European Monitoring Centre
for Drugs and Drug Addiction

CRP SANTÉ

POINT FOCAL OEDT
GRAND-DUCHE DE LUXEMBOURG

2005 NATIONAL REPORT TO THE EMCDDA by the Reitox National Focal Point

"GRAND DUCHY OF LUXEMBOURG"

New Development, Trends and in-depth information on selected issues

Alain Origer

REITOX

Table of Contents

Foreword

The present report on the drug situation in the Grand Duchy of Luxembourg has been compiled for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) by the Luxembourgish EMCDDA focal point.

The report has been edited by Alain Origer, head of the EMCDDA national focal point in collaboration with the following national actors: Andrée Clemang (Ministry of Justice), Georges Neu (Special Drug Department of the Judicial Police), Dr Jos Schlink (State Prison CPL), Prof. Dr Robert Wennig (National Laboratory of Health LNS), Henri Goedertz (AIDS Berôdung asbl), Dr Robert Hemmer (Surveillance Committee on AIDS), Henri Grün (JDH), Arianne Moyse (National Methadone Programme JDH), Romain Pauly (CTM), Dr Ferdy Kasel (CHNP-BU-V), Dr Mühe (CHL), Alain Massen (MSF), Simone Schram (Directorate of Health), Helène Dellucci, Pascale Straus and Nathalie Removille (NFP – CRP-Santé), Daniel Schroeder (Consultant), Céline Victoire (Administration du Contrôle médical), J.-P. Juchem (Union des Caisses de Maladie), J.-M. Schanck and Guy Reinart (Ministry of Health).

Luxembourg, 28 October 2005

Author:

Alain Origer
Head of Focal Point
PFN - CRP-Santé

Summary

Annual National Report on the Drug Situation
(Edition 2005)

The report on the Drug Situation in the G. D. of Luxembourg has been prepared on behalf of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), a decentralized agency of the European Union. The report has been edited by the Luxembourgish focal point of the EMCDDA and provides an overview of current developments regarding the political and legal framework, the epidemiological situation, demand reduction interventions and selected key issues of current interest in the fields of drugs and drug addiction.

Political, legal and organizational framework

Following the parliamentary elections of June 1999 the government entrusted the Ministry of Health with the overall coordination of drug-related demand and risk reduction actions. The strategic framework was set up by the national drug coordinator's office, mandated to elaborate the **2000-2004 action plan on drugs and drug addiction**.

The governmental programme presented following the **parliamentary elections of June 2004** has introduced no changes concerning competences and attributions in the drugs field and constitutes the framework for the elaboration of the **strategy and action plan 2005-2009 for the fight against drugs and drug addiction. The national strategy and action plan 2005-2009** relies upon the priorities of the Ministry of Health and a sustained concertation with field actors and civil society. In order to optimize its impact, the new action plan has taken into account pertinent elements issued from **EU and EC treaties, the EU anti drugs strategy 2005-2012** and the **EU drugs action plan 2005-2008** having been endorsed under the Luxembourg presidency. The **general aim** of the national strategy and action plan is to contribute to a high level of protection in terms of public health, public security and social cohesion.

An effective drugs strategy should rely on **two pillars**, namely on demand reduction and supply reduction as also on **four transversal axes**: risk, damage, nuisance reduction, research and information, international relations and finally coordination mechanisms. The national drugs coordinator jointly with the Interministerial Committee on Drugs (ICD) follows up the implementation process of the national drugs plan.

The **global budget of the Ministry of Health** granted to drug-related services and programmes went up from 1,270,169 EUR in 1999 to 4,861,841.- EUR in 2003 indicating a **progression rate of 283%** since 1999. The 2004 budget went up to 5,770,643.- EUR representing a supplementary raise of 18.7% in reference to the 2003 budget. In regard to the 2005 budget, 6,195,518.- EUR have been allocated to concerned services representing an increase of 7.4% compared to 2004.

Epidemiological indicators

Worldwide some 200 million people, representing 5% of the world population aged between 15 to 64 years, have consumed drugs at least once the last 12 months. This number, representing an increase of 15 million persons compared to the last years estimation, still remains significantly lower than the number of persons having used licit psychoactive substances. The spread of cannabis consumption, the most commonly consumed illicit drug in the world, shows the most important increase. In the last decade, the most important increase besides cannabis, applies to ATS (including ecstasy) followed by cocaine and opiates. A similar evolution is observed within the **EU** and the micro-geographical level of the **Grand Duchy of Luxembourg**, however accompanied by more or less sustained local variations with regard to prevalence.

National drug prevalence in the general population

***D**rug prevalence in school population*

Comparable data from national school surveys conducted between 1992 and 2000, show increasing **lifetime prevalence in young people** (16-20 years) for all common illicit substances. According to the most representative studies, the **disproportional increase of cannabis** and ATS deserves particular attention. In relation to younger school populations (13-14 and 15-16 years), one observes a similar trend, particularly visible when it comes to lifetime prevalence of cannabis use. **The use of opiates by school-aged youngsters shows a low prevalence having progressed weakly within the considered period.**

National prevalence of problem drug use (PDU)

***D**ata on institutional contacts and drug treatment demands*

The **number of problem PDUs** indexed by national institutions in 2004 figures 3,597 (1994: 2,213) (double counting included). For comparison, 873 users have been indexed by national specialised drug demand reduction agencies and 1,340 persons by supply reduction agencies in **1994.** In 2004 the same agencies have indexed 1,700 and 1,897 persons respectively, which equals to a total **increase rate of 62%. 5%** of respondents are **first treatment demanders**, all treatment centres included. More recently one has observed a **stabilisation of treatment demands in outpatient drug agencies** and an increasing demand for inpatient therapies and at the opposite for low threshold offers.

The male/female ratio of the PDU population is 3:1. The last ten years the proportion of indexed non-native PDUs has shown an increasing tendency. The **population of non-natives** drug users largely consists of Portuguese nationals, a proportion constantly increasing and consistently higher than the one observed in general population. Moreover, one observes a non-uniform evolution of PDUs coming from Eastern countries.

The **mean age** of indexed PDUs evolved from 28 years and 4 months in 1995 to 30 years and 6 months in 2004. **The gap between youngest and oldest PDUs continues to grow**. One observes an average aging of the population of long-term drug injectors and a sensitive decrease in age referred to "new" PDUs. Worth mentioning is the significant increase of the **average age of overdose victims** and a **significant but currently stable proportion of minors** among drug law offenders STUP. Respectively 86% and 41% of current PDUs have tried cannabis and heroin (i.v.) while being minor of age. In 1995 the same proportions figured 71% et 23% .

***P**roblem drug use prevalence and consume trends*

The multi-methods prevalence study on PDUs at the national level, published in 2001 (Origer 2001), provides a prevalence rate of 8.42 per thousand inhabitants aged 15-64 (absolute figure 2,450 PDUs). According to post 2000 indicators (Origer 2004), **prevalence figures** applied to the national population aged 15-64 currently situate between 2,500 and 2,800 PDUs**.**

Intravenous heroin use associated to **poly-drug use** has been reported as the most common consume pattern in PDUs. The switch to **intravenous drug use** occurs earlier. The ratio of **intravenous opiates consume** to **the inhalation** mode has stabilised at 2:1.

The number of persons in contact with the national specialised network for (preferential) **cannabis** use had known a sensitive increase the last three years but decreased again in 2004. **Amphetamine like substances and ecstasy** are only weakly represented, which however does not inform about prevalence in general population as RELIS data refer to PDUs and not to the overall population of **recreational drug users.**

The proportion of **poly drug use** (93%) has reached a record level in 2004. The average ages at **first time consumption of a preferred drug** and **illicit drugs in general**, show a slow but continuous decrease for the last 8 years. In general, the proportion of PDUs aged more than 35 years and of users under 19 years is increasing continuously as also the gap between these two groups.

***D**rug-related morbidity and mortality*

HBV (hepatitis B) and the HIV/AIDS prevalence among PDUs have not been increasing in recent years while the **infection of HCV (hepatitis C) showed a clear progression** and currently tends to stabilise around the European average. Data from the Laboratory of Retrovirology of the CRP-Santé suggest a **general decreasing tendency of average proportion of IVDUs in newly diagnosed HIV cases** over the last years. **HIV infection rates in IVDUs** situates around 5 percent thus allowing a weakly increasing trend compared to 2003. Attention has to be paid to the strong increase of the **HIV infection rate in female IVDUs** figuring more than 10% in 2004. An inverse trend has been observed for male IVDUs during recent years.

