of u akkoord bent.	
Start opname			
Mogelijke stellingen	Max. 20 min.	Er is nood aan een nieuw drugsbeleidsplan met focus op de verschillende beleidsdomeinen en beleidsniveaus in functie van een integrale en geïntegreerde aanpak. Hoe moet dat plan er uit zien? In de vorm van een nieuwe gemeenschappelijke verklaring? Wie houdt de regie voor het drugsbeleidplan? Timing: Hoe wordt de opmaak van het beleidsplan in tijd beperkt? Welk tijdsinterval moet het beleidplan hebben (bijv. één plan per legislatuur?)?	
	Max. 10 min.	De Algemene Cel Drugsbeleid moet een actievere rol krijgen in het voorbereiden, ontwikkelen en opvolgen van een integraal en geïntegreerd drugbeleid. Welke rol moet de Algemene Cel Drugs krijgen? Wie moet zetelen in de Algemene Cel Drugs?	
	Max. 15 min.	Er is nood aan een *evidence-informed* beleid, waar naast wetenschappelijke evidentie ook het maatschappelijk middenveld en ervaringsdeskundigen structureel worden betrokken. Hoe kunnen we tot een *evidence-informed* beleid komen?	
	Max. 15 min.	Pijler handhaving: Er moet een gemeenschappelijk actieplan komen tussen de verschillende handhavingsactoren (onder andere om de infoflux te bevorderen, om aan gemeenschappelijke prioriteiten te werken, …) Welke actoren moeten in zo een gemeenschappelijk actieplan betrokken worden? Wie neemt de regie in dat plan?	
	Max. 15 min.	Pijler preventie – vroeginterventie en schadebeperking: Er moeten meer overheidsuitgaven komen voor preventie, vroeginterventie en schadebeperking.	

		Uitgaand van een beperkt budget: Waar moet de nadruk op liggen?	
	Max. 15 min.	Pijler hulpverlening: We moeten een gedifferentieerd hulpverleningsaanbod (geografisch, en qua bereik van doelgroepen) verenigen met de autonomie van de zorgsector. Hoe kunnen beiden met elkaar verenigd worden?	
Nog te behandelen thema's?	10 min.	Zijn er zaken waar we het nog niet over hebben gehad en die belangrijk zijn om aan bod te laten komen?	
Afsluit	2 min.	Dan rest ons enkel nog om u uitgebreid te bedanken voor uw aanwezigheid. Verschillende mensen hier aanwezig vandaag hebben reeds in verschillende fasen van de evaluatie ons bijgestaan met informatie, en dat is niet altijd eenvoudig binnen jullie drukbezette agenda's. Daarom: een welgemeende dankuwel.	
Stop opname			
Afsluit			

Stelling 1:

Er is nood aan een nieuw drugsbeleidsplan met focus op de verschillende beleidsdomeinen en beleidsniveaus in functie van een integrale en geïntegreerde aanpak.

Un nouveau plan d'action en matière de drogues est nécessaire. Il devrait notamment mettre l'accent sur l'organisation de la collaboration entre domaines d'action et niveaux de pouvoir dans le cadre d'une approche intégrée et globale.

- À quoi devrait ressembler ce plan ?

Stelling 2:

De Algemene Cel Drugsbeleid moet een actievere rol krijgen in het voorbereiden, ontwikkelen en opvolgen van een integraal en geïntegreerd drugbeleid.

La Cellule Drogues Générale doit avoir un rôle plus actif dans la préparation, le développement et le suivi d'une politique globale et intégrée en matière de drogues.

- Comment développer cela ?

Stelling 3:

Er is nood aan een *evidence-informed* beleid, waar naast wetenschappelijke evidentie ook het maatschappelijk middenveld en ervaringsdeskundigen structureel worden betrokken.

Il faut développer une politique en matière de drogues qui est plus basée sur les évidences scientifiques et qui permet une meilleure implication des acteurs de terrain et des experts d'expérience.

- Comment parvenir à cela ?

Stelling 4:

Pijler handhaving: Er moet een gemeenschappelijk actieplan komen tussen de verschillende handhavingsactoren (onder andere om de infoflux te bevorderen, om aan gemeenschappelijke prioriteiten te werken, …)

En ce qui concerne le pilier "répression" : il faut élaborer un plan d'action commun entre les différents acteurs de ce pilier (par exemple, en vue d'améliorer le flux d'informations, pour déterminer des priorités communes, etc.)

- -Quels acteurs impliquer et comment ?

Stelling 5:

Pijler preventie – vroeginterventie en schadebeperking: Er moeten meer overheidsuitgaven komen voor preventie, vroeginterventie en schadebeperking.

Pilier prévention, intervention précoce et réduction des risques : il faut renforcer les moyens dédiés à ces secteurs.

- Sachant que les budgets sont limités, quelles doivent être les priorités ?

Stelling 6:

Pijler hulpverlening: We moeten een gedifferentieerd hulpverleningsaanbod (geografisch, en qua bereik van doelgroepen) verenigen met de autonomie van de zorgsector.

Pilier assistance : il faut réconcilier une offre d'assistance différenciée (géographiquement et en fonction des groupes cibles) et l'autonomie des acteurs de ce secteur.

- Comment faire?

PART 2

TARGETED EVALUATION: AN IN-DEPTH EVALUATION OF TWO INTERVENTIONS

CHAPTER 1

Evaluating a targeted intervention:
Drug treatment in detention

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Lead researcher:

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1 CONTENT

1. Introduction

Mental health and drug use problems in prison are still a source of worry. Detained persons (who use drugs) in Europe, but also in Belgium specifically, consistently present poorer (mental) health compared to the general population, with 37% of those detained experiencing severe mental health issues (European Monitoring Centre for Drugs and Drug Addiction, 2021b; Favril et al., 2017; Vyncke et al., 2015).

Meanwhile, mental health service delivery in Belgian prisons remains insufficient and fragmented (Algemene Cel Drugsbeleid, 2019; Favril & Vander Laenen, 2018; Mistiaen et al., 2017). Insufficient supply, long waiting lists and a lack of care continuity currently characterize health care delivery in Belgian prisons (Mistiaen et al., 2017). This is the case in spite of the explicit premise on how health care in prisons should be equivalent to health care in society in the Belgian law of January 12th 2005 on the rights of prisoners and its explanatory memorandum of October 31th 2018 (Vander Laenen, 2015; Vander Laenen & Eechaudt, 2018).

In terms of drug use, one third of detained persons report the use of illegal substances during their detention (Favril & Vander Laenen, 2018; Van Malderen et al., 2011). Addressing needs of persons who use drugs in prison and after their release, is prioritized in the new EU Drugs Strategy 2021-2025 (Council of the European Union, 2020). Drug treatment programmes in prison may consist of various types of interventions, consisting of both physiologic and psychosocial treatment, at different phases of imprisonment (cf. Figure 1). However, research on the effectiveness of these health- and drug-related interventions in prison remains sparse, with often ill-defined outcomes (European Monitoring Centre for Drugs and Drug Addiction, 2021b).

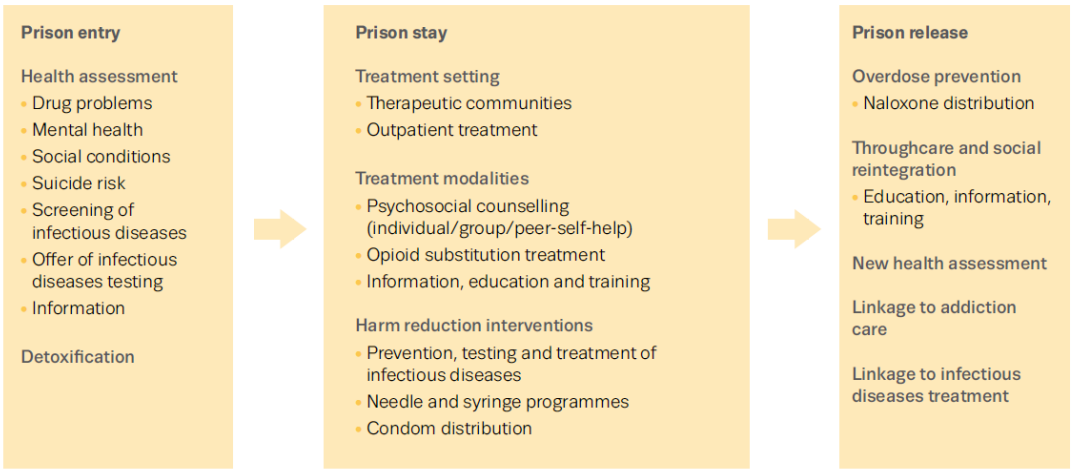

Figure 22: Drug-related and other health and social care interventions targeting people who use drugs in prison, by phase of imprisonment (EMCDDA, 2021, p.52)

Drug treatment programmes are only provided in a few Belgian prisons (e.g. drug-free wards) (Mistiaen et al., 2017; Wittouck & Vander Laenen, 2020). Belgian policy makers identify the lack of sufficient budget and staff, together with the low priority of this issue as the main barriers to implement an integrated drug policy in prisons (Kazadi Tshikala & Vander Laenen, 2015). Yet, drug treatment programmes in prison hold a unique position. As half of the drug users in detention has never been in contact with drug treatment initiatives in society (Vandevelde et al., 2020), these prison programmes have the capacity to reach this unidentified group of drug users (European Monitoring Centre for Drugs and Drug Addiction, 2021b). In addition, these drug users can be referred towards community drug treatment initiatives (Favril & Vander Laenen, 2018; Rousselet et al., 2019).

Currently, the Belgian federal Justice Department holds jurisdiction over health care delivery, and thus drug treatment, in prison. However, the transfer of this jurisdiction towards the federal Department of Public Health is planned (Mistiaen et al., 2017; Vander Laenen et al., 2019), which holds the promise of improved (priority of) health care delivery in prison (European Monitoring Centre for Drugs and Drug Addiction, 2021b). In this context, the Belgian federal Minister of Public Health initiated a drug treatment pilot project in 2017 in 3 federal prisons (i.e. Hasselt, Lantin and the Brussels Penitentiary Complex) (Algemene Cel Drugsbeleid, 2019; FOD Volksgezondheid, 2021; Vandevelde et al., 2021). The pilot project is intended to identify the preconditions and practical requirements to implement drug treatment programmes in all Belgian prisons (Vander Laenen et al., 2019).

The pilot project "drug treatment programme for persons in detention" in the prison of Hasselt was selected to be one of the targeted interventions for evaluating the Belgian drug policy in this study. This intervention is situated in the national drug policy at both the pillar "Treatment, risk reduction and reintegration", where policy makers aspire (among other things) to create a comprehensive and integrated treatment offer and to stimulate cooperation between the criminal justice system and treatment sector (cf. Chapter 5), and the pillar "Enforcement", where policy makers aim to develop a legislative framework for drug treatment in penitentiary institutions (cf. Chapter 6). This intervention was selected for its clearly demarcated scale and goals, framed by six policy documents (cf. infra), which facilitates the conduct of an output and outcome evaluation. Next, this policy is only recently developed and continues to do so, which makes its evaluation interesting to further inform good policy making on this topic.

In this study, we provide an in-depth process-, output- and outcome evaluation of the drug policy implementation concerning this particular prison drug treatment project. The guiding policy documents for the pilot project in the prison of Hasselt are:

- Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018
- Koninklijk besluit van 17 Augustus 2018 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 13 September 2018
- Koninklijk besluit van 23 Maart 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 14 Mei 2019
- Koninklijk besluit van 11 Juni 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 22 Juli 2019
- Koninklijk besluit van 17 December 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 15 Januari 2020
- Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 12 Augustus 2020

On June 3th of 2021, the new Royal Decree of May 12th 2021[112] has been published concerning the drug treatment project in the prison of Hasselt.

2. Methodology

[112] Koninklijk besluit van 12 Mei 2021 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 3 Juni 2021

The aim of this study is to provide an in-depth evaluation of the drug policy implementation concerning the targeted intervention of the "drug treatment programme for persons in detention" in the prison of Hasselt, hereafter referred to as 'D&D project'. To this end, we need to take a few steps (cf. Table 1).

Research question	Method
Understanding the intervention policy: 1. What is the logic of the targeted intervention policy?	Document analysis Critical appraisal
Process evaluation: 1. To what extent have the activities set out in the Royal Decrees been realized? 2. What challenges obstructed and which enabling factors facilitated the implementation of these activities? 3. To what extent do these activities correspond to the needs of persons who use drugs in prison?	Document analysis 23 semi-structured interviews
Output and outcome evaluation : 1. Which quantitative and qualitative measurable indicators can be identified to evaluate this intervention? 2. Which quantitative and qualitative measurable indicators would be beneficial to evaluate this intervention?	Literature review Document analysis 23 semi-structured interviews

Table 15: Overview of research questions and their methodology

First, we needed to get acquainted with and analyse the necessary policy documents. To do so, we rely on logic models as an evaluation framework, as explained in the methodological chapter of this report (cf. chapter 2, Part 1). Logic models are a systematic and coherent description of a policy that identify the objectives, activities, resources, intended outputs and intended outcomes underpinning a certain policy (EMCDDA, 2017b). Logic models make the underlying assumptions explicit of how policy aims to achieve change. To estabish a logic model for the D&D pilot project in the prison of Hasselt, a document analysis was conducted of the six central policy documents (i.e. Royal Decrees) for this project (cf. supra). We extracted the aims, the activities, the inputs (or resources) for the project, the intended outputs and the intended outcomes word for word from these documents, and rearranged them in a logical sequence (shown by Figure 3). This logic model was then critically appraised for its internal validity (Funnell & Rogers, 2011).

The most recent Royal Decree of May 12th 2021[1] has not been included in this study. This Decree has been published on June 3th 2021, in the midst of the data collection for this research, which would, if included, implicate that part of our data reflect on either 6 (for the first 11 interviews) or 7 Royal Decrees (for the next 12 interviews). In addition, the new Royal Decree of May 12th 2021 does not essentially diverges from the Royal Decree of July 31th 2020[113], except for an increased budget (325.000€/year compared to 255.000€/year in 2020). The increase in budget is apparently not tied to an expanded set of activities or goals. Therefore, this study does not exclude any essential policy changes concerning the drug treatment programme in the prison of Hasselt. In conclusion, we have choosen to included only the first six Royal Decrees (cf. supra) and ensure this study's data reflect on the same policy documents, without excluding any recent or relevant policy changes.

[113] Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 12 Augustus 2020

Second, a process analysis allowed us to understand how the policy objectives have been implemented by the D&D project team in the prison of Hasselt. In particular, a document analysis of the yearly project activity reports gives a good overview of the resources and implemented activities of the drug treatment pilot project over the previous years (2017-2020). Thus, the document analysis supports a factual check of the implemented activities and resources. In addition, key stakeholders to the D&D project in the prison of Hasselt have been interviewed in a semi-structured form and questioned about the activities implemented in the project, along with the alignment with drug needs in the prison of Hasselt and the outputs and outcomes of the D&D project. The semi-structured interviews took place during the months of May, June and July of 2021. In turn, the data collected in these interviews supports the document analysis in understanding how key stakeholders to the D&D project perceived its implementation.

In total, 23 key stakeholders were interviewed. The key stakeholders can be divided in tree groups. At the macro-level, we conducted interviews with four policy makers from both the federal Department of Public Health, the federal Department of Justice and their minister's cabinet. At the meso-level, we interviewed four persons of prison management. At the micro-level, we interviewed D&D project staff (n = 6), prison officers (n = 2) or prison (health) staff in relation to the D&D project (n = 7) (e.g. religious counsellors, medical staff, psychosocial service staff, a health professional from an external mental health service). Every participant gave informed consent for their participation to the research. The interviews lasted between 32 minutes and 1 hour and 17 minutes, and took place either online (for policy makers) or in the prison of Hasselt. These semi-structured interviews were audio or video recorded and afterwards listened to 1 or 2 times to get familiar with the data. The data were analysed through an excel analysis grid (see Figure 2) which allowed for general tendencies and reflections to be noted and structured in an orderly manner.

Who	Logic model	Implementation	Barrieres & facilitators	Alignment needs of detained persons	Results	Registration	Desired registration	Recommendations

Figure 23: Analysis grid for data from semi-structured interviews

Third, an output and outcome analysis is a summative evaluation form and answers the question whether the goals of this project were achieved in terms of intended outputs and outcomes. The answer to this question has been informed by multiple methods, i.e. a literature review, a document analysis and the semi-structured interviews. A literature review was conducted to identify quantitative and qualitative indicators used in international literature to evaluate drug treatment projects. Two scientific databases (i.e. Pubmed & Google Scholar) have been searched, respectively on May 27th and May 3th 2021. The key words 'drug treatment evaluation' AND 'prison' yielded respectively 245 results with full text available and 30.500 results published between the years 2001 and 2021, of which only the first tree pages were consulted for relevant articles. The results were first screened on their title which generated a database of 60 full-text articles. After reading the abstracts and full text, another 29 articles were excluded and 2 duplicates were removed. Exclusion criteria in this review were evaluation studies of physical health programmes (e.g. COVID-19), drug related infectious disease programmes (i.e. Hepatitis C or HIV), non-prison programmes or studies on drug use prevalence rates. The final dataset contained 39 articles on the evaluation of drug treatment programmes in prison (cf. Annex 1). The included articles were screened for indicators used for effectiveness evaluation in drug treatment interventions in prison. These indicators were then compared to those registered and monitored in the D&D project, as identified through the document analysis of the yearly activity reports and the semi-structured interviews with D&D staff. This comparison makes us understand the differences between international scientific effectiveness evaluation and current practices within the drug treatment project

in the prison of Hasselt, and gives inspiration to further enhance an output and outcomes evaluation for drug treatment interventions in Belgian prisons.

3. A logic model

A logic model for the policy documents concerning the D&D project in the prison of Hasselt is construed. Figure 3 shows this logic model with the extracted aims, the activities, the inputs, the intended outputs and the intended outcomes in a logical sequence. In text, the content and evolution of the policy documents are explained in detail.

I. Aims

Article 4 of each of the six consecutive Royal Decrees[114] concerning the D&D project in Hasselt, refers to the aims of this project. The overarching aim of the D&D project is to develop a drug treatment programme in detention. In this respect, the policy makers of the federal Department of Public Health want to achieve high-quality care for persons in detention with a drug related problem. Therefore, a tailor-made care trajectory for detained people is to be developed. This care trajectory should be equivalent to regular health care in society, and adapted to the specific circumstances of detention and the 'current care situation'. Yet, it is unclear what this 'current care situation' implies.

Furthermore, these Decrees state that the aims should be developed and tested in the context of a pilot project in three Belgian prisons, i.e. Hasselt, Lantin and the Brussels Penitentiary Complex.

While the enumeration of aims seems logical, the participants in the interviews line out that the intention to *develop a good practice* for other prisons is not mentioned in these policy documents. In addition, they call for reflection on the aims of the drug treatment programme relating to their target population. For example, it should be considered what the impact of the programme is on detained persons (i.e. increased insight in drug use problem, increased wellbeing). Next, it is noted how these policy documents focus solely on drug use (problems). Yet, the participants claim, if you want to provide care equivalent to the provision in society, the drug treatment programme should be integrated in general mental health care in prison in the same way as it is organised in society.

[114] Art. 4 Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018

Art. 4 Koninklijk besluit van 17 Augustus 2018 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 13 September 2018

Art. 4 Koninklijk besluit van 23 Maart 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 14 Mei 2019

Art. 4 Koninklijk besluit van 11 Juni 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 22 Juli 2019

Art. 4 Koninklijk besluit van 17 December 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 15 Januari 2020

Art. 4 Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 12 Augustus 2020

"Do we have to continue seeing it as a separate issue, or are drug problems merely an element of mental healthcare in prison? […] Over the last years, there have been efforts to integrate it [drug treatment] in mental healthcare and I would find that useful here [prison] as well."

(Participant 4)

II. Inputs

The D&D project in the prison of Hasselt has received funding to realise its aims. Article 1 and 2 of the Royal Decrees[115] determine the allocated budget and other financial provisions (i.e. procedures for disbursement of the funds). Funding was allocated for 6 months and from 2020 onwards on a yearly basis.

The D&D project received the following sums from the federal Department of Public Health:

Royal Decree	Phase of the project	Period	Funding
29/11/2017	Phase 1	15/12/2017 – 15/06/2018	125.000€
17/08/2018	Phase 2	16/06/2018 – 15/01/2019	145.833,33€
23/03/2019	Phase 3	16/01/2019 – 30/06/2019	117.329€
11/06/2019	Phase 3	01/07/2019 – 15/12/2019	120.632€
17/12/2019	Phase 3	16/12/2019 – 31/07/2020	164.939€
31/07/2020	Phase 4	01/08/2020 – 31/07/2021	255.000€

Table 16: Funding and phases of Royal Decrees

A local project coordinator is appointed to coordinate the D&D project in article 4§1 of the Royal Decrees[116]. The local project coordinator in the prison of Hasselt is the *Centre for Alcohol and other*

[115] Art. 1 & 2 Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018

Art. 1 & 2 Koninklijk besluit van 17 Augustus 2018 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 13 September 2018

Art. 1 & 2 Koninklijk besluit van 23 Maart 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 14 Mei 2019

Art. 1 & 2 Koninklijk besluit van 11 Juni 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 22 Juli 2019

Art. 1 & 2 Koninklijk besluit van 17 December 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 15 Januari 2020

Art. 1 & 2 Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 12 Augustus 2020

[116] Art. 4 § 1 Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018

Art. 4 § 1 Koninklijk besluit van 17 Augustus 2018 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 13 September 2018

Drug problems Limburg vzw (hereafter CAD Limburg). In 2020, *CAD Limburg* merged with a centre for mental health care (i.e. *CGG VGGZ)*, becoming *ZorGGroep Zin*. Since then, *ZorGGroep Zin* fulfils the role of project coordinator in the prison of Hasselt.

Not only funding and local project coordination are supposed to ensure a good implementation of the project, the Royal Decrees also appoint a guidance committee in article 3§1[117]. This guidance committee is composed of members from the Directorate-General (DG) Health Care of the federal Department of Public Health, members from the Directorate-General (DG) Penitentiary Facilities of the federal Department of Justice and the local staff members responsible for the 3 pilot projects in Hasselt, Lantin and the Brussels Penitentiary Complex. In addition, 'experts', without specifying who this might be, can be invited by the committee to join the meetings.

Article 4§1 of the Royal Decree of 31/07/2020[118] further specifies how only the Director-General of the DG Health Care is mandated to alter the missions and assignments of the project with respect to its general aim, based on the project's scientific evaluation and the advice of the guidance committee.

However, the participants in the interviews noticed how some inputs are missing in the policy documents. First, the responsible policy makers have ensured scientific support from a research team at Ghent University (i.e. RECO-PRIS(bis) project). Their objectives are to support the development of an efficient screening procedure, identify efficient treatment models for drug treatment in a penitentiary context, identify preconditions to implement such a treatment model and screening procedure, and to identify an efficient monitoring or registration instrument to guarantee qualitative treatment for people

Art. 4 § 1 Koninklijk besluit van 23 Maart 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 14 Mei 2019

Art. 4 § 1 Koninklijk besluit van 11 Juni 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 22 Juli 2019

Art. 4 § 1 Koninklijk besluit van 17 December 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 15 Januari 2020

Art. 4 § 1 Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 12 Augustus 2020

[117] Art. 3 § 1 Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018

Art. 3 § 1 Koninklijk besluit van 17 Augustus 2018 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 13 September 2018

Art. 3 § 1 Koninklijk besluit van 23 Maart 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 14 Mei 2019

Art. 3 § 1 Koninklijk besluit van 11 Juni 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 22 Juli 2019

Art. 3 § 1 Koninklijk besluit van 17 December 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 15 Januari 2020

Art. 3 § 1 Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 12 Augustus 2020

[118] Art. 4 § 1 Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 12 Augustus 2020

who use drugs in prison. Yet, according to a policymaker, the scientific support and their objectives could not be explicitly defined in the Royal Decree because it is not a competency of the federal Department of Public Health. Second, the unequivocal support of prison management is an important input for any (drug treatment) programme in prison.

"I think it is perceived too much as 'just a project'. It should really be a policy choice of the prison […] to say as a Justice actor: drugs is a public health issue, but we have this issue and we will deal with it" (Participant 22)

III. Activities

The project activities are implemented in four phases (cf. Table 1). Thus, the project activities are subjective to change for each project phase. **Phase 1** of the D&D project refers to the first 6 months (15/12/2017 – 15/06/2018) of the project[119]. The main focus of the first phase is:

1. The **identification** of detained persons through a screening instrument for a more adequate guidance and referral of these persons, considering the severity and complexity of their issues.
2. The **education** of project and medical service staff concerning this screening instrument and the guidance/care of detained persons with a drug problem.
3. The **better exchange of information and knowledge** between internal and external health professionals of the detained persons to enhance continuity of care during and after detention.

However, it is not clear *how* staff should be educated on these topics, *what* more adequate 'guidance' or 'care' for detained persons with a drug problem entails, *who* the internal and external health professionals are and *what type of information* can be shared. And, besides its support for health professionals in guidance and referral, more requirements for the screening instrument (e.g. policy relevance, measuring patient or drug use characteristics, routine measurement) are not specified.

The second phase of the D&D project refers to the next six months (16/06/2018 – 15/01/2019)[120]. The same activities of the first phase are resumed, in addition to:

- **Awareness-raising and education** among detained persons and prison staff to create support for the project,
- **The evaluation of the screening instruments**,
- And, **the development of a tailor-made care trajectory** for detained persons (i.e. individual, group or motivational).

The third phase of the D&D project refers to the next one and a half year (16/01/2019 – 31/07/2020)[121] and retakes the activities formulated in phase 1 and 2. It includes that the evaluation of screening instruments should be done by the research team responsible for the evaluation of the project. Although

[119] Art. 4 § 1 Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018

[120] Art. 4 § 1 Koninklijk besluit van 17 Augustus 2018 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 13 September 2018

[121] Art. 4 § 1 Koninklijk besluit van 23 Maart 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 14 Mei 2019

Art. 4 § 1 Koninklijk besluit van 11 Juni 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 22 Juli 2019

Art. 4 § 1 Koninklijk besluit van 17 December 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 15 Januari 2020

the research team is not specified, it is known that the RECO-PRIS(bis) research team has been entrusted with this task. As such, it seems that the first six months of the D&D project (phase 1) were preparatory and experimental in their set up with a minimum of requirements, whereas the next 2 years (phase 2 and 3) allowed for a gradual build-up of the project guided by the policy guidelines.

In **the fourth phase** of the project, which runs from 01/08/2020 until 31/07/2021[122], a transformation of the project activities can be observed. The key activities of screening, education of project and medical staff, the better exchange of information and the awareness-raising and education for detained persons and prison staff, are preserved. These key activities are supplemented with additional targets, being:

- **The use of a unique screening instrument**,
- The **cooperation with 'scientific research'** *(without any further specification)* to verify the project's practices against evidence,
- The **formulation of policy recommendations** for the enhancement of the project and possible further implementation of the project at other prison wards or facilities,
- **The continuing implementation** of the approach concerning tailor-made care and continuity of care, and the D&D team is now explicitly compelled to implement this **from a primary health care position[123]**.

The policy makers, however, do not specify which screening instrument is ultimately selected or what the cooperation between the project and research team should entail.

In this respect, the issue of screening clearly has been subjected to change over the years. In the first phase of the project, policy makers state they require the use of a screening instrument by medical and project staff in the D&D project in the prison of Hasselt. Then, in the second phase, they require the evaluation of different clinically relevant screening instruments. In the third phase, policy makers emphasise how this evaluation should be managed by an appointed research team and finally in the fourth phase, a *uniform* screening instrument should be operational. The question unanswered is which screening instrument is ultimately selected and where uniformity is expected (e.g. between medical and project staff, between all pilot projects).

Other project activities have seen a similar development over the years. In the first phase, the focus seems to be on exchanging information and knowledge between health professionals, in addition to educating medical and project staff for detained persons with a drug use problem. Only later, from the second phase onwards, policy makers expand their activities towards detained persons and prison officers, alongside the development of tailor-made treatment and care trajectories.

In contrast, the set of activities on the **level of the guidance committee** remains unchanged in these policy documents over the last 4 years[124]. The guidance committee is supposed to supervise the

[122] Art. 4 § 1 Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 12 Augustus 2020

[123] Primary health care is "*a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment*" (WHO. (2021). *Primary health care*. Retrieved 30/09 from Primary health care consists of "integrated health services with an emphasis on primary care and public health functions, multisectoral policy and action and aims to empower people and communities" (WHO, 2020, p.3).

[124] Art. 3 § 2 Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018

project's activities, and facilitate the relations and transfer of data between the different services of the federal Public Health and Justice Departments, the local project coordination and experts (i.e. all members of the committee).

On the **level of the local project coordination** by *CAD Limburg* (since 2020: *ZorGGroep Zin*) a range of management and substantive activities is formulated[125]. First, management tasks are to report and participate in the guidance committee. Next, they have to monitor and financially manage the project. Also, they have to make an inventory of all needed and available resources, in addition to selecting, hiring and training staff (i.e. 1 full-time nurse, 1 full-time psychologist and a part-time physician or psychiatrist) in the first phase of the project. Furthermore, the project coordination has to organise its internal communication.

Second, policy makers formulate more substantive tasks for the local project coordination which relate closely to those formulated in the four project phases (i.e. educating project and medical service staff, raising awareness among prison officers) (cf. supra). Yet, the local project coordination is also responsible for the (internal and external) network alignment, the coordination of (internal and external) meetings and intervision moments, and support of its staff through providing advice, access to methods and information about screening. These tasks are not defined in terms of *who* the internal or external partners are for network alignment, meetings or intervision (e.g. housing or social services, prison psychosocial services). Next, the local project coordinator has the ensure the registration of data and the monitoring of indicators in deliberation with the concerned governmental bodies and researchers.

Art. 3 § 2 Koninklijk besluit van 17 Augustus 2018 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 13 September 2018

Art. 3 § 2 Koninklijk besluit van 23 Maart 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 14 Mei 2019

Art. 3 § 2 Koninklijk besluit van 11 Juni 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 22 Juli 2019

Art. 3 § 2 Koninklijk besluit van 17 December 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 15 Januari 2020

Art. 3 § 2 Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 12 Augustus 2020

[125] Art. 4 § 2 Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018

Art. 4 § 2 Koninklijk besluit van 17 Augustus 2018 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 13 September 2018

Art. 4 § 2 Koninklijk besluit van 23 Maart 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 14 Mei 2019

Art. 4 § 2 Koninklijk besluit van 11 Juni 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 22 Juli 2019

Art. 4 § 2 Koninklijk besluit van 17 December 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 15 Januari 2020

Art. 4 § 2 Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 12 Augustus 2020

What type of data needs to be registered and *which* indicators should be monitored is not further specified.

The participants in the interviews would like to accentuate the importance of cooperation between intra- and extramural staff (e.g. prison officers or medical service, community (mental) health services) as a foundation which facilitates all other activities. Currently, this cooperation is strained due to divergent competencies and responsibilities (i.e. public health or security approach), distrust of prison staff towards 'external' care professionals in prison (e.g. community mental health services) and stigma held by prison staff towards detained persons with a drug use problem. Therefore, more concrete guidelines on cooperation are indispensable. For example, it could be specified who should be involved in this cooperation and what each actor's responsibility towards the project is.

Overall, it is not clear why these project phases and the activities of the project coordination are not more integrated, since there is an overlay. In addition, participants find these activities rather vaguely defined. As such, the policy documents should provide more guidelines on the creation of differentiated care (e.g. both low and high threshold, prevention and treatment, harm reduction and abstinence), always implemented in coherence with the recovery paradigm (Anthony, 1993). These guidelines should not only consist of vision (i.e. recovery) and treatment (i.e. differentiated) but also stress its multidisciplinary approach. And, this should be aligned with existing prison practices, for example detention and reintegration trajectories.

At the moment, the respondents state that D&D project team is taking guidance from its own project proposals and not by the Royal Decrees because of the absence of a (therapeutic) vision.

IV. Outputs

For **the guidance committee**, only one output has been explicitly described in the Royal Decrees[126]: a number of meetings (without specification on the number of meetings).

Most outputs are formulated at the specific level of the **local project coordination**[127] in article 5. The main output for the local project coordination is the yearly activity report.

[126] Art. 3 § 2 Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018

Art. 3 § 2 Koninklijk besluit van 17 Augustus 2018 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 13 September 2018

Art. 3 § 2 Koninklijk besluit van 23 Maart 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 14 Mei 2019

Art. 3 § 2 Koninklijk besluit van 11 Juni 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 22 Juli 2019

Art. 3 § 2 Koninklijk besluit van 17 December 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 15 Januari 2020

Art. 3 § 2 Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 12 Augustus 2020

[127] Art. 5 Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018

This activity report should, by Royal Decree, contain:

- A financial summary
- A description of the vision and goals of the project (plus, a description of and arguments for any changes)
- A description of the achievements of the project
- A summary of attended conferences, seminars,…
- A description of how the project makes itself known internally (penitentiary) and externally (towards other institutions)
- A detailed description of the project staff (i.e. education, terms of contract, seniority and relevant qualifications)
- Policy recommendations
- And, a summary of the above.