The implementation of the 2000-2004 action plan has been accompanied by a significant decrease of **overdose cases** in the Grand-Duchy of Luxembourg and has stabilised in 2004 (13 cases). Expressed in the number of overdose cases in the general population of the Grand-Duchy of Luxembourg, this proportion figured 2.87 overdose death per 100,000 inhabitants in 2004 (2000:, 5.9 cases per 100,000 inhabitants). **Forensic data** of 2004 confirm that nearly every drug-related death involved heroin use associated to multiple substance use. Detected associated drugs in blood samples of overdose victims showed primarily methadone and cocaine as also the involvement in a majority of cases of alcohol and benzodiazepine type medicaments. To date no lethal intoxication related to ecstasy type substances has been reported.

In 2004, 17 **indirect drug death cases** have been indexed. Main causes of indirect deaths between 1996 and 2004 are, in order of importance: suicide, traffic accidents, undefined intoxication, associated cardio-vascular or pulmonary complications pharmaco-dependance, liver failure and immune deficiency diseases.

The overall number of indexed direct and indirect drug death cases informs about **drug-related mortality**. Drug-related mortality prevalence has been showing small variations since 1996 figuring roughly 26 to 33 cases per year.

Law enforcement indicators [1]

***S**eizures of illicit substances at the national level*

Striking variations have been observed as to the **quantity of illicit substances seized** since the beginning of the nineties. A longitudinal data analyses indicates a general decreasing tendency of heroin, cocaine and cannabis seizures until 2002[2]. Since 2002 however, one observes a significant increase in the quantity of drug seizures mainly concerning heroin and herbal cannabis. **Cocaine** seizures (quantity) are highly variable since the beginning of the nineties.

Notwithstanding the quantities seized, the **number of seizures** has grown discontinuously since 1993. Since 2000 the number of cannabis and cocaine seizures has markedly increased and the number of heroin tends to stabilise. For instance, the number of cannabis seizures has risen from 167 to 623 between 1994 and 2004. The total **number of persons** involved in traffic has followed a constant upward trend until 2002 and seems to have stabilised since then. A confirmed majority of offenders are involved in cannabis traffic and are non-natives.

[1] If not specified, data refer to 2004. Figures between brackets refer to 2003 if not specified.
[2] Non –transit drugs destined to the nation market

The first national seizures of **ecstasy type substances** (MDMA, MDA, etc.) were recorded in 1994. The availability of ecstasy appeared to soar between 1994 and 1996 however stabilization at low level occurred the last six years.

***D**rug law offenders and prison sentences*

The **number of police records** for presumed offences against the modified drug law of 1973 has more than doubled between 1995 (764) and 2004 (1,468) even though a decrease has been observed between 2003 and 2004. The same evolution has been observed with regard to the **number of drug law offenders**. In 2004, 178 **arrests** for presumed offences against the modified 1973 drug law have been reported. In other words, the number of police records and the number of drug law offenders has slightly decreased whereas the number of people arrested on the same charge has increased compared to previous years.

90% of drug law offenders are male, a proportion which has been varying between 79% and 90% during the last ten years. Since 1998, the proportion of **non-native drug law offenders** passed from 50% to 68% (increasing tendency). In 2004, 32% of the cases are **first drug law offenders** (lowest level since 1998); the percentage of **minors** in drug law offenders has increased from 5.4% in 1993 to 13.8% in 2003 and decreased to 8.7% in 2004.

National prison data of 2004 refer to 1,033 (1,072) new admissions of which 89 (9%) were related to drug law offences; a proportion having represented 42.6% in 1996 and constantly decreasing since then.

Profile of the national drug market

According to data provided by the Special Drug Unit of the Judicial Police, a majority of **illicit drugs consumed in the Grand Duchy of Luxembourg originate** from the Netherlands, followed by Belgium and Morocco. Heroin consumed in Luxembourg originate primarily from Afghanistan, Laos and Myanmar. Cocaine distributed on the national illegal market originate mainly from Brazil and ATS like substances mostly come from the Netherlands followed by Poland and the Czech Republic. The road network is still the main transport and transit route of drugs destined to the national market.

For several years, the expansion of **more structured distribution networks** by organized criminal associations have been reported. The national market increasingly attracts “drug professionals” aiming to set up a purely commercial distribution network. The proportion of non-natives implicated in drug trafficking is increasing. Asylum demanders implicated in illicit cocaine trafficking come from West Africa, particularly the Ivory Cost, as also from Albania and Kosovo. In regard to heroin trafficking no predominant profile of nationality has been reported. A large number of drug traffickers come from North Africa by transiting through Belgium. A large number of traffickers have changed from heroin to cocaine traffic and currently are also implicated in cannabis traffic. Regardless the type of drugs, selling and distribution techniques have become more aggressive in the course of 2004.

At beginning of 2003 a **clandestine laboratory** of amphetamine production has been discovered in the south of the country. Local cultures of cannabis and magic mushrooms are rather insignificant in terms of quantity and quality.

Average street prices of heroin (brown), cocaine and ecstasy type substances have fallen during 1996 to 2003 but broader price ranges as also more pronounced maximum prices for cocaine and heroin have been observed in 2004. Cannabis and derivates however have known a certain stability during the last 4 years.

As far as **purity** is concerned, samples of suspected substances analysed by the National Laboratory of Health announced a constant increase of THC rate in cannabis derivates, an increase of heroin purity and a constant cocaine quality. In regard to other substances, tendencies are not clear, however low MDMA concentrations have been observed in ecstasy like substances.

Harm reduction activities

The number of **sterilised syringes** (2004: 435,000/ 1996: 76,259) distributed in the framework of the **national needle exchange programme** has been constantly rising from the start of the latter. The same trend is observed with regard to the number of **used syringes collected** (2004: 376,000 (87%)/ 1996: 28,646 (38%)). The majority of injectors (35%) procure their syringes in pharmacies followed by specialised agencies and automatic dispensers.

The **number of contacts** registered by low threshold structures has increased dramatically over the last 8 years (2004: 39,526/ 1996: 6,456) and so has the number of syringes distributed by the same agencies. The proportion of **new clients** within low threshold settings, however, has stabilised.

The national **methadone substitution programme** has been implemented in 1989 by the Ministry of Health and the JDH Foundation. The number of participants went from 30 in 1993 to 120 in 2004 (decreasing tendency since 1998). In addition to the methadone substitution programme financed by the Ministry of Health, an important number of PDUs address substitution treatment demands to **independent general practitioners**. Data delivered by the Union of Health Insurance Founds refer to 1,553 patients who did receive substitution treatment in 2004 (2002: 1,478 patients/ double counting included) by means of the prescription of methadone or buprenorphine containing medicaments (MEPHENON ®, METHADICT ® and SUBUTEX ®) and 158 prescribing GPs (1999: 125).

Selected issues

● GENDER DIFFERENCES

Gender distribution in PDUs has stabilized around 3 males for 1 female for several years. However, behaviour of female PDUs has been showing significant differences compared to their male counterparts during recent years. One should emphasize the decreasingly lower age of men at the moment of the first illicit drug use although women tend to switch earlier to iv use.

Polydrug use is wide spread in male and female PDUs. **Drug-related drug deaths** data show a fairly stable predominance of male victims, especially in indirect drug fatalities. **Substitution treatment** is the only offer that shows a higher (ca. 40%) and still increasing proportion of female demanders.

Although men are most prevalent in **newly diagnosed HIV cases** one observes a discontinuous increase of the proportion of female cases since the end of the 90.

The **availability of gender-specific treatment** and low threshold offers are adjusted to current the national drug situation but future developments in gender specific drug use behaviour should be paid particular attention to.

In 1999 the government entrusted the Ministry of Health with the **overall coordination** of drug-related demand reduction issues. The first national strategy and action plan on drugs and drug addiction covered the period from 2000 to 2004. In December 2004, the Minister of Health presented the new strategy and action plan 2005-2009.

The **national anti-drug strategy 2005 – 2009** relies on two pillars: demand reduction and supply reduction and on four transversal axes: risk, nuisance and damage reduction; research and information; international relations and horizontal coordination mechanisms.

In the light of the high prevalence rate of problematic drug use, the national drugs strategy ostensibly gives priority to the fight against **illicit** use of drugs and related consequences. The target group of the national drugs action plan is primarily constituted of **problematic drug users of illicitly acquired drugs and polydrug users.**

The national approach towards addiction **prevention** focuses on the individual and his environment rather than on drugs and drug addictions. According to observed needs, specific substances and behaviours may be subject of prevention activities or campaigns.

The creation of the **National Dug Prevention Centre** in 1996 was a clear political signal of national authorities with regard to the development of addictions in society. The designation of a **national drugs coordinator** in 2000 and successive national action plans further witnessed the willingness of the government to tackle addictive behaviours by a complementary approach putting however emphasis on problematic drug use in the light of the high national prevalence, the prevention of health damages and deaths of PDUs and the safeguard of public security.

The overall fight against drugs and drug addiction is a **competence shared by different ministerial** departments. **The Inter- ministerial Drug Group (GID),** chaired by a delegate of the Ministry of Health, assures the political coordination of the different ministries competent in drug related issues.

● DEVELOPMENTS IN DRUG USE WITHIN RECREATIONAL SETTINGS

'**Recreational settings'** are referred to as non-educational and occupational environments with special emphasise on leisure activities and nightlife settings.

Research into drug use within recreational settings has developed recently due to **increasing problems observed in urban settings** in terms of city planning or public security issues.

Generally speaking youngsters report an easier **access to illicit drugs** near the place they live and near school or college than at parties, in pubs or clubs compared to the European average. A closer analysis of recent survey outcomes, however, shows that **availability is highly dependant on the type of drugs involved**. Ecstasy-type drugs are most available at nightlife venues, cannabis in city parks and cocaine is most commonly found in the PDU scene areas.

As far as **national policies and legal developments** in the field of drug use within recreational settings are concerned emphasis has been put during recent years on ecstasy and cannabis use as well as on legal substance use/misuse among youngsters. Legal amendments concerning the prohibition of the sale of tobacco and alcohol (in supermarkets) to youngsters below 16 years are currently in preparation. The Minister of Health also proclaimed to increase taxes of the so-called mix-drinks or 'alcopops' especially targeting youngsters

The action plan on drugs and drug addiction (2005-2009) foresees a needs assessment in nightlife settings in order to plan risk, damage and nuisance reduction measures as well as a study on drugs and minors in order to plan future interventions.

Part A: New Developments and Trends

1. National policies and context

Overview

Drug use is defined as behaviour potentially associated to health and social damage. Consequently national drug policies are based on shared political competencies and responsibilities.

National parliamentary elections of June 2004 have resulted in a new coalition government of social democrats (CSV) and socialists (LSAP). Competencies and ministerial attributions in the drugs field have not been modified. The governmental declaration of 2004[3], and the subsequent coalition agreements, emphasised the need of further development and diversification of specialised health care, a more pragmatic approach towards law enforcement by means of legislative amendments and the promotion of harm reduction measures, where appropriate.

In June 2005, the Minister of Health presented the new drug strategy and action plan 2005 – 2009, elaborated by the National Drug Coordinator's Office. The referred action plan is based on the evaluation outcome of the previous action plan and the assessment of current and future needs. One of the first achievements of the new drugs action plan is the implementation of the first national drug consumption room in Luxembourg City (July 2005).

● LEGAL FRAMEWORK[4]

❍ Laws (2001- 2004)

The **basic national drug law**, namely: 'Loi concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie[5]' regulates both, the selling of controlled medicaments and the fight against drug addiction and dates back to the 19 February 1973. It has been last amended by the law of 8 August 2000.

- law of 27 April 2001[6] modifying the basic drug law of 19 February 1973. Besides the decriminalisation of cannabis use, alleviation of penalties for simple drug use, and an enhanced overall differentiation of penalties according to the type of drug offences and the nature of controlled substances involved, the law of 27 April 2001 foresees a legal framework for a series of harm reduction and maintenance measures, namely, drug substitution treatment, needle exchange and other state accredited means, which, in addition to article 13 of the grand ducal decree of 30 January 2002 (see below) could materialise in shooting galleries or medically controlled heroin distribution programmes.

- law of 14 June 2001[7] endorses the Convention on Laundering, Search, Seizure and Confiscation of the proceeds from crime of the Council of Europe (Strasbourg 8 November 1990) introducing amendments to the criminal code and the basic modified drug law from 19 February 1973.

---

[3] Governmental Declaration of 2004, http://www.gouvernement.lu:80/gouv/fr/gouv/progg/declu.html

[4] The referred legal texts from 1971 onwards as well as English summaries may be consulted in the ELDD legal database

[5] Official gazette A 1973, p.319

[6] Official gazette A 2001, p.1180 (Adoption: 27/04/2001, Entry in force: 17/05/2001)

[7] Official gazette A 2001, p.1708 (Adoption: 14/06/2001, Entry in force: 17/06/2001)

❍ **Grand ducal decrees (2004/2005)**

- The **grand ducal decree of 18 January 2005** establishes the model of prescription forms of narcotic based pharmaceutics[8]. The referred prescription forms contains 2 separate annexes. The first to be used in case of ordinary medical treatment and the second to be completed in case of substitution treatment of patients.

- The **grand ducal decree of 7 October 2004[9]** modifies the national list of controlled psychotropic substances.

The following substances complete annex A:
2C-I (2,5-diméthoxy-4-iodophénéthylamine)
2C-T-2 (2,5-diméthoxy-4-éthylthiophénéthylamine)
2C-T-7 (2,5-diméthoxy-4-(n)-prophylthiophénéthylamine)
TMA-2 (2,4,5-triméthoxyamphétamine)»

Annex B includes GHB, «acide gamma-hydroxybutyrique» in the list of nationally controlled substances.

- The **grand ducal decree of 30 January 2004[10]** modifies the substance lists annexed to the grand ducal decree of 2 February 1995. (list cf. footnote)

As regards **regulation mechanisms on the control of substances and precursors,** the national drug legislation relies on the following Grand ducal decrees, amended (text or annexes) according to decisions on new substances' inscription into national law:

- Grand ducal decree of 4 **March 1974** regarding certain toxic substances
- Grand ducal decree of 20 **March 1974** regarding certain psychotropic substances
- Grand ducal decree of 26 **March 1974** establishing the list of controlled narcotics
- Grand ducal decree of 8 **May 1993** regarding commerce of narcotics and psychotropic substances
- Grand ducal decree of 2 **February 1995** regarding the production and distribution of certain substances used in the illicit production of narcotics and psychotropic substances
- Grand ducal decree of 6 **February 1997** regarding substances listed in schedules III and IV of the UN Convention on psychotropic substances of 21 February 1971.

The full text of the current basic national drug law as well as recent decrees can be accessed trough the following web sites: http://www.legilux.public.lu or http://eldd.emcdda.org/databases/eldd_search.cfm.

❍ **Projects and propositions of law**

No projects or propositions of law have been deposited during the reporting period.

As far as previous propositions of law are concerned, it should be stressed that the "Proposition of establishing a prescription programme for cannabinoïds-based medicaments, deposited in 2004, has been disapproved by the State Council in its statement of 26/10/2004 (Doc. Parl.5020)

[8]Official gazette A 2005, (Adoption: 18/01/2005, Entry in force: 14/02/2005) Règlement grand-ducal du 18 janvier 2005 déterminant le modèle du carnet à souches prévu à l'article 30-1 de la loi modifiée du 19 février 1973 concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie.
http://www.legilux.public.lu/leg/a/archives/2005/0211402/0211402.pdf?SID=cac954462991e49701fd54f107a49282#page=5

[9] Official gazette A 2004, (Adoption: 07/10/2004, Entry in force: 21/10/2004) Règlement grand-ducal du 7 octobre 2004 modifiant le règlement grand-ducal modifié du 20 mars 1974 concernant certaines substances psychotropes ainsi que le règlement grand-ducal modifié du 6 février 1997 relatif aux substances visées aux tableaux III et IV de la Convention sur les substances psychotropes, faite à Vienne, le 21 février 1971.
http://www.legilux.public.lu/leg/a/search/resultHighlight/index.php?linkId=4&SID=e598ed3498d37aa98708757b0b038d49

[10] Official gazette A 2004, (Adoption: 30/01/2004, Entry in force: 13/02/2004)
Règlement grand-ducal du 30 janvier 2004 modifiant le règlement grand-ducal modifié du 2 février 1995 relatif à la fabrication et à la mise sur le marché de certaines substances utilisées pour la fabrication illicite de stupéfiants et de substances psychotropes.
http://www.legilux.public.lu/leg/a/search/resultHighlight/index.php?linkId=1&SID=e0622007c5892b499e6269171b466eaf

❍ Laws implementation

Legally speaking, police has no discretional power: every offence, once ascertained, must be reported. However, depending on the case, (e.g. first 'interpellation' for cannabis use) it may occur that no further action is taken. Once a drug law offence case has been reported to the Public Prosecutor, the latter decides on the opportunity to prosecute or not. The legal concept of 'prosecution opportunity' may be applied, which implies a case-by-case decision.