From 2019 onwards, the policy makers also require the aggregated statistics of the target population in the yearly activity report. One could wonder *what* these statistics should entail and *how* they are to be collected, as this output is not connected to an activity (e.g. screening).

Moreover, in the description of **the four phases of the D&D project**[128] no specific outputs are linked to its activities. Yet, the implemented activities (e.g. the use of a screening instrument, education of project and medical staff, develop a tailor-made treatment or care trajectory for detained persons) clearly contribute to the yearly activity report as well, as these can be categorized under the broad category of "achievements of the project". Apparently, it is the responsibility of the local project coordination to

Art. 5 Koninklijk besluit van 17 Augustus 2018 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 13 September 2018

Art. 5 Koninklijk besluit van 23 Maart 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 14 Mei 2019

Art. 5 Koninklijk besluit van 11 Juni 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 22 Juli 2019

Art. 5 Koninklijk besluit van 17 December 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 15 Januari 2020

Art. 5 Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 12 Augustus 2020

[128] Art. 4 § 1 Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018

Art. 4 § 1 Koninklijk besluit van 17 Augustus 2018 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 13 September 2018

Art. 4 § 1 Koninklijk besluit van 23 Maart 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 14 Mei 2019

Art. 4 § 1 Koninklijk besluit van 11 Juni 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 22 Juli 2019

Art. 4 § 1 Koninklijk besluit van 17 December 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 15 Januari 2020

Art. 4 § 1 Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 12 Augustus 2020

communicate all outputs of the project towards the policy makers under the title of “achievements of the project” in a yearly activity report, which seems a more administrative instrument which keeps track of the implementation process rather than a systematic output or outcome registration method.

Some outputs are not explicitly mentioned in the policy documents, but can be deducted from the policy documents. For example, if the local project coordinator is required to make an inventory of all needed and available resource, one expects this inventory as an output. Similarly, if the project coordinator needs to organize meetings and intervision moments with internal and external partners, the yearly activity report should contain a listing of these meetings. Also, a tailor-made treatment or care trajectory has to be developed within the pilot project. At least, this should result in a description of the implemented care trajectories and treatment formats, and how a screening instrument contributes to the tailor-made character. And, if the transfer of information and knowledge between internal and external health professionals, during and after detention, should be facilitated, then procedures on how to safely manage this information have to be set up. Finally, if policy makers expect prison staff and detained persons to be educated on drug use and the project aims by the project staff, outputs should be expected, for example flyers or information meetings. In addition to deducted output, no outputs can be identified on the level of the detained persons (e.g. trajectory process indicators) or the prison (e.g. cooperation model for prison services).

Overall, the required feedback of the project team towards the project’s commissioner primarily concentrates on the implementation of the project activities, and the project’s progress. On the other hand, many expected outputs are not reported in the Royal Decrees. As such, the outputs give input for a process evaluation of the drug treatment programme but not for an outcome evaluation.

V. Outcomes

In general, policy makers expect the project to contribute to *a better continuity of care*, during and after detention.

Initially, only three outcomes are described in article 4 of the Royal Decrees[129]. The first outcome is overarching (for all three pilot projects), while the last two outcomes are expected of each local project team to achieve.

1. Policy makers want to **improve the coordination** between the three pilot prisons of Hasselt, Lantin and the Brussels Penitentiary Complex.
2. The actions taken in the project should also lead to **a more adequate referral and treatment** of detained persons with a drug problem.

[129] Art. 4 Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject “drughulpverleningsprogramma voor personen in detentie”, B.S. 11 Januari 2018

Art. 4 Koninklijk besluit van 17 Augustus 2018 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject “drughulpverleningsprogramma voor personen in detentie”, B.S. 13 September 2018

Art. 4 Koninklijk besluit van 23 Maart 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject “drughulpverleningsprogramma voor personen in detentie”, B.S. 14 Mei 2019

Art. 4 Koninklijk besluit van 11 Juni 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject “drughulpverleningsprogramma voor personen in detentie”, B.S. 22 Juli 2019

Art. 4 Koninklijk besluit van 17 December 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject “drughulpverleningsprogramma voor personen in detentie”, B.S. 15 Januari 2020

Art. 4 Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject “drughulpverleningsprogramma voor personen in detentie”, B.S. 12 Augustus 2020

3. And, these actions in this project presume an **integrated approach** towards the issue of drug treatment in detention, with an **adequate cooperation and alignment** between all partners concerned.

Next, the Royal Decrees from 2018 onwards formulate an additional outcome for the D&D project team, which is to obtain **increased acceptance of and involvement in** the project on the part of detained persons and their prison officers. From 2020 onwards, policy makers formulate the aim for the D&D project team to **further enhance the project** while policy makers want to **expand these services** to other prison wards or facilities.

These outcomes are only vaguely described, and it remains unclear what this 'enhancement of the project' entails (e.g. more staff or budget) or how exactly 'a more adequate referral and treatment' looks like (e.g. client-centred, harm reduction, increased referrals, number of 'show-ups' after referral). As the outcomes and their operationalisation is not clearly defined, the outcome evaluation will prove to be challenging.

The participants in the interviews outline what their expected outcomes are, situated both at the level of the detained persons with a drug problem and at the level of the prison. For detained persons, they expect an increased trust in care professionals and a differentiated outcome in terms of drug use (i.e. safer, controlled substance use or abstinence) depending on the individuals' needs.

"That they develop trust in healthcare professionals, that is your first goal and then we'll see. […] You need to consider the continuum. It is not only about harm reduction and not only about abstinence."

(Participant 2)

On the prison level, the expectations are to decrease drug related problems and thus increase safety, and to create a positive prison climate on the wards. At the policy level, the respondents do not only expect coordination and expansion of the pilot project(s), but also an aligned vision on penitentiary healthcare and cooperation between all involved governmental actors (i.e. federal and regional, justice and health) (cf. infra: Policy recommendations, page 422). Thus, *an integrated approach and adequate cooperation and alignment between all partners concerned* is not only restricted to the project/prison level but should be extended to supralocal policy makers as well.

Logic model:

An analysis of the policy logic found that:

- ⇨ The policy documents provide essential input and guidelines for the implementation of an intervention.
- ⇨ The activities on the level of the project and the project coordination are not sufficiently integrated.
- ⇨ An overall (therapeutic) vision on drug treatment and its implementation in a penitentiary context seems to be missing.
- ⇨ Goals and outcomes are vaguely described and could be further specified at the level of both the detained person and the prison.
- ⇨ The outputs are rather administrative, incomplete and primarily focus on the project's progress and not on its effectiveness.

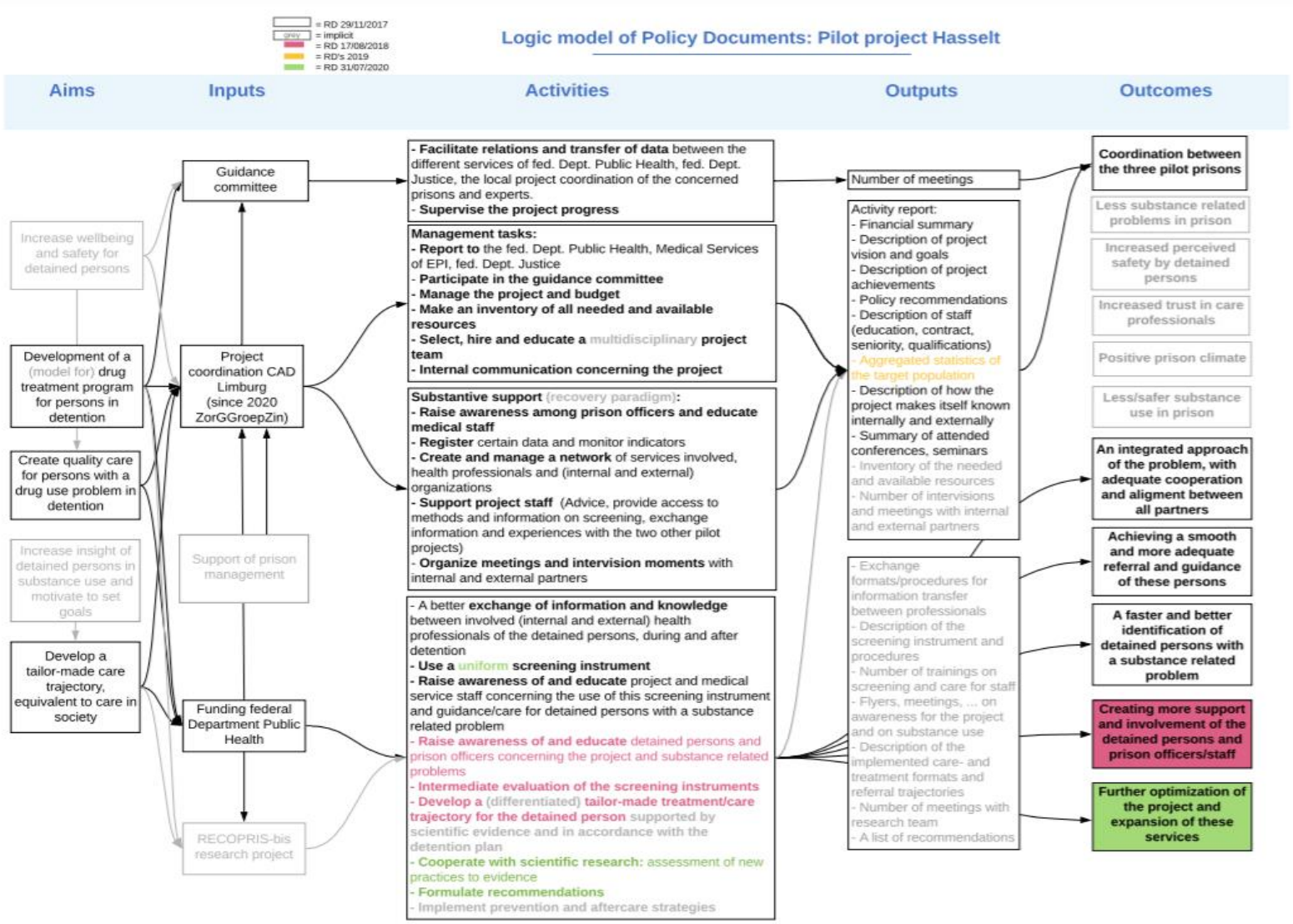

Figure 24: Logic model of the Royal Decrees concerning the drug treatment programme in the prison of Hasselt

4. Critical appraisal

In this section, we address the research question 'To what extent are logical model of the Royal Decrees consistent, coherent and logical?'. This critical appraisal of the policy theory is a first step of the process and outcome evaluation, in the sense that it allows us to control whether possible policy issues are attributable to a poor policy theory or not.

Building further on the document analysis of the Royal Decrees, we critically analyse the logic models, relying on indicators of internal validity (Funnell & Rogers, 2011). The discrepancies, inconsistencies and omissions in the policy's theory that have been raised in the section of the logic model, will be analysed further in this section.

The internal validity of the policy theory shows to what extent the policy theory is clear, realistic and logical about what the policy wants to achieve, and how the policy wants to achieve these outcomes (Funnell & Rogers, 2011). In this section, we assess this internal validity based on five indicators: Clarity of description, the outcome chain, demonstration of how the outcomes are related to the problem, the logical argument of the policy theory, and the articulation of mechanisms for change.

I. Clarity of the description

A first measure of internal validity is the 'clarity of description'. It assesses whether the policy documents describe how the policy works with enough detail.

First, a comprehensive **problem description** is lacking. In none of the policy documents, the policy makers illustrate the extent of the problem, its causes or consequences. Therefore, it is difficult to comprehend how the project should tackle the issue of drug use in prison, and how the expected outcomes are desirable or feasible. However, problem descriptions are not common in Royal Decrees as this is a legislative document. Probably, the policy makers rely on the problem description of the project proposals. These project proposals, written by *CAD limburg/ZorGGroep Zin*, include a detailed contemporary context, policy and treatment analysis for persons who use drugs in the prison of Hasselt, yet the prevalence and profile of drug using persons in the Hasselt prison is still missing. Thus, the policy makers have an up-to-date (yet incomplete) problem description[130] to rely on for the formulation of the project goals, inputs, activities, outputs and intended outcomes.

The **activities** in the Royal Decrees[131] for the D&D project in the prison of Hasselt are not described with sufficient detail. The participants in the interviews consider the content of these Royal Decrees

[130] A problem description, including drug use prevalence, will be provided by the PRS20 research (partners: Sciensano & HoGent). The results of this study are expected in 2022.

[131] Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018

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rather "vague" and "too general", which gives too much leeway for the project in terms of implementation and expected outcomes.

"I think it is necessary to make things more detailed and to operationalise them. The things described [in the Royal Decrees] are rather general. […] What is described here applies to any project, it's a passe-partout […] and not specifically adapted to drug treatment."

(Participant 19)

For example, key activities for the local project coordination are "to register certain data and monitor indicators" or "raise awareness among prison officers" without any specification. In some cases, activities are more illustrated, such as the activity to "support project staff" where policy makers formulate additional activities in order to clarify how this activity should be implemented (e.g. provide advice, provide access to methods and information on screening). However, even with these illustrations, the exact definition of the activity remains vague and thus gives too much leeway for their implementation.

Similar to the activities, most substantive **outputs** are rather vaguely formulated. For example, one of the expected outputs is "a description of the achievements of the project" which could contain any output of any activity implemented in the project. In contrast, administrative outputs seem to be quite clearly formulated, for example provision of "the detailed description of the project staff (education, terms of contract, seniority and relevant qualifications)". Meanwhile, this ambiguity is also considered an advantage by the respondents, as this gives freedom during the pilot phase to experiment and try out new, innovative practices based on local needs.

"What I missed the most is an underlying vision but at the same time it is an advantage. It enabled us to reflect upon it ourselves. Because it is a pilot project, we had the liberty to try out things."

(Participant 2)

In any case, the policy documents clearly describe the available **resources** for the project[132] (i.e. funding, local project coordination, guidance committee) and policy makers intend to assess the

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Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 12 Augustus 2020

[132] Art. 1 & 3 Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018

Art. 1 & 3 Koninklijk besluit van 17 Augustus 2018 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 13 September 2018

Art. 1 & 3 Koninklijk besluit van 23 Maart 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 14 Mei 2019

Art. 1 & 3 Koninklijk besluit van 11 Juni 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 22 Juli 2019

Art. 1 & 3 Koninklijk besluit van 17 December 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 15 Januari 2020

available and needed resources (cf. activities). It seems that the resources for this project are the only section reported on with such accuracy.

While detention is a very particular contextual aspect, which is likely to influence the outcomes of the project, it is hardly mentioned in the concerned Royal Decrees.

"It seems as if a project falls from above and lands into prison, without taking into account prison reality. That is, I believe, a blind spot."

(Participant 19)

At only three instances the Royal Decrees refer to the prison context[133]. First, the aim is to develop care trajectories in check with the specific circumstances of detention. Second, when project and medical staff should be trained in using screening instrument and treating detained persons with a drug problem, they should be trained in the specific elements of drug treatment *in prison*. Third, when raising awareness among prison officers and staff, this education should concern drugs *in prisons*. What exactly (the effect of the) penitentiary context is, either on developing care trajectories, training and treatment or awareness-raising, is not further explained.

Yet, the participants in the interviews stress the importance of the penitentiary context, in particular the cooperation with and division of roles between all prison staff (e.g. management, prison officers, psychosocial/medical care and welfare staff) in order to successfully implement a drug treatment programme. As such, the project is described in the policy documents as "an island", not connected with other services and staff in the prison.

If we consider the **connection** between activities, outputs and outcomes, it is notable that the vaguely described activities in the policy document are not directly connected with a clearly defined output. The only output directly linked to an activity, is the number of meetings which results from the activities of the guidance committee.

In a like manner, the outcomes described in the policy are formulated without a clear operationalisation (i.e. outputs) and thus, are not well connected to the expected outputs. For example, one of the outcomes of the project is a "better exchange of information and knowledge between involved internal and external care professionals of the detained person". There is no further specification of who these

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[133] Art. 4 § 1 Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018

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Art. 4 § 1 Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 12 Augustus 2020

care professionals may be (e.g. social services, psychosocial services) or which information and knowledge exactly should be exchanged. Similarly, policy makers hope to realise “a smoother and more adequate referral and guidance of [detained persons with a substance related problem]”. However, a clear definition of what a smooth and adequate referral and guidance entails is missing.

In conclusion, the mostly vague formulation and connection of planned activities, outputs and outcomes, and how these elements would contribute to addressing the problem, raises difficulties for the project implementation and certainly its output and outcome evaluation. Besides, it remains unclear to what extend these policy documents build upon an up-to-date problem description and the prison as a very specific implementation context is rarely considered.

II. The outcomes chain

A second assessment of the policy's internal validity questions whether it is built around the outcomes it wants to achieve. Are the outcomes central to the logic model, or are there other elements (e.g. activities, inputs) that are accentuated?

The policy documents concerning the D&D project in the prison of Hasselt largely focus on the project activities and much less on the desired outcomes. In effect, the policy makers do not distinguish between short-, medium- and long-term outcomes. They assume the project activities lead to an outcome, however do not identify *how* activities might influence these outcomes. Also, the outcomes are only formulated on the organisational and policy level without consideration of outcomes on the level of the individual (i.e. detained person) or society. For example, there is no reference to whether the treatment programme aims to reduce the drug use in detained persons or wants to contribute to a more inclusive (mental) healthcare in general.

The focus on project activities instead of outcomes enables a process evaluation, however is a challenge for an output and outcome evaluation. As such, these policy documents would benefit from reformulating the activities into expected outputs and outcomes, and to extend these outcomes to the individual or societal level.

III. Demonstration of how desired outcomes relate to addressing the problem

A third measure of internal validity questions whether the policy indicates how the outcomes address the problem(s). This means that we assess if and how the problem(s) that gave rise to the establishment of the policy are linked to the intended outcomes.

Without a clear problem description in the Royal Decrees, and an incomplete description in the project proposals, it is difficult to assess whether the desired outcomes relate to the problem of drug treatment in detention. If we then focus on how the project aims are linked to its outcomes, they seem to align with each other. The general aim of the pilot project is to develop a high-quality drug treatment programme for detained persons through a tailor-made care trajectory, equivalent to care in society. The desired outcomes focus on identification of detained persons with a drug problem, their referral and/or guidance through an integrated approach in alignment with different partners (i.e. a continuum of care). In addition, from 2020[134] onwards policy makers express the wish to expand these services to other prison wards or facilities, which indicates they want to provide these services to even more detained persons.

However, aspects of the project aims, such as *tailor-made* care which is *equivalent to care in society,* are not repeated nor operationalised in the project’s outputs or outcomes. Then, how are these essential

[134] Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject “drughulpverleningsprogramma voor personen in detentie”, B.S. 12 Augustus 2020

treatment aspects guaranteed? In this respect, the more general question arises how the quality and continuity of care in this project (or in the future in all prisons) will be monitored.

In sum, the policy documents on the "drug treatment programme for detained persons" in the prison of Hasselt[135] would benefit from a clear problem description to assess whether the project's aims and outcomes are adequate and feasible. In addition, the outcomes and outputs should be operationalised more precisely, to ensure that achievement of these goals can be monitored.

IV. The logical argument

A fourth assessment of internal validity is 'the strength of the logical argument'. This means that we measure the extent to which the policy is 'logic' in terms of coherence, sequence and completeness.

The logic model, based on the six Royal Decrees concerning the D&D project in the prison of Hasselt[19], is not entirely logical. First, in terms of **sequence**, the activities formulated do not logically follow from the project aims. Rather, the activities are connected to an executive body (e.g. guidance committee, project (coordination)) and not to the aims. Similarly, these executive bodies are responsible for the output of these activities. This reveals a disproportionate emphasis of the policy on the project activities, managed by these executive bodies.

As highlighted before, not every activity is connected to its own output, the outputs are not clearly connected to the outcomes, and some outputs and outcomes are missing in the policy documents. This is an apparent gap in the **sequence, completeness and coherence** of the policy. It seems that the activities, reported as outputs in the yearly activity report should 'automatically' lead to the outcome of an integrated approach towards detained persons with a drug problem, consisting of screening, treatment and network building.

While the project aims and outcomes are more or less consistent (cf. page 402), the activities and outputs do not necessary relate to these aims and outcomes. In this respect, it seems clear *what* the policy makers hope to accomplish with the project, however, *how* to accomplish this remains vague and unstructured.

Last, only the activities, outputs and outcomes formulated on the level of the guidance committee seem logical. The policy documents clearly describe the tasks of the guidance committee (i.e. supervision, facilitate relations, transfer data), the output (i.e. number of meetings), the outcome (i.e. coordination of the three pilot projects in Hasselt, Lantin and the Brussels Penitentiary Complex) and their sequence.

[135] Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018

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This leads us to conclude that the policy is, for the most part, not logical. It lacks coherence, sequence and completeness primarily concerning the activities, outputs and outcomes of the D&D project.

V. Mechanisms for change

The last assessment of internal validity is 'the articulation of the mechanisms for change'. This entails the question 'Does the policy clearly identify the assumed mechanisms of change that underpin its selection of outcomes and activities'. Funnell & Rogers (2011) describe these mechanisms for change as the 'because' statements: if A happens, then it will result in B, because of C. 'C' is the mechanism for change in this case.

For the D&D project, clear 'if-then' statements are described in the policy documents concerning the drug treatment project in the prison of Hasselt, mainly in terms of activities and outcomes. The general idea is that the implementation of an activity (*if*), will lead to a certain outcome (*then*). For example, the project aim is to deliver high-quality care for persons in detention with a drug related problem through the provision of substantive (e.g. expertise, education) and organisational (e.g. staff) support in the pilot prisons. Thus, *if* we support the pilot prisons substantively and organisationally, *then* high-quality care for persons in detention will follow.

In another case, the policy declares how the project better identifies detained persons with a drug related problem through the use of a screening instrument. And, *if* we raise awareness and educate prison officers and detained persons, *then* this will increase their involvement with the project and drug issues in prison. Similarly, the intervision moments with project staff of all pilot prisons should lead to a better coordination of these projects. Last, *if* a smooth cooperation and exchange of information between all involved care professionals is developed, *then* this will improve continuity of care. A general '*if*' is that these activities are dependent on an integrated approach and adequate cooperation between all partners concerned[136].

However, in many other cases, especially concerning the activities and outputs, no 'if-then' statements are made. As such, outputs are not directly related to any activities or their desired outcomes.

Despite some clear 'if-then' statements in the policy, no further elaboration has been made concerning the mechanism for change in this project. In that respect, it remains obscure if any of the underlying processes will actually address the (unspecified) needs or ensure the effective realisation of the project aims.

[136] Art. 4 § 1 Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018

Art. 4 § 1 Koninklijk besluit van 17 Augustus 2018 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 13 September 2018

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Art. 4 § 1 Koninklijk besluit van 11 Juni 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 22 Juli 2019

Art. 4 § 1 Koninklijk besluit van 17 December 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 15 Januari 2020

Art. 4 § 1 Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 12 Augustus 2020

Critical appraisal:

A critical appraisal of the policy logic found that:

- ⇨ The policy is, for the most part, not logical.
- ⇨ Without a complete problem description it is not possible to assess whether the formulated aims, resources, activities, outputs and expected outcomes are adequate and feasible.
- ⇨ The focus of the policy is more on activities then on outcomes, which enables a process evaluation but might challenge the effectiveness and outcome evaluation of the project.
- ⇨ Despite some clear 'if-then' statements (e.g. screening will lead to better detection of drug using persons, education of prison officers will lead to more involvement in the project), the mechanisms for change in this project are not defined in the policy.

5. Process evaluation

The key research questions of the process evaluation are:

1. To what extent have the activities set out in the Royal Decrees been realized?
2. What challenges obstructed and which enabling factors facilitated the implementation of the activities set out these Royal Decrees?

The answer to these research questions is based upon the 23 semi-structured interviews with key stakeholders to the drugs treatment programme in the prison of Hasselt and the document analysis of the project's activity reports. The research questions will be answered in the subsequent paragraphs.

I. Implementation

Despite their vague description, the D&D project team (consisting of healthcare professionals from ZorGGroep Zin) has implemented all activities, as set out in the Royal Decrees[137], in their entirety. Moreover, they defined some activities as of key importance and thus emphasised these in the implementation of the project. For example, the D&D project team considered the **screening procedure, group moments for detained persons, education and involvement of prison officers and the scientific support of the project as essential**, giving them a key position in the

[137] Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018

Koninklijk besluit van 17 Augustus 2018 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 13 September 2018

Koninklijk besluit van 23 Maart 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 14 Mei 2019

Koninklijk besluit van 11 Juni 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 22 Juli 2019

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Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 12 Augustus 2020

implementation phase. Meanwhile, their attitude was to be **'available and approachable'** for their colleagues, and to work in a connective way.

"We stop by frequently and make our presence known. We are visible and approachable. If there is anything, they know where to find us. They know who we are because we stop by frequently, even if only for a short conversation or to drink a cup of coffee. If there is anything, such as a detained person who shows difficult behaviour or they don't know what to do with them, they can approach us every day. I think that's why our project is doing so well."

(Participant 6)

It is exactly this approach which ensured the structural integration of the D&D project team in the prison of Hasselt. They are no longer seen as an 'external healthcare service' and have established **good working relations with most prison staff** (e.g. prison officers, judicial welfare professionals, psychosocial prison service and prison management), except for the prison medical service.

The D&D project team has even extended or supplemented the project's framework. As such, they explicitly adopted an **integral and integrated approach** according to the biopsychosocial model (Engel, 1977) and the recovery paradigm (Anthony, 1993). In accordance with the division between imprisonment phases of the European Monitoring Centre for Drugs and Drug Addiction (2021) (cf. page 384), **tiered treatment activities** have been developed. In addition, they primarily focus on persons who use drugs in prison, yet they welcome any vulnerable detained person (with a history of drug use).

"To access our project there needs to be drug use in the past or the present. Well, everyone has smoked a joint once so we consider that drug use in the past. In the end, it is not always clear if there is any drug use or not. But, for our credibility on the prison ward you cannot say 'that person is not using [drugs], so we are not going to talk to him'."

(Participant 20)

Some activities are part of an **ongoing process**, such as maintaining good working relations with prison officers, or informing and educating detained persons and prison officers. The liaison with the prison medical service has been arduous from the start, and needs continuing attention from all key stakeholders (i.e. staff from both teams, prison management, policy makers). The participants in the interviews acknowledge that the **network with external partners** (e.g. community mental health and drug treatment services, social and welfare services) could be enlarged **and the follow-up** after release of detained persons who use(d) drugs could be improved. The D&D project team has good contacts with a few external partners, mainly through the part-time employment of D&D team members in these services (e.g. an inpatient mental health facility, an outpatient drug treatment service). Yet, the participants indicate that the D&D team could increase efforts to introduce themselves to other external partners and reflect on aligning care trajectories. Last, while there is a lot of attention for **the screening procedure**, the data collected through them are not systematically analysed on a group level due to limited (human) resources.

In conclusion, in terms of a process evaluation the D&D project team has implemented all required activities, some of which need ongoing attention, and thus achieved all outcomes defined by the Royal Decrees[138]:

[138] Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018

Koninklijk besluit van 17 Augustus 2018 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 13 September 2018

- To establish an integrated approach of the problem, with adequate cooperation and alignment between al partners concerned.
- To achieve a smooth and more adequate referral and guidance of detained persons with a substance related problem.
- To achieve a faster and better identification of detained persons with a substance related problem.
- To create more support and involvement of the detained persons and prison officers/staff.

An adapted logic model presenting extensions and refinements made by the D&D project team, based on the document analysis of the project's activity reports and the data of the semi-structured interviews, is presented in Figure 4.

II. Challenges and facilitators

Challenges

Challenges to implementing the drug treatment project in the prison of Hasselt can be situated at 3 levels, i.e. the staff level, organization level and policy level. They are supplemented with the challenge of referral after release and challenges concerning the COVID-19 health crisis. Surprisingly, the respondents identified no challenges in engaging with detained persons for drug treatment.

At the staff level, the D&D project team initially encountered **distrust from prison staff** (i.e. prison officers and medical service) towards this new project. The distrust had primarily developed from earlier negative experiences with temporary projects in prison. In addition, prison officers are not always knowledgeable on drugs and drug treatment, which caused a reluctance in some of the prison officers to cooperate with the D&D project team. Similarly, the collaboration with staff members of the prison medical service has been characterized by friction due to understaffing of the medical service and a perceived threat of their position and role as care taker. However, the participants explain that this friction is probably mainly a local phenomenon in the prison of Hasselt, and may not always be a problem in other prison facilities. In any case, the D&D project team and the prison medical service in Hasselt have failed to develop a shared approach towards drugs in detention, an adequate allocation of tasks in drug treatment and corresponding communication flow.

"The counselling role [of prison medical service] has eroded, among other things through their low staff capacity. That's why they considered the D&D project in a way as threatening, because at the start they thought it would be extra work for them but also… [hesitation] I'm just going to say as it is, I think they considered is as threatening that they [D&D project team] actually listened to the detained persons and could make time for them, and they could not. […] The cooperation was difficult and I think it still is."

(Participant 9)

Koninklijk besluit van 23 Maart 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 14 Mei 2019

Koninklijk besluit van 11 Juni 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 22 Juli 2019

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Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 12 Augustus 2020

Similarly, some participants have encapsulated these frictions in the statement that this concerns **tension between the logic of justice in internal prison staff,** (i.e. prison officers and the medical service), **and the logic of healthcare in 'external' welfare and mental health staff**.

At the level of the organization, participants in the interviews identify the **cumbersome prison system** with its rusty structures and procedures as a challenge to implement any new project. Every prison service seems to be working on their own 'island', which is exacerbated by **ineffective communication flows**. For example, there are no automated GDPR-proof information exchange possibilities (e.g. electronic case file) or procedures on who needs to be informed in case of suspected drug use (e.g. prison medical service, D&D project or both). Another challenge is the extensive power of the prison officers **syndicate**. They have the ability to hinder any project activity (e.g. adjustment of regime, organization of group moments).

"The fact that external partners do not get the opportunity to do their work because of a strike or insufficient staff presence, that, according to me, gives some kind of ranking… That means that prison officers can decide what will or will not… And that is something that according to me, in an ideal world, should not be able to happen. Essentially we are equal, partners of each other and we should ensure that we come to the best possible solution for detained persons.[…] Now there is too much focus on pure security but security is not static. You create security by working with someone and this dynamic security contributes to a better prison climate for everyone."

(Participant 17)

At the policy level, the **fragmentation of competencies** between the federal justice and healthcare and the regional welfare (and justice) sector make the implementation of an integrated and integral drug treatment programme in prison a complex issue. For example, the management of prisons is a competency of the federal Justice department, inpatient mental health treatment is a competency of the federal department of Public Health, drug prevention interventions and outpatient mental health treatment are a competency of the regional Welfare department and since 2021 in the Flanders region, welfare services in prison have become a competency of a new regional Justice department. Furthermore, penitentiary health is a competency at limbo and the transfer of this competency from the federal Justice department towards the federal department of Public health is awaited. In any case, a continuous dialogue and harmonisation of activities is and will be necessary at both the policy (i.e. responsible governmental bodies) and organization level (i.e. prison management), whether or not the federal Public Health Department will be(come) responsible.

Besides, the **short-term financing of the pilot project** has created uncertainty within the D&D project team and full prison staff about the sustainability of the project, thus reducing expectations and perhaps even efforts in prison staff to engage with the project.

Another challenge that has been outlined by the participants in the interviews, concerns the **low accessibility of drug treatment after release**. For example, few general practitioners are familiar with opioid substitute treatment, and the referral to residential drug treatment facilities or mental health care remains difficult due to the stigma of detention or the exclusion criteria of these facilities (e.g. psychiatric illness, dual diagnosis). As such, it is challenging to consolidate continuity of care and ensure a smooth referral as an expected outcome of this project.

"I would prefer to have a direct cooperation with the general practitioner who will monitor that person. […] That we contact him and send him a medical report on what happened and what the goal is. Because substitution outside, my colleagues are afraid to do that. […] The colleagues do not like that because they are not knowledgeable on it [substitution treatment] and don't know what the consequences are."

(Participant 17)

Last, the **COVID-19 health crisis** and health measures have put a strain on the implementation of the project. Organizing group activities or individual follow-up has been difficult or even impossible. Yet, the D&D project team were granted access to the prison throughout the lockdown periods and were able to reach out to the detained persons in a creative way (e.g. short conversations at the cell door, provision of leisure materials).

Facilitators

The prison of Hasselt accommodates a drug free ward in cooperation with *Katarsis vzw* and *ZorGGroep Zin* since 2015. In this respect, drug use was already a policy priority in the prison of Hasselt, some prison staff was **familiar with the issue of drug treatment** and the **external drug treatment partners were known**. Especially the person of the D&D project coordinator, connected to both *Katarsis vzw* and *ZorGGroep Zin*, is considered an asset because of her accessibility and knowledgeability.

Many participants stress that the implementation of the D&D pilot project has been largely enabled by the entire D&D project team. **The team is praised for its accessibility**, both in location and in attitude, **and their respect for prison staff**. For example, at the start of the project, they took the time to experience every prison working place (e.g. prison officers, prison kitchen) and thus talk to all prison staff. This experiential approach has been positively appreciated by prison staff, and created, in addition to the good results of the D&D project activities, trust in the project.