The **law of 27 April 2001**[11] modifying the basic drug law of 19 February by decriminalising cannabis use, and enhancing the differentiation of penalties according to the type of drug offences and the nature of controlled substances involved and the **grand ducal decree of 30 January 2002**[12] on substitution treatment, have largely contributed to increase the congruity between drug legislations and prosecution routines.

Current drug legislation and prosecution policies put high priority on drug dealing and trafficking and lower priority on drug consumption and promote harm and risk reduction measures.

- INSTITUTIONAL FRAMEWORK, STRATEGIES AND POLICIES

❍ Coordination arrangements

Following the 1999 parliamentary elections, the coordination of drug demand reduction, risk reduction and research has been transferred to the Ministry of Health. In November 2000 a National Drug Coordinator was appointed by the Minister of Health. He is in charge of the overall co-ordination in the domains of drug-related demand and harm reduction and represents Luxembourg at the international level. However, supply reduction and international cooperation aspects remain a competence of the Ministry of Justice and the Ministry of Foreign Affairs respectively.

At the national level, the co-ordination among the competent ministries takes place in the *Inter-ministerial Commission on Drugs (ICD)*, chaired by the Ministry of Health (the national drug coordinator is vice-chair and will be chairing the ICD in the beginning of 2006). It is composed of senior delegates from the main governmental departments and delegates from selected NGO's and constitutes the top decision level with respect to co-ordination and orientation of actions. Both, the ICD and the Ministry of Health are responsible for the implementation of national drugs strategies and action plans, supervise field activities and are bound to guarantee an effective consultation process with other involved ministries (e.g. Justice, Foreign Affairs). The ICD meets regularly to exchange information. There are four permanent agenda items: the implementation of action plans, the early warning system on drugs, emerging trends and legal changes and international affairs.

The more technical co-ordination between the Ministry of Health, the Ministry of Justice and the Ministry of National Education respectively occurs through the 'HEALTH – JUSTICE' and the 'HEALTH – EDUCATION' ministerial groups.

At the governmental level, there exists a Special Parliamentary Commission on Drugs, that functions as an advisory body to the government. At the level of the Ministry of Health, the national drug coordinator as well as the head of the Division of Social Medicine and Drug Addiction are the main advisors of the Minister in the referred field.

A close link between the EMCDDA national focal point and the policy level is ensured by the fact that the head of focal point has been appointed National Drug Co-ordinator. The national Drug

[11] Official gazette A 2001, p.1180 (Adoption: 27/04/2001, Entry in force: 17/05/2001)
[12] Official gazette A 2002, p.232 (Adoption: 30/01/2002, Entry in force: 12/02/2002)

coordinator is also the head of the national delegation within the Horizontal Drugs Group and the national permanent correspondent within the Pompidou Group. Furthermore, he is a member of the national substitution treatment surveillance commission and the national AIDS surveillance commission.

At the micro-level the drug coordinator meets monthly with the NGOs involved in the field on a bilateral basis or in plenary in order to share information and elaborated responses to emerging trends.

❍ National plan and/or strategies

The **national drugs strategy and action plan 2005-2009** has been endorsed by the State Council in May 2005 and officially presented by the Minister of Health and the national drug coordinator in July 2005.

Having taken into consideration the EU drugs strategy 2005-2012 and the EU drugs action plan 2005-2008, endorsed under Luxembourg Presidency in June 2005, the national strategy and drugs action plan are meant to contribute to a high level of health protection, public security and social cohesion and rely on **two policy pillars**, namely supply reduction and demand reduction.

Furthermore the national action plan includes, in addition to international cooperation and research, information, evaluation (retained by the EU action plan), two **more cross-cutting themes**: coordination and harm, risk and nuisance reduction. Luxembourg considers the latter two activity fields to be essential and of transversal nature.

The national plan contains **43 separate actions** associated to a clear definition of tasks, involved management actors, financial requirements and deadlines. The action plan reflects priorities set by the government: primary prevention (4 projects), treatment and care (6), socio-professional reintegration (5), reduction of risks and damages (5), research, evaluation and information (8), supply reduction (7), coordination and international relations (8). Special focus is placed on primary prevention (considered as crucial), offers of accommodation and housing, socio-professional reinsertion measures and therapeutic offers.

A final external output evaluation will be undertaken in the course of 2009.

❍ Implementation of policies and strategies

The outcome of a national drugs action plan highly relies on the way it has been elaborated. The successive action plans reflect the general strategy of the Ministry of Health in order to optimize the overall interventions in the fight against drugs and drug addiction in the light of stated priorities, assessed needs and available resources. It constitutes an open framework meaning that complementary projects can be included if required. In 2004, in order to best meet current needs in the elaboration of the 2005-2009 action plan, the national drug coordinator has launched a second multilateral consultation process involving ministerial departments, specialised NGOs and civil society. The priorities set by the Ministry of Health were discussed and, if necessary, complementary measures were added. A consensus on priority rankings of listed actions has been reached among involved parties. Finally all retained actions were structured in a clear, simple and output oriented way as follows:

Description/objective of action - responsibilities – budget – outcome – deadlines for outcome and evaluation.

The active involvement of specialised NGOs and civil society from the very start of the conceptualisation work and consensus making prior to the implementation phase have shown to be a major criteria to guarantee an effective implementation process. Indeed 87% of the measures retained by the 2000-2004 national drugs action plan have been materialised within the retained

deadlines. The measures not yet implemented (e.g. heroin distribution programme) have been delayed not for technical, budgetary or administrative reasons but for political ones. These actions have been included in the new drugs action plan, and by the time of writing one of the most controversial delayed actions has been implemented: the first national drug consumption room.

Summarily one should stress that the multilateral involvement of competent actors and the fact that most agencies involved in the implementation process are financed and controlled by the centrally coordinating Ministry of Health highly promote the effectiveness of the national strategic model.

❍ **Impact of policies and strategies**

As the 2000 - 2004 drugs action plan was the first of its kind to be implemented at the national level any comparison with previous achievements must be considered with care. However, it is a fact that budgetary means and the implementation of new drug-related facilities and programmes have been consistently more important during the referred period than ever before. Implementation progress of the drugs action plan have been kept on the political agenda since its start in 2000 and consequently the pressure to perform was continuously high. Media also contributed to this enhanced awareness and activity boosting, especially since they have been able to identify a central personalised key actor in the person of the national drug coordinator. Another positive side effect of the drugs action plan is an increased commitment of NGOs and civil society in the drug policies as they have been involved since the very beginning of the process. The general public has largely welcomed the previous and the current action plan since it enables them to follow up public efforts to fight a problem that is of great concern for them and to compare announced objectives with achieved actions.

As far as the final output is concerned there is no doubt that the national strategy and drugs action plan have met to the specific national needs. An internal evaluation showed that nearly all projects retained in the action plan have been realised. Budgetary means invested allowed to increase resources in terms of primary prevention, to extend admission capacities of low threshold services, to increase the number of post-therapeutic offers, to regionalize ambulatory treatment offers, to improve technical control measures related to substitution treatment, to reduce risks and damages, especially related to synthetic drugs and the transmission of certain infectious diseases, endemic for the population of PDUs, to reduce considerably the number of drug overdoses and finally to promote research activities in the field.

- BUDGET AND PUBLIC EXPENDITURE

❍ **Law enforcement, social and health care, research, international actions, coordination and national strategies**

The structure of the national state budget does not allow for a comprehensive drug budget allocation analysis since several budgetary subsections include both, drug specific and other activities. The same comment applies to the funding of drug treatment activities that are ensured by specialised agencies and general health care services and to research and training centres. Therefore, in accordance to national needs and the work plan of the EMCCDA, **a national study on direct economic costs of drug policies and interventions** has been performed from 1999 to 2002 and refers to data from 1999 (Origer 2002 b). (*Etude du coût économique direct des interventions et de la politique publique en matière de drogues et de toxicomanies).* (http://www.relis.lu).

The original research report can be accessed under: http://www.relis.lu.

As a national study on drug related expenses is highly time and cost intensive, the NFP has decided to follow-up the budgetary evolution between two consecutive national studies by means of the most representative indicator, which is the annual budget of the Ministry of Health allocated to drug-related activities:

Fig. 1.1 Annual budget of the Ministry of Health allocated to drug-related activities

Year	2000	2001	2002	2003	2004	2005
Budget (EUR)	2,066,000.-	3,210,000.-	4,294,000.-	4.862,000.-	5,771,000.-	6,196,000.-
Progression rate	Reference year	55%	108%	135%	180%	200%

Source: Projet de loi concernant le budget des recettes et des dépenses de l'Etat pour l'exercice 2005. Volume 1. (Ministère des Finances 1999-2005)

❍ Funding arrangements

Funding of drug-related interventions is **centralised at state level**. There exist no specific regional or local funding mechanisms. Few drug prevention activities are subsidised by council districts on an ad hoc basis. Respective ministries or governmental departments, according to their attributions, are co-ordinating the creation, the implementation and the funding of required infrastructures. Governmental departments directly rely on the state budget while NGOs involved in drug treatment or research activities have either signed a financial and quality control agreement called '**convention de collaboration'** with concerned ministries or are financed on basis of regular subventions. The convention between the ministries and NGOs entitles the former to control the functioning and the financial management of each NGOs via a governmental delegate within a management committee, called 'coordination platform'.

The Ministry of Health guaranteed financial and human resources required for the implementation of the drugs action plan 2000 – 2004. The **funding of the 2005 – 2009** action plan is subject to annual budgetary decisions. Specific local projects designed by non-governmental actors requiring external financial support are generally submitted to respective ministries or to other national funding sources (Fund Against Drug Trafficking, Foundations, private funds, etc.) or international bodies (EU, EMCDDA, etc.). Proposals are analysed and might be supported by short-term state subventions.

One may add that the **EDDRA** questionnaire is applied as a standard application form for drug-related projects' funding requests addressed to the Ministry of Health.

- SOCIAL AND CULTURAL CONTEXT

❍ Public opinions of drug issues

No large-scale national public opinion survey focusing on drugs and drug addiction has been conduced thus far. Several surveys however have included items on public perceptions on legal and illegal drugs at the local or regional level.

Several local or community based surveys on public opinions and attitudes towards drugs and drug use have been conduced in recent years. Results of these surveys have been produced in the 2003 report.

Within the scope of the Eurobarometer 57.2, a public opinion poll named "Attitudes and opinions of young people in the European Union on drugs[13]" was carried out in the 15 Member States between April and June 2002 at the request of the European Commission. This survey included a representative sample of the national population aged 15 to 24. In Luxembourg this public opinion poll was performed by ILRES in 2002 in the framework of EUROBAROMETER wave surveys.

In 2004 a Flash Eurobarometer 158 survey "Young people and Drugs" was conducted at the request of the European Commission with the objective to study the evolution of the attitudes on drugs of the target group. The same questionnaire as for the Eurobarometer 57.2 survey of 2002 was used and 7,659 young people aged between 15 and 24 were interviewed face to face between April and May 2004. In Luxembourg, this survey was also performed by ILRES and 571 young people were interviewed (national representativity).

[13] **EORG (2002). PUBLIC OPINION REGARDING ATTITUDES AND OPINIONS OF YOUNG PEOPLE IN THE EUROPEAN UNION ON DRUGS**

Tab. 1.1 Main reasons for trying drugs, stopping use and consequences of drug use (2002/2004)

	QUESTION a. Main reasons for experimenting									
	1. Curiosity		2. Peer pressure		3. Thrill seeking		4. Problems at home		5. Expected effects	
	2002	**2004**	**2002**	**2004**	**2002**	**2004**	**2002**	**2004**	**2002**	**2004**
Luxembourg	58.5	63	44.2	37	17.6	26	45.6	44	26.7	32
EU	61.3	64	46.4	45	40.7	37	29.7	32	21.5	22
	QUESTION b. Main reasons why it is hard to stop using drugs									
	1. Dependence		2. Lack of willpower		3. Effects of drugs		4. Peer pressure		5. Loneliness	
Luxembourg	*66.6*	*78*	*44.0*	*50*	*45.3*	*45*	*24.6*	*20*	*21.1*	*20*
EU	*73.9*	*72*	*50.5*	*50*	*40.5*	*41*	*27.4*	*28*	*16.2*	*16*
	***QUESTION c**. Consequences of drug use*									
	1. Dependence		*2. Problems with the law*		*3. Mental problems*		*4. Communicable diseases*		*5. Relief from pain or stress*	
Luxembourg	52.3	63	32.1	36	33.2	32	32.4	30	26.5	22
EU	63.0	64	38.3	39	35.4	40	33.7	33	26.4	25

Expected effects and problems at home seem to be major arguments for experimenting drugs for youngsters in Luxembourg in 2004. Compared to 2002, the argument of thrill seeking has gained more importance even it is still situated below the European average. There is no significant variation in the ranking of the reasons most often chosen in 2004 compared to 2002. In 2004, it seems that lesser youngsters rate problems with the law, mental problems, communicable diseases and relief from pain or stress as a consequence of drug use as the European average.

Tab. 1.2. Perceived dangerousness of different substances (2002/2004)

	Assessment of danger of the three substances: % of "very dangerous" responses					
	1. Heroin		2. Ecstasy		3. Cannabis	
	2002	**2004**	**2002**	**2004**	**2002**	**2004**
Luxembourg	87.2	87	60.6	63	16.2	19
EU	88.8	89	63.5	66	20.6	24

The percentages of responses among young people in Luxembourg approach the ranking of the European average. The population of youngsters in Luxembourg, all though presenting a higher risk rating in 2004 compared to 2002, seem to perceive cannabis as less dangerous than the European average.

Tab. 1.3 Priorities in management of drug-related problems (2002/2004)

	Most effective methods of management					
	1. Measures against dealers and traffickers		2. Treatment and rehabilitation		3. Information campaigns	
	2002	**2004**	**2002**	**2004**	**2002**	**2004**
Luxembourg	70.2	65	34.2	37	46.4	41
EU	59.1	60	53.3	53	38.9	42

The opinions from young people in Luxembourg differ from the European average. Priority is given to measures of repression against dealers and traffickers. Luxembourg's youngsters quote the effectiveness of information campaigns as second priority, reflecting the European average. Treatment and rehabilitation measures are seen as lesser effective methods in the management of drug related problems compared with the average EU figures.

Other results worth mentioning are that 82% of youngsters in Luxembourg declared knowing people who use cannabis (European average: 68%) and 56% declared knowing people who use drugs other than cannabis (EU av.:47%). 59% of youngsters declared having already been offered cannabis (EU av.:50%).

The public debate on the creation of injection rooms and heroin distribution programmes has been highly influenced by the perceived need to reduce nuisance and risks associated to iv drug use. Moreover, the fact that a high percentage of the homeless people population is composed of drug addicts, public debate tends to assimilate related nuisance predominantly to drug addicts although

a significant proportion of homeless persons are primarily alcohol misusers, youngsters on the run or clandestine people.

❍ Debates and initiatives in Parliament and civil society

The Governmental declaration of 2004 and the subsequent coalition agreements as well as the drugs action plan of the Ministry of Health put emphasis on the need to develop primary prevention measures, therapeutic treatment offers, post-therapeutic structures and socio-professional reinsertion measures. The Luxembourg Presidency of the EU and its preparation in 2004 have been in the centre of interest for national Parliament and civil society, with special attention to the EU and the national drugs strategy and action plans.