"They come to the workplace, something I've been asking for since years. They are the first who come to the workplace and talk at the cell door. Judicial welfare services or psychosocial services, you rarely see them, but they [D&D project team] do it."

(Participant 11)

Not only the D&D project team has made a good impression, other prison staff (e.g. prison psychiatrist, prison management) are complimented for their **flexible attitude towards D&D project activities** as well. For example, prison management would facilitate conditions for the D&D team to implement their activities (e.g. no attendance lists needed). Where the cooperation between the D&D project team and the prison medical service proved to be challenging, the use of **a liaison staff member** has been considered helpful to align both teams.

At the policy level, the D&D pilot project has received **extensive support from policy makers** through the guidance committee, but also from **the RECO-PRIS(bis) academic team and the Hasselt prison management**. The latter has been identified as an essential precondition to implement any prison project.

"If you implement something like that, you have to firmly support that as prison management. Otherwise it [treatment programme] doesn't stand a change in such an organisation."

(Participant 18)

To a lesser extent, the participants in the interviews point out how the **small scale and relatively new infrastructure of the prison of Hasselt** is well suited for the initiation of pilot projects compared to other prison facilities.

Overcoming challenges

Considering the challenges and enabling factors for the implementation of the D&D pilot project in the prison of Hasselt, the participants in the interviews proposed strategies to overcome these challenges.

First, it is essential to develop a **cooperation model at the local and supralocal policy level**, between all actors in prison and especially with the support of prison management and prison officers. This cooperation model should allow for **the development of a positive prison climate** for all prison staff and the detained persons, in order to create a context where positive change (e.g. drug treatment) can

happen. In this positive prison climate, **dynamic security** should be equally important to static security (United Nations Office on Drugs and Crime, 2015).

Second, the **project team** should always be selected based on their accessible character, their respectful attitude for justice logics and the competence to build trust between different prison services. In addition, the familiarity of the project team members with prison contexts and/or drug treatment enables good results during the project implementation and in turn also increases trust between the project and prison services.

Process evaluation:

A process evaluation of the implementation of the D&D pilot project in the prison of Hasselt found that:

- ⇨ In terms of a process evaluation, all activities and outcomes defined by the Royal Decrees are implemented by the D&D project team.
- ⇨ Challenges are met at the staff (e.g. distrust), organizational (e.g. inadequate cooperation) and policy (e.g. fragmentation in competencies) level.
- ⇨ Barriers are identified in the referral towards healthcare services after release and the COVID-19 health crisis has put a strain on the implementation of the project.
- ⇨ The implementation of the pilot project was enabled by positive and respectful attitude of the D&D project team, and their support by prison management and policy makers.
- ⇨ It is essential to develop a local and supralocal cooperation model between all justice, healthcare and welfare actors involved, which includes working towards a positive prison climate.

6. Alignment with drug needs in prison

Next, we try to understand to what extent the objectives and activities of the drug treatment pilot project, set out in the Royal Decrees[139], are in line with the current drug needs in the prison of Hasselt.

For the drug treatment policy to adequately answer to the needs of persons who use drugs in prison, the participants in the interviews identify a large number of steps to take:

[139] Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject “drughulpverleningsprogramma voor personen in detentie”, B.S. 11 Januari 2018

Koninklijk besluit van 17 Augustus 2018 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject “drughulpverleningsprogramma voor personen in detentie”, B.S. 13 September 2018

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Koninklijk besluit van 11 Juni 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject “drughulpverleningsprogramma voor personen in detentie”, B.S. 22 Juli 2019

Koninklijk besluit van 17 December 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject “drughulpverleningsprogramma voor personen in detentie”, B.S. 15 Januari 2020

Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject “drughulpverleningsprogramma voor personen in detentie”, B.S. 12 Augustus 2020

- The policy should preferably fit within a **broader mental health perspective** and entail a **global and integrated policy** concerning drug treatment (cf. Four Pillars approach: Prevention, Harm Reduction, Enforcement and Treatment). Therefore, a policy supported by all governmental bodies involved is essential. In the previous section, the importance of a **local and supralocal cooperation model** to this end has been outlined (cf. page 409).
- In line with the previous argument, the **role of the judicial context** in drug treatment should be better integrated. For example, the care trajectory for persons who use drugs in prison should ideally be aligned with their judicial trajectory. In particular, the care trajectory should always be organized by (mental) health professionals which are bound by professional confidentiality to ensure its therapeutic nature, in contrast to judicial actors.
- The policy documents currently lack a **vision on treatment**, which is preferably recovery oriented, and this needs to be connected to the prison context in which treatment is taking place. In a positive prison climate, recovery is more likely to occur.
- More emphasis is needed on a **differentiated care offer**, not only according to phase of imprisonment (cf. Figure 1, introduction), but also for vulnerable groups in prison and their characteristics (e.g. ethnic-religious, gender, trauma).
- Moreover, to adequately address the needs of persons who use drugs in prison, these drug treatment programmes should be **implemented at all wards of the prison of Hasselt, and by extension in all Belgian prisons**.
- Without denying the importance of a **screening procedure**, the participants are critical of the weight attached to it. They stress that equal importance should be attributed to the organisation of a differentiated **treatment offer and prevention initiatives**.
- In addition, a structured screening procedure is valuable, however it can have adverse effects on the development of trust during the initiation of a therapeutic process. And, the **development of trust in healthcare professionals** with this often distrustful population is crucial. As such, the D&D project team considers establishing trust as an imperative outcome of the treatment programme (cf. Figure 4). In many cases, persons who use drugs in prison are primarily looking for someone to talk to, whether this takes place during group moments, individual conversations or the screening procedure.

Overall, the policy on drug treatment programmes seems to be developed over the heads of persons who use drugs in prison. While these remarks made by the respondents give guidance towards a policy adapted to the needs of persons who use drugs in prison, above all, they claim is essential to listen to these persons and their experienced needs in prison.

7. Output and outcome evaluation

First, we aim to understand what the D&D pilot project in the prison of Hasselt has realized since its start in 2017 to identify whether, next to the process-based outcomes (cf. page 405), any other outputs and outcomes have been realised. These conclusions are based on the data of the 23 semi-structured interviews and the analysis of the project activity reports. Next, an interest is taken in the registration of data, or output, within the D&D project and which data would preferably be registered to evaluate the effectiveness of the intervention.

I. Realisations of the project

Realisations of the D&D pilot project in the prison of Hasselt can be situated at three levels. At the micro level, realisations concerning persons who use drugs in prison and prison staff are described. At the meso level, the realisations concerning the prison organization are described and at the macro level policy realisations are reported. For the realisations on the micro level, we also refer to the results of the RECO-PRIS research project, that mapped the lived experience of detained persons with the D&D project in the prison of Hasselt (Debaere et al., 2020).

Micro level

Due to the implementation of the D&D pilot project in the prison of Hasselt, detained persons at the designated wards have been able to access low-threshold therapeutic activities organised by (mental) health professionals which are bound by professional confidentiality. Participants in the interviews and the RECO-PRIS research project see many positive effects of these therapeutic activities among detained persons:

- Insight in and coping with their drug use,
- Lower or safer addictive medication and drug usage,
- Increased confidence in (mental) health professionals,
- Increased self-determination,
- And, the feeling of being heard and treated like a human being.

At the same time, the efforts of the D&D project team on educating prison officers have proven to be effective. The prison officers hold a different, more understanding attitude towards persons using drugs.

"If we, through some information or setting exemplary behaviour, can enable a different interaction between prison staff and detained persons, then I think we have booked a great success."

(Participant 6)

If these prison officers suspect any problem with drugs in a detained persons, their reflex is now to signal this to the D&D project team.

"Sometimes, for something to happen, you need to break through a wall. That doesn't always work with a uniform and then we ask the D&D team to talk to them."

(Participant 11)

Meso level

The participants in the interviews indicate multiple realisations at the organizational level. The first is the development of a **needs-based accessible range of therapeutic activities** (e.g. medical, psychiatric and psychosocial consults, peer support groups, educational sessions). The participation to these therapeutic activities can, despite of the exclusion criteria and stigma often held by external mental health facilities, enable admission due to the demonstrated motivation for treatment and therapeutic process of the detained person. In the meantime, good relations have developed between the D&D project team and local external healthcare partners (e.g. psychiatric hospital, social services) which also **facilitates referral and thus continuity of care**.

As mentioned before, the D&D project team and its activities have been **well integrated in the prison** of Hasselt, upholding good working relations with different prison services (except for the friction with the prison medical service).

"Once the D&D project has been labelled as the 'missing piece of the puzzle', and that's true. We are very connective, we have a very connective effect between prison services but also between prison officers and prison services."

(Participant 2)

They have educated prison staff on drugs, addiction and its related risks, which **increased awareness** not only among prison staff but also in prison management. For prison management, the D&D project team has become an vital source of information on drug use rates and issues in the prison. This information is essential to **inform prison drug policy**. For example, the D&D project team has developed a policy on benzodiazepine use in prison.

In cooperation with prison management, the D&D project has also been able to create **differentiated regimes** according to the needs of detained persons who (wish not to) use drugs. For example, a 'safe

ward' has been created for those vulnerable persons (some even without a drug using problem) who choose for a drug free detention.

"I find it important that colleagues see how there are more possibilities than you think. Because such a care offer… Okay, not everyone needs a drug free ward but more is possible than you think. […] You need to think more in terms of possibilities than limitations."

(Participant 9)

Overall, the D&D project team succeeded in **introducing a healthcare logic in prison**, resulting in an attentive and supportive attitude of prison staff towards persons who use drugs. Their activities and cooperation with all services involved have enabled a safer and more peaceful atmosphere at prison wards, and in general **a more positive prison climate**. This prison climate is identified as a mechanism of change.

"It created a lot of opportunities to evolve the prison towards something less totalitarian in approach and more towards a place with possibilities for self-determination. Creating the climate where these changes are possible, that's not to be underestimated. […] The prison climate is affected in a healthy way so in itself it creates opportunities to live a healthier drugfree life."

(Participant 18)

Macro level

The participants in the interviews are enthusiastic about the initiative of the federal department of Public Health to pilot test a drug treatment programme in prison. They consider it favourable that **a public health logic is increasingly adopted in prison** through these projects.

"I've always found it so frustrating there was nothing [drug treatment] in prison. While the needs are immense, really. And now, with the D&D project finally something is changing. [The department of] Public health is supporting it, they want to further implement it. Thank God!" (Participant 5)

During the pilot phase of this drug treatment programme, **new working relations were developed between staff from the Public Health and Justice administration and people from the Cabinets of the Ministers of Health and Justice**, which increases efficient cooperation at the supralocal policy level.

While there is growing support for a healthcare based approach towards drug use in prisons, and the federal department of Public Health is actively taken the lead, participants hope this support and these initiatives continue to grow. For now, there is still insufficient consideration of drug issues in prisons on the policy level.

The most important is, I think, that the prison has become a warmer place."

(Participant 20)

In conclusion, and as reflected in Figure 4, the D&D project team in the prison of Hasselt has realised far more than originally indicated in the policy framework (i.e. Royal Decrees), in terms of activities but also regarding outputs and outcomes. While the outputs and outcomes indicated in the Royal Decrees reveal a primary focus of the policy makers on the process evaluation of the project, its realisations inform possible outputs and outcomes for an effectiveness evaluation.

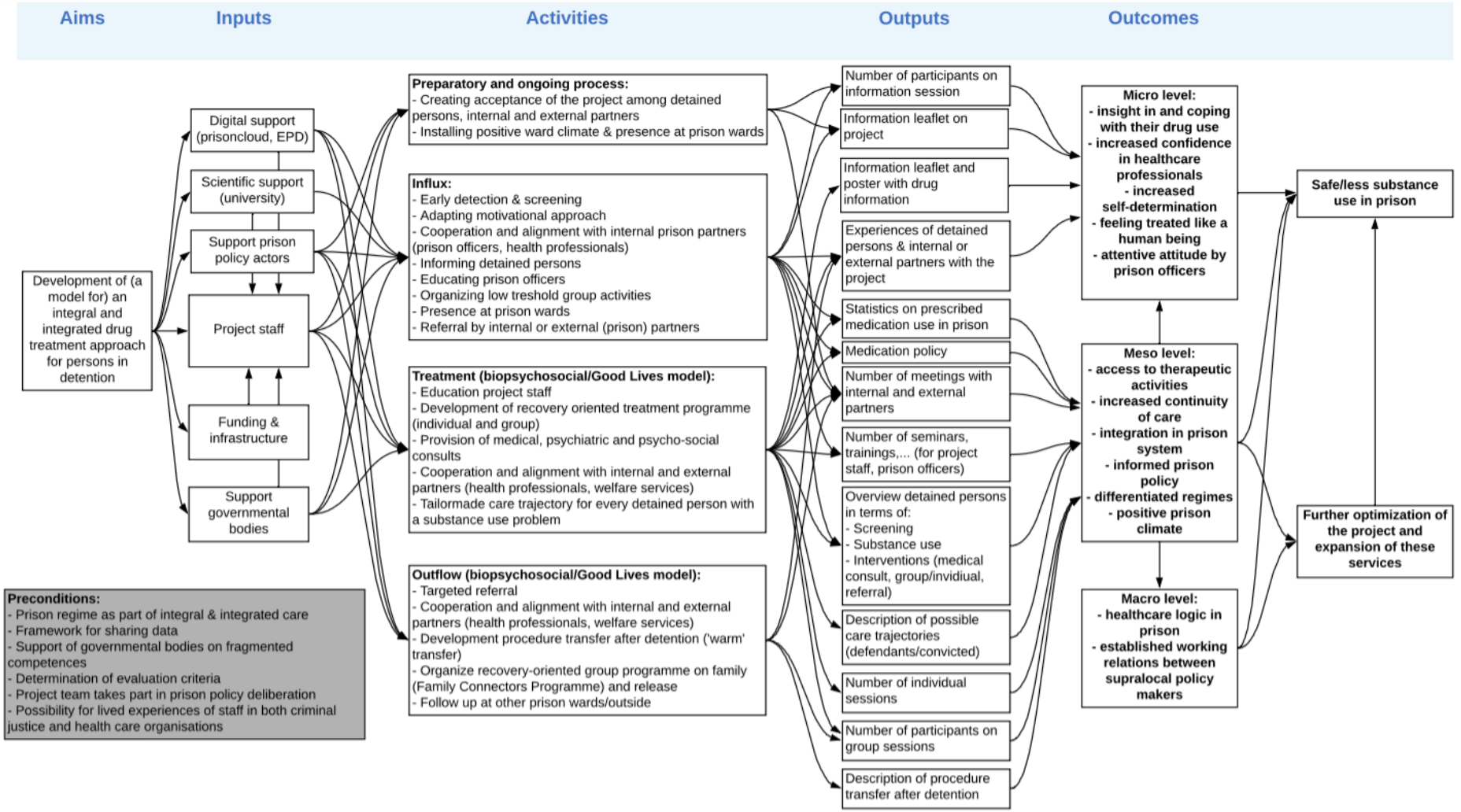

Figure 25: Logic model of the pilot project in Hasselt

II. Monitoring realisations

Contemporary registration

Next to product outputs (i.e. information leaflets, addictive medication policy, description of care trajectories and an 'after release' procedure), the D&D project generates qualitative and quantitative data. These outputs are required for and extensively described in their periodical activity reports, commissioned by the federal department of Public Health, and are summarized here.

The D&D project team consistently registers:

- The number of participants to the information sessions
- The number of individual sessions
- The number of group sessions and their participants
- Case reports on detained persons in the D&D project (i.e. whether screened, characteristics of drug use, interventions and whether referred to (which) external services
- Statistics on prescribed medication (i.e. benzodiazepines, Suboxone/Methadone, antipsychotics, antidepressants, stimulants/Strattera)
- The number of meetings with prison staff and external healthcare professionals
- The number of seminars and trainings for the D&D project team
- The number of seminars and trainings organized by the D&D project team for prison staff

The first three types of data in the list (i.e. participants to information sessions, group and individual sessions) aim to describe **the reach of the D&D project activities**. Next, the D&D project team keeps track of **individual care trajectories** through the case reports and statistics on prescribed medication. They record the characteristics of the detained person and their individual progress (i.e. interventions and psychopharmacological medication use). Additionally, the D&D project team monitors their efforts in **creating cooperative relations** with prison staff and a network with external healthcare professionals, in **educating prison staff** and improving **their own expertise**.

These quantitative data are supplemented with qualitative data in the activity reports. Feedback (i.e. notes, e-mails) from detained persons, colleagues in prison and external healthcare partners demonstrate their **perception on and satisfaction with the D&D project activities and team**.

With this registration, the D&D project team actively reports on their performance of the activities set out in the Royal Decrees[140] to the commissioner of the project, and thus contribute to its process evaluation.

[140] Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018

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Koninklijk besluit van 23 Maart 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 14 Mei 2019

Koninklijk besluit van 11 Juni 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 22 Juli 2019

Koninklijk besluit van 17 December 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 15 Januari 2020

Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 12 Augustus 2020

Meanwhile, team members struggle with this registration, because they do not feel sufficiently skilled to adequately measure and monitor the effectiveness of their interventions.

"I think it is difficult for us to express wat we do here. The activity reports are focused on what we have done, e.g. a flyer. But you can't substantively express which feeling you created here, which need for help you have fulfilled because you can't express that in numbers and words."

(Participant 6)

From 2020 to 2022, the D&D pilot project is supported by scientific teams to monitor certain data. The RECO-PRISbis study from Ghent University and NICC studied the feasibility of the screening procedure, the preconditions for optimal screening and treatment, and the feasibility of the BelRAI Suite as an evaluation- and monitoring instrument. A screening instrument has been by the study developed which collects quantitative indicators at the moment of prison entry, such as demographic data, living conditions, drug use, substitute treatment, risk behaviour and screening, earlier counselling or treatment for drug use, social support, work or activities in prison and preparation for release. The RECO-PRISbis study ends in September 2021 and it remains uncertain who will further analyse the data collected in this screening procedure.

The PRS-20 study[141], a HoGent and Sciensano cooperation funded by the European Union, will identify the needs of persons during and after detention through the validated European Questionnaire on Drug Use among Prisoners (EQDP) questionnaire and qualitative interviews. The EQDP questionnaire has been developed in 2017 by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) to collect and analyse internationally comparable data on drug use among detained persons. It collects demographic data, drug use (history), drug related health risk behaviour, health status and health & addiction service use. These data are collected in (ex-)detained persons to understand drugs use, health profiles and prison service use of this population, while the qualitative interviews aim to gather information on the psychosocial well-being of (ex-)detained persons. Their findings are expected to be published in December 2022.

Overall, the data collection by the D&D project team generally focusses on process indicators (e.g. network creation, education of prison staff and D&D team, development care trajectories), in line with the requirements stipulated in the Royal Decrees[142]. In terms of outcome evaluation, the data collected by the D&D project team, in cooperation with the RECO-PRISbis and the PRS-20 research teams enable the monitoring of the programme's effect on (ex-)detained persons (i.e. in terms of drug use,

[141] More information on https://onderzoek.hogent.be/projecten/prs20-address-and-reduce-drug-use-of-inmates-and-ex-inmates-through-data-analysis-and-intervention-programs/

[142] Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018

Koninklijk besluit van 17 Augustus 2018 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 13 September 2018

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health status, psychosocial well-being, programme satisfaction) and the programme's coverage in prison. Last, the D&D project team collects qualitative information of the programme's effect on prison staff (i.e. programme satisfaction).

Performing an output and outcome evaluation

To perform an output and outcome evaluation of an intervention, the outputs and outcomes have to be clearly defined. However, the critical appraisal of the logical model clearly demonstrates that this is not the case for the project policy (cf. page 399). In this context, we outline which indicators are generally defined and how they are operationalised in international research on drug programme effectiveness in prison. Next, the participants in the interviews, which are key stakeholders to the D&D project, clarify how the effectiveness of a drug treatment prison programme, according to them, could be monitored. Based on these two datasets, conclusive recommendations on monitoring drug treatment programmes in prison are made.

International research

The literature review demonstrates that the evaluation of drug treatment programmes in prison can be organised in different ways. Data can be collected at one or multiple points (e.g. before treatment, after 1 months, after 6 months, after 3 years) in time. Quantitative data are usually collected through questionnaires, surveys, urine tests (as indication for drug use) or from health, legal or prison files or databases. Qualitative data on the other hand are often obtained through interviews or focus groups.

Table 3 gives an overview of which outcomes are measured in drug treatment programmes in prison and how they are operationalised (i.e. outputs), mostly through valid questionnaires[143] and in combination with other data collection methods (e.g. surveys, urine tests, data from health, legal or prison files and databases). The last column of Table 3 indicates how frequent the outcome is measured in international drug treatment evaluation research.

Outcomes	Operationalisation	Frequency
Criminal behaviour	Recidivism (TOP, Lifestyle Criminality Screening Form), re-arrest, re-incarceration, amount of days re-incarcerated, criminal thoughts (CTS), desistance from crime (IOMI)	X = 19
Health status	Mortality, health service utilization, pregnancy, overdose, sexual risk behaviour, HIV risk behaviour, injecting risk behaviour (TOP)	X = 7
Mental health status	(SCL-90-R), Self-harm, suicide, depression (PHQ-9), post-traumatic stress (PDS)	X = 7
Social status (after release)	Occupational data, housing (TOP), social network	X = 4
Treatment readiness	Participation in drug or substitute treatment programme (MOUD Treatment adherence and satisfaction, adapted CSRI, Brief Inspire), readiness for treatment (SOCRATES, CRMS)	X = 9
Drug use	Frequency and amount of drug, prescribed medication and alcohol use	X = 15

[143] The questionnaires used to operationalise outcomes in these studies, are indicated between brackets.

	(ASSIST screening tool, ASI-Lite, TOP, LDQ, DATS-20)	
Skills	Self-efficacy (SSDD, GSE), problem solving skills	X = 4
Treatment completion	Whether drug treatment programme is completed by participant	X = 2
Well-being	Quality of Life as defined in validated questionnaires (WHO QoL-BS, HRQoL, EQ-5D-5L, ICECAP-A)	X = 5
Prison behaviour	Misconduct in prison	X = 1

Table 17: International quantitatively measured outcomes and their operationalisation

The TCU CJ Client Evaluation of Self and Treatment, used by Joe et al. (2010), is a validated questionnaire for persons who offended to evaluate the counsellor, therapeutic groups and the treatment programme in general, in this case a drug treatment programme in prison.

Overall, quantitative outcomes evaluations of drug treatment programmes in prison primarily study the effects of the programme on its participants (i.e. detained persons who use drugs), mainly in terms of recidivism and drug use. Only the study by Joe et al. (2010) evaluates the treatment programme in general.

Similar to quantitative studies, outcomes in qualitative studies are also measured in terms of the effects of the treatment programme on the participant (e.g. criminal behaviour, drug use, health and social status, skills, motivation and perseverance for treatment). In contrast, qualitative studies focus to a larger extent on the *perception* of participants towards the effectiveness of the treatment programme, for example in terms of patient-centredness, side effects or characteristics of staff.

Outcomes	Operationalisation	Frequency
Criminal behaviour	Criminal lifestyle, re-arrest	X = 3
Health status	Sexual risk behaviour	X = 2
Social status (after release)	Housing, occupational status, social network	X = 4
Treatment satisfaction	Side effects and advantages substitute treatment, patient-centred, needs-based, general satisfaction of treatment, motivation and perseverance for participation in treatment programme, expertise and professional confidentiality of staff, care after release	X = 7
Drug use	Frequency and amount of drug use	X = 4
Skills	Correct use of substitute treatment	X = 2
Programme completion	Whether the drug treatment programme is completed by the participant	X = 2

Table 18: International qualitatively measured outcomes and their operationalization

In conclusion, international evaluation research focusses extensively on the effects of the drug treatment programme on detained/released persons and their perception of the programme's effectiveness. The outcomes measured are a combination of criminal, (mental) health, social and behavioural characteristics, next to drug use and treatment perception.

Key stakeholders

The participants in the interviews agree it is interesting to register outcomes before and after treatment, and to monitor these on a long-term basis. While international evaluation studies primarily focus on individual outcomes for detained persons who use drugs, key stakeholders to the D&D project would like to include outcomes for prison staff and outcomes on the programme, organisation and society level. These outcomes can, according to them, be either qualitative or quantitative, yet are preferably standardized and thus internationally comparable (e.g. EQDP questionnaire developed by EMCDDA).

First, on an **individual level** the participants identify about the same outcomes as international studies to measure the effectiveness of a drug treatment programme in prison, except for skills, programme completion and treatment readiness. Table 5 gives an overview of interesting individual outcomes and their operationalisation, according to the participants, to measure programme effectiveness.

Outcomes	**Operationalisation**
Criminal behaviour	Recidivism
Drug use	Drug and medication use, drugs found during controls, number of overdoses
Health status	Use of substitution treatment services, Disability Adjusted Life Years (DALYs)
Mental health status	Use of mental health services after release, mental health while detained
Social status (after release)	Housing
Programme satisfaction	Needs-based, satisfaction of treatment programme
Prison behaviour	Misconduct in prison

Table 19: Individual outcomes to monitor programme effectiveness according to key stakeholders

In addition, participants would find it interesting to measure outcomes at the level of the prison staff, such as increased knowledge on drugs in prison officers, changed attitudes in prison staff, their needs and perception of drug treatment.

For an outcome evaluation on the **programme level**, participants indicate that the coverage of the treatment activities can be monitored. For example, how many detained persons are screened or have an individual care trajectory, and how inclusive the programme activities are (e.g. for persons belonging to migrant and minority groups).

At the **organisational level**, the prison climate is highlighted by the respondents as an essential component of an effective drug treatment programme, and thus needs to be monitored.

"You need research to prove it but inside [the prison] here you don't need to convince anybody [of its importance]."

(Participant 7)

In addition, prison safety indicators can be monitored (e.g. aggressive incidents, forced drug use, threats and extortion linked to drug trade), and the cooperation between prison services can be mapped.

Last, researching the **societal** effect of drug treatment programmes in prison would be interesting. For example, when recidivism rates of drug using persons decrease due to drug treatment in prison, economic and social profits can be obtained.

" I see the same people returning. […] The damage is so enormous that we have to do everything, if we can only alleviate a little bit we are already very successful. […] The money you invest here and the small moments of success have a great return. That is huge societal profit but we don't reflect on this. If you count the policemen's hours, the prosecution office, the court. The societal cost of it… The damage to the victims, to themselves, to families, the healthcare system and their medication, the welfare benefits, the working hours of social services, housing, the imprisonment,…"

(Participant 18)

Thus, the central research questions for an output and outcome evaluation, according to the participants in the interviews, are:

- What is the effect of the drug treatment programme on persons who use drugs in prison? And, is this programme adequate to meet their needs?
- What is the effect of the drug treatment programme on prison staff? And, is this programme adequate to meet their professional needs?
- What is the coverage of the drug treatment programme?
- What is the effect of the drug treatment programme on the prison organisation?
- What is the effect of the drug treatment programme on the society?

However, the participants identify some preconditions to register and monitor outcomes. Registration and monitoring has to be facilitated through software programmes which allow for standardized registration (e.g. electronic patient file) and a swift processing of data. This can be supported by sufficient academic and human resources to register, process and analyse the data.

"I think software… That it's easier to put something in and to get something out of it, with simple formulas. Yes, that would certainly help. If that [drug treatment programmes] will ever be implemented, it is necessary. Otherwise, you quickly lose oversight."

(Participant 2)

Overall, quality standards with structured quality indicators for penitentiary health care could provide guidelines to which drug treatment programmes in prison, as a component of penitentiary health care, has to adhere (European Monitoring Centre for Drugs and Drug Addiction, 2021a).

In contrast, participants outline that not all project activities (i.e. small daily interventions at the prison ward, daily contact with prison staff) or mechanisms of change (i.e. approachability and accessibility) can be measured.

"Our greatest strength lies within the conversations at the door, or going to distribute the meals. The approachability is difficult to express in numbers. […] But for me that is essential because that is how we differ from other services, because we work with a low-threshold. It is almost outreach and you can't express that in numbers. It is a way of being."

(Participant 20)

Conclusion

The initial interest of policy makers seems to lie in a process evaluation of the pilot project (cf. critical appraisal, page 399), which is not unusual during a piloting phase. The outputs formulated in the Royal Decrees inform this process evaluation. However, an outcome evaluation is able to demonstrate the effectiveness of the programme and substantiate the importance of its implementation. For now, the desired outcomes lack a clear operationalisation (i.e. outputs) in the Royal Decrees to measure and monitor them. In this respect, our findings correspond with those of the RECO-PRIS(bis) study (Debaere et al., 2020; Zerrouk et al., 2021).

A review of the international literature and the analysis of the interviews identify numerous indicators (i.e. outputs) to evaluate and monitor the programme's effectiveness. Outcomes can be measured at different levels and focus on various aspects (cf. Figure 5).

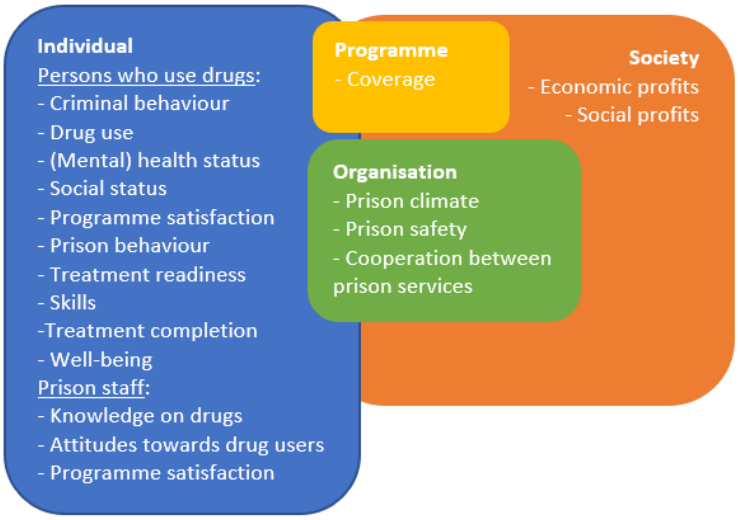

Figure 26: Indicators for evaluation of programme effectiveness

At present, only a fraction of these indicators are measured or monitored by the D&D project team, with support of the PRS-20 and RECO-PRISbis study, namely:

- Individual level: drug use (history), health status, social status, well-being and programme satisfaction
- Programme level: coverage

The reformulation of the project intervention from activity-centred towards outcome-centred (cf. critical appraisal, page 402) permits the selection of indicators (i.e. outputs) which inform the outcome evaluation of the D&D project. Beneath, we describe **some illustrative cases** for possible outcome evaluation initiatives. The cases are fictional but inspired by the current situation. More inspiration for the evaluation of drug treatment interventions can be found in the guidelines of the European Monitoring Centre for Drugs and Drug Addiction (2007), and a reflection on the use of the BELRAI suite in the monitoring of health indicators in a prison context is found in the latest RECO-PRISbis report (Zerrouk et al., 2021).

- Case 1: The expected outcomes of the drug treatment programme in prison are, among others, **reduced recidivism, reduced drug use and an improved mental health status** in detained persons. Recidivism can be operationalised as re-incarceration. These data can be collected in the individual judicial files by a staff member at the federal Justice department, at a yearly rate. At the same time, the D&D project team together with the prison medical service can collect data on self-reported drug use and mental health status through the quantitative screening questionnaire (developed in cooperation with the Ghent University RECO-PRISbis research team) and the internationally validated Symptom CheckList (SCL-90-R) questionnaire (Arrindell & Ettema, 2005). These assessments need to be done before, during (e.g. six-monthly) and after treatment. In agreement, these data can be analysed by a university research team.
- Case 2: The central mechanism of change of the drug treatment programme in prison is the **prison climate**, which is expected to be experienced as positive by detained persons and prison staff. The prison climate is operationalised within the internationally validated Essen – Climate Evaluation Scale (Essen-CES) questionnaire (Schalast & Tonkin, 2016). The D&D project team can quantitively monitor the prison climate by collecting and analysing the Essen-CES assessment forms from detained persons and prison officers every six months or at major

events (e.g. regime changes). These assessment forms are available in multiple languages (e.g. English, Spanish, Polish) which holds the advantage of including non-Dutch speaking detained persons. In addition, prison management can adopt a qualitative approach for evaluation, where every six months a participative meeting with representatives of detained persons, prison officers and other prison staff can evaluate the prison climate and propose new actions to further improve this.

- Case 3: The expected outcome of the drug treatment programme in prison is a **decrease in societal costs**. These societal costs are operationalised as estimated diminished re-incarceration, and thus court costs, prison facility costs and prison staff costs resulting from reduced recidivism (idib. Socost study - (D. Lievens et al., 2016). To estimate these indicators in relation to recidivism, a skilled research team is needed. Therefore, the federal department of Justice or Public Health can commission a university research team to conduct a study on this subject when the drug treatment programmes are well-established in prison (e.g. after two to five years).

Certainly, a thorough outcome evaluation will combine many of these methods. The monitoring of multiple indicators can inform effective policy and programme implementation, whereby adaptations can be made according to the evaluation results. Besides, in these cases it becomes apparent that not only *what* will be monitored is important, but also *who* will collected these data and analyse them. In light of the uncertainty felt by the D&D team members to adequately register and monitor indicators, it is essential to determine responsibilities in (elements of) the outcome evaluation and provide sufficient (human) resources to achieve this.