The amendment of the national driving code is foreseen in order to allow police forces to use new drug detection devices.

Debates related to tobacco started in civil society after the Minister of Health proclaimed to prohibit smoking in restaurants. Some members of parliaments raised parliamentary questions concerning this topic. It is also discussed to proceed to legal amendments in order to prohibit the selling of cigarettes to minors as also to increase the taxes of the so-called “alcopops”.

The opening of the first national injection room in Luxembourg City in June 2005 was largely expected and subject to major discussions between the Ministry of Health and civil society.

❍ Media representations

A national and international press review on drugs, jointly compiled by the State’s Press Service and the NFP since 1998, allows a close follow-up of the media approach towards the drug phenomenon.

Most of national media fit to objective information although a few more socially oriented radio stations and newspapers put further emphasis on controversial, yet constructive, analysis of the current situation.

A NFP in-house analysis of main daily and weekly Luxembourg newspapers revealed that, during 2004, nearly 50% of the topics most currently covered by the national press concerned demand reduction topics as prevention campaigns focussing psychotropic medicaments and gambling addiction, legal substances (alcohol, tobacco and doping substances), annual reports of NGO’s (especially low threshold services), the opening of drug consumption rooms and harm reduction facilities for drug users.

Articles covering themes of supply reduction came on second place (more than one third of articles). They mainly concerned drug traffic, drug seizures and addressed the evolution of the drug scene in the area of the main railway station of Luxembourg City and stressed on drug-related nuisances perceived by residents.

Several articles informed about the launch of the EMCDDA annual report as also the launch of the national focal point RELIS report, including main information about the European and national drug situations.

Finally, some articles addressed the national action plan on drugs and drug addiction. As the citations of international organisations, European drug policy, EU strategy and action plan have been relatively rare, one may note that, even though the topics were quite varied, press interest focussed predominantly on national topics.

2. Drug Use in the Population

Overview

Drugs referred to in the present report include narcotic drugs and psychotropic substances covered by the international drug control conventions (the Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol, the Convention on Psychotropic Substances of 1971 and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988). Drugs not listed in the latter UN conventions are addressed by the present strategy only in the context of their associated use to listed drugs.

'Drug use' is hereinafter defined as the self-administration of a psychoactive substance, that is a substance that, when ingested, affects mental processes. Psychoactive substances may be of licit or illicit production, sale, or use and associated risks may by considered more or less important.

Prevalence estimations on drug use in the general population are based on data collected in more (e.g. schools) or less (general population: age group 15-64 years) targeted and representative samples of the national overall population. According to the most recent surveys, cannabis and derivates are by far the most common illicitly used psychoactive substances in the national population followed by Amphetamine Type Stimulants (ATS). Cannabis use is still increasing and shows the highest prevalence regardless considered age categories, whereas the prevalence of other psychoactive drugs varies according to age and data collection setting factors.

'Hard drugs' and ecstasy are considered to be the most dangerous substances by general public. The hierarchy of perceived risks associated to referred drugs is independent of respondents' age.

- DRUG USE IN THE GENERAL POPULATION

To date, no national, large-scale (representative) general population survey on drug use has been conduced. Several community or targeted population surveys however allow estimating current prevalence.

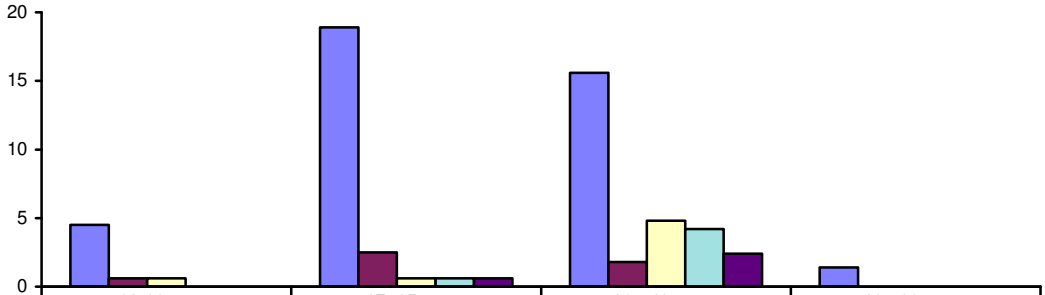
A primary prevention pilot project at community level was launched by the CePT in 1995. In 2000, 13 council districts participated in this project. In the framework of this project a non-representative survey on drug use in general population (reference 1: "Fischer 1999 study") was conducted. The survey results currently indicate most valid data in terms of non-representative description of drug use in general population.

REFERENCE 1.	Fischer U. CH. Et Krieger W. (1999) Suchtpräventioun an der Gemeng – Entwicklung, Durchführung und Evaluation eines Modells zur gemeindeorientierten Suchtprävention, CePT, Luxembourg. **EN:** Drug prevention at the communal level
Year of data collection	1998
Single/repeated study	Single study
Context	Drug Prevention – Public Health – Cross sectional
Area covered	7 council districts of the Grand Duchy of Luxembourg
Age range	12-60 years
Data coll. Procedure	Anonymous self-administrated questionnaires
Sample size	667 valid cases

Substance	LIFETIME PREVALENCE (15-34 years)	LAST 30 DAYS PREVALENCE (15-34)
Cannabis	15.8%	5.6%
Ecstasy:	1.2%	0%
Heroin	1.9%	0.3%
Cocaine:	0.3%	0.3%
LSD:	1.3%	0.0%
Magic mushrooms	2.6%	1.3%

Source: Fischer 1999

Fig. 2.1 Lifetime prevalence according to age (valid %)
(Fischer 1999)



	12-16 years	17- 25 years	26 - 40 years	41 - 60 years
Cannabis	4,5	18,9	15,6	1,4
Ecstasy	0,6	2,5	1,8	0
LSD	0,6	0,6	4,8	0
Cocaine	0	0,6	4,2	0
Heroin	0	0,6	2,4	0

A second survey organized by the CePT was published in 2000 ("Fischer 2000 study"). Even if cannabis consumption was the main subject of the study, several other substances have been taken into account. The samples have been drawn on the one hand from a cinema visitor's population in Luxembourg city (ref.:2.1) and on the other hand from a population of 6 council districts (ref.:2.2).

REFERENCE 2.1: Fischer U. CH. (2000) Cannabis in Luxemburg – Eine Analyse der aktuellen Situation, CePT, Luxembourg.
EN.: Cannabis in Luxembourg

Year of data collection	1999
Single/repeated study	Single study
Context	Drug Prevention – Public Health – Cross sectional
Area covered	Cinemas in Luxembourg-City
Age range	15-64 years
Data coll. Procedure	On-site interviews
Sample size	991 valid cases
Sampling procedure	Random sampling of cinema customers
Remark	*Detailed results of both surveys are provided in EMCDDA standard tables*

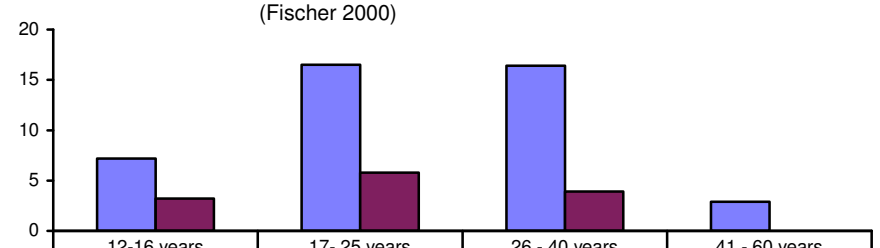
Fig. 2.2 Current and lifetime prevalence of cannabis use according to age: Cinema sample
(valid %)
(Fischer 2000)

	10-16 years	17- 25 years	26 - 40 years	41 - 60 years
Cannabis - lifetime prevalence	26,3	40,1	30,9	14,3
Cannabis - current use prevalence	17,6	23,3	11,2	7,9

REFERENCE 2.2: Fischer U. CH. (2000) Cannabis in Luxemburg – Eine Analyse der aktuellen Situation, CePT, Luxembourg.
EN.: Cannabis in Luxembourg

Year of data collection	1999
Single/repeated study	Single study
Context	Drug Prevention – Public Health – Cross sectional
Area covered	6 district councils
Age range	12 to 60 years
Data coll. Procedure	Mail questionnaire
Sample size	486 valid cases
Sampling procedure	Random sampling
Response rate	27.7%

Fig. 2.3 Current and lifetime prevalence of cannabis use according to age
Sample: Council districts (valid %)
(Fischer 2000)



	12-16 years	17- 25 years	26 - 40 years	41 - 60 years
Cannabis - lifetime prevalence	7,2	16,5	16,4	2,9
Cannabis - current use prevalence	3,2	5,8	3,9	0

Regarding **lifetime prevalence**, the Fischer 1999 study reveals that youngsters from the age group 17 to 25 (18.9 %) are most vulnerable to cannabis consumption. The Fischer 2000 study even reveals 40.1% of lifetime prevalence concerning cannabis use (cinema sample).

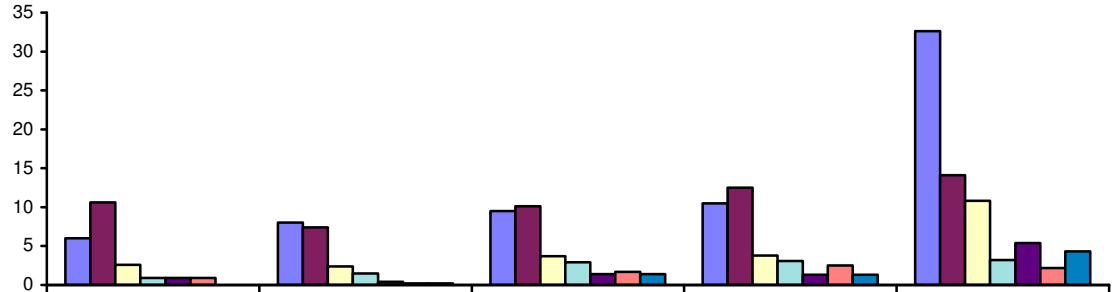
- DRUG USE IN THE SCHOOL AND YOUTH POPULATION

National school surveys may be divided in **two categories**. A first category refers exclusively to drug prevalence surveys in schools; the second refers to cross-sectional surveys combining data collection in school settings and other youth environments.

Surveys: category 1

REFERENCE **1**:	**Matheis J. et al.** (1995) 'Schüler an Drogen', IEES, Luxembourg. **EN.**: Students and Drugs
Year of data collection	1992
Single/repeated study	Repeated study 1983 – 92
Context	Public Health
Area covered	Nation wide
Type of school	5th years of all types of secondary school classes at the national level
Age range	16-20 years (AGE ENTERING 5TH CLASS)
Data coll. Procedure	Anonymous self-administrated questionnaires in school classes
Sample size	1,341
Response rate (M, F, T)	96% Matheis and Prussen (1985) have conduced a survey on 1983 data relying on the same methodological criteria than the 1995 survey. The referred study will be addressed in the comparative analysis part.

Fig. 2.4 Lifetime prevalence of drug use according to age (valid %)
(Matheis, Prussen 1995)



	up to16 years	17 years	18 years	19 years	20 years and more
Cannabis	6	8	9.5	10.5	32.6
Stimulants	10.6	7.4	10.1	12.5	14.1
Solvents	2.6	2.4	3.7	3.8	10.8
LSD	0.9	1.5	2.9	3.1	3.2
Cocaine	0.9	0.4	1.4	1.3	5.4
Ecstasy	0.9	0.2	1.7	2.5	2.2
Heroin	0	0.2	1.4	1.3	4.3

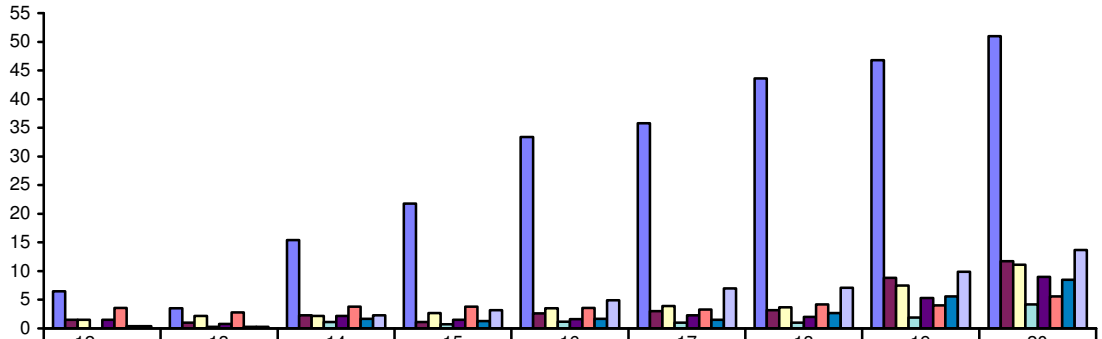
REFERENCE **2**:	**Dickes P. et al.** (1996), La consommation de drogues légales et illégales des élèves des 6ième de l'enseignement secondaire et des 8ième de l'enseignement secondaire technique, CEPS/INSTEAD. Luxembourg. **EN.**: The use of licit and illicit drugs by students in 6th and 8th classes of national secondary schools.
Year of data collection	1994
Single/repeated study	Single study
Context	Drug prevention. Commissioned by the National Drug Prevention Centre (CePT)
Area covered	City of Luxembourg
Type of school	6th secondary school level and 8th secondary technical school level
Age range	13-16 years
Data coll. Procedure	Anonymous self-administrated questionnaires in school classes
Sample size	650
Response rate (M, F, T)	100%

Substance	Lifetime prevalence (13-16 years)	Current use prevalence (13 – 16 years)
Cannabis	4.5%	2.9%
Solvents	3.7%	2.9%
Heroin	5.2%	0.8%
Cocaine:	1.4%	1.2%
LSD:	1.8%	1.4%

Source : Dickes 1996

REFERENCE **3**:	Das Wohlbefinden der Jugend – HBSC Studie (in press), Ministère de l'Education Nationale de la Jeunesse et des Sports, Direction de la Santé, Luxembourg. **EN.**: Health and Health Behaviour of Young People
Year of data collection	1999
Single/repeated study	Repeated study (intended each 4 years)
Context	Health and Health Behaviour among Young People – WHO cross-national study
Area covered	Nation wide, representative
Type of school	Secondary schools
Age range	12-21 years
Data coll. Procedure	Anonymous self-administrated questionnaires in school classes
Sample size	7,347
Response rate (M,F,T)	97%

Fig. 2.5 Lifetime prevalence according to age (valid %)
(HBSC 2000)



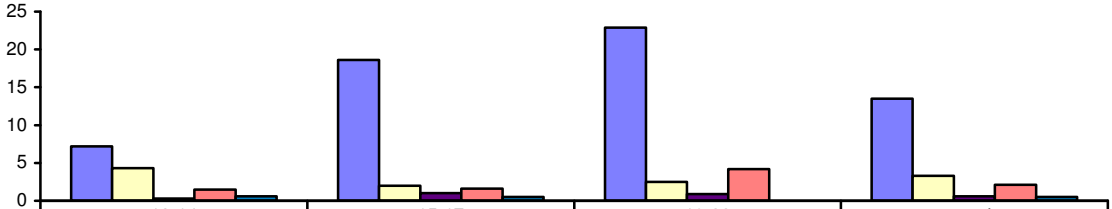
	12 ans	13	14	15	16	17	18	19	20
Cannabis	6.5	3.5	15.4	21.8	33.4	35.8	43.6	46.8	51
XTC	1.5	1	2.3	1.1	2.6	3	3.2	8.8	11.7
STA	1.5	2.2	2.2	2.7	3.5	3.9	3.7	7.5	11.1
Heroin	0	0.3	1.1	0.7	1.2	1	1	1.9	4.2
Cocaine	1.5	0.8	2.2	1.5	1.6	2.3	2	5.3	9
Solvents	3.6	2.8	3.8	3.8	3.6	3.3	4.2	4	5.6
LSD	0.4	0.3	1.7	1.3	1.7	1.5	2.7	5.6	8.5
Mushrooms	0.4	0.3	2.3	3.2	4.9	7	7.1	9.9	13.7

The consumption of illegal drugs has clearly increased the last years. A comparison of the Matheis 1992 study and the most recent HBSC 2000 study reveal that in 1992, 18.1% of secondary school students of 5th class of secondary school (16-20 years) declared having had contact with illegal drugs. In 2000, this proportion increased to 41.1%. The HBSC study even reports a proportion of nearly 50% of youngsters aged 18 having consumed at least once in their life an illegal drug. However, the consumption of "hard" drugs is not widespread among youngsters. Approximately 4 to 5% of youngsters report consumption of "hard" drugs, mostly due to experimenting, while a lower proportion effectively develops a related dependency. Cannabis consumption however increased the last years. A major proportion of students (15.1%), not especially youngsters from risk groups, reported repeated cannabis consumption over the last year.