Overall, it is recommended that policy makers decide on essential indicators for outcome evaluation in all drug treatment projects and thus develop **minimum requirements for indicator monitoring**. These minimum requirements can be presented as quality indicators within a quality framework for drug treatment in prison. In this respect, it is important to balance the human resources for this registration against the necessity of monitoring to inform policy. Ideally, the selected indicators for monitoring:

- Are logically connected to the project's goals and activities (cf. critical appraisal, page 399).
- Assess at least the effects of the drug treatment programme on detained persons who use drugs and prison staff, programme satisfaction, programme coverage and its effects on the prison climate.
- Are integrated in a broader vision or quality standards for penitentiary health.

Output and outcome evaluation:

An output and outcome evaluation of the D&D pilot project in the prison of Hasselt found that:

- ⇨ Key stakeholders observe realisations of the project at the individual (i.e. detained persons and prison staff), organisation (i.e. prison system) and supralocal policy level.
- ⇨ Mechanisms of change are identified as the project team's accessibility and approachability, and the positive prison climate.
- ⇨ Contemporary monitoring of the project by the D&D team mostly informs a process evaluation (i.e. progress of project implementation). In terms of effect evaluation, the programme's effect on (ex-)detained persons is monitored, in addition to the programme's reach and programme satisfaction of both detained persons and prison staff.
- ⇨ Outcomes can be further defined and operationalised by policy makers on the individual, programme, organisational and societal level (cf. Figure 5).
- ⇨ Minimum requirements for indicator monitoring should be developed, including at least outcomes on the individual, programme and organisational level.

8. Policy recommendations

The reform and transfer of competencies concerning penitentiary healthcare from the federal Justice department to the federal department of Public Health, is perceived by the participants in this study as an important step towards effective drug treatment in prison. However, it is uncertain when this transfer will take place and what the details of the reform will be. In anticipation, the participants reflected on the contemporary situation and formulated multiple recommendations for a more effective prison drug treatment policy.

First, there is a need for an **integral vision** (e.g. prevention, harm reduction, treatment, follow-up) on penitentiary health in prison by all involved policy actors, being the federal Justice and Public Health departments together with the regional Welfare (and Flemish Justice) department. In light of this, the (in)accessibility of drug or mental health treatment in society for released persons should be addressed. In any case, the participants would prefer a more holistic approach of drug problems, where mental health and physical health are fully integrated. This should result in **a single health service in prison,** comprised of the prison medical service for physical healthcare (i.a. substitution treatment for drug using persons) but also drug and mental health professionals for psychosocial treatment. Yet, it is important that psychosocial treatment should be provided by professionals bound by **professional confidentiality**. Specialized external drug and mental health professionals are a preferred partner to deliver this type of treatment because of their expertise and network among community drug and mental health services. In this respect, an integrated health service which consists of the prison medical service and 'external' drug and mental health professionals are considered the most favourable option to provide penitentiary health care.

"That should be one healthcare service. […] It is madness, different healthcare service next to each other."

(Participant 7)

Next to an integral vision on penitentiary health, the **therapeutic (recovery-based) approach** towards persons who use drugs in prison should be considered. The participants to this study in the interviews stress the importance of the accessibility, inclusiveness and needs-based character of drug treatment initiatives in prison. Also, a motivational approach towards persons who use drugs in prison and the employment of experts-by-experience are perceived as valuable.

"I've seen a lot of projects in my career, what I think had the most positive impact on the prison and its clients? I think the D&D project. […] There is no need for a specialised answer on every special problem in every prison but this is the basis."

(Participant 18)

Hence, a **road map with quality indicators** is considered to be helpful to implement a good quality and effective drug treatment in prison. A road map is a policy document, which is regarded as more suitable to include a vision text, and is preferred over binding Royal Decrees. Such a road map would ensure the uniformity of all drug treatment projects in every prison in terms of (therapeutic) vision, activities, expected outcomes and quality indicators, which would facilitate their evaluation. Finally, it should be based on the input of prison staff and the needs of detained persons.

"Please listen to the people on the ground. Listen to them because they are the ones who know it and encounter it. Let it not be something that is decided over their heads. […] If it is decided that you have to do it and it is not what the detained persons ask, then I found that very difficult."

(Participant 15)

Ultimately, this road map should provide guidelines on how to effectively implement a drug treatment programme, and how to monitor this, while giving sufficient leeway to the project team to anticipate local

needs. The RECO-PRISbis research report (Ghent University & NICC) provides inspiration and guidelines to develop such a framework. In addition, the participants to this study suggest that a road map for drug treatment in prison could also be an incentive for prison management to develop a clear drug policy in their facility, as the **support of prison management** for this drug treatment programme is essential.

Similar to an integral vision between the involved policy actors, the need for an **integrated cooperation model** is indicated. This cooperation model should also be translated to the local level, so every person involved in drug treatment in prison understands who is responsible and approachable at what level (i.e. policy, prison organisation) for which task (e.g. prevention, referral, social services). As such, this cooperation model also regulates **communication flows**. The imperative result of an improved cooperation and communication is the **integration** of this drug treatment programme **in the local prison context**. Ideally, this programme is also integrated **in the local (mental) healthcare network**. Commissioning the project to a well-established healthcare partner, specialized in drug treatment and integrated with the prison medical service (cf. supra – a single prison health service), could facilitate the integration of the prison project in healthcare networks.

"The most important for me is to get some clarity on what the needs are and who is doing what to address these needs throughout detention."

(Participant 22)

On a more pragmatic level, policy makers should provide sufficient **resources** (e.g. budget, electronic patient file)**, staff and time** to implement, conduct and evaluate the treatment programme. The education of both prison staff and the project team (e.g. training on substitution for project physicians) is, according to the participants, essential to ensure a high-quality programme.

Last, the participants highlight the need for drug treatment **in every Belgian prison**. However, not every prison is sufficiently ready to implement a drug treatment programme similar to that in the prison of Hasselt. Therefore, it might be necessary to begin with a preparatory process in those prisons which might only later evolve to the full implementation of a drug treatment programme.

Policy recommendations:

- ⇨ Key stakeholders highlight the need to develop a (therapeutic) vision on drug treatment and penitentiary healthcare.
- ⇨ In addition, a local and supralocal cooperation model with clear responsibilities needs to be developed.
- ⇨ A quality framework with quality indicators would improve the implementation of an effective drug treatment programme in every Belgian prison, and facilitate its evaluation.

9. Conclusion

Drug use prevalence in Belgian prisons is high and the (mental) health status of drug using persons in prison is generally poorer compared to the general population (European Monitoring Centre for Drugs and Drug Addiction, 2021b; Favril & Vander Laenen, 2018; Van Malderen et al., 2011). In 2017, in anticipation of the transfer of penitentiary health from the federal Justice department to the federal department of Public Health, the latter initiated a drug treatment pilot project in three federal prisons (i.e. Lantin, Hasselt and the Brussels penitentiary complex).

The analysis of the Royal Decrees[144], which are the policy frameworks for these projects and in particular for the project in the prison of Hasselt, revealed several discrepancies and omissions in its policy. While they provide essential input and guidelines for the implementation of an intervention, they lack an overall vision on penitentiary health, drug treatment and its implementation in a penitentiary context. All aspects of the policy (i.e. goals, inputs, activities, outputs and outcomes) are rather vaguely described, lack a clear operationalisation (e.g. what entails an adequate treatment?) and essential elements (e.g. outcomes on the level of detained persons). Clear mechanisms of change are not defined and there is no up-to-date problem description (although this is expected in 2022 following the PRS20 research project). Therefore, the policy is for the most part not logical. The policy is more activity- and process-oriented, while more attention to the outputs and outcomes could facilitate the evaluation of the project's effectiveness.

A process evaluation of the D&D project in the prison of Hasselt revealed that challenges are met at the staff (e.g. distrust), organisational (e.g. inadequate cooperation) and policy level (e.g. fragmentation of competencies). In addition, it remains difficult to ensure a smooth referral towards community healthcare services after release. However, the positive and respectful attitude by the D&D project team and the support of prison management and policy makers have enabled a good implementation of the project.

The D&D project team implemented all activities stated by the Royal Decrees, and has even expanded its activities towards an explicit integral and integrated approach, and it has developed low-threshold tiered treatment activities. In turn, this expansion resulted in multiple additional outputs and outcomes compared to those stated in the Royal Decrees. The D&D project team achieved results at the individual (e.g. reduced drug use), organisation (e.g. organisation of needs-based accessible therapeutic activities) and supralocal policy level (e.g. new collaborations). The mechanisms of change are identified as the project team's approachability and accessibility, next to a positive prison climate.

Since clearly defined outcomes are lacking in the policy documents, additional outcomes should be defined and monitored on the individual, organisational and societal level (cf. Figure 5) to understand whether the project is effective. Importantly, sufficient resources (e.g. financial, expertise) should be provided for their professional registration and monitoring in terms of strengthening the human capital of the D&D team or the federal Public Health department for this purpose, or providing scientific support. Currently, the project's progress, their activities' reach and the programme satisfaction by detained persons and prison staff are monitored by the project staff, as mandated for the yearly activity report. However, this dataset is not structurally monitored and analysed in terms of project effectiveness, and

[144] Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject "drughulpverleningsprogramma voor personen in detentie", B.S. 11 Januari 2018

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an effectiveness evaluation should be more clearly linked to (yet to be) operationalised outputs and outcomes in the policy documents.

To develop a more effective policy towards drug treatment in prison, which is aligned with detained persons' needs, it is recommended for policy makers to generally reflect upon a vision on penitentiary healthcare and specifically on a therapeutic vision towards treatment in prison. Ideally, drug treatment should occur within broader integral and integrated health interventions (i.e. holistic healthcare). Supported by that (therapeutic) vision on penitentiary health, and in deliberation with prison staff and detained persons, a road map with quality standards can be developed (cf. recommendations of RECO-PRISbis research project). Such quality standards indicate quality indicators which are essential as minimum standards for monitoring the effectiveness of the (health/drug) programme (European Monitoring Centre for Drugs and Drug Addiction, 2021a).

In addition, there is a need for a cooperation model both at the local (i.e. prison) and supralocal (i.e. administration, politics) policy level, to ensure everyone knows *who* to approach for *which* issue. In any case, the reflection upon penitentiary health and the development of a cooperation model are logic acts in the preparation of a competency transfer between the federal Justice and Public Health department. But, the involvement of regional policy actors should not be overlooked because of their responsibilities with regard to specialised drug treatment and assistance and services towards detained persons.

Based on the positive process evaluation and their realisations, the D&D project should at least be structurally accessible for all detained persons in Hasselt to ensure the inclusiveness of the intervention (e.g. female detained persons). An output and outcome evaluation, based on the recommendations in this report (cf. pages 420-421) and preferably framed within quality standards and quality indicators, can inform both policy and practice on its effectiveness. Inspiration can be found at internationally developed implementation frameworks, for example the EMCDDA report on implementation of quality standards (European Monitoring Centre for Drugs and Drug Addiction, 2021a) and RE-AIM (cf. Annex 3) which provides ideas for both process- and effectiveness evaluation. Then, together with a (therapeutic) vision and a clear cooperation framework, this project can be expanded and implemented in all Belgian prisons.

1.1 Reference List

Algemene Cel Drugsbeleid. (2019). *Realisaties 2014-2019 & aanbevelingen voor de volgende legislatuur*. Brussel Retrieved from https://overlegorganen.gezondheid.belgie.be/sites/default/files/documents/20190325_rapport_acd_2014-2019_nl_def.pdf

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, *16*(4), 11-23. https://doi.org/10.1037/h0095655

Arrindell, W. A., & Ettema, J. H. M. (2005). Symptom checklist: handleiding bij multidimentionale psychopathologie-indicator. Pearson Assessment and Information B.V: Amsterdam.

Council of the European Union. (2020). *EU Drugs Strategy 2021-2025*. Retrieved from https://www.emcdda.europa.eu/system/files/attachments/13642/Council%20of%20the%20EU%20%282020%29%20EU%20Drugs%20Strategy%202021-25.pdf

Debaere, V., Schil, E., Vandevelde, S., Vander Laenen, F., Vanderplasschen, W., Colman, C., Maes, E., & Mine, B. (2020). *RECOvery in PRISon (RECO-PRIS): Evaluatie van het pilootproject in drie Belgische gevangenissen*.

Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. *Science*, *196*(4286), 129-136. https://doi.org/10.1126/science.847460

European Monitoring Centre for Drugs and Drug Addiction. (2021a). *Implementing quality standards for drug services and systems: a six-step guide to support quality assurance.* Publications Office of the European Union: Luxembourg

European Monitoring Centre for Drugs and Drug Addiction. (2021b). *Prison and drugs in Europe: Current and future challenges*. Publications Office of the European Union: Luxembourg.

European Monitoring Centre for Drugs and Drug Addiction (2017a). *European Questionnaire on Drug Use among People living in prison (EQDP)*. Lisbon.

European Monitoring Centre for Drugs and Drug Addiction (2017b). *Evaluating drug policy: a seven-step guide to support the commissioning and managing of evaluations.* Publications Office of the European Union: Luxembourg.

European Monitoring Centre for Drugs and Drug Addiction (2007). *Guidelines for the evaluation of treatment in the field of problem drug use – A manual for researchers and professionals.* Office for Official Publications of the European Communities: Luxembourg.

Favril, L., Laenen, F. V., & Audenaert, K. (2017). Psychiatrische morbiditeit bij gedetineerden in Vlaanderen. *Panopticon*, *38*(4), , 231-245.

Favril, L., & Vander Laenen, F. (2018). Predictoren van druggebruik tijdens de detentieperiode: data van 1326 gedetineerden uit 15 Vlaamse gevangenissen. *Panopticon*, *39*(4), 296-312.

FOD Volksgezondheid. (2021). *Blikvanger gezondheidszorg: Geestelijke gezondheidszorg*. Retrieved from: https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/blikvanger_gezondheidszorg_ggz_nl.pdf

Funnell, S. C., & Rogers, P. J. (2011). *Purposeful Program Theory: Effective Use of Theories of Change and Logic Models.* Jossey-Bass.

Joe, G. W., Rowan-Szal, G. A., Greener, J. M., Simpson, D. D., & Vance, J. (2010). Male methamphetamine-user inmates in prison treatment: During-treatment outcomes. *Journal of substance abuse treatment*, *38*(2), 141-152. https://doi.org/https://doi.org/10.1016/j.jsat.2009.08.002

Kazadi Tshikala, T., & Vander Laenen, F. (2015). Het Belgisch penitentiair drugbeleid: Sleutelfiguren uit de top van de administratie kijken vooruit. *FATIK*, *146*(16-20).

Lievens, D., Vander Laenen, F., Verhaeghe, N., Schils, N., Putman, K., Pauwels, L., Hardyns, W., & Annemans, L. (2016). *The social cost of legal and illegal drugs in Belgium*. Maklu.

Mistiaen, P., Dauvrain, M., Eyssen, M., Roberfroid, D., Miguel, L. S., & Vinck, I. (2017). *Gezondheidszorg in Belgische gevangenissen: Huidige situatie en stockrooms scenario's*. Retrieved from: https://kce.fgov.be/sites/default/files/atoms/files/KCE_293As_Gezondheidszorg_Belgische_gevangenissen_Synthese.pdf

Rousselet, M., Guerlais, M., Caillet, P., Le Geay, B., Mauillon, D., Serre, P., Chameau, P.-Y., Bleher, Y., Mounsande, S., Jolliet, P., & Victorri-Vigneau, C. (2019). Consumption of psychoactive substances in prison: Between initiation and improvement, what trajectories occur after

incarceration? COSMOS study data. *PloS one*, *14*(12), e0225189-e0225189. https://doi.org/10.1371/journal.pone.0225189

Schalast, N., & Tonkin, M. (2016). *Essen climate evaluation schema*. Retrieved from https://www.uni-due.de/rke-forensik/essenerstationsklimafragebogenessences.php

United Nations Office on Drugs and Crime. (2015). *Handbook on dynamic security and prison intelligence*. United Nations Office: Vienna.

Van Malderen, S., Pauwels, L., Walthoff-Born, C., Glibert, P., & Todts, S. (2011). Drug use in Belgian prisons: monitoring of drug related health risks 2010. *Brussels: Federal Departement of Justice*.

Vander Laenen, F. (2015). Memorandum naar een volwaardige gezondheidszorg voor gedetineerden en geïnterneerden in België. *FATIK*, *145*, 28-30.

Vander Laenen, F., & Eechaudt, V. (2018). Gelijkwaardigheid van de gezondheidszorg in detentie: De wet is er, nu nog de toepassing. *FATIK*, *160*, 3-6.

Vander Laenen, F., Van Remoortel, J., Hanoulle, K., De Boeck, M., Balthazar, T., & Opgenhaffen, T. (2019). Tien jaar forensische geestelijke gezondheidszorg in Vlaanderen: De trein is blijven rijden, zij het niet voor elke wagon met dezelfde snelheid. *Panopticon*, *40*(5), 450-469.

Vandevelde, S., Debaere, V., Schils, E., Vander Laenen, F., Colman, C., Mine, B., Vanderplasschen, W., & Maes, E. (2021). De pilootprojecten drughulpverlening in de gevangenis: aanbevelingen op basis van het 'RECOvery in PRISon' – RECOPRIS project. *Panopticon*, *42*(2), 189-195.

Vandevelde, S., Vander Laenen, F., Mine, B., Maes, E., De Clercq, L., Deckers, L., & Vanderplasschen, W. (2020). Linkage and continuity of care after release from prison: an evaluation of central registration points for drug users in Belgium. *International Journal of Prisoner Health*.

Vyncke, V., Hanssens, L., Steenberghs, E., & Willems, S. (2015). *Onderzoeksrapport 'Gezondheidsprofiel Gedetineerden'*. Retrieved from: https://www.departementwvg.be/sites/default/files/media/Eindrapport_gezondheidsprofiel_gedetineerden_def.pdf

WHO (2020). *Operational framework for primary health care: transforming vision into action.* World Health Organization and the United Nations Children's Fund (UNICEF): Geneva.

WHO (2021). *Primary health care*. Retrieved from https://www.who.int/news-room/fact-sheets/detail/primary-health-care

Wittouck, C., & Vander Laenen, F. (2020). Na internering, tijd voor zorg voor gedetineerden en personen met een drugproblematiek. *Panopticon*, *41*(3), 313-319.

Zerrouk, E.-A., Schils, E., Vandevelde, S., Vander Laenen, F., Vanderplasschen, W., Colman, C., Maes, E., & & Mine, B. (2021). *Evaluatie van het pilootproject in drie Belgische gevangenissen: Uitbreiding van het RECO-PRIS onderzoek*.

1.2 Reference List: Policy Documents

Koninklijk besluit van 29 November 2017 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject “drughulpverleningsprogramma voor personen in detentie”, B.S. 11 Januari 2018

Koninklijk besluit van 17 Augustus 2018 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject “drughulpverleningsprogramma voor personen in detentie”, B.S. 13 September 2018

Koninklijk besluit van 23 Maart 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject “drughulpverleningsprogramma voor personen in detentie”, B.S. 14 Mei 2019

Koninklijk besluit van 11 Juni 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject “drughulpverleningsprogramma voor personen in detentie”, B.S. 22 Juli 2019

Koninklijk besluit van 17 December 2019 houdende toekenning van een toelage aan vzw CAD Limburg ter ondersteuning van een pilootproject “drughulpverleningsprogramma voor personen in detentie”, B.S. 15 Januari 2020

Koninklijk besluit van 31 Juli 2020 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject “drughulpverleningsprogramma voor personen in detentie”, B.S. 12 Augustus 2020

Koninklijk besluit van 12 Mei 2021 houdende toekenning van een toelage aan de vzw ZorGGroep Zin ter ondersteuning van een pilootproject “drughulpverleningsprogramma voor personen in detentie”, B.S. 3 Juni 2021

1.3 Annex 1: Reference list of literature review

Awgu, E., Magura, S., & Rosenblum, A. (2010). Heroin-dependent inmates' experiences with buprenorphine or methadone maintenance. *Journal of psychoactive drugs*, *42*(3), 339-346. https://doi.org/10.1080/02791072.2010.10400696

Bahr, S. J., Masters, A. L., & Taylor, B. M. (2012). What works in substance abuse treatment programs for offenders? *The Prison Journal*, *92*(2), 155-174.

Burdon, W. M., Dang, J., Prendergast, M. L., Messina, N. P., & Farabee, D. (2007). Differential effectiveness of residential versus outpatient aftercare for parolees from prison-based therapeutic community treatment programs. *Substance Abuse Treatment, Prevention, and Policy*, *2*(1), 16. https://doi.org/10.1186/1747-597X-2-16

Butzin, C. A., Martin, S. S., & Inciardi, J. A. (2002). Evaluating component effects of a prison-based treatment continuum. *Journal of substance abuse treatment*, *22*(2), 63-69.

Doyle, M. F., Shakeshaft, A., Guthrie, J., Snijder, M., & Butler, T. (2019). A systematic review of evaluations of prison-based alcohol and other drug use behavioural treatment for men. *Australian and New Zealand Journal of Public Health*, *43*(2), 120-130. https://doi.org/https://doi.org/10.1111/1753-6405.12884

Frank, V. A., Dahl, H. V., Holm, K. E., & Kolind, T. (2015). Inmates' perspectives on prison drug treatment:A qualitative study from three prisons in Denmark. *Probation Journal*, *62*(2), 156-171. https://doi.org/10.1177/0264550515571394

Freudenberg, N., Ramaswamy, M., Daniels, J., Crum, M., Ompad, D. C., & Vlahov, D. (2010). Reducing Drug Use, Human Immunodeficiency Virus Risk, and Recidivism Among Young Men Leaving Jail: Evaluation of the REAL MEN Re-entry Program. *Journal of Adolescent Health*, *47*(5), 448-455. https://doi.org/https://doi.org/10.1016/j.jadohealth.2010.01.008

Gossop, M., Marsden, J., Stewart, D., Edwards, C., Lehmann, P., & Wilson, W. (1997). The National Treatment Outcome Research Study in the United Kingdom: Six-Month Follow-Up Outcomes. *11*, 324-337. http://dx.doi.org/10.1037/0893-164X.11.4.324

Hall, E. A., Prendergast, M. L., Wellisch, J., Patten, M., & Cao, Y. (2004). Treating drug-abusing women prisoners: An outcomes evaluation of the Forever Free program. *The Prison Journal*, *84*(1), 81-105.

Hicks, D. L., Comartin, E. B., & Kubiak, S. (2021). Transition Planning from Jail; Treatment Engagement, Continuity of Care, and Rearrest. *Community mental health journal*. https://doi.org/10.1007/s10597-021-00820-x

Hopkin, G., Evans-Lacko, S., Forrester, A., Shaw, J., & Thornicroft, G. (2018). Interventions at the Transition from Prison to the Community for Prisoners with Mental Illness: A Systematic Review. *Administration and policy in mental health*, *45*(4), 623-634. https://doi.org/10.1007/s10488-018-0848-z

Inciardi, J. A., Martin, S. S., & Butzin, C. A. (2004). Five-year outcomes of therapeutic community treatment of drug-involved offenders after release from prison. *Crime & Delinquency*, *50*(1), 88-107.

Joe, G. W., Rowan-Szal, G. A., Greener, J. M., Simpson, D. D., & Vance, J. (2010). Male methamphetamine-user inmates in prison treatment: During-treatment outcomes. *Journal of substance abuse treatment*, *38*(2), 141-152. https://doi.org/https://doi.org/10.1016/j.jsat.2009.08.002

Kendall, S., Redshaw, S., Ward, S., Wayland, S., & Sullivan, E. (2018). Systematic review of qualitative evaluations of reentry programs addressing problematic drug use and mental health disorders amongst people transitioning from prison to communities. *Health & justice*, *6*(1), 4. https://doi.org/10.1186/s40352-018-0063-8

Kerrison, E. M. (2018). Exploring how prison-based drug rehabilitation programming shapes racial disparities in substance use disorder recovery. *Social Science & Medicine*, *199*, 140-147. https://doi.org/https://doi.org/10.1016/j.socscimed.2017.08.002

Kirkpatrick, T., Lennox, C., Taylor, R., Anderson, R., Maguire, M., Haddad, M., Michie, S., Owens, C., Durcan, G., Stirzaker, A., Henley, W., Stevenson, C., Carroll, L., Quinn, C., Brand, S. L., Harris, T., Stewart, A., Todd, R., Rybczynska-Bunt, S., Greer, R., Pearson, M., Shaw, J., & Byng, R. (2018). Evaluation of a complex intervention (Engager) for prisoners with common mental health problems, near to and after release: study protocol for a randomised controlled trial. *BMJ Open*, *8*(2), e017931.

Kreager, D. A., Schaefer, D. R., Davidson, K. M., Zajac, G., Haynie, D. L., & De Leon, G. (2019). Evaluating peer-influence processes in a prison-based therapeutic community: a dynamic

network approach. *Drug and Alcohol Dependence*, *203*, 13-18. https://doi.org/https://doi.org/10.1016/j.drugalcdep.2019.05.018

Lehman, W. E. K., Rowan, G. A., Greener, J. M., Joe, G. W., Yang, Y., & Knight, K. (2015). Evaluation of WaySafe: A Disease-Risk Reduction Curriculum for Substance-Abusing Offenders. *Journal of substance abuse treatment*, *58*, 25-32. https://doi.org/https://doi.org/10.1016/j.jsat.2015.05.007

Liebrenz, M., Gamma, A., Buadze, A., Schleifer, R., Baggio, S., Schwartz, B., Schneeberger, A., & Uchtenhagen, A. (2020). Fifteen years of heroin-assisted treatment in a Swiss prison—a retrospective cohort study. *Harm Reduction Journal*, *17*(1), 67. https://doi.org/10.1186/s12954-020-00412-0

Matsumoto, T., Imamura, F., Kobayashi, O., Wada, K., Ozaki, S., Takeuchi, Y., Hasegawa, M., Imamura, Y., Taniya, Y., & Adachi, Y. (2014). Evaluation of a relapse-prevention program for methamphetamine-dependent inmates using a self-teaching workbook and group therapy. *Psychiatry and Clinical Neurosciences*, *68*(1), 61-69. https://doi.org/https://doi.org/10.1111/pcn.12084

Messina, N., Grella, C. E., Cartier, J., & Torres, S. (2010). A randomized experimental study of gender-responsive substance abuse treatment for women in prison. *Journal of substance abuse treatment*, *38*(2), 97-107. https://doi.org/https://doi.org/10.1016/j.jsat.2009.09.004

Mitchell, O., Wilson, D. B., & MacKenzie, D. L. (2007). Does incarceration-based drug treatment reduce recidivism? A meta-analytic synthesis of the research. *Journal of Experimental Criminology*, *3*(4), 353-375.

Moradi, G., Farnia, M., Shokoohi, M., Shahbazi, M., Moazen, B., & Rahmani, K. (2015). Methadone maintenance treatment program in prisons from the perspective of medical and non-medical prison staff: a qualitative study in Iran. *International journal of health policy and management*, *4*(9), 583-589. https://doi.org/10.15171/ijhpm.2015.60

Murphy, S. M., Jeng, P. J., Poole, S. A., Jalali, A., Vocci, F. J., Gordon, M. S., Woody, G. E., & Polsky, D. (2020). Health and economic outcomes of treatment with extended-release naltrexone among pre-release prisoners with opioid use disorder (HOPPER): protocol for an evaluation of two randomized effectiveness trials. *Addiction Science & Clinical Practice*, *15*(1), 15. https://doi.org/10.1186/s13722-020-00188-5

Pelissier, B., Wallace, S., O'Neil, J. A., Gaes, G. G., Camp, S., Rhodes, W., & Saylor, W. (2001). Federal prison residential drug treatment reduces substance use and arrests after release. *The American Journal of Drug and Alcohol Abuse*, *27*(2), 315-337. https://www.tandfonline.com/doi/full/10.1081/ada-100103712

Prendergast, M. L., Hall, E. A., Wexler, H. K., Melnick, G., & Cao, Y. (2004). Amity prison-based therapeutic community: 5-year outcomes. *The Prison Journal*, *84*(1), 36-60.

Prendergast, M. L., McCollister, K., & Warda, U. (2017). A randomized study of the use of screening, brief intervention, and referral to treatment (SBIRT) for drug and alcohol use with jail inmates. *Journal of substance abuse treatment*, *74*, 54-64. https://doi.org/10.1016/j.jsat.2016.12.011

Rosenberg, A., Heimer, R., Keene, D. E., Groves, A. K., & Blankenship, K. M. (2019). Drug Treatment Accessed through the Criminal Justice System: Participants' Perspectives and Uses. *Journal of Urban Health*, *96*(3), 390-399. https://doi.org/10.1007/s11524-018-0308-9

Shavit, S., Aminawung, J. A., Birnbaum, N., Greenberg, S., Berthold, T., Fishman, A., Busch, S. H., & Wang, E. A. (2017). Transitions Clinic Network: Challenges And Lessons In Primary Care For People Released From Prison. *Health affairs (Project Hope)*, *36*(6), 1006-1015. https://doi.org/10.1377/hlthaff.2017.0089

Sheard, L., Wright, N. M. J., Adams, C. E., Bound, N., Rushforth, B., Hart, R., & Tompkins, C. N. E. (2009). The Leeds Evaluation of Efficacy of Detoxification Study (LEEDS) Prisons Project Study: protocol for a randomised controlled trial comparing methadone and buprenorphine for opiate detoxification. *Trials*, *10*(1), 53. https://doi.org/10.1186/1745-6215-10-53

Stöver, H. (2017). Drug services and harm reduction practice in prisons. In *Emerging issues in prison health* (pp. 143-167). Springer.

Sullivan, E., Ward, S., Zeki, R., Wayland, S., Sherwood, J., Wang, A., Worner, F., Kendall, S., Brown, J., & Chang, S. (2019). Recidivism, health and social functioning following release to the community of NSW prisoners with problematic drug use: study protocol of the population-based retrospective cohort study on the evaluation of the Connections Program. *BMJ Open*, *9*(7), e030546. https://doi.org/10.1136/bmjopen-2019-030546

Vandevelde, S., Vander Laenen, F., Mine, B., Maes, E., De Clercq, L., Deckers, L., & Vanderplasschen, W. (2020). Linkage and continuity of care after release from prison: an evaluation of central registration points for drug users in Belgium. *International Journal of Prisoner Health*.

Velasquez, M., Flannery, M., Badolato, R., Vittitow, A., McDonald, R. D., Tofighi, B., Garment, A. R., Giftos, J., & Lee, J. D. (2019). Perceptions of extended-release naltrexone, methadone, and buprenorphine treatments following release from jail. *Addiction Science & Clinical Practice*, *14*(1), 37. https://doi.org/10.1186/s13722-019-0166-0

Waddell, E. N., Baker, R., Hartung, D. M., Hildebran, C. J., Nguyen, T., Collins, D. R. M., Larsen, J. E., Stack, E., Bialas, T., Bielavitz, S., Gregg, J., Korthuis, P. T., Kunkel, L., Lee, J. D., Leichtling, G., Meyer, D. L., Nichols, C., Wiest, K., & the, R. P. D. T. (2020). Reducing overdose after release from incarceration (ROAR): study protocol for an intervention to reduce risk of fatal and non-fatal opioid overdose among women after release from prison. *Health & justice*, *8*(1), 18. https://doi.org/10.1186/s40352-020-00113-7

Welsh, W. N. (2007). A multisite evaluation of prison-based therapeutic community drug treatment. *Criminal Justice and Behavior*, *34*(11), 1481-1498.

Welsh, W. N. (2010). Inmate responses to prison-based drug treatment: A repeated measures analysis. *Drug and Alcohol Dependence*, *109*(1-3), 37-44.

Welsh, W. N., McGrain, P., Salamatin, N., & Zajac, G. (2007). Effects of prison drug treatment on inmate misconduct: A repeated measures analysis. *Criminal Justice and Behavior*, *34*(5), 600-615.

Welsh, W. N., & Zajac, G. (2013). A multisite evaluation of prison-based drug treatment: Four-year follow-up results. *The Prison Journal*, *93*(3), 251-271.

Werb, D., Kamarulzaman, A., Meacham, M. C., Rafful, C., Fischer, B., Strathdee, S. A., & Wood, E. (2016). The effectiveness of compulsory drug treatment: A systematic review. *International Journal of Drug Policy*, *28*, 1-9. https://doi.org/https://doi.org/10.1016/j.drugpo.2015.12.005

1.4 Annex 2: Information letter and informed consent for the participants to the interviews

INFORMATIEBRIEF

BELSPO-onderzoek 'De evaluatie van het Belgische drugsbeleid'

Monitoring en evaluatie zijn een integraal onderdeel van beleidsvoering. Het evalueren van een beleids(maatregel) kan nagaan of het beleid het gewenste resultaat bereikt, geeft een beter begrip van de werking van een beleid, en zorgt ook voor transparantie en verantwoording over het gevoerde beleid.

Het basisdocument van het Belgische drugsbeleid, de Federale Drugsnota, kreeg rond de eeuwwisseling vorm en werd in 2010 versterkt met de Gemeenschappelijke Verklaring van de Interministeriële Conferentie over Drugs (nu Volksgezondheid). Ondertussen zijn heel wat initiatieven en projecten gerealiseerd, zoals de pilootprojecten voor drughulpverlening in detentie in de gevangenissen van Hasselt, Lantin en het Brussels Penitentiair Complex vanaf 2017. Toch is **evaluatieonderzoek** naar het Belgische drugsbeleid niet de norm en zien we eerder sporadische en gefragmenteerde evaluatie-initiatieven.

Een onderzoeksteam, samengesteld uit prof. Charlotte Colman, prof. Freya Vander Laenen en prof. Tom Decorte (Universiteit van Gent), prof. Pablo Nicaise (Université Catholique de Louvain), prof. Lode Godderis en Marie-Claire Lambrechts (Katholieke Universiteit Leuven), dhr. John-Peter Kools (Trimbos Instituut) en de onderzoekers Marjolein De Pau, Eva Blomme en Vanessa Makola, voert daarom een proces- en uitkomstenevaluatie uit naar het Belgische drugsbeleid. In dit onderzoek zal nagegaan worden hoe en in welke mate de beoogde acties binnen het Belgische drugsbeleid geïmplementeerd werden en in welke mate die acties in lijn liggen met de huidige noden en behoeften in België. Als deelstudie, onderzoeken we hoe het drugbeleid concreet geïmplementeerd werd **in een specifieke interventie**, nl. het drughulpverleningsproject in de gevangenis van Hasselt.

Om een duidelijk en betrouwbaar zicht te krijgen op de implementatie van het beleid, de afstemming op de doelgroep en de evaluatie indicatoren van het pilootproject, is het van belang dat praktijkmensen uit de verschillende beleidsdomeinen en -niveaus deelnemen aan het onderzoek. Het is binnen deze context dat we contact met u opnemen voor het afleggen van een interview.

Het interview duurt ongeveer 1 à anderhalf uur en zal peilen naar de implementatie van de beleidslijnen uitgetekend door de Koninklijke Besluiten van 29/11/2017, 18/08/2018, 23/03/2019, 11/06/2019, 17/12/2019 en 31/07/2020, en naar de indicatoren die gebruikt kunnen worden om de effectiviteit van het drughulpverleningsproject op te volgen.

De informatie die tijdens deze interviews verzameld wordt, is enkel toegankelijk voor de onderzoekers en zal op beveiligde wijze bewaard worden voor een maximum termijn van 5 jaar (mits uw toestemming). De informatie zal op vertrouwelijke en geanonimiseerde wijze verwerkt en gepubliceerd (in de vorm van een onderzoeksrapport en/of wetenschappelijke publicatie) worden.

Indien u bijkomende vragen hebt, aarzel dan niet om de onderzoekers te contacteren via de onderstaande contactgegevens.

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INFORMED CONSENT

Ik, ondergetekende, …….. verklaar hierbij dat ik, als participant aan het BELSPO onderzoek 'Een evaluatie van het Belgische drugsbeleid',

(1) de informatiebrief voor deelnemers heb gelezen en begrepen. Ik kreeg op die manier uitleg over de aard, het doel en de duur van de studie en over wat men van mij verwacht. Er werd mij de mogelijkheid geboden om bijkomende informatie te verkrijgen.
(2) begrijp dat deelname aan de studie vrijwillig is en dat ik mij op elk ogenblik uit de studie mag terugtrekken zonder een reden voor deze beslissing op te geven.
(3) me ervan bewust ben dat mijn deelname geen kosten met zich meebrengt.
(4) weet dat ik op aanvraag een samenvatting van de onderzoeksbevindingen kan krijgen nadat de studie is afgerond en de resultaten bekend zijn.
(5) weet dat UGent de verantwoordelijke eenheid is m.b.t. persoonsgegevens verzameld tijdens het onderzoek. Ik weet dat de *data protection officer* me meer informatie kan verschaffen over de bescherming van mijn persoonlijke informatie. Contact: Hanne Elsen (privacy@ugent.be).

Hierbij stem ik toe om:

- Mijn antwoorden op vertrouwelijke en anonieme wijze te bewaren volgens het informatieveiligheidsbeleid van Universiteit Gent, voor een maximale duurtijd van 5 jaar, zodat deze kunnen gebruikt worden voor wetenschappelijk onderzoek en onderwijs.
- Mijn antwoorden op vertrouwelijke en anonieme wijze te verwerken en te rapporteren (vb. onderzoeksrapport, wetenschappelijke publicatie).

Gelezen en goedgekeurd op …….. (datum),

Handtekening van de participant ……..

Charlotte Colman (Universiteit Gent), coördinator
Freya Vander Laenen (Universiteit Gent), promotor
Marjolein De Pau (Universiteit Gent), onderzoeker
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1.5 Annex 3: RE-AIM implementation framework

Original source: www.re-aim.org

Here : Dutch visualisation by Gezond Leven, consulted on 01/09/2021 at https://www.gezondleven.be/files/gezondheidsbevordering/RE-AIM_Gezond-Leven.pdf

RE-AIM kader

Relevante vragen, niveau, metingen, beïnvloedende factoren en verbeterstrategieën per dimensie

Dimensie (doel)		Stel je de vraag…	Niveau	Meting	Beïnvloedende factoren	Verbeterstrategieën
REACH (bereik bevorderen)	Procesevaluatie	1. **Welk %** van te bereiken doelgroep wil je laten deelnemen? (o.b.v. context-analyse) 2. Zijn de bereikte deelnemers **representatief**? Lage SES reflex, geslacht, leeftijd… 3. Wat zijn de **kanalen** en **barrières** van deelname?	Individu	1. Formule: aandeel deelnemers binnen het totaal aantal te bereiken personen 2. Vergelijking tussen de deelnemers en het totaal aantal te bereiken personen 3. Kanalen/stimuli en barrières bevragen	• Sterkte van implementatie (bv. subsidies, personeel, en stakeholders) • Waargenomen voordelen vs. nadelen • Verplichte deelname vs. vrijblijvend (beleid)	• Leg barrières bloot en zoek oplossingen • Vergelijk feedback van deelnemers en niet-deelnemers • Voorzie aanpassingen indien nodig en nieuwe ideeën

VLAAMS INSTITUUT GEZOND LEVEN

EFFECT(IVITEIT) positief effect op gedragsdeterminanten of gedrag)	Effectevaluatie	1. **Welke effecten** wil je bereiken? 2. Zijn er **neveneffecten**? Bv. impact levenskwaliteit, kosten, negatieve effecten. 3. Zijn de effecten **veralgemeenbaar**? Lage SES reflex, geslacht, leeftijd…	Individu	1. Consequent meten: - indien doelstelling op gedragsniveau → ook gedrag meten! - meting van gedragsdeterminanten geeft je inzichten in het waarom 2. Neveneffecten bevragen (+ en -). 3. Vergelijking effecten tussen verschillende groepen.	• Evidence-based strategieën = meer kans op succes • Intensiteit en kwaliteit van implementatie (cfr. Implementatie)	• Ontwikkel en voorzie systemen voor (regelmatige) monitoring en documentatie: zelf bevragen of samenwerken met stakeholders of wetenschappelijke instituten. • Participatie en input van doelgroep
(□ deskundigheid, □ verspreiding…)		1. **Welke effecten** wil je bereiken? 2. Zijn er **neveneffecten**? Bv. andere positieve effecten, kosten, negatieve effecten. 3. Zijn de effecten **veralgemeenbaar**? Type, ligging, grootte van intermediair…	Setting/ intermediair	1. Consequent meten: definitie 'effect' afstemmen op de doelstelling van je project: - bv. □ deskundigheid pre-post - bv. □ projectbekendheid bij intermediairs ,, (disseminatie) - bv. □ implementatiekwaliteit ,, 2. Neveneffecten bevragen (+ en -). 3. Vergelijking effecten tussen verschillende soorten intermediairs/organisaties.	• Evidence-based strategieën (deskundigheidsbevor-dering) • Relevante kanalen en stakeholders • Cfr. implementatie (verhoging kwaliteit)	• Ontwikkel en voorzie systemen voor (regelmatige) monitoring en documentatie: zelf bevragen of samenwerken met stakeholders of wetenschappelijke instituten. • Participatie en input van intermediairs/organisaties.
ADOPTIE ((intentie tot) toepassing bevorderen)	Procesevaluatie	1. **Welk %** van de totaal te bereiken organisaties moet de methodiek (willen) toepassen? (o.b.v. context-analyse) 2. Zijn deze toepassende **organisaties representatief**?	Setting/ intermediair	1. Formule: aandeel toepassers binnen het totaal aantal te bereiken organisaties 2. Vergelijking tussen de toepassers en het totaal aantal te overtuigen organisaties 3. Succesfactoren en barrières van toepassing bevragen	• Juiste match met de waarden en mate van deskundigheid van de organisaties (voorafgaande productevaluatie) • Juiste match met de terreinnoden op dat moment	• Overleg met de intermediairs tijdens de ontwikkeling en productevaluatie • Meer compatibel maken met de waarden en mate van deskundigheid van de organisaties (draagvlak)

VLAAMS INSTITUUT GEZOND LEVEN

		Type, ligging, grootte van intermediair… 3. Wat zijn **redenen voor** en **barrières** van toepassing? *Binnen* organisaties: 4. Is het toepassend **personeel representatief?** Ervaring, geslacht, …		4. Vergelijking tussen de toepassers en het totaal aantal te bereiken personeelsleden binnen de organisatie	• Bewezen effectiviteit • Capaciteit van de organisatie: budget en personeel • Moeilijkheidsgraad om te implementeren	• Begroot en communiceer de verwachte kosten en nodige middelen • Voorzie bevorderende maatregelen voor draagvlak binnen de organisaties
IMPLEMENTATIE (kwaliteit van implementatie bevorderen)	Procesevaluatie	1. **Welk %** van de werkzame elementen moet minimaal geïmplementeerd worden? 2. Wat zijn **redenen voor** en **barrières** van kwaliteitsvolle implementatie? 3. Is er nood aan **aanpassingen**? 4. Welke inzichten in **tijdsinvestering** en **kosten** zijn nodig?	Setting/ intermediair	Baken de belangrijkste ondersteuningsmiddelen (=interventiecomponenten) eerst af! Bevraag het gebruik en frequentie. 1. Formule: gebruik van de verschillende werkzame elementen t.o.v. totaal aantal elementen 2. Succesfactoren en barrières van implementatie bevragen 3. Suggesties voor aanpassing bevragen. 4. Tijdsinvestering en kosten bevragen.	• Complexiteit van de methodiek en interventiecompo-nenten • Kenmerken organisatie • Kenmerken personeel • Kosten (tijd en budget) • Planningsproces • Rekrutering van individuen en organisaties • Samenwerkingspro ces	• Overleg met de intermediairs tijdens de ontwikkeling en productevaluatie • Analyseer implementatie reeds in pilootfase • (Meer) aanpassingen maken aan lokale realiteit en noden • Vormingen, technische ondersteuning en richtlijnen • Monitor implementatie regelmatig
		1. **Welke producten van de methodiek** zijn gebruikt door de individuen (burger, werknemer, leerling, …)? 2. Is het gebruik **veralgemeenbaar**? Lage SES reflex, geslacht, leeftijd, andere profielen,..	Individu	1. Formule: gebruik van de verschillende producten t.o.v. totaal aantal producten 2. Vergelijking tussen de gebruikers van de producten en het totaal aantal te bereiken personen	• Waargenomen voordelen vs. nadelen • Verplicht gebruik vs. vrijblijvend (beleid)	· Leg barrières bloot en zoek oplossingen · Vergelijk feedback van gebruikers en niet-gebruikers · Voorzie aanpassingen indien nodig en nieuwe ideeën

MAINTENANCE (behoud van effecten bevorderen)	Effectevaluatie	1. Blijven de effecten **behouden** na > 6 maanden? 2. Wat is de mate van **drop-out**? Lage SES reflex	Individu	1. Consequent meten: - indien doelstelling op gedragsniveau → ook gedrag meten! - meting van gedragsdeterminanten 2. Bevraging naar herhaalde deelname.	• Blijvende ondersteuning: sociaal, structureel, en beleid • Waargenomen voordelen vs. nadelen	• Herhaal monitoring en documentatie: zelf bevragen of samenwerken met stakeholders of wetenschappelijke instituten. • Ondersteunende maatregelen (sociaal, financieel, beleidsmatig)
(verankering bevorderen)	Proces -en effectevaluatie	1. **Welk %** van de toepassende organisaties continueert, verankert, en verandert de methodiek? 2. Wat zijn **redenen voor** en **barrières** van verankering? 3. Blijven de effecten behouden (indien je effectiviteit op intermediairniveau hebt bepaald)	Setting/ intermediair	1. Formule: aandeel toepassende organisaties binnen het totaal aantal te bereiken organisaties 2. Vergelijking tussen toepassende organisaties en het totaal aantal te overtuigen organisaties 3. Redenen voor toepassing en barrières bevragen 4. Vergelijking tussen de toepassers en het totaal aantal te bereiken personeelsleden	• Waargenomen voordelen vs. nadelen • Beschikbare vormingen, technische ondersteuning en richtlijnen • Blijvende financiering of subsidies	• Beperk de kosten en middelen die nodig zijn om de methodiek te kunnen verankeren • Complexiteit van de methodiek beperken • Aanpasbare methodieken

CHAPTER 2

Evaluating a targeted intervention:

CAO 100 / CCT 100

Collectieve Arbeidsovereenkomst
Convention Collective de Travail
Collective Labour Agreement

Promotor:

Prof. Dr. Lode Godderis, KU Leuven

Lead researcher:

Marie-Claire Lambrechts, KU Leuven

2 CONTENT

1. Introduction

Alcohol and other drug (AOD) use by workers is a private matter. However, it is a different story when it comes to **work-related substance use**: i.e. AOD use during the hours (immediately) before work, at work, on 'specific occasions' at work, and during travel to and from work (Frone, 2013). Even a limited and/or occasional amount of AOD use, both in the personal sphere and at the workplace, might have a negative impact on the performance of the workers themselves as well as on that of their colleagues. Excessive job-related consumption of AOD may lead to higher levels of sick leave, (short-term) absenteeism (Salonsalmi et al, 2017; Corral et al, 2012; Vahtera et al, 2002) and reduced performance and productivity (Corral et al, 2012). Moreover, AOD use has important implications for safety at the workplace (Lambrechts et al, 2019; Aas et al, 2017; Roche et al, 2015; Frone, 2013; Corral et al, 2012; Watt et al, 2004).

Results of a cross-sectional study among Belgian workers (n=5367) in 2016 revealed that alcohol was the most prevalent drug, with 83.1% reporting alcohol consumption at least once during the 12 months prior to the study (Lambrechts et al, 2019). Of last-year drinkers (n=4197), 37.1% consumed alcohol at least two to three times a week and 24% had an average daily consumption of three to four standard units on drinking days. Of last-year drinkers, 22.7% and 8.6% exhibited binge drinking[289] at least once a month and once a week, respectively. Based on the AUDIT-C questionnaire (Alcohol Use Disorders Identification Test-Consumption), 39.1% of last-year drinkers in this study had an indication of problematic drinking (Lambrechts et al, 2019). This AUDIT-C Screening Questionnaire is the short version (3 questions) of the 10-questions AUDIT instrument (Saunders et al, 1993; Kaarne et al, 2010).[290]

Cannabis (7.4%) was the most frequently used illicit drug during the 12 months prior to the study, followed by cocaine (1.4%), XTC (1.1%) and speed (0.6%). Of all respondents, 17.1% took prescribed psychoactive medication, i.e. hypnotics (9.3%), tranquillisers (5.5%) or antidepressants (7.9%). Job-related effects include being late at work, absenteeism, loss of productivity, injuries, conflicts with co-workers and sanctions by employers. The likelihood of experiencing job-related effects was 3.6 times larger among workers with an indication of problematic drinking than among workers without. Respondents who used illicit drugs more frequently (more than once a month) also had an increased risk of facing job-related effects (nearly six times higher) (Lambrechts et al, 2019).

There is a growing interest in the potential of the **workplace for preventing harmful alcohol or other drug** use (Liira et al, 2016). The workplace provides a structured context through which the entire working population can be reached for health promotion initiatives and AOD interventions (Liira et al, 2016; Jepson et al, 2010). Workplaces also seem to be appropriate sites for conducting brief interventions for AOD problems (Schulte et al, 2014; Osilla et al, 2010; Webb et al, 2009).

Occupational physicians (OPs) are important actors in the prevention and management of substance abuse among workers. OPs are in regular contact with a significant proportion of the working population, mostly in a preventive medical setting. This puts them in a unique position to intervene early when problems at the workplace occur due to substance abuse (Ames & Bennett, 2011; Lambert, 2002, Roman & Blum, 2002). When discovering AOD-related harm, OPs can intervene or provide appropriate advice, as well as play an important supportive role in the rehabilitation of workers with substance abuse (Takeshita, 2017; Webb et al, 2009). In addition, they can also take into account the work-related context

[289] Following international guidelines, the gender-specific definition of binge drinking has been used, i.e. four or more standard units for women and six or more standard units for men within 2 hours (Gmet et al, 2003; Wechsler & Austin, 1998)

[290] AUDIT-C measures the frequency (Likert scale from 'never' to 'four or more times a week') of alcohol consumption, the quantity of what respondents drink on a typical day, and binge drinking. AUDIT-C thus focuses on consumption patterns of alcohol (Kaarne et al, 2010; Saunders et al, 1993)

in which this substance abuse has developed, e.g. the relation with work stressors and shift work (Virtanen et al, 2015; Tan et al, 2014; Marchand, 2008; Frone, 2008; Lambert, 2002).

Internationally, a **multicomponent policy** is considered to be an asset in the face of AOD-related problems at work (Liira et al, 2016; Webb et al, 2009). It includes rules on the availability and consumption of AOD in the workplace; intervention procedures in case of malfunctioning; assessment and referral of workers with an alcohol or drug problem; and information and education (Webb et al, 2009). Having a job seems to be a motivating and protective factor to tackle alcohol or drug problems, and to prevent relapse (McHugo et al, 2012). Therefore, a prevention policy might be applied to both targeted workers (e.g. safety functions) and all workers (universal prevention) (Webb et al, 2009). Also the importance of an environmental approach should be emphasized, in which both individual and organisational factors, as well as the responsibility of workers and employers are taken into account (Harvey et al, 2014; Ames & Bennett, 2011; Marchand, 2008 and Bacharach et al, 2002).

Most European countries have some form of general legislation or agreements intended to prohibit or regulate the consumption of alcohol and drugs in the workplace. However, there is considerable diversity in the type of legislation in force (Corral et al, 2012). Following the Collective Bargaining or Labour Agreement No 100 (in short CLA 100)**, as of April 1st 2010 all private companies in Belgium are required to have a policy statement on workplace-related AOD use.** This collective labour agreement has been concluded in the National Labour Council (Nationale Arbeidsraad, NAR in Dutch/Conseil Central de l'Economie, CNT in French) by the 'Group of 10', in which the employers organisations and trade unions are represented (Belgisch Staatsblad, 2009). An extension of this regulation to the public sector is still expected.

Figure 27: An integrated alcohol and drug policy at work. Guidebook NAR/CNT (2009, 2020)

In this EVADRUG-study, the 'Collective Labour Agreement 100 concerning a preventive alcohol and drug policy at the workplace' (in short 'CAO100/CCT100' project) is the second targeted intervention for evaluating the Belgian drug policy.

The Federal Drug Note of 2001 and the Joint Declaration of the Interministerial Conference of Drugs of 2010 identified seven main objectives within the 'Prevention' pillar (cf. chapter 4). Besides limited actions mentioned under both Objective 3 (cf. 4.1.1.3: '*Second, a prevention offer will be provided for families and in the workplace*') and Objective 4 (cf. 4.1.1.4: *'Targeted prevention at the neighbourhood level or at the local level (in which there is cooperation between educational institutions, health care, social services, justice, leisure organisations, employers and trade unions) is recommended)*, actions aimed **'at social prevention at work'** are stipulated in Objective 6. On the one hand, the focus is on extending the obligation to implement an alcohol and drug policy to the public sector. On the other hand,

interventions are planned to provide guidance to employers, employees and prevention experts on the alcohol and drug policy at work, and on ensuring compliance with the CAO100/CCT100.

The developments within the objective 'to develop social prevention at work' are mostly related to the CAO100/CTT100. The obligation to have a drug and alcohol policy, implied that (private) companies were obliged to include in the work regulations a policy statement on the implemented alcohol and drug policy. The implementation of the CAO100/CTT100 was accompanied by an information campaign, in which the NAR/CNT distributed a brochure along with a practical manual. Both employers and trade unions organised seminars and information sessions, often at a sectoral level. Moreover, many initiatives were held by prevention experts, by the SPF Employment, Labour and Social Dialogue (FOD WASO/SPF ETCS), and at the organisation level itself. The expansion of the CAO100/CTT100 to the public sector and to the subsidised personnel in the free education sector was not achieved.

The developments within the objective 'to develop social prevention at work' are mostly related to the CAO100/CTT100. The obligation to have a drug and alcohol policy, meant that (private) companies were obliged to include a policy statement in the work regulations with regard to the implemented alcohol and drug policy. The implementation of the CAO100/CTT100 was accompanied by an information campaign. In this campaign, the NAR/CNT provided and widely distributed a brochure together with a practical manual. Both employers and trade unions organized seminars and information sessions, often at a sectoral level. Moreover, many initiatives were held by prevention experts, by the SPF Employment, Labour and Social Dialogue (FOD WASO/SPF ETCS), and at the organization level itself. The expansion of the CAO100/CTT100 to the public sector and to the subsidized personnel in the free education sector was not achieved.

Additionally, there have also been two BELSPO research projects on this topic: UPTODATE 1[291] on attitudes and experience of occupational physicians concerning work-related alcohol and drug use of employees, and UPTODATE 2, an implementation research that measures prevalence of and guidelines for screening and early detection. Moreover, the recent PREVPED study investigated performance enhancing drugs in the work setting (among other settings)[292].

The CAO100/CTT100 is the result of a **long process** that started in 2006 and achieved its final output with the signing of the agreement by the Group of 10, in Brussels, on April 1st 2009. Furthermore, the CAO100/CCT 100 got a first evaluation made by the social partners in 2016, followed by new initiatives. All these steps are well defined and illustrated, which makes them interesting to evaluate.

In what follows, we provide an in-depth process-, output- and outcome evaluation of the CAO100/CCT100-project, based on the following policy documents:

- Nota minister van Werk, de heer Peter Vanvelthoven, aan de Nationale Arbeidsraad (2006). Niet gepubliceerde nota. Note du ministre du travail, M. Peter Vanvelthoven, au Conseil National du Travail (2006). Notice inédite.
- Interprofessioneel akkoord (IPA)[293] voor de periode 2007-2008 (2/2/2007) van de sociale partners (Groep van 10). Accord interprofessionnel AIP) pour la période 2007-2008 (2/2/2007) des partenaires sociaux (Groupe des 10).

[291] https://www.belspo.be/belspo/fedra/proj.asp?l=en&COD=DR%2F60
[292] http://www.belspo.be/belspo/fedra/proj.asp?l=en&COD=DR/87
[293] An interprofessional agreement (IPA) is an intersectoral agreement made by the representatives of the social partners from the private sector (the so-called Group of 10) concluded every 2 years. Members of the Group of 10: Verbond van Belgische Ondernemingen (VBO/FEB) (2), Unie van Zelfstandige Ondernemers (Unizo) (1), Union des Classes Moyennes (UCM) (1), en Boerenbond (1) and 5 representatives of the trade unions (Algemeen Christelijk Vakverbond (ACV/CSC) (2), Algemeen Belgisch Vakverbond (ABVV/FGTB) (2) en Algemene Centrale der Liberale Vakbonden van België (ACLVB/CGSLB) (1) (www.werk.belgie.be).

- Advies Nr. 1.655. Zitting van vrijdag 10 oktober 2008. Een alcohol- en drugbeleid in de onderneming met in bijlage het 'ontwerp van collectieve arbeidsovereenkomst nr. … van … betreffende het voeren van een preventief alcohol- en drugbeleid in de onderneming. Verslag. Avis N° 1.655. Séance du vendredi 10 octobre 2008. Une politique en matière d'alcool et de drogues dans l'entreprise. Annexe 'Projet de convention collective de travail N° … du … concernant la mise en oeuvre d'une politique préventive en matière d'alcool en de drogues dans l'entreprise. Rapport.
- Wet van 8/04/1965 tot instelling van de arbeidsreglementen, art.14 gewijzigd door de wet van 6/05/2009 (BS 19/05/2009) houdende diverse bepalingen, Artikel 59. Loi du 8 avril 1965 instituant les règlements de travail, art. 14 adapté par le Loi portant des dispositions diverses 6/05/2009 (MB 19/05/2009). Article 59.
- Collectieve arbeidsovereenkomst nr. 100 van 1 april 2009 betreffende het voeren van een preventief alcohol- en drugsbeleid in de onderneming. Convention collective de travail n° 100 du 1er avril 2009 concernant la mise en œuvre d'une politique préventive en matière d'alcool et de drogues dans l'entreprise (ratifiée par l'AR du 28 juin 2009, paru au MB du 13 juillet 2009).
- Koninklijk Besluit waarbij algemeen verbindend wordt verklaard de collectieve arbeidsovereenkomst nr. 100 van 1 april 2009, gesloten in de Nationale Arbeidsraad, betreffende een preventief alcohol- en drugbeleid in de onderneming (28 juni 2009). Gepubliceerd in Belgisch Staatsblad van 13 juli 2009. Arrêté royal rendant obligatoire la convention collective de travail n° 100 du 1er avril 2009, conclue au sein du Conseil national du Travail, concernant la mise en oeuvre d'une politique préventive en matière d'alcool et de drogues dans l'entreprise (28 juin 2009). Paru au Moniteur Belge du 13 juillet 2009.
- Koninklijk besluit tot opheffing van artikel 99 van het Algemeen Reglement voor de Arbeidsbescherming (ARAB) van 19 mei 2010, gepubliceerd in het Belgisch Staatsblad op 3 juni 2010. Arrêté royal abrogeant l'article 99 du Règlement général pour la protection du travail du 19 mai 2010, paru dans le Moniteur belge du 3 juin 2010.
- Algemene beleidsnota werk. Minister Joëlle Milquet, vice-eersteminister, minister van Werk en Gelijke Kansen, belast met het Migratie- en asielbeleid. Doc 52 2225/025. Belgische Kamer van Volksvertegenwoordigers. 25 november 2009. Note de politique générale. Ministre Joëlle Milquet, la vice-première ministre, ministre de l'Emploi et de l'Égalité des Chances, chargée de la Politique de migration et d'asile. Doc 52 2225/025. Chambre des représentants de Belgique.
- Ministerieel besluit tot toekenning van een subsidie aan de Vereniging voor Alcohol- en andere Drugproblemen vzw voor het begeleiden van 28 bedrijven bij het ontwikkelen en implementeren van een alcoholbeleid. Vlaamse Minister van Welzijn, Volksgezondheid en Gezin (2/12/2009).
- Ministerieel besluit tot toekenning van een subsidie aan de Vereniging voor Alcohol- en andere Drugproblemen vzw voor het begeleiden van bedrijven bij het ontwikkelen en implementeren van een alcoholbeleid. Vlaamse Minister van Welzijn, Volksgezondheid en Gezin (2/12/2010).

Related to the evaluation made by the Committee on Individual Labour Relations (Commissie Individuele arbeidsverhoudingen/la Commission des Relations individuelles du Travail):

- Notulen van de vergadering van de Commissie Individuele Arbeidsverhoudingen van 21 oktober 2016. Punt 2. Cao nr.100 betreffende een preventief alcohol- en drugsbeleid in de onderneming - Evaluatie - Verdere bespreking (Dossier 2.830 - 38/D.16-18 en 46). Procès-verbaux de la réunion de la Commission des Relations individueles du Travail du 21 oktober 2016. Point 2. CCT n° 100 concernant la mise en œuvre d'une politique préventive en matière d'alcool et de drogues dans l'entreprise – Évaluation. Poursuite de la discussion (Dossier 2.830 - 38/D.16-18 et 46).

- Notulen van 9 december 2016 - Cao nr.100 betreffende een preventief alcohol- en drugsbeleid in de onderneming (38/16-18 N). Procès-verbaux de la réunion du 9 décembre 2016. CCT n° 100 concernant la mise en œuvre d'une politique préventive en matière d'alcool et de drogues dans l'entreprise (38/16-18 F). Évaluation.

- Non-paper 2017-86. Cao nr.100 betreffende een preventief alcohol- en drugsbeleid in de onderneming – Evaluatie. Non-paper 2017-86. CCT n° 100 concernant la mise en œuvre d'une politique préventive en matière d'alcool et de drogues dans l'entreprise. Évaluation.

- Non-paper 2018-38. Cao nr.100 betreffende een preventief alcohol- en drugsbeleid in de onderneming – Evaluatie. Non-paper 2018-38. CCT n° 100 concernant la mise en œuvre d'une politique préventive en matière d'alcool et de drogues dans l'entreprise. Évaluation.

- Een preventief alcohol- en drugsbeleid in de onderneming. In overleg werken aan preventie. Leidraad voor de uitwerking van een preventief alcohol- en drugsbeleid in de onderneming. Herziene versie. Januari 2020. Une politique préventive en matière d'alcool et de drogues dans l'entreprise. La concertation au service de la prévention. Guide pour l'élaboration d'une politique préventive en matière d'alcool et de drogues dans l'entreprise. Version révisée. Janvier 2020.

2. Methodology

The aim of this study is to provide an in-depth evaluation of the drug policy implementation concerning the targeted intervention of the 'Collective Labour Agreement 100 concerning a preventive alcohol and drug policy at the workplace', in short 'CAO100/CCT100-project'. Therefore, we took the following steps (Table 1).

Research question	Method
Understanding the intervention policy: 2. What is the logic of the targeted intervention policy?	Document analysis Critical appraisal
Process evaluation: 4. To what extent have the activities set out in the CAO100/CCT100 been realised? 5. What challenges obstructed and which enabling factors facilitated the implementation of these activities? 6. To what extent do these activities correspond to the objectives of the CAO100/CCT100?	Document analysis - Evaluation NAR/CNT - Results UPTODATE 1 & 2 Semi-structured interviews Focus group
Output and outcome evaluation : 3. Which quantitative and qualitative measurable indicators can be identified to evaluate this intervention? 4. Which quantitative and qualitative measurable indicators would be beneficial to evaluate this intervention?	Document analysis Semi-structured interviews Focus group Ginger-report

Table 20: Overview of research questions and their methodology

In the methodological part of this report (cf. chapter 2, Part 1), we explained why we rely on logic models to analyse the available policy documents. Logic models are a systematic and coherent description of a policy that identify the objectives, activities, resources, intended outputs and intended outcomes underpinning a certain policy (EMCDDA, 2017a). Logic models specify the underlying assumptions on

how policy aims to achieve its aims and accentuate the crucial elements in a policy, strategy or intervention (cf. chapter 2, Part 1).

To establish a *logic model* for the CAO100/CCT100 project, we *first* started with the **analyses of the policy documents** related to the CAO100/CCT100 agreement itself. To achieve this, ten policy documents were analysed, including the unpublished memorandum from Minister Vanvelthoven in 2006 (cf. p.5). Further we analysed the text of the Interprofessional Agreement of the social partners of 2007. Finallly, the text of the Collective Labour Agreement itself and the accompanying advice were analysed. We extracted the aims, the activities, the inputs (or resources) for the project, the intended outputs and the intended outcomes word for word from these documents, and rearranged them in a logical sequence (shown by Figure 3). This logic model was then critically appraised for its internal validity (Funnell & Rogers, 2011).

Second, we performed a *process analysis* to verify and to understand how the objectives of CAO100/CCT100 have been implemented. For this purpose, we analysed the **evaluation documents of the NAR/CNT** in the period 2016-2017, for which we could rely on the minutes of the meetings of the Committee on Individual Labour Relations. In addition, we analysed the results and the recommendations of the UPTODATE 1 survey[294], in which the role of occupational physicians in an alcohol and drug policy at work was assessed. Among other questions, the extent to which the collective labour agreement facilitated the work of occupational physicians was discussed.

In a next phase, we **interviewed** several key stakeholders to the CAO100 project. The semi-structured interviews (both individual and via focus group) took place in the period June – November 2021. In order to get a complete overview, we organised an extra interview in January 2022. In total, we interviewed 21 stakeholders. We conducted interviews with six persons directly involved in the making of the collective labour agreement. The other participants are all working in the field, both as prevention advisors (mainly for safety at work; n = 8), or as prevention workers (n = 7, focus group) specialised in the field of alcohol and drug prevention. Due to to COVID-19 restrictions, all interviews took place online (via Teams or ZOOM). All participants gave their informed consent for their participation to the research. The interviews lasted between 25 minutes and 2 ½ hours. All interviews were video recorded and replayed afterwards. The focusgroups were transcribed for analyses.

The data were analysed by means of an excel analysis grid (see Figure 2) which allowed for general tendencies and reflections to be noted and structured in an orderly manner.

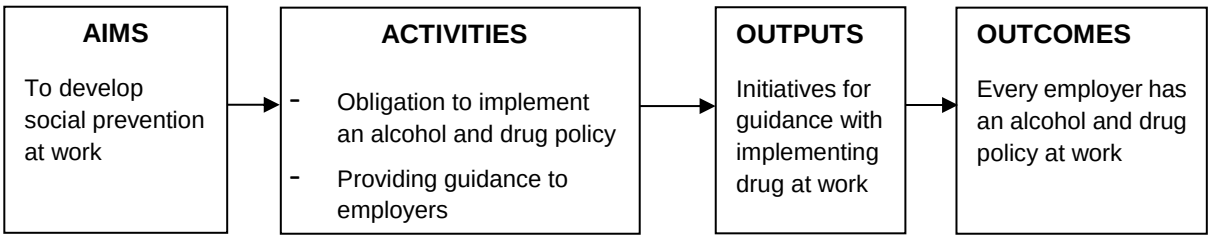
Who	Logic model	Implementation 2010	Barriers and facilitators	Evaluation NAR/CNT 2016-2017	UPTODATE 1&2 2015-2017	Results	Recommendations
				Barriers and facilitators	Barriers and facilitators		

Figure 28: Analysis grid for data from semi-structured interviews

[294] https://www.belspo.be/belspo/fedra/proj.asp?l=en&COD=DR%2F60

3. A logic model

We build further on this logic model (infra) by concretising the aims, inputs, activities, intended outputs and intended outcomes, derived from both the policy documents and the evaluation documents as described on pages 443-445.



I. Aims

All policy documents refer to an overarching aim, ic the **development of an alcohol and drug policy at work.** In the note of minister Vanvelthoven, one can read the objective of creating a safe working environment. In addition, it is emphasised that it is important that the government encourages and supports companies in developing a prevention policy. The interprofessional agreement of 2007-2008 (IPA/AIP 2007-2008) intends to create a strong responsibility among employers and employees to avoid alcohol or drug use with impact at the workplace. Therefore 'Ankerpunt 5' specifies that the collective agreement should cover prevention (good practices, models and procedures for the prevention of alcohol and drug use), rules regarding alcohol and/or drug use during work, and procedures for tackling problematic behaviour related to alcohol and/or drug use. Further procedures related to alcohol and drug testing and to assistance for workers are to be included.

In the CAO100/CCT-documents, the objective is to elaborate an instrument in order to avoid functioning problems caused by alcohol or drug use, or to intervene early so that workers can recover and keep their job and function (CAO100/CCT100 – Advice 1.655). Article 2 of the CAO100/CCT100 Royal Decree text makes this aim more concrete:

- To discuss dysfunctioning at work as a result of work related alcohol or drug use
- To improve productivity and to reduce absenteeism
- To prevent and to remedy dysfunctions because of the adverse consequences associated with it for both employers and employees
- To create support through consultation
- To offer assistance in order to increase the chance of recovery
- To make managers and employees aware of alcohol and drug policy measures

Furthermore, in the comments of article 2, the CAO100/CCT100 emphasises two crucial issues in the development of an alcohol and drug policy. First, the objectives and its concretisation are both **collectively** (e.g. the relation between risk factors and alcohol or drug use) and **individually** (assistance for individual workers with problems due to substance use) oriented. Second, they must be realised via **a two-track policy**: on the one hand, an AOD policy is part of an integrated health and safety policy and, on the other hand, it must be part of a global personnel policy in which employees are held accountable for their performance.

Finally, in the General Policy Document - Work of November 25th 2009, the federal minister of Work Milquet refers to CAO100/CCT100. She announces to take the initiative to extend the principles of the CAO100/CCT100 to the public sector (Deel 1. V. Meer veiligheid en kwaliteit in het werk. 1.1.1.2.

Bestrijden van alcohol en drugs. Partie 1. Plus de sécurité et qualité dans le travail. 1.1.1.2. Lutter contre l'alcool et les drogues).

II. Inputs

Hearings

In order to gain a better understanding of the problems that alcohol and drugs pose in companies and the way in which the latter deal with them, the National Labor Council organised a number of hearings to prepare the CAO100/CCT100 (Advice 1.655 (p.3). During these hearings, the council was informed about this issue by a number of prevention advisors from external (Provikmo, Arista[295]) and internal services (from Ensival Moret, Volvo Truck, Aleris Aluminum, Rijksdienst voor Pensioenen/ Service fédéral des Pensions). In addition, the Flemish association for Alcohol and Drug problems (VAD, now Flemish expertise centre on Alcohol and other Drugs) (cf. Annexes) and representatives of FPS WASO/ETCS (Directorate Humanization of Labour) were invited.

Based on the information provided and the discussions in the Commitee of Individual Labour Relations, the employers and employees' organisations represented in the NAR/CNT agreed on the text of a collective labour agreement regarding a preventive alcohol and drug policy at the workplace.

Consultation

With regard to the concretisation of an AOD policy, employers and trade unions are advised to add this topic to the agenda of the Committees on prevention and protection at work (Comités voor de Preventie en Bescherming op het Werk/Comités pour la prévention et la protection au travail) and the Works Council (Ondernemingsraad/Conseil d'entreprise). Further, companies may rely on the prevention advisors (for safety and health) from internal and external prevention services, and on the FPS WASO/ETCS.

Funding Flemish government

The Flemish minister of Health funded VAD for an amount of 144.900 euro. Article 2 (§1 and 2) of the Ministerial Decree (2/12/2009) specifies the activities that have to be achieved during the period 15/12/2009-14/12/2010. These include the organisation of 28 regional initiatives to sensibilise companies, the coaching of 28 companies in the development and the implementation of an alcohol policy, and the organisation of at least 140 training sessions related to an alcohol policy at work. In order to realise this project, collaboration with the alcohol and drugs prevention workers of the centres for mental health was recommended. This project was prolonged by the Ministerial Decree of December 2, 2010 for the period from 15/12/2010 to 31/12/2011 (budget 144.900 euro).

III. Activities

Preliminary phase

The Council notes that a number of points cannot be regulated by a collective labour agreement itself (Advice 1.655, p.4). It wishes to draw the government's attention to a number of special aspects of the alcohol and drug problem in companies. Before signing this agreement, the council points out that certain elements of the collective labour agreement **require adjustments to a number of legislative and regulatory texts**. In particular, this is 'necessary to ensure that the principles and objectives of an alcohol and drug policy in the company and the policy statement can be included in the Work Rules[296] (Arbeidsreglement in Flemish; Réglement du Travail in French) without having to follow the procedure for drafting and amending these rules'. Concerning the Council, the consultation procedure as

[295] Liantis (since 2018) and Cohezio (since 2020) respectively

[296] Workrules ('Arbeidsreglement / Règlement de travail'), i.e mandatory document including a set of rules to the employer and the employees of his/her undertaking

mentioned in Article 6 of the collective labour agreement may suffice as a preliminary procedure to do this. To this end, the Council proposes an amendment to Article 14, 2° of the Law of 8 April 1965, which includes the list of amendments to the regulations for which the procedure for drawing up and amending the work regulations does not have to be followed.

Further, the Council recommends the abolition of Article 99 of the ARAB/RGPT (Algemeen Reglement voor de Arbeidsbescherming/Règlement général pour la protection du travail (RGPT) concerning the introduction into the company of alcoholic beverages. The Council notes that Article 99 prohibits the introduction into the working environment of distilled alcoholic beverages and fermented drinks with more than 6% alcohol by volume. The Council believes that this article is not very effective since it does not prohibit the consumption of alcohol (but only concerns its introduction) and only refers to the introduction as an active act (and not to the lack of control by the employer). Moreover, the penal restraint of this provision (by art. 81 of the Welfare Act) is not efficient, since it only concerns the employer, his employees or agents.

Phase 1

On April 1, 2009, the CAO100/CCT100 was conducted. Private organisations were obliged to introduce a preventive alcohol and drugs policy by 1 April 2010 at the latest (art.15). The Council emphasises the importance of having sufficient support for the principles and objectives of the policy, benefitting the effectiveness of the policy. Therefore, an AOD policy should be elaborated by a broad working group (e.g. prevention services, committee for prevention and protection at work, works council, the hierarchical line). Concrete initiatives, such as questionnaires for the workers, might be useful. Concerning the **role of the employer** in this phase, it is mentioned that:

- Every employer must take the necessary measures to promote the well-being of employees when performing their work. The use of alcohol and drugs at work or with influence at work is one of the factors that can negatively affect the safety, health and well-being of employees and their environment (art.2).
- The employer ensures that the policy is adapted to the size of the company, the nature of the activities and the specific risks inherent in those activities, as well as the specific risks specific to certain groups of persons (art.3§1).
- The employer must take the initiative to at least determine the principles and objectives of the preventive alcohol and drug policy in his company and to specify these in a policy statement (art.3§3).
- The employer informs the employees about his proposal and about the advice of the prevention services if applicable (art.6).
- The employer acts appropriately to ensure that the members of the hierarchical line and the employees receive all information about the policy (art.7).

Phase 2

Insofar as the realisation of the principles and objectives require it, the **employer** will further elaborate the policy statement:

- By drawing up rules on the availability of alcohol at work, on the introduction of alcohol and drugs and regarding the work-related use of alcohol and drugs (art.3§4.1);
- By determining the procedures that must be followed in case of dysfunction of workers due to (possible) alcohol or drug use, or in case of violation of the rules as mentioned supra (art.3§4.2);
- By working out the procedure that must be followed in case of the incapacity for work of an employee with regard to the transport of the person towards home, his guidance and the cost involved; (art.3§4.3);
- By determining the rules that must be followed when testing for alcohol and drug use, taking into account all legal conditions (art.3§5; art.4);
- By organising trainings with regard to the implementation of phase 1 and/or phase 2.

When developing, programming, implementing and evaluating this alcohol and drugs policy, the employer requests the advice and cooperation of the prevention and protection services as referred to Article 33 of the Welfare Act (art.5).

The role of the **line management** has been described as follows (art.10):

- The members of the line management implement the preventive alcohol and drug policy within their competence and at their level (art.10);
- In particular, they must include their role in the procedures that, if necessary, must be followed in the company when dysfunctional performance at work is established as a result of possible alcohol or drug use;
- When determining incapacity for work, members of the hierarchical line must act in accordance with the procedures mentioned in the AOD policy, based on Article 3, paragraph 4 of the CAO100/CCT100;
- For reasons of objectivity and efficiency, it is recommended that performance problems that may be caused by AOD use will be treated like any other functioning problem (art.2).

Article 13 of the collective labour agreement describes the role of the **prevention advisors**. The Council asks them to act when they identify risks at work that may be the result of alcohol and drug use. In that case, the prevention advisor informs the employee about the possibilities for assistance available in the company, and about the possibility to contact his general physician or specialised services. In addition, the prevention advisor may contact an external care provider himself, if he considers that the employee is unable to do so, and with his formal consent.

Finally, the council asks **every employee** to work to the best of his ability on the preventive alcohol and drug policy in the company. He refers to the application of Article 6 of the welfare legislation that says that every employee must, in accordance with his training and the instructions given by the employer, do his best for his own safety and health and that of the other persons involved (art.10).

IV. Outputs

The document review (cf. chapter 7) indicates that almost all the actions intended by the Federal Drug Note and the Joint Declaration for the objective 'to develop social prevention at work' were realised. Most developments are related to the CAO100/CCT100. Infra we give an overview of these initiatives.

Adjustments of legislative and regulatory texts

- Adjustment of Article 14, 2° of the Law of April 8, 1965 which includes the list of amendments to the regulations for which the procedure for drawing up and amending the work regulations does not have to be followed. This adjustment was made by the law of 6/05/2009, article 59 (BS/MB 19/05/2009).

- Abolition of Article 99 of the ARAB/RGPT concerning the introduction into the company of alcoholic beverages. This adjustement was made by the Royal Decree of 19/5/2010 (BS/MB 3/06/2010).

- Expansion of the CA0100/CCT to the public sector and subsidized education personnel. Not achieved.

- We also refer to the Joint Declaration of the Ministers of Health on the future alcohol policy, which specifies the need to investigate the installation of alco-locks in vehicles of recidivists and professional drivers (17/06/2008, published BS/MB 17/7/2008). In an answer to a parliamentary question (no. 9876, J. Van den Bergh, 2009), Minister Milquet refers to the draft Cao, in which the installation of an alco-lock depends on the preventive alcohol policy pursued by the employer.

Information campaign NAR/CNT

It is important to underline that CAO100/CCT100 aims to encourage discussion, and to prevent and deal with failure at work caused by alcohol and drug use in companies, due to its detrimental consequences for both employers and employees. Because of the diverse circumstances of the numerous companies involved the agreement does not impose one preventive alcohol and drugs policy, but rather creates a **framework (so called 'kader-cao')** allowing each individual company to develop its own policy. Overall, company policies in this regard should focus on prevention and not on sanctions.

As such, the agreement requires the employer to establish the basic principles and goals of the company's alcohol and drug policy in a declaration of intent. This will be part of the company's workplace rules. Because of this obligation, in practice all private organisations have such a declaration of intent. The policy agreement may also incorporate an optional phase that renders such principles more concrete. For example, besides training and sensibilisation activities, and guidance, rules can be introduced to cover:

- The availability or prohibition of alcohol in the workplace;
- The bringing of alcohol or drugs into company premises;
- Work-related consumption of alcohol;
- Procedures for investigation and action if an employee is found to be unable to perform their work owing on the use of alcohol or drugs

The NAR/CNT made a guidebook to support companies in making their own alcohol and drug policy. Four models of policy declarations have been included in this guideline, which can meet the differing needs of different companies (depending on the consensus that can be found about the policy and depending on the specific activities of the company, the image or the corporate culture).

Een preventief alcohol- en drugsbeleid in de onderneming (2009). In overleg werken aan preventie. Leidraad voor de uitwerking van een preventief alcohol- en drugsbeleid in de onderneming. Une politique préventive en matière d'alcool et de drogues dans l'entreprise (2009). La concertation au service de la prevention. Guide pour l'élaboration d'une politique préventive en matière d'alcool et de drogues dans l'entreprise. 74 pp.

During the entire process of drafting the collective labor agreement, concluding it and entering into force, both (sectoral) employers and trade unions took numerous initiatives to inform an motivate their members. An example of a concrete sectoral action is the 2009 CNAC/NAVB information bundle (Bundle No. 124. Alcohol and Drug Prevention in Construction).

V. Outcomes

In the CAO100/CCT100 document, the social partners formulate the outcomes of an AOD policy rather concrete:

- **Prevention comes first** in an integrated approach (An alcohol and drug policy is integrated in the welfare and personnel policies of each company);
- Employers and workers take **their responsibility** regarding work related alcohol and drug use.
- **Transparent role definition** about the role of line management, prevention advisors, especially of occupational physicians.
- **Clarity and legal certainty about testing** on alcohol and drugs at work

In the long term, they want to achieve:

- **Less taboo**. Open culture in which workers discuss work related alcohol and drugs use, and its impact on the job, in a more open way.

- A more **effective approach** of work related alcohol and drug use

Logic model:
An analysis of the policy logic found that:

- ⇨ CAO100/CCT100 is clear in its global vision: a two-track policy based on performance behaviour and a multi-component policy in an integrated welfare and safety approach;
- ⇨ CAO100/CCT100 is clear with regard to its objectives and the activities that are necessary in achieving them, and in its outputs and outcomes: the prevention and early management of performance problems as a result of alcohol and drug use;
- ⇨ CAO100/CCT100 consists of two phases: a mandatory and an optional phase, each with specific conditions;
- ⇨ CAO100/CCT100 made a framework for work related testing for alcohol and drug use.

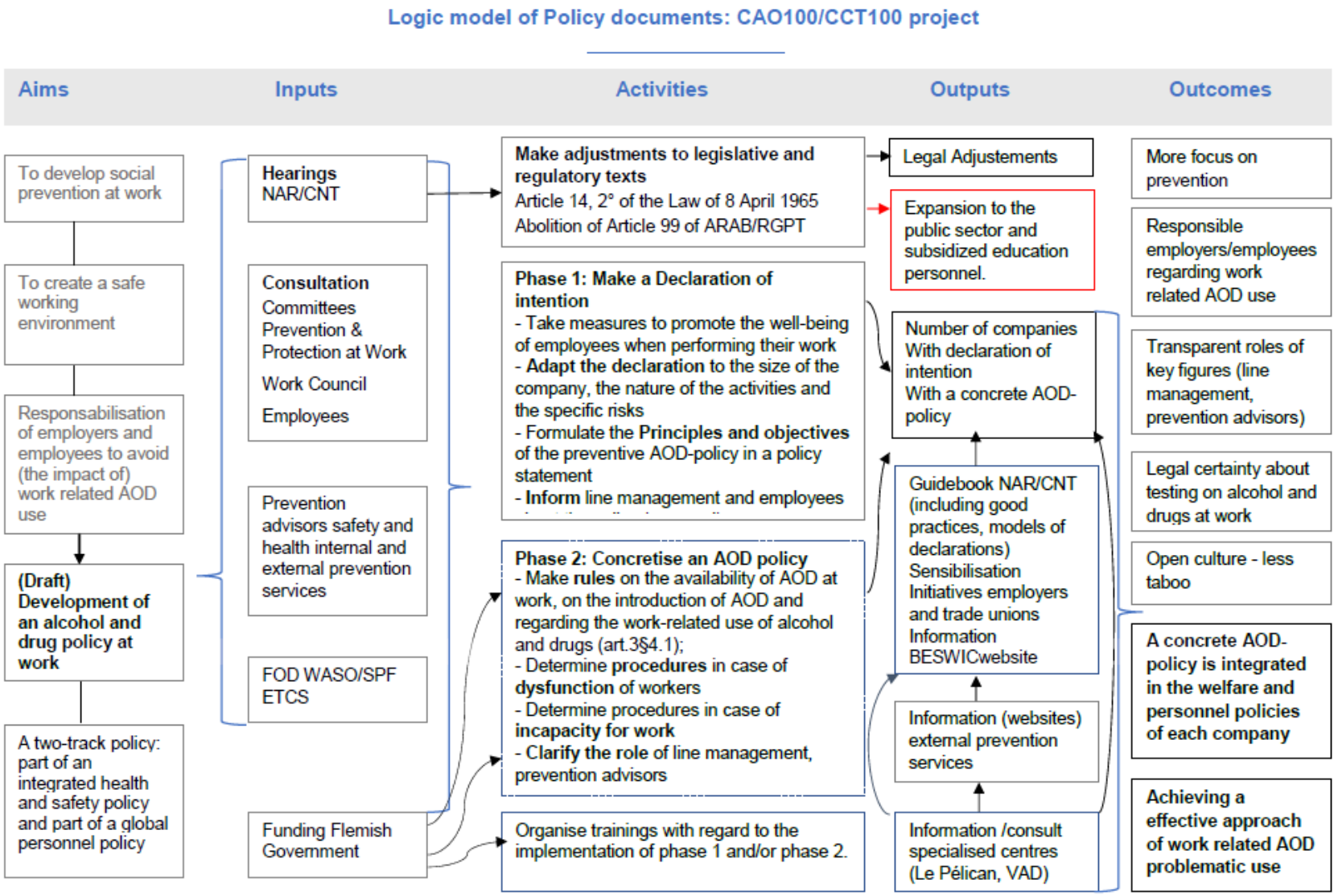


Figure 29: Logic model of the Policy documents concerning the CAO100/CCT 100 project

4. Critical appraisal

In this section, and similar with the other targeted intervention in prisons, we now address the research question '*To what extent is the logical model based on the Policy documents regarding CAO100/CCT100 consistent, coherent and logical?'* This critical appraisal of the policy theory is a first step of the process and outcome evaluation, because it allows us to verify whether possible policy issues are attributable to a poor policy theory or not.

The internal validity of the policy theory shows to what extent the policy theory is clear, realistic and logical about what the policy intends to achieve, and how the policy wants to achieve these outcomes (Funnell & Rogers, 2011). In this section, we assess this internal validity based on five indicators: Clarity of description, the outcome chain, demonstration of how the outcomes are related to the problem, the logical argument of the policy theory, and the articulation of mechanisms for change.

I. Clarity of the description

A *first m*easure of internal validity is the 'clarity of description'. It assesses whether the policy documents describe how the policy works with enough detail.

A comprehensive problem description is available, especially because of the availability of the Advice 1.605 document and the **guidebook** made by the social partners (2009). Those documents are complementary to the CAO100/CCT100 policy text. Employers and trade unions/employees get a broad overview of all topics involved:

- Arguments for establishing an alcohol and drug policy at work;
- Information regarding the objectives and the modus operandi of the CAO100/CCT100;
- Information on both the obliged phase and the facultative phase of the CAO100/CCT100;
- A very extensive part regarding testing at work;
- Annexes with examples of procedures, and of declarations of intention;
- Information about expertise centres in Flanders, Brussels and Wallonia.

In 2020, the NAR/CNT made a revision of this guidebook, in which they updated the problem description (e.g. with recent prevalence data on work related alcohol and drug use). In 2017, the FPS WASO/ETCS published 'Alcohol en andere drugs. Handleiding voor een preventiebeleid op het werk - Psychosociale risico's. Alcool et autres drogues: manuel pour une politique de prévention au travail - Risques psychosociaux. In this brochure, the focus is on information about all types of drugs, and its psychosocial impact (Handleiding/Manuel FOD WASO/ETCS, 2017).

In addition, extensive information on this topic was/is available on the websites of FOD WASO/FPS ETCS (including Beswic), and on the website of external prevention services and expertise organisations such as Le Pelican (https://lepelican-asbl.be/formations-en-entreprise/) and VAD (www.gado.be and www.druglijn.be).

To conclude, in terms of implementation and expected outcomes, up to date information is available via different channels.

II. The outcomes chain

A *second* assessment of the policy's internal validity questions whether it is built around the outcomes it wants to achieve. Are the outcomes central to the logic model, or are there other elements (e.g. activities, inputs) that are accentuated?

The great strength of CAO100/CCT100 is also its weakness. By conducting the collective labour agreement in the National Labor Council, a framework was created at the highest level to introduce an alcohol and drug policy at work. This created a process with a lot of consultation, which was taboo breaking. However, no matter how clearly the objectives, activities and outcomes were described, they remain non-binding, with the exception of the mandatory declaration of intent. In other words, companies are not obliged to concretise such an AOD policy in line with their own corporate culture. This is precisely what makes an approach (more) effective, because a link is needed between the existing functioning systems in the organisation (performance monitoring, sanctions policy) and the activities within the framework of the welfare legislation. As a result, the output and outcome of the collective labour agreement are less than its intrinsic quality.

This also poses a problem for the **role clarification of key figures** in companies. The CAO100/CCT100 stipulates that prevention counsellors have an important role in informing and assisting employees with problematic use. However, when this role is not elaborated or is not clear to all employees, it will be of little benefit.

"When there is not a well-developed A&D policy in the companies, it is difficult to talk about alcohol and drugs. I still experience a lot of resistance from both the employee and the working environment. Owing to the absence of comprehensive policies, my role and that of other actors also remain unclear and vague."
(Participant 5)

We should also emphasize that the collective labour agreement **only applies to the private sector.** Although the public sector and the free education sector get their inspiration in the CAO100/CCT100, there is no legal framework to motivate them to do the same.

"The lack of an alcohol and drug policy for the public sector should be brought to the attention… "
(Minutes NAR/CNT, 2016)

III. Demonstration of how desired outcomes relate to addressing the problem

A *third* measure of internal validity questions whether the policy indicates how the outcomes address the problem(s). This means that we assess if and how the problem(s) that gave rise to the establishment of the policy are linked to the intended outcomes.

The CAO100/CCT100 emphasises that a copy paste method would not work as many individual and organisational aspects might influence the prevention and approach of work related alcohol and drug use. As small companies differ from big companies, as working in commercial driven organisations differs from non-profit ones, we need tailored interventions and policies. To have an impact, it is also appropriate that alcohol and drug policies are situated in an organizational culture that values prevention. An effective AOD policy allows employers and employees to be clear about what is acceptable and not acceptable in the workplace. It provides a framework for the prevention, screening, early intervention and treatment of substance use problems experienced by workers, with clear roles for stakeholders (e.g. supervisors, management, trade unions, occupational doctors). It ensures that organisational goals related to productivity, safety, and employee relations are met. Therefore, it is important to link such an AOD policy to related policy domains such as safety and wellbeing programs, and productivity and Human Resources policies.

Again, in theory, this is highlighted in the CAO100/CCT100, but the outcomes and outputs should be operationalised in each company, or at least sector specific.

"It is very good that companies can define their own policy. However, they must have the tools to know exactly what they can do, what works and what does not.

There are tools availals, but they don't know them. Perhaps the guide should also be more practical.
(Participant 7)

An interesting issue in this regard is alcohol and drug testing, which was **one of the most important arguments for a legislative initiative.** Although the collective labour agreement does not want to focus on testing, the social partners nevertheless wanted to create a clear framework in which testing is possible.

The introduction of AOD testig meets a number of conditions in order to remain valid. In order to protect the privacy of an employee, the agreement strictly regulates the use of such testing:

- No biological or medical tests may be used. Only tests that give no exact percentage of intoxication, but just a positive or negative indication – such as breath tests or psychomotor skills tests – are permitted;
- The testing can only be part of a package of policy implementation measures (cf. Phase 2 of the agreement);

Further, the AOD testing has to fulfil certain conditions:

- It can only be used for prevention purposes;
- The test results cannot be used in a way that is incompatible with the prevention objective – they do not allow for sanctioning the employee concerned;
- Tests must be adequate, objective and proportional;
- The employee concerned has to consent to the test;
- The processing of test results as personal data is forbidden.

There are **two bottlenecks** regarding testing.

First, companies cannot test if they only have a declaration of intention (Phase 1). This applies to most companies. Second, the social partners want to clarify when testing is possible and when not. In practice, however, there remain many questions. Many companies refer to the **saliva test** in the context of traffic legislation. They also want to introduce this option in the working environment. However, the collective labour agreement does not mention the saliva test.

Many companies are confronted with dealing. What does the cao say about this?
(Participant 7)

For me, all tests are covered by the collective labour agreement. You have the general part of tests (which the occupational physician can do), and you have the preventive tests of the collective labour agreement, such as the breath test and the psychomotor reaction tests. But you can only use it to determine whether someone is still functioning or not. The other tests are not mentioned anywhere. .. I would really like a judge to rule on this.
(Participant 7)

There is a lot of discussion about testing again, also related to Covid19. In that case, there are also many questions about privacy. Privacy issues will become even more important.
(Participant 4)

If unions and employers agree on testing, why not?
(Participant 8)

IV. The logical argument

A *fourth* assessment of internal validity is 'the strength of the logical argument'. This means that we measure the extent to which the policy is 'logic' in terms of coherence, sequence and completeness.

In that way, the logic model based on the 10 policy documents is quite logical, especially on the level of making the CAO100/CCT100. The Council got external input to draft and finalise the agreement (e.g. adjustments of legislation). Further activities were carried out to implement the CAO100/CCT100 to the private sector (e.g., the transition phase between the signing of the agreement and the official start April, 1, 2010).

This is different for an individual company, partly determined whether the organisation only fulfils the mandatory phase or develops a concrete policy. Relatively few companies fully elaborate such a concrete policy.

The collective labour agreement attach great importance to consultation. Furthermore, they aim at increasing support for an alcohol and drug policy ("why should we have a policy") among all partners in the organisation. In this regard, the council mainly relies on the committees' prevention and protection committees and on the works councils.

"It is still not clear how to fulfil the requirements of the collective labour agreement"
(Minutes NAR/CNT, 2016)

"We got a question about the committees' involvement in this policy. 20% said they were not involved at all, 20% said they were involved, and the rest were more or less satisfied with their involvement."
(Minutes NAR/CNT, 2016)

V. Mechanisms for change

The *last* assessment of internal validity is 'the articulation of the mechanisms for change'. This concerns the question 'Does the policy clearly identify the assumed mechanisms of change that underpin its selection of outcomes and activities'. Funnell & Rogers (2011) describe these mechanisms for change as the 'because' statements: if A happens, then it will result in B, because of C. 'C' is the mechanism for change in this case.

For the CAO100/CCT100, clear *'if-then'* statements are described in the policy documents. The general idea is that the introduction of the declaration of intention (*if*) will lead to a certain outcome (*then*; an integrated alcohol and drug policy). However, **due to the facultative character of phase 2, the 'C' is very unpredictable.**

"We find that a great deal of companies only carry out the legally required phase 1."
(Minutes NAR/CNT, 2016)

Critical appraisal:
A critical appraisal of the policy logic found that:

- ⇨ The policy is rather logical, but the division of CAO100/CCT100 in a mandatory and optional phase undermines its effectiveness.
- ⇨ Numerous tools are available, but many companies do not know them or find them too abstract.
- ⇨ CAO100/CCT100 provided a framework for work-related testing for alcohol and drug use. However, legal certainty is not accomplished.

5. Process evaluation

The key research questions of the process evaluation are:

3. To what extent have the activities set out in the CAO100/CCT100 policy document been realized?
4. What challenges obstructed and which enabling factors facilitated the implementation of the activities set out these CAO100/CCT100

The answer to these research questions is mainly based on the **evaluation of the NAR/CNT** during different meetings in the period 2006-2007. In addition, we add some results (illustrations) of the semi-structured interviews.

I. Implementation

In February 2016, the Federal Minister of Employment Kris Peeters, asked the National Labour Council to make an evaluation of the collective labour agreement N°100. Moreover, when necessary, it had to take the necessary steps and/or formulate recommendations with a view to update existing information and to optimise the application of this collective labour agreement. In addition, the Federal Minister of Health, Maggy Deblock was working on a general alcohol plan. In that context, an evaluation of the collective labour agreement might provide useful information.

K. Peeters indicated that the evaluation of the implementation of CAO100/CCT100 was one of the recommendations of a study - commissioned by the Federal Science Policy BELSPO, the FPS Public Health and the FPS Employment - that was entrusted to a research consortium. The study mentioned was the UPTODATE study.

All members of the Council (Committee Individual Relations) agreed to this proposal. The following questions were discussed:

- Do we need a quantitative or qualitative evaluation or both?
- Did the CLA achieve its objective of breaking the taboo?
- Is the guidebook (2009) still up to date?
- Is there sufficient information available or are additional tools required?
- How can we expand the agreement to the public sector?
- To what extent do Committees on Prevention and Protection at work and the Labour Councils work on this cao?
- What is the situation regarding illegal drugs?
- What is the situation regarding psychoactive medication?
- What about new trends? (e.g. performance enhancing drugs)?

In a following meeting, the topics mentioned supra were meticulously addressed. The committee was also informed about 10 good practices (based on written information).

<u>The following output was accomplished.</u>

The social partners agreed that the focus should be on **a qualitative evaluation** of the collective labour agreement. They motivated that there was sufficient information to conclude that only a minority of companies had implemented the second phase, i.e. make their policy more concrete. More important than the quantity is the companies their explanation.

The **involvement of the committees** in the elaboration of the policy appears to be of varying quality. Sometimes there is only passive involvement and the proposals come from the employer. Sometimes there is no involvement at all. There is also concern about the lack of focus on the relation between work related AOD use and psychosocial risks in the workplace. The suggestion is to optimize the link between the CAO100/CCT100 and other legislation, in particular with the legislation on psychosocial risks.

Furthermore, the committee stressed the importance of **evaluating at regular intervals**. It might be useful to provide an instrument to the companies about the attention points in such an evaluation. However, the planned follow-up by the NAR itself was also not realised (bi-monthly report to the Group of 10).

It is also considered positive that the legal options with regard to **testing** were clarified, even though it appears that merely a small minority of companies do this effectively.

The members of the committee agreed that there were no arguments for amendments to the CAO100/CCT100 agreement. The vision and approach of the agreement was still approved by the social partners.

The Committee also reached a consensus on the following suggestions:

- the development of a tool for companies to check their obligations
- the possibility of a revision of the guidebook (online version, more interactive)
- more attention and information regarding 'other drugs' in the existing instruments

Therefore, it was decided that the NAR secretariat would collaborate with VAD, Le Pélican and the FPS WASO. The revision should provide information on the next 10 topics:

1. Collective Labor Agreement No. 100: what is it?
2. Why is there a need for an alcohol and drug policy in companies?
3. The Collective Labor Agreement No. 100 does not contain a ready-made alcohol and drug policy, but puts the companies to work
4. CLA no. 100 only applies to the private sector, but is a source of inspiration for the public sector
5. The five main thrusts of Collective Labour Agreement no. 100
6. An alcohol and drug policy is a two-track policy
7. The four pillars of an efficient alcohol and drug policy
8. Using Preventive Testing
9. The concrete elaboration of a preventive alcohol and drug policy: how does one proceed?
10. How to evaluate your company's alcohol and drug policy?

"There was no concrete cause, it was a confluence of events.
The realisation that there was a shared responsibility."
(Participant 2)

"A missed opportunity is the following up on the cao. We should have tracked better what was happening in practice. Now the topic has bled to death. There is also not enough scientific follow-up."
(Participant 1)

"It remains a challenging task for SME's. In that case, you are both the employer as well as the one who helps when people have a problem. It is difficult to keep these two circuits separated."
(Participant 9; and several times mentioned in the focusgroup)

"The hearings were extremely interesting, which was rather exceptional in the first place. Also, the fact that an instruction manual had been made."
(Participant 1)

"The CLA emphasizes on the functioning, which is more objective. Actually, we should also look at it in this way for other subjects, whether we can separate the functioning problem from the underlying issues. The agreement could have served as an example, but it did not."
(Participant 8)

"I have to be invested in so many topics, you can not be the expert everywhere."
(Participant 11)

"There is no more interest in alcohol and drugs; I ask myself how we can bring it back."
(Participant 4, ***confirmed by almost every one)***

"At a certain point in time, all the puzzle pieces come together: it receives media attention, there are incidents, companies ask for advice."
(Participant 4)

"Alcohol is already being asked about, that seems to be working all right, we're confronted with that every once in a while. Drugs is something different, not even in standard questionnaires. We realise that we're all doing too little and that we probably also know far too little about these matters. That can be very confronting.
We're more likely to talk about medication.
(UPTODATE 1, OP1, M, 39y, Dutch)

II. Challenges and facilitators

Occupational physicians

Earlier in this study, we mentioned the UPTODATE-studies. UPTODATE 1[304] concerns the attitudes and experiences of occupational physicians concerning work-related alcohol and drug use of employees. UPTODATE 2[305] is the follow-up study.

The UPTODATE 1-study concludes that occupational physicians in Belgium are more motivated to tackle workers' substance abuse when working in a **supportive work environment**, including an integrated alcohol and drug policy facilitated by a national collective labour agreement.

At the beginning of my career, lots of employers sent me cases and asked me to deal with the alcohol problem. They pass the buck, unwilling to take their responsibility. You're a little desperate when you start out and I'm very glad that the CLA 100 has been passed.
(OP12, F, 61y, French)

In that respect, CLA n°100 is of tremendous added value. Alcohol in company restaurants, a beer or two with your meal at lunchtime, never used to be a problem. Now that is no longer allowed in theory. (…) That's definitely an added value. In fact, that legislation has been very positive.
(OP1, M, 39y, Dutch)

[304] https://www.belspo.be/belspo/fedra/proj.asp?l=nl&COD=DR%2F60
[305] https://werk.belgie.be/nl/onderzoeksprojecten/2018-date-2-vervolgproject-gebruik-van-alcohol-illegale-drugs-en-slaap-en

When the employer is confronted with somebody who drinks, he contacts us to let us know and we try to make that person aware, but it is not binding; it is written in our alcohol/drugs procedure, there is collaboration. The management has the task of seeing the person and talking to him, not about his alcohol problem but about him not doing his job properly. And there is a procedure after x-number of reminders to go and meet the company doctor. A few years ago, we told all employees about it, and gave them a leaflet to take home and read.
(OP14, F, 48y, French)

However, the UPTODATE-study revelead that occupational physicians do not have **clear guidelines on screening and dealing** with substance abuse among employees. Screening for alcohol use among employees can be organised during various occupational health examinations (e.g. during recruitment examination, suitability examination) and/or in the context of a survey of the employee's wellbeing or lifestyle. Screening offers the occupational physician the opportunity to inform employees about their alcohol use and, where necessary, to take preventive measures.There is a variety of convincing references for the effectiveness of brief interventions, mainly for Primary Healthcare. Studies on the potential impact of Screening and Brief Interventions, and Referral to Treatment (SBIRT) brief interventions in occupational health are promising (Watson et al, 2015; Schulte et al, 2014). The introduction of these tools during periodic health surveillance might be very useful in motivating the employee. In coll In collaboration with a representative group of occupational physicians, a first consensus guideline regarding the screening of alcohol use among employees was made.

In addition, initiatives such as operational guidelines and standardized procedures of communication, are needed to tackle multiple barriers and to encourage **cooperation between occupational physicians and general practitioners** [46]. This is essential in order to achieve an overall improvement of workers well-being and to realize succesful reintegration projects [47, 48].

Process evaluation:
A process evaluation of the implementation of the CAO100/CCT100 found that the members of the committee agreed that there were no arguments for amendments to the CAO100/CCT100 agreement. However,

- ⇨ The social partners agreed that the focus should be on a qualitative evaluation of the collective labour agreement.
- ⇨ The involvement of the committee's protection and safety in the elaboration of the policy might be better.
- ⇨ A revision of the guidebook is necessary.

6. Output and outcome evaluation

III. Realisations of the project

- Advies Nr. 1.655. Zitting van vrijdag 10 oktober 2008. Een alcohol- en drugbeleid in de onderneming met in bijlage het 'ontwerp van collectieve arbeidsovereenkomst nr. … van … betreffende het voeren van een preventief alcohol- en drugbeleid in de onderneming. Verslag. Avis N° 1.655. Séance du vendredi 10 octobre 2008. Une politique en matière d'alcool et de drogues dans l'entreprise. Annexe 'Projet de convention collective de travail N° … du … concernant la mise en oeuvre d'une politique préventive en matière d'alcool en de drogues dans l'entreprise. Rapport.
  http://www.cnt-nar.be/ADVIES/advies-1655.pdf
  http://www.cnt-nar.be/AVIS/avis-1655.pdf

- Wet van 8/04/1965 tot instelling van de arbeidsreglementen, art.14 gewijzigd door de wet van 6/05/2009 (BS 19/05/2009) houdende diverse bepalingen, Artikel 59. Loi du 8 avril 1965 instituant les règlements de travail, art. 14 adapté par le Loi portant des dispositions diverses 6/05/2009 (MB 19/05/2009). Article 59.
  https://etaamb.openjustice.be/nl/wet-van-06-mei-2009_n2009202053.html
  https://etaamb.openjustice.be/fr/loi-du-06-mai-2009_n2009202079.html

- Collectieve arbeidsovereenkomst nr. 100 van 1 april 2009 betreffende het voeren van een preventief alcohol- en drugsbeleid in de onderneming. Convention collective de travail n° 100 du 1er avril 2009 concernant la mise en œuvre d'une politique préventive en matière d'alcool et de drogues dans l'entreprise (ratifiée par l'AR du 28 juin 2009, paru au MB du 13 juillet 2009).
  http://www.cnt-nar.be/CAO-COORD/cao-100.pdf
  http://www.cnt-nar.be/CCT-COORD/cct-100.pdf

- Koninklijk Besluit waarbij algemeen verbindend wordt verklaard de collectieve arbeidsovereenkomst nr. 100 van 1 april 2009, gesloten in de Nationale Arbeidsraad, betreffende een preventief alcohol- en drugbeleid in de onderneming (28 juni 2009). Gepubliceerd in Belgisch Staatsblad van 13 juli 2009. Arrêté royal rendant obligatoire la convention collective de travail n° 100 du 1er avril 2009, conclue au sein du Conseil national du Travail, concernant la mise en oeuvre d'une politique préventive en matière d'alcool et de drogues dans l'entreprise (28 juin 2009). Paru au Moniteur Belge du 13 juillet 2009.
  https://etaamb.openjustice.be/nl/koninklijk-besluit-van-28-juni-2009_n2009202709.html
  https://etaamb.openjustice.be/fr/arrete-royal-du-05-septembre-2018_n2018013329.html

- Koninklijk besluit tot opheffing van artikel 99 van het Algemeen Reglement voor de Arbeidsbescherming (ARAB) van 19 mei 2010, gepubliceerd in het Belgisch Staatsblad op 3 juni 2010. Arrêté royal abrogeant l'article 99 du Règlement général pour la protection du travail du 19 mai 2010, paru dans le Moniteur belge du 3 juin 2010.

- Een preventief alcohol- en drugsbeleid in de onderneming. In overleg werken aan preventie. Leidraad voor de uitwerking van een preventief alcohol- en drugsbeleid in de onderneming. Originele versie (2009) en herziene (2020). Une politique préventive en matière d'alcool et de drogues dans l'entreprise. La concertation au service de la prévention. Guide pour l'élaboration d'une politique préventive en matière d'alcool et de drogues dans l'entreprise. Version originale (2009 et révisée (2020).
  http://www.cnt-nar.be/Publications.htm

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On page 465, an adapted version of the logic model is presented.

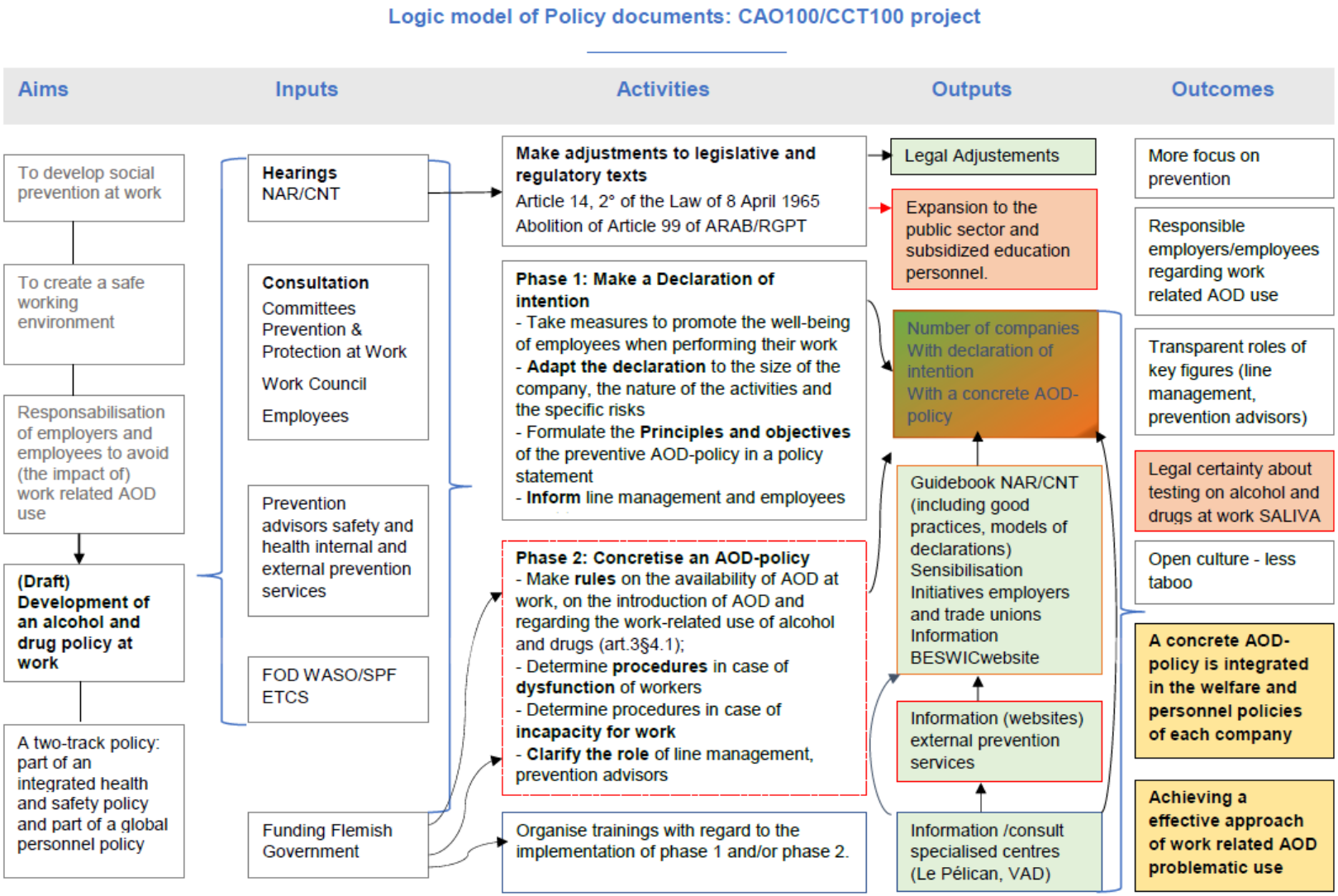


*Figure 30: **Adapted** Logic model of CAO100/CCT100*

II. Monitoring realisations

To conclude this phase of output and outcome analysis, we also investigated the results of the **Ginger-report by VAD**, the Flemish expertise centre on Alcohol and other Drugs. Ginger is a registration program for prevention workers in **Flanders** to register their prevention activities in different settings, including the workplace. Every year, VAD bundles the results of this registration in a monitoring report. Ginger maps out which prevention activities are carried out and what the nature and scope of these activities are. No similar monitoring system is available in Brussels and Wallonia.

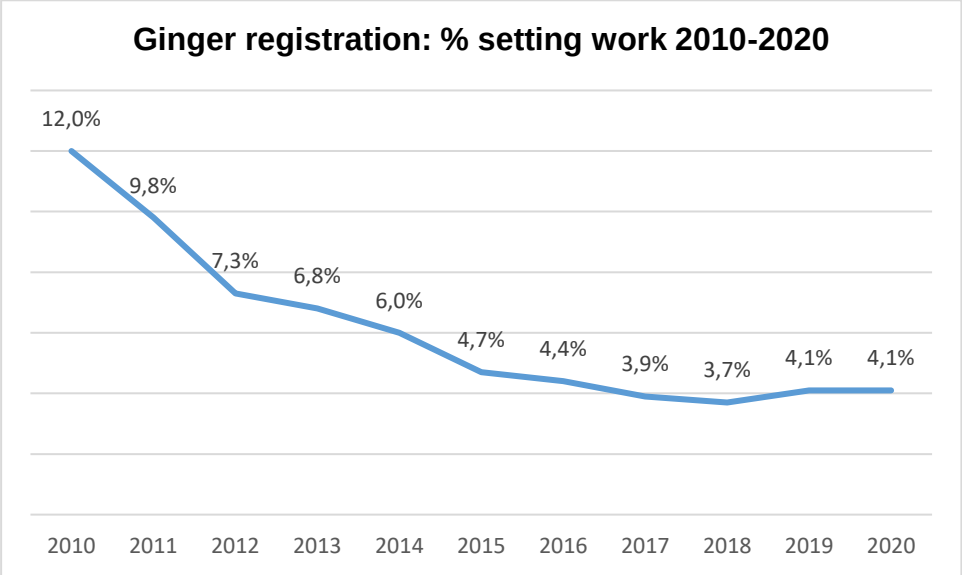


Figure 31: Ginger registration (VAD, 2021)

We observe a clear decline between 2010 and 2020. In 2010, the ratio of prevention-related activities in the labour sector to the total number of prevention-related activities in Flanders amounted to 12% (of 100). In 2020, merely 3.7% remained.

The following reasons might explain this noteable drop:

1. The boost in the number of initiatives caused by the entry into force of the CAO100/CCT100.
2. The fact that the AOD prevention workers of the CGG received additional resources from the Flemish government in the period between December 2009 until December 2011, aiming to advise companies with the making of an alcohol- and drug policy.

Output and outcome evaluation:
An output and outcome evaluation of the CAO100/CCT100 project found that:

⇨ Adjustments to legislative and regulatory texts were done

⇨ The revision of the guidebook (NAR/CNT) including was published (2020)

⇨ A minority of companies introduced a concrete alcohol and drug policy

- ⇨ There is no legal certainty about testing on alcohol and drugs at work (especially not regarding illegal drugs (cf. saliva test)
- ⇨ Long term outcomes are vague

7. Policy recommendations

Research:

- ⇨ We recommend more (longitudinal) research on work-related AOD use, especially on the diversity of motives and situations in which workers use AOD. Specific initiatives are needed with respect to illicit drugs/performance enhancing drugs, and concerning AOD use among vulnerable working people (e.g. young workers, workers with existing AOD problems, workers in non-commercial organisations).

Renewed attention for the importance of a preventive alcohol- and drug policy, focused on phase 2 of the CAO100/CCT100:

- ⇨ Social partners and supporting organisations have an important role to play in this
- ⇨ Extension of the legal framework to the public sector and to the subsidised education personnel might give a boost
- ⇨ Attention for concrete problems in the practical elaboration of the policy
- ⇨ Focus on performance: interesting for other health related topics in the workplace – a story of rights and obligations

Practice-oriented support with an eye to evaluation:

- ⇨ More attention for illegal drugs (cannabis, cocaine) and new trends (performance enhancing drugs)
- ⇨ Implementation of the consensus guideline regarding the screening of alcohol use among employees. Extension of the guideline to other drugs

8. Conclusion:

Work has a major impact on our physical and mental health. Working in a healthy environment boosts the well-being of employees. The benefits of a job are numerous and include a secure income, structure and a contribution to a person's feeling of self-worth. These material, physical and psychosocial factors are essential contributors to workers' quality of life. On the other hand, several aspects of labour pose a threat to the health of the employee. Flexible working, e-working, working longer hours and the challenges of balancing work duties with a family life and leisure time can all cause employees to suffer from increased pressure and stress at work (Lambrechts & Godderis, 2019). In addition, job performance problems due to alcohol and drug use occur in the workplace.

The great strength of CAO100/CCT100 is also its weakness

Following a Collective Labour Agreement, since April 1, 2009 all private organisations in Belgium must have a policy statement on alcohol and drugs (A&D) in the workplace. This agreement also promotes the development of an appropriate prevention policy. Now, more than ten years later, we look back. We performed a targeted intervention study in the framework of a broader research study related to the evaluation of the Belgian drug policy. As a first conclusion, we find that in most companies today, work related alcohol and drug use is not a priority, despite its important and complicated nature.

Yet, the CAO100/CCT100 project supports companies by providing them with a legal framework. An analysis of the policy concludes that the CAO100/CCT100 has a clear global vision. It promotes a two-track policy based on performance behaviour. The objective is to prevent and ensure an early management of performance problems due to alcohol and drug use. It also provides a framework for work-related testing on alcohol and drug use. Guidebooks were distributed and many seminars were organised.

The policy is rather logical, even though the division of CAO100/CCT100 in a mandatory and optional phase undermines its effectiveness. Only a small number of companies apply to the second phase. This phase is the most important in reaching the goals of an AOD policy. It regulates the availability or prohibition of alcohol and drugs in the workplace; it includes intervention procedures in case of malfunctioning; it governs the assessment and referral of workers with an alcohol or drug problem and it provides information and education (Webb et al, 2009).

In this study, we formulate recommendations to initiate a revival of this topic. We also emphasise the need for an interdisciplinary collaboration that will integrate the best knowledge and practice in order to prevent work-related alcohol and drug use.

Finally, we have to look for alternative ways to achieve the goals of the CAO100/CCT100 project. This could include the (further) introduction of work-related alcohol and drug use in policies on absenteeism, since there is a significant relationship between alcohol and drug use and workplace absences (Aas et al, 2017; Corral et al, 2012). Further, there is a link with re-integration programmes. In a research report by Bauld and colleagues, the approach to addressing 'addiction' is rooted in the concept of recovery and reintegration (Bauld et al, 2010).

Reference List

Aas, R. W., Haveraaen, L., Sagvaag, H., & Thørrisen, M. M. (2017). The influence of alcohol consumption on sickness presenteeism and impaired daily activities. The WIRUS screening study. *PLoS One*, *12*(10), e0186503. https://doi.org/10.1371/journal.pone.0186503

Ames, G. M., & Bennett, J. B. (2011). Prevention interventions of alcohol problems in the workplace: a review and guiding framework. *Alcohol Research & Health*, *34*(2), 175. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3860571/

Bacharach, S. B., Bamberger, P. A., & Sonnenstuhl, W. J. (2002). Driven to drink: Managerial control, work-related risk factors, and employee problem drinking. *Academy of Management Journal*, *45*(4), 637-658. https://doi.org/10.5465/3069302

Bauld, L., et al. (2010). *Alcohol Misusers' experiences of employment and the benefit system.*

Belgisch Staatsblad, 28 JUNI 2009. Koninklijk besluit waarbij algemeen verbindend wordt verklaard de collectieve arbeidsovereenkomst nr. 100 van 1 april 2009, gesloten in de Nationale Arbeidsraad, betreffende een preventief alcohol- en drugbeleid in de onderneming. 28 JUIN 2009. - Arrêté royal rendant obligatoire la convention collective de travail n° 100 du 1er avril 2009, conclue au sein du Conseil national du Travail, concernant la mise en oeuvre d'une politique préventive en matière d'alcool et de drogues dans l'entreprise, B.S.-F.O. Justitie and M.B.-S.P.F. Justice, Editors. 2009: Brussel. https://www.stradalex.com/en/sl_src_publ_leg_be_moniteur/toc/leg_be_moniteur_nl_13072009_1/doc/bs2009202709

Corral, A., Durán, J., & Isusi, I. (2012). European Foundation for the Improvement of Living and Working Conditions The tripartite EU agency providing knowledge to assist in the development of better social, employment and work-related policies.

European Monitoring Centre for Drugs and Drug Addiction (2017b). *Evaluating drug policy: a seven-step guide to support the commissioning and managing of evaluations.* Publications Office of the European Union: Luxembourg. https://www.eurofound.europa.eu/publications/report/2012/use-of-alcohol-and-drugs-at-the-workplace

Frone, M. R. (2013). *Alcohol and illicit drug use in the workforce and workplace*. American Psychological Association. https://psycnet.apa.org/doi/10.1037/13944-000

Frone, M. R. (2008). Are work stressors related to employee substance use? The importance of temporal context assessments of alcohol and illicit drug use. *Journal of Applied Psychology*, *93*(1), 199. https://psycnet.apa.org/doi/10.1037/0021-9010.93.1.199

Funnell, S. C., & Rogers, P. J. (2011). *Purposeful Program Theory: Effective Use of Theories of Change and Logic Models.* Jossey-Bass.

Gmel, G., Rehm, J., & Kuntsche, E. (2003). Binge drinking in Europe: definitions, epidemiology, and consequences. *Sucht*, *49*(2), 105-116.

Godderis, L. & Lambrechts M. (2019). Make healthy employees a priority and prevent chronic diseases. ILO: Safety and Health at the Heart of the Future of Work. A Compilation of Think Pieces.

Harvey, S. B., Joyce, S., Tan, L., Johnson, A., Nguyen, H., Modini, M., & Groth, M. (2014). Developing a mentally healthy workplace: A review of the literature. *Sydney: University of New South Wales*. http://hdl.voced.edu.au/10707/382142

Jepson, R. G., Harris, F. M., Platt, S., & Tannahill, C. (2010). The effectiveness of interventions to change six health behaviours: a review of reviews. *BMC public health*, *10*(1), 1-16. https://doi.org/10.1186/1471-2458-10-538

Kaarne, T., Aalto, M., Kuokkanen, M., & Seppä, K. (2010). AUDIT-C, AUDIT-3 and AUDIT-QF in screening risky drinking among Finnish occupational health-care patients. *Drug and alcohol review*, *29*(5), 563-567. https://doi.org/10.1111/j.1465-3362.2010.00172.x

Lambert, S. D. (2002). The role of the occupational physician in substance abuse. *Occupational Medicine (Philadelphia, Pa.)*, *17*(1), 1-12.

Lambrechts, M.C. (2020). *Substance abuse among the working population in Belgium. Or should we say: work-related alcohol and drug use?* Dissertation presented in partial fulfilment of the requirements for the degree of Doctor in Biomedical Sciences. KU Leuven, 205 pp.

Lambrechts, M.C., Vandersmissen, L., & Godderis, L. (2019). Alcohol and other drug use among Belgian workers and job-related consequences. *Occupational and environmental medicine*, *76*(9), 652-659. https://oem.bmj.com/content/76/9/652

Liira, H., Knight, A. P., Sim, M. G., Wilcox, H. M., Cheetham, S., & Aalto, M. T. (2016). Workplace interventions for preventing job loss and other work related outcomes in workers with alcohol misuse. *The Cochrane Database of Systematic Reviews*, *2016*(9). https://dx.doi.org/10.1002%2F14651858.CD012344

Marchand, A. (2008). Alcohol use and misuse: what are the contributions of occupation and work organization conditions? *BMC public health*, *8*(1), 1-12. https://doi.org/10.1186/1471-2458-8-333

McHugo, G. J., Drake, R. E., Xie, H., & Bond, G. R. (2012). A 10-year study of steady employment and non-vocational outcomes among people with serious mental illness and co-occurring substance use disorders. Schizophrenia research, 138(2-3), 233-239. https://doi.org/10.1016/j.schres.2012.04.007

Osilla, K. C., Dela Cruz, E., Miles, J. N., Zellmer, S., Watkins, K., Larimer, M. E., & Marlatt, G. A. (2010). Exploring productivity outcomes from a brief intervention for at-risk drinking in an employee assistance program. *Addictive behaviors*, *35*(3), 194-200. https://doi.org/10.1016/j.addbeh.2009.10.001

Roche, A. M., Lee, N. K., Battams, S., Fischer, J. A., Cameron, J., & McEntee, A. (2015). Alcohol use among workers in male-dominated industries: A systematic review of risk factors. *Safety science*, *78*, 124-141. https://doi.org/10.1016/j.ssci.2015.04.007

Roman, P. M., & Blum, T. C. (2002). The workplace and alcohol problem prevention. *Alcohol Research & Health*, *26*(1), 49.

Salonsalmi, A., Rahkonen, O., Lahelma, E., & Laaksonen, M. (2017). The association between alcohol drinking and self-reported mental and physical functioning: a prospective cohort study among City of Helsinki employees. *BMJ open, 7*(4), e014368.W http://dx.doi.org/10.1136/bmjopen-2016-014368

Saunders, J. B., Aasland, O. G., Babor, T. F., De la Fuente, J. R., & Grant, M. (1993). Development of the alcohol use disorders identification test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption-II. *Addiction*, *88*(6), 791-804. https://doi.org/10.1111/j.1360-0443.1993.tb02093.x

Schulte, B., O'Donnell, A. J., Kastner, S., Schmidt, C. S., Schäfer, I., & Reimer, J. (2014). Alcohol screening and brief intervention in workplace settings and social services: a comparison of literature. *Frontiers in psychiatry*, *5*, 131. https://doi.org/10.3389/fpsyt.2014.00131

Tan, L., Wang, M. J., Modini, M., Joyce, S., Mykletun, A., Christensen, H., & Harvey, S. B. (2014). Preventing the development of depression at work: a systematic review and meta-analysis of universal interventions in the workplace. *BMC medicine*, *12*(1), 1-11. https://doi.org/10.1186/1741-7015-12-74

Vahtera, J., Poikolainen, K., Kivimäki, M., Ala-Mursula, L., & Pentti, J. (2002). Alcohol intake and sickness absence: a curvilinear relation. *American journal of epidemiology*, *156*(10), 969-976. https://doi.org/10.1093/aje/kwf138

Virtanen, M., Jokela, M., Nyberg, S. T., Madsen, I. E., Lallukka, T., Ahola, K., ... & Kivimäki, M. (2015). Long working hours and alcohol use: systematic review and meta-analysis of published studies and unpublished individual participant data. *Bmj*, *350*. https://doi.org/10.1136/bmj.g7772

Watson, H., et al. (2015). Screening and brief intervention delivery in the workplace to reduce alcohol-related harm: a pilot randomized controlled trial. *Int J Nurs Stud, 52(1)*: p. 39-48. https://doi.org/10.1016/j.ijnurstu.2014.06.013

Watt, K., Purdie, D. M., Roche, A. M., & McClure, R. J. (2004). Risk of injury from acute alcohol consumption and the influence of confounders. Addiction, 99(10), 1262-1273. https://doi.org/10.1111/j.1360-0443.2004.00823.x

Webb, G., Shakeshaft, A., Sanson-Fisher, R., & Havard, A. (2009). A systematic review of work-place interventions for alcohol-related problems. *Addiction*, *104*(3), 365-377. https://doi.org/10.1111/j.1360-0443.2008.02472.x

Wechsler, H., & Austin, S. B. (1998). Binge drinking: the five/four measure. *Journal of studies on alcohol*, *59*(1), 122-124. https://doi.org/10.15288/jsa.1998.59.122

Reference List: Policy Documents

- Nota minister van Werk, de heer Peter Vanvelthove, aan de Nationale Arbeidsraad (2006). Niet gepubliceerde nota. Note du ministre du travail, M. Peter Vanvelthove, au Conseil National du Travail (2006). Notice inédite.

- Interprofessioneel akkoord (IPA) voor de periode 2007-2008 (2/2/2007) van de sociale partners (Groep van 10). Accord interprofessionnel AIP) pour la période 2007-2008 (2/2/2007) des partenaires sociaux (Groupe des 10).
  http://www.cnt-nar.be/INTERP-AKKOORD/IPA-2007-2008-NL.pdf
  http://www.cnt-nar.be/INTERP-AKKOORD/IPA-2007-2008-FR.pdf

- Gemeenschappelijke verklaring van de Ministers, die de Volksgezondheid onder hun bevoegdheden hebben, betreffende het toekomstige alcoholbeleid. Déclaration conjointe des Ministres, qui ont la Santé publique dans leurs attributions, sur la politique future en matière d'alcool (17/06/2008 – BS/MB 17/07/2008).
  https://etaamb.openjustice.be/nl/document-van-17-juni-2008_n2008024267.html
  https://www.etaamb.be/fr/document-du-17-juin-2008_n2008024267.html

- Advies Nr. 1.655. Zitting van vrijdag 10 oktober 2008. Een alcohol- en drugbeleid in de onderneming met in bijlage het 'ontwerp van collectieve arbeidsovereenkomst nr. … van … betreffende het voeren van een preventief alcohol- en drugbeleid in de onderneming. Verslag. Avis N° 1.655. Séance du vendredi 10 octobre 2008. Une politique en matière d'alcool et de drogues dans l'entreprise. Annexe 'Projet de convention collective de travail N° … du … concernant la mise en oeuvre d'une politique préventive en matière d'alcool en de drogues dans l'entreprise. Rapport.
  http://www.cnt-nar.be/ADVIES/advies-1655.pdf
  http://www.cnt-nar.be/AVIS/avis-1655.pdf

- Wet van 8/04/1965 tot instelling van de arbeidsreglementen, art.14 gewijzigd door de wet van 6/05/2009 (BS 19/05/2009) houdende diverse bepalingen, Artikel 59. Loi du 8 avril 1965 instituant les règlements de travail, art. 14 adapté par le Loi portant des dispositions diverses 6/05/2009 (MB 19/05/2009). Article 59.
  https://etaamb.openjustice.be/nl/wet-van-06-mei-2009_n2009202053.html
  https://etaamb.openjustice.be/fr/loi-du-06-mai-2009_n2009202079.html

- Collectieve arbeidsovereenkomst nr. 100 van 1 april 2009 betreffende het voeren van een preventief alcohol- en drugsbeleid in de onderneming. Convention collective de travail n° 100 du 1er avril 2009 concernant la mise en œuvre d'une politique préventive en matière d'alcool et de drogues dans l'entreprise (ratifiée par l'AR du 28 juin 2009, paru au MB du 13 juillet 2009).
  http://www.cnt-nar.be/CAO-COORD/cao-100.pdf
  http://www.cnt-nar.be/CCT-COORD/cct-100.pdf

- Koninklijk Besluit waarbij algemeen verbindend wordt verklaard de collectieve arbeidsovereenkomst nr. 100 van 1 april 2009, gesloten in de Nationale Arbeidsraad, betreffende een preventief alcohol- en drugbeleid in de onderneming (28 juni 2009). Gepubliceerd in Belgisch Staatsblad van 13 juli 2009. Arrêté royal rendant obligatoire la convention collective de travail n° 100 du 1er avril 2009, conclue au sein du Conseil national du Travail, concernant la mise en oeuvre d'une politique préventive en matière d'alcool et de drogues dans l'entreprise (28 juin 2009). Paru au Moniteur Belge du 13 juillet 2009.
  https://etaamb.openjustice.be/nl/koninklijk-besluit-van-28-juni-2009_n2009202709.html
  https://etaamb.openjustice.be/fr/arrete-royal-du-05-septembre-2018_n2018013329.html

- Koninklijk besluit tot opheffing van artikel 99 van het Algemeen Reglement voor de Arbeidsbescherming (ARAB) van 19 mei 2010, gepubliceerd in het Belgisch Staatsblad op 3 juni 2010. Arrêté royal abrogeant l'article 99 du Règlement général pour la protection du travail du 19 mai 2010, paru dans le Moniteur belge du 3 juin 2010.

- Algemene beleidsnota werk. Minister Joëlle Milquet, vice-eersteminister, minister van Werk en Gelijke Kansen, belast met het Migratie- en asielbeleid. Doc 52 2225/025. Belgische Kamer van Volksvertegenwoordigers. 25 november 2009. Note de politique générale. Ministre Joëlle Milquet, la vice-première ministre, ministre de l'Emploi et de l'Égalité des Chances, chargée de la Politique de migration et d'asile. Doc 52 2225/025. Chambre des représentants de Belgique. http://www.dekamer.be/FLWB/PDF/52/2225/52K2225025.pdf

- Ministerieel besluit tot toekenning van een subsidie aan de Vereniging voor Alcohol- en andere Drugproblemen vzw voor het begeleiden van 28 bedrijven bij het ontwikkelen en implementeren van een alcoholbeleid. Vlaamse Minister van Welzijn, Volksgezondheid en Gezin (2/12/2009).

- Ministerieel besluit tot toekenning van een subsidie aan de Vereniging voor Alcohol- en andere Drugproblemen vzw voor het begeleiden van bedrijven bij het ontwikkelen en implementeren van een alcoholbeleid. Vlaamse Minister van Welzijn, Volksgezondheid en Gezin (2/12/2010).

Related to the evaluation made by the Committee on Individual Labour Relations (Commissie Individuele arbeidsverhoudingen/la Commission des Relations individuelles du Travail):

- Notulen van de vergadering van de Commissie Individuele Arbeidsverhoudingen van 21 oktober 2016. Punt 2. Cao nr.100 betreffende een preventief alcohol- en drugsbeleid in de onderneming - Evaluatie - Verdere bespreking (Dossier 2.830 - 38/D.16-18 en 46). Procès-verbaux de la réunion de la Commission des Relations individueles du Travail du 21 oktober 2016. Point 2. CCT n° 100 concernant la mise en œuvre d'une politique préventive en matière d'alcool et de drogues dans l'entreprise – Évaluation. Poursuite de la discussion (Dossier 2.830 - 38/D.16-18 et 46).
- Notulen van 9 december 2016 - Cao nr.100 betreffende een preventief alcohol- en drugsbeleid in de onderneming (38/16-18 N). Procès-verbaux de la réunion du 9 décembre 2016. CCT n° 100 concernant la mise en œuvre d'une politique préventive en matière d'alcool et de drogues dans l'entreprise (38/16-18 F). Évaluation.
- Non-paper 2017-86. Cao nr.100 betreffende een preventief alcohol- en drugsbeleid in de onderneming – Evaluatie. Non-paper 2017-86. CCT n° 100 concernant la mise en œuvre d'une politique préventive en matière d'alcool et de drogues dans l'entreprise. Évaluation.
- Non-paper 2018-38. Cao nr.100 betreffende een preventief alcohol- en drugsbeleid in de onderneming – Evaluatie. Non-paper 2018-38. CCT n° 100 concernant la mise en œuvre d'une politique préventive en matière d'alcool et de drogues dans l'entreprise. Évaluation.

Other

- Een preventief alcohol- en drugsbeleid in de onderneming. In overleg werken aan preventie. Leidraad voor de uitwerking van een preventief alcohol- en drugsbeleid in de onderneming. Originele versie (2009) en herziene (2020). Une politique préventive en matière d'alcool et de drogues dans l'entreprise. La concertation au service de la prévention. Guide pour l'élaboration d'une politique préventive en matière d'alcool et de drogues dans l'entreprise. Version originale (2009 et révisée (2020).
  http://www.cnt-nar.be/Publications.htm

- Alcohol en andere drugs: handleiding voor een preventiebeleid op het werk – Psychosociale risico's. FOD WASO (2017). Alcool et autres drogues : manuel pour une politique de prévention au travail – Risques psychosociaux.
https://werk.belgie.be/sites/default/files/nl/modules_pages/publicaties/document/psychosoc%20risico/alcohol-en-drugsnl2013lightdefinitief.pdf
https://emploi.belgique.be/fr/themes/bien-etre-au-travail/principes-generaux/politique-preventive-en-matiere-dalcool-et-de

Annexes

1. Presentation VAD – NAR/CNT 27/3/2007

Randvoorwaarden voor de uitwerking
en de inhoud van een preventief alcohol- en
drugbeleid binnen een onderneming

Marie-Claire Lambrechts
coördinator sector arbeid
Vereniging voor Alcohol- en andere Drugproblemen (VAD, vzw)

Nationale Arbeidsraad
Commissie Individuele Arbeidsverhoudingen
Brussel – 27 maart 2007

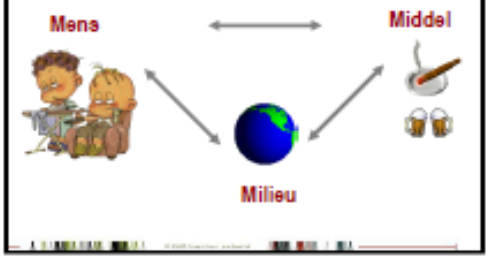
(rand)voorwaarden

- Afstemming probleemdefiniëring
  - Wat is gebruik en problematisch gebruik ?
  - Wat is werkgerelateerd alcohol- en druggebruik ?
  - Ontstaansfactoren: persoons- en werkgebonden factoren
- Geïntegreerde aanpak met focus op arbeidsgedrag
  - Uitgangspunten
  - Pijlers van een A&D-beleid
    - Toeleiding in zijn juiste context plaatsen
  - Accenten beleidsmatige aanpak

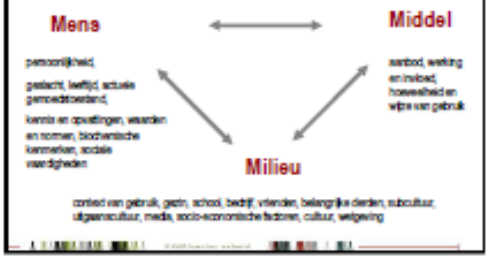
Voorwaarde 1

✧ Afstemming probleemdefiniëring

(problematisch) gebruik en MMM (Zinberg, 1984)



(problematisch) gebruik: MMM-interactie



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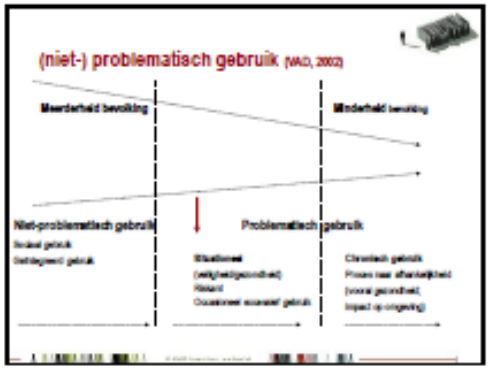

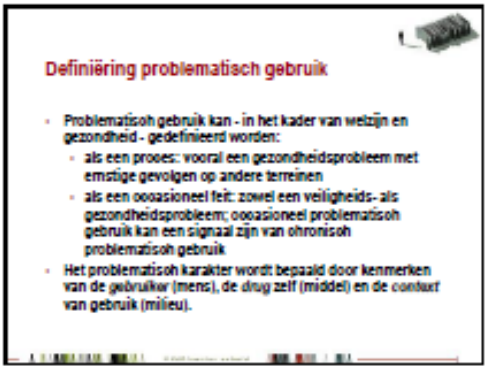

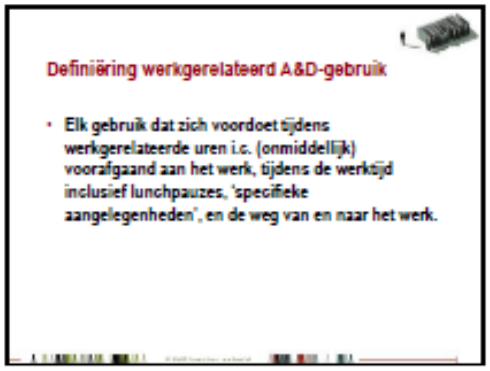

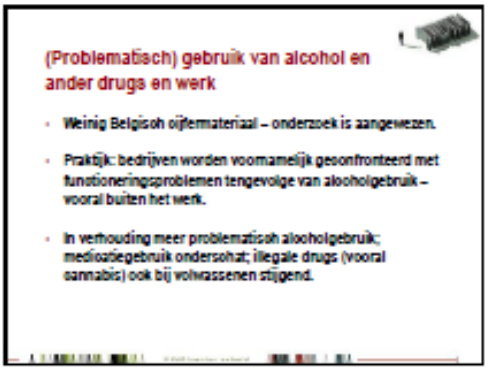

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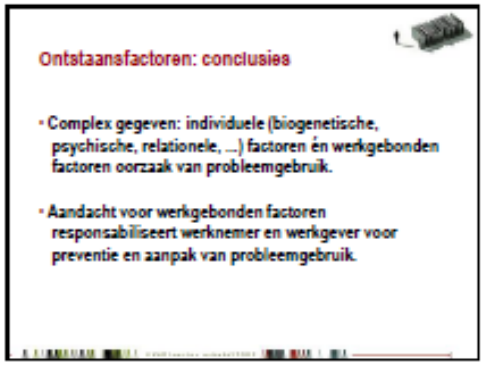

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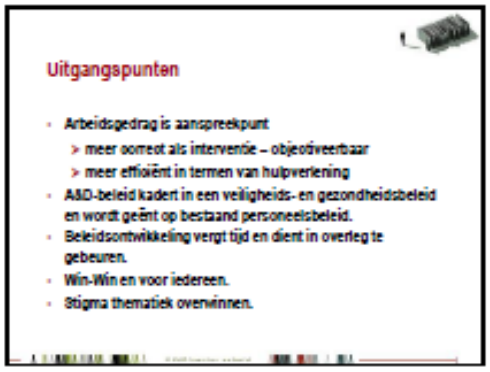

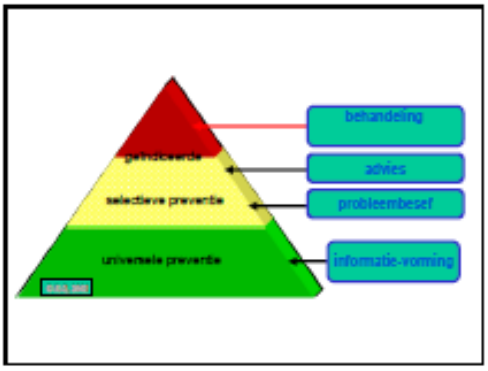

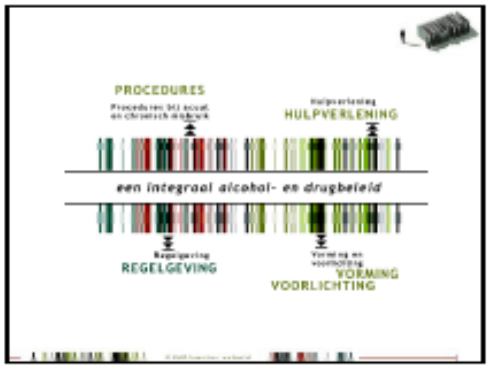

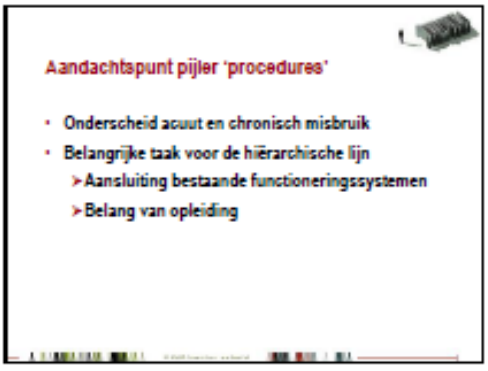

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Onderscheid acuut - chronisch

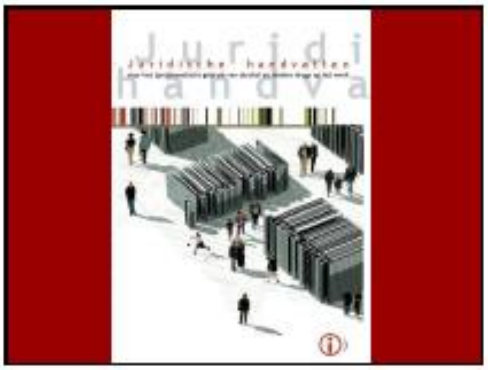
- *acuut problematisch gebruik*: wn-er heeft zoveel alcohol of drugs gebruikt dat men op dat ogenblik niet meer normaal kan functioneren. Vaststelling van werkonbekwaamheid. Onmiddellijke tussenkomst is (meestal) nodig omwille van veiligheidsrisico's voor de werknemer zelf en zijn omgeving.
- *chronisch problematisch gebruik*: wn-er functioneert gedurende een bepaalde periode minder goed tot slecht als gevolg van een (vermoedelijk) alcohol- of drugprobleem. Chronisch misbruik uit zich, tt tot een acute situatie, meestal niet in dronkenschap.

Aandachtspunt pijler 'hulpverlening'

- Bedrijfshulpverlener (preventieadviseur-arts / PA – PA / maatschappelijk werker / vertrouwensfiguren:
  - Onderliggend alcohol- of drugprobleem
  - Doorverwijzing externe hulpverlening (evt. alcohol- of drugspecifiek)
  - Beroepsgeheim en vertrouwelijkheid gegevens
- Optreden bedrijfshulpverlener meer effectief indien ook hiërarchische lijn rol opneemt
  - Opvolging functioneren parallel / complementair laten verlopen met aanpak binnen bedrijfshulpverlening.

Aandachtspunt pijler 'regelgeving'

- Te zeer gericht op gebruik zelf en veel minder op consequenties voor het werk terwijl gebruik veelal buiten de onderneming.
- Regelgeving beschikbaarheid werkt vooral preventief.
- Veel aandacht voor vaststelling bij vermoeden van gebruik. Enkel vaststelling van intoxicatie, niet (per definitie) van verminderd arbeidsgedrag.
  - Vooral voor illegale drugs
  - Juridisch niet evident (cf. VAD, Juridische Handvatten, 2005)
  - Geen evidentie effectiviteit (Independent Inquiry, 2004a; Cook & Schlenger, 2002)

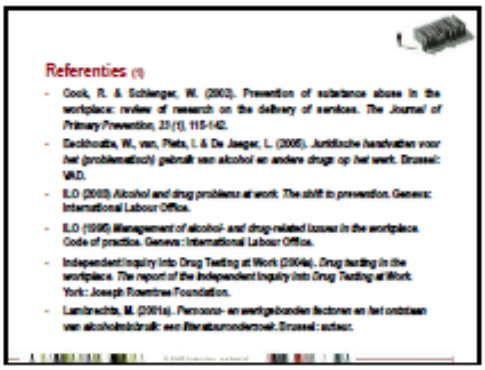


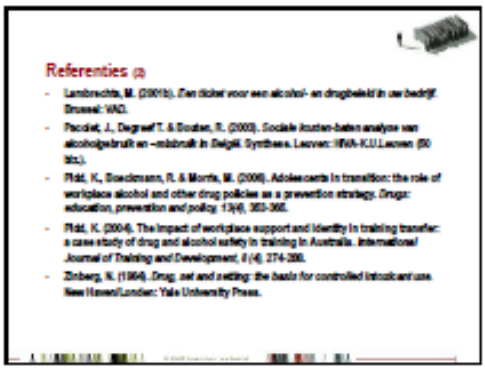
Aandachtspunt pijler 'voorlichting en vorming'

- Verhoudingsgewijs veel tijd en aandacht voor de aanmaak van een alcohol- en drugbeleid, veel minder voor de uitvoering ervan.
- Implementatie vaak beperkt tot communicatie over het beleid (schriftelijk). Toepassing van een beleid vraagt motivatie en opnemen van rol. Info en opleiding nodig.
  - Draagvlak voor training erg belangrijk. Draagvlak wordt positief beïnvloed als trainingsaanbod rekening houdt met zowel persoonlijke als omgevingsfactoren (Pidd, 2004).

Voorwaarde 2: conclusie geïntegreerde aanpak

- Geen paniekvoetbal nav ongewenst probleemgeval.
- Gericht op het voorkomen van én vroegtijdig signaleren van functioneringsproblemen tgv van A&D-problemen.
- A&D-problemen worden behandeld als andere functioneringsproblemen.
- Gericht op werknemer én bedrijf.
- Kadert binnen globaal veiligheids- en gezondheidsbeleid.
- Evalueren en bijsturen: tot nog toe eerder zeldzaam. Noodzakelijk om beleid te blijven toepassen én ook in functie van nieuwe medewerkers/wijziging directie.





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2. Perscommuniqué NAR – Communiqué de presse CNT

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NAR Nationale Arbeidsraad CNT Conseil Nat

Perscommuniqué – Communiqué de presse

NL FR

De Nationale Arbeidsraad is op vrijdag 1 april 2009 in plenaire zitting samengekomen onder het voorzitterschap van de heer P. Windey.

De collectieve arbeidsovereenkomst nr. 100 betreffende het voeren van een preventief alcohol- en drugsbeleid in de onderneming

1. De sociale partners hebben in hun interprofessioneel akkoord voor de periode 2007-2008 beslist dat een preventief alcohol- en drugsbeleid in elke onderneming absoluut noodzakelijk is.

De mogelijke gevolgen op de werkvloer van het gebruik van alcohol en drugs mogen niet onderschat worden :

- veelvuldige afwezigheid of te laat komen,
- arbeidsverzuim door arbeidsongeschiktheid (is twee tot zes keer hoger),
- motivatie- en productiviteitsdaling (in de Europese Unie bedraagt het verlies aan productiviteit ten gevolge van afwezigheid jaarlijks 9 tot 19 miljard euro en ten gevolge van werkloosheid 6 tot 23 miljard euro),
- arbeidsongevallen door verminderde waakzaamheid of door roekeloos gedrag (de kans op ongevallen is twee tot vier keer hoger. Ramingen wijzen er op dat 15 % tot 30 % gebeurt mede onder de invloed van alcohol);
- verantwoordelijkheid en aansprakelijkheid van de werkgever;
- imagoverlies voor de onderneming enz.

Niet alle gevolgen zijn te becijferen. Het is duidelijk dat alcohol- en drugsproblemen niet alleen de betrokken werknemer zelf en zijn werkgever raken, maar ook zijn collega's. Men hoeft maar te denken aan de werkorganisatie die verstoord wordt, de werkdruk die vergroot, de werksfeer die verslechtert, het grensoverschrijdend gedrag dat men riskeert (lagere drempel voor verbale of fysieke agressie of ongewenst seksueel gedrag) of de betrokkenheid bij een arbeidsongeval.

Het is in het belang van iedereen dat dergelijke problemen voorkomen of aangepakt worden. Dit voor de gezondheid en veiligheid van alle werknemers en voor de werking van de organisatie, maar vooral voor de werknemer met een probleem. Men helpt hem niet door niets te doen. Integendeel, de problemen worden doorgaans erger.

2. Op 1 april 2009 sluiten de sociale partners daarom in de Nationale Arbeidsraad de collectieve arbeidsovereenkomst nr. 100 betreffende het voeren van een preventief alcohol- en drugsbeleid in de onderneming (zie ook het advies nr. 1655 van 10 oktober 2008).

Door dit te regelen in een cao verhogen zij het draagvlak voor een delicate oefening in de onderneming.

De bepalingen van de collectieve arbeidsovereenkomst (cao) zijn gebaseerd op de uitgebreide informatie die de sociale partners in de Nationale Arbeidsraad verkregen hebben over de problematiek van het alcohol- en drugsgebruik in het arbeidsmilieu. In het bijzonder konden zij hiervoor een beroep doen op VAD, de Vereniging voor Alcohol- en andere Drugproblemen, die als één van haar missies heeft om een kwaliteitsvolle en wetenschappelijk onderbouwde aanpak van de alcohol- en drugthematiek te ondersteunen.

De cao legt aan alle werkgevers van de private sector op om voor het geheel van hun personeel een preventief alcohol-en drugsbeleid uit te werken.

De cao wil echter geen kant-en-klaar alcohol- en

drugsbeleid voor elke onderneming opleggen. Elk bedrijf is anders en heeft zijn eigen opvattingen en regels, ook op het vlak van alcohol en drugs.

De cao zet de bakens uit voor een preventief alcohol- en drugsbeleid dat in de ondernemingen moet worden uitgedacht en dit op verschillende terreinen: de door de werkgever te nemen maatregelen, de voorlichting en de opleiding van de werknemers, de verplichtingen van de hiërarchische lijn en de werknemers, de rol van de preventieadviseurs, de uitwerking van het beleid in overleg en de periodieke evaluatie ervan.

Aan de bepalingen van de cao liggen de volgende vijf krachtlijnen ten grondslag :

- Het alcohol- en drugsbeleid dient om problemen te voorkomen, en waar nodig, vroegtijdig in te grijpen (preventie). Daarom is het (dis)functioneren van de werknemer de invalshoek voor het optreden.

- Er wordt van uitgegaan dat de ondernemingen stapsgewijs en in fasen tewerk dienen te gaan. De uitdieping van het beleid zal afhankelijk zijn van de concrete omstandigheden in de onderneming en de consensus die over het te voeren beleid gevonden kan worden.

- Er wordt uitgegaan van het belang om gedurende de verschillende fasen een sfeer van onderling vertrouwen en dialoog in de onderneming te behouden.

- Bij de uitwerking van het beleid dient er rekening mee gehouden te worden dat de initiatieven op maat van de onderneming zijn.

- Het beleid dient te gelden voor iedereen in de onderneming, van hoog tot laag.

Concreet legt de cao aan de ondernemingen de verplichting op om de uitgangspunten en de doelstellingen van het preventief alcohol- en drugsbeleid in hun onderneming te bepalen en deze op te nemen in een beleids- of intentieverklaring, die de krijtlijnen voor het beleid bevat. Deze verklaring is bepalend voor alle initiatieven die nadien genomen worden (art. 3 van de cao). Ze zal door middel van een participatieve procedure, die in de cao bepaald wordt, aangenomen dienen te worden. De beleidsverklaring wordt opgenomen in het arbeidsreglement en alle werknemers worden over de beleidsverklaring geïnformeerd.

De verdere uitwerking van het alcohol- en drugsbeleid in een eventuele tweede fase zal afhankelijk zijn van de inhoud van de beleids- of intentieverklaring en de concrete omstandigheden in de onderneming. De cao geeft wel aan waarin een nuttige verdere uitwerking van het beleid kan bestaan. Testen kunnen een onderdeel zijn van het beleid, onder beperkende voorwaarden en binnen het kader geschetst in de CAO.

De cao vereist bovendien dat de vorming die aan alle werknemers dient gegeven te worden betreffende het welzijn van de werknemers ook betrekking dient te hebben op de maatregelen die genomen worden in het kader van het alcohol-en drugsbeleid.

3. De collectieve arbeidsovereenkomst is op 1 april 2009 in werking getreden, maar om de ondernemingen de tijd te geven om de nodige initiatieven te nemen en het overleg hierover in de onderneming te voeren, krijgen de ondernemingen tot 1 april 2010 de tijd om een preventief alcohol- en drugsbeleid uit te werken of een bestaand beleid aan te passen aan de vereisten van de cao en de wetgeving.

De sociale partners stellen tevens een informatiebrochure ter beschikking. Deze brochure is een praktische leidraad voor allen die in de ondernemingen betrokken zijn bij de uitwerking van het beleid (de werknemers en hun vertegenwoordigers, de personeelsdienst, de preventieadviseurs, ...).

De website van de Raad (www.nar-cnt.be) bevat in de rubriek "Thema's" een dossier waarin de tekst van het advies nr. 1655, van de cao nr. 100 en de leidraad kunnen geconsulteerd worden.

Terug

Le Conseil national du Travail s'est réuni en séance plénière le vendredi 1 avril 2009 sous la présidence de monsieur P. Windey.

La convention collective de travail n° 100 concernant la mise en œuvre d'une politique préventive en matière d'alcool et de drogues dans l'entreprise

1. Les partenaires sociaux ont décidé, dans l'accord interprofessionnel pour la période 2007-2008, qu'une politique préventive en matière d'alcool et de drogues est une nécessité absolue dans chaque entreprise.

Les éventuelles conséquences de la consommation d'alcool et de drogues sur le lieu de travail ne doivent pas être sous-estimées :

- fréquentes absences ou arrivées tardives ;
- absentéisme en raison d'une incapacité de travail (deux à six fois plus élevé) ;
- baisse de la motivation et de la productivité (au sein de l'Union européenne, sur une base annuelle, la perte de productivité due à l'absentéisme est de 9 à 19 milliards d'euros et la perte de productivité due au chômage est de 6 à 23 milliards d'euros) ;
- accidents du travail en raison d'une vigilance réduite ou d'un comportement irréfléchi (le risque d'accidents est deux à quatre fois plus élevé. Des estimations indiquent que l'influence de l'alcool explique en partie 15 à 30 % des accidents) ;
- responsabilité de l'employeur ;
- dégradation de l'image de marque de l'entreprise, etc.

Toutes les conséquences ne sont pas chiffrables. Il est clair que les problèmes d'alcool et de drogues ne touchent pas uniquement le travailleur concerné lui-même et son employeur, mais aussi ses collègues. Il suffit de penser à l'organisation du travail qui est perturbée, à la charge de travail qui augmente, à l'ambiance de travail qui se dégrade, au comportement abusif que l'on risque (seuil plus bas pour une agression verbale ou physique ou pour le harcèlement sexuel) ou à l'implication dans un accident du travail.

Il y va de l'intérêt de tous que de tels problèmes soient évités ou résolus et ce, pour la santé et la sécurité de tous les travailleurs et pour le fonctionnement de l'organisation, mais surtout pour le travailleur qui a un problème. On ne l'aide pas en ne faisant rien ; au contraire, cela aggrave généralement les problèmes.

2. Le 1er avril 2009, les partenaires sociaux ont par conséquent conclu, au sein du Conseil national du Travail, la convention collective de travail n° 100 concernant la mise en oeuvre d'une politique préventive en matière d'alcool et de drogues dans l'entreprise (voir également l'avis n° 1.655 du 10 octobre 2008).

En réglant cette question dans une CCT, ils augmentent le soutien pour un exercice délicat dans l'entreprise.

Les dispositions de la convention collective de travail (CCT) sont basées sur les informations détaillées que les partenaires sociaux réunis au sein du Conseil national du Travail ont obtenues au sujet de la problématique de la consommation d'alcool et de drogues dans le milieu de travail. En particulier, ils ont pu compter pour ce faire sur la collaboration de la VAD, la "Vereniging voor Alcohol- en andere Drugproblemen", dont l'une des missions est de soutenir une approche qualitative et scientifiquement fondée de la thématique de l'alcool et des drogues.

La CCT impose à tous les employeurs du secteur privé d'élaborer une politique préventive en matière d'alcool et de drogues pour l'ensemble de leur personnel.

La CCT n'entend toutefois pas imposer une politique toute faite en matière d'alcool et de drogues pour chaque entreprise. Chaque entreprise est différente et a ses propres points de vue et ses propres règles, sur le plan de l'alcool et des drogues également.

La CCT pose les jalons d'une politique préventive en matière d'alcool et de drogues qui doit être conçue dans les entreprises et ce, dans différents domaines : les mesures à prendre par l'employeur, l'information et la formation des travailleurs, les obligations de la ligne hiérarchique et des travailleurs, le rôle des conseillers en prévention, l'élaboration de la politique en concertation et son évaluation périodique.

Cinq lignes directrices sont à la base des dispositions de la CCT :

3. Overview initiatives VAD/CGG 2009-2010

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Stand van zaken
9juli10

ORGANISATOR	INITIATIEF	AARD - input	LOCATIE	DATUM	FED	VLA	REG	REG	VIE	EVALUATIE
2009 - STUDIEDAGEN/SEMINARIES							XX	X		
PVI Antwerpen	Navorming 2009	workshop 2u	Malle	20/ma		x	<1			8.5/10
	2-daagse									
Fairtec	SECURA	sessie 2u	Brussel	25/ma	x					NT FORMEEL
166 pp.	3-daagse conferentie									goede respons
Essers	PilootOpleiding Veiligheid	sessie 2u	Genk	20/apr		x				13/13 heel tevreden
	54u over diverse dagen									
VVVB	Portfolio 09	bijdrage 45min	Antwerpen	24/apr		x				3.2/4 (overall)
bedrijfsverpleegk										3.7/4 inhoud
166 pp.										3.7/4 vorm
VBO										
66 pp.	Infosessies	bijdrage 60min	Brussel	14/mei	x	x				in aanvraag
87 pp.	halve dag		Hasselt	15/mei		x				4.55/5
76 pp.			Zwijnaarde	25/mei		x				3.79/5
			Antwerpen	28/mei		x				in aanvraag
Prov.Com VLBr	Studienamiddag	bijdrage 60min	Leuven	5/jun			x			22% ZG (overall)
125 pp.										76% G (overall)
LOGO pr.A'pen	Provinciaal overleg	bijdrage 60min	Antwerpen	5/jun				x		nt formeel
	2jaarlijks									goede respons
SSC vzw	Studienamiddag	bijdrage 45min	Leuven	9/jun			x			4.04/5 (alg.)
Soc.sec. Caritas			Gent	12/jun			x			4.23/5 (alg.)
AGORIA	Infonamiddag									
65 pp.	halve dag	bijdrage 40min	Brussel	9/jun		x				in aanvraag
145 pp.	Oost- & WestVl.		Gent	16/jun			x			3.26/4

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ORGANISATOR	INITIATIEF	AARD - input	LOCATIE	DATUM	FED	VLA	REG zz	REG z	WIE	EVALUATIE
56 pp.	Antw. & Limburg		Berchem	18/jun			x			7.7 (overall)
CRESEPT	DIPLOMA-uitreiking	bijdrage 45min	Drogenbos	12/jun		x				nt formeel: OK
VVBI	Symposium	bijdrage 60min	N-O-Heem	12/jun		x				nt formeel:
interne artsen	halve dag	en panel								zeer OK
PREBES	PreNNe	bijdrage 45min	Oostende	16/jun	x					in aanvraag
113 pp.	Prebes Nation Network Event									
FEVIA	Opleiding	volledig	Brussel	23/jun	x					zeer goed (5/6)
voedingsindustrie	halve dag									
Nationale Bank	CPBW	2u	Brussel	8/sep	x					nt formeel:
										zeer OK
BASF	CPBW	4u	Antwerpen	24/sep		x				nt formeel:
										zeer OK
SOCIARE	Vorming	volledig	Brussel	22/sep		x				8.02 overall - 7.78
sociocult sector	1 dagdeel		Brussel	2/okt		x				8.54 overall - 8.44
			Brussel	23/okt		x				verplaatst 2/2/10
			Brussel	18/dec		x				8.75 overall - 8.66
PREBES	PreNNe	bijdrage 45min	Genk	24/sep	x					
LPV	Studienamiddag	bijdrage 60min	Alden Biesen	25/sep				x		
FOD VASO	Infosessie Heizel	bijdrage 60min	Brussel	1/okt	x					
750 pp.	halve dag		Brugge	2010			xx			
TdT arbeid	Vorming pw-ers	volledig	Brussel	6/okt	x					8.7/10
6 pp.										

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ORGANISATOR	INITIATIEF	AARD - input	LOCATIE	DATUM	FED	VLA	REG zz	REG z	WIE	EVALUATIE
LUCINA	Infodag/opleiding	volledig	Pellenberg	8/okt		x				
36 pp.										
ROTARY GENT	Seminarie	bijdrage	Gent	17/okt				x		
		beleidsinstrument								
Prov.Com Limb	Studiedag	bijdrage	Hasselt	26/okt				x		
AMELIOR	Updating PA	bijdrage over	Kortrijk	17/nov	x					
	nationaal opleidingscentrum	CAO 100	Affligem	9/dec	x					
PREBES	PreNNe	bijdrage 45min	Gent	1/dec	x					
VVKHO	Seminarie	2u	Brussel	7/dec		x				
Project VVL	Avondseminarie	2u	Kortrijk	25/nov				x		
	(8 totaal - 3ismVAD)		Roeselare	30/nov				x		
			Oostende	5/feb				x		
				2/jul						
2010 - STUDIEDAGEN/SEMINARIES										
Interunivers.	Seminarie	bijdrage +	VUB	8/jan		x				
arbeidsgenees.		panel								
Vlaams VV	Seminarie	toelichting	Gent	27/jan			x			
COC Oost-Vl.										
SOCIARE	Vorming	volledig	Brussel	2/feb		x				
sociocult sector	1 dagdeel									

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ORGANISATOR	INITIATIEF	AARD - input	LOCATIE	DATUM	FED	VLA	REG xx	REG x
Project VVL	Ontbijtseminarie	bijdrage	Oostende	5/feb				x
Provinc.Comité Bevordering	Seminarie	bijdrage	Leuven	8/feb			x	
PVI Antwerpen	Navorming	volledig	Malle	4/mrt		x		
PREBES	PreNNe	bijdrage 45min	Affligem	23/mrt	x			
		bijdrage 45min			x			
	Prebes Nation Network Event	bijdrage 45min	Oostende	17/jun	x			
		bijdrage 45min	edegem	21/sep	x			
Nat.opleidingsc. FOD VASO	Seminarie	bijdrage 17/3	Lanaken	15/16/17ma	x			
FOD VASO	Seminarie	bijdrage	Brussel	18/mei	x			
[redacted]	Middagseminarie	volledig	Brussel	3/jun	x			
VAD AV	Algemene Vergadering	bijdrage	Brussel	18/jun		x		
[redacted]	seminaries mei/juni	volledig	Zemst	18/mei		x		
		volledig	Zemst	28/mei		x		
		volledig	Zemst	11/jun		x		
		volledig	Zemst	29/jun		x		
[redacted]	2daags congres	bijdrage	Brussel	22/jun	x			
[redacted]	Luchseminarie	volledig	Brussel	24/sep	x			
INTERSECTORALE INITIATIEVEN								

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FOD VASO	aanmaak brochure: uiterlijk juni 2010 ism Santé et Entreprise							
SECTORALE INITIATIEVEN								
Bouwsector		aanmaak brochure: ok 20 januari 2010						
Voedingsindustrie		communicatie leden						
VVKHO koepel h	hogescholen							
Vlaams verbond welzijnsinstellingen		cf. 27 januari						
PERS								
(behalve dagbladpers en specifieke pers sociale partners)								
Radio Nostalgie	17/02/2009	[redacted]						
Radio 2	2/04/2009							
Klasse	jun/09							
Groep S	web TV november 09							