Surveys: category 2

REFERENCE **4** :	**Meisch, P.** (1998), Les drogues de type ecstasy au Grand-Duché de Luxembourg, CePT, Luxembourg. **EN:** Ecstasy type drugs in the G. D. of Luxembourg
Year of data collection	1997
Single/repeated study	Single
Context	Public Health – primary drug prevention
Area covered	Nation wide
Type of school	2nd and 6th years of classical (N: 311) and technical (N: 355) secondary schools
Age range	13-22 years (13-14: N347; 15-17: N193; 18-22: N118)
Data coll. Procedure	Self-administrated questionnaires
Sample size	666
Sampling frame	Schools participating in the "European 'Health-Schools' network
Response rate (M,F,T)	100%

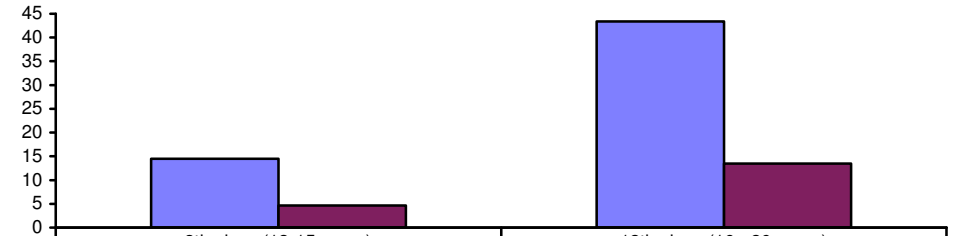
Fig 2.6 Lifetime prevalence of drug use according to age groups (valid %) (Meisch 1998)



	13-14	15-17	18-22	total
Cannabis	7.2	18.6	22.9	13.5
Solvents	4.3	2	2.5	3.3
Cocaine	0.3	1	0.9	0.6
Ecstasy	1.5	1.6	4.2	2.1
heroin	0.6	0.5	0	0.5

REFERENCE **5**:	**Fischer U. CH.** (2000), Cannabis – Eine Analyse der aktuellen Situation, CePT, Luxembourg. *EN.*: Cannabis – Rapid assessment of the current national situation.
Year of data collection	1999
Single/repeated study	Single
Context	Cannabis prevalence
Area covered	Nation wide
Type of school	2nd and 6th years of secondary schools
Age range	13-20 years
Data coll. Procedure	Self-administrated questionnaires
Sample size	562
Sampling frame	Schools selected on basis of their geographical situation (national representativity), exhaustive student sampling within the selected schools.
Response rate (M, F, T)	100%

Fig. 2.7 Current and lifetime prevalence of cannabis use according to school levels (valid %) (Fischer 2000)



	8th class (13-15 years)	12th class (16 - 20 years)
Cannabis - Lifetime prevalence	14.5	43.4
Cannabis - current use prevalence	4.64	13.45

SYNOPSIS OF MAIN COMPARABLE RESULTS AND OBSERVED TRENDS

LIFETIME PREVALENCE: SCHOOL POPULATION:

Prevalence figures for age group **12-20**, provided by HBSC (2000) and Fischer (1999) vary between narrow limits and stress increasing lifetime prevalence rates for cannabis, psilocybin and amphetamines/ecstasy, in accordance to results of previous surveys. The most relevant differences according to gender are lower prevalence figures for females with regard to cannabis, amphetamines and magic mushrooms use but a higher prevalence of medicament use.

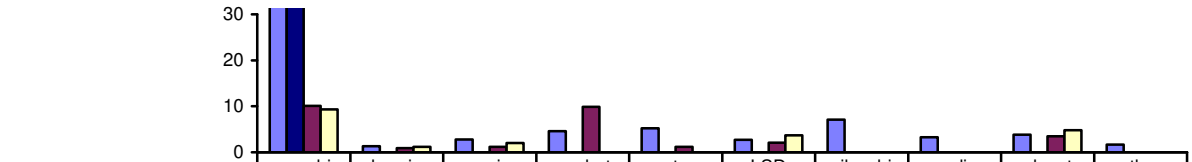
The HBSC study (2000), the Fischer study (2000) and the serial surveys by Matheis (1985/95) provide trends in lifetime prevalence between 1983 and 1999 applied to age group **16-20**. Cannabis use has shown the most significant increase during the referred period. Also on the increase in order of importance are magic mushrooms, ecstasy, cocaine and heroin. LSD and solvents use shows stable figures since 1992.

Regarding age group **13-14**, one should emphasise the increase of cannabis (9.7 – 10.5%) and cocaine (1.6 – 2%) lifetime prevalence over the last two years. In age group **15 –16** years, all prevalence rates show increasing figures since 1992 (cannabis: 27.7%, psilocybin: 4.1%). Compared with the latter group, age group **17-18** (HBSC) shows doubled lifetime prevalence rates except for cannabis, medicaments and solvents.

Fig. 2.8 LIFETIME PREVALENCE: SCHOOL POPULATION - 12-20 years

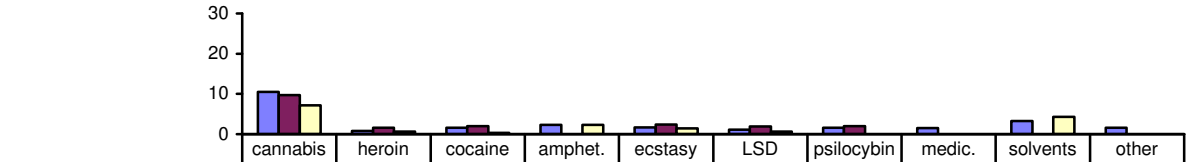
	cannabis	heroin	cocaine	amphet.	ecstasy	LSD	psilocybin	medic.	solvents	other
HBSC (2000) 1999 data	27.4	1.2	2.3	3.7	3.1	2.1	4.8	2.5	3.8	1.6
Fischer (2000) 1999 data	25.3	1.3	2.9		3.4	2.8	5.3			

Fig. 2.9 LIFETIME PREVALENCE: SCHOOL POPULATION - 16-20 years



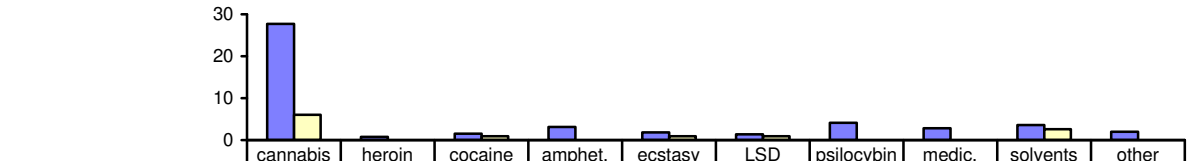
	cannabis	heroin	cocaine	amphet.	ecstasy	LSD	psilocybin	medic.	solvents	other
HBSC (2000) 1999 data	38.9	1.3	2.8	4.6	5.2	2.7	7.1	3.3	3.8	1.7
Fischer (2000) 1999 data	43.3									
Matheis (1995) (1992 data	10.1	0.9	1.2	9.9	1.2	2.1			3.5	
Matheis (1985) 1983 data	9.3	1.2	2			3.7			4.8	

Fig. 2.10 LIFETIME PREVALENCE: SCHOOL POPULATION - 13-14 years



	cannabis	heroin	cocaine	amphet.	ecstasy	LSD	psilocybin	medic.	solvents	other
HBSC (2000) 1999 data	10.5	0.8	1.6	2.3	1.7	1.1	1.6	1.5	3.3	1.6
Fischer (2000) 1999 data	9.7	1.6	2		2.4	1.9	2			
Meisch (1998) 1997 data	7.2	0.6	0.3	2.3	1.4	0.6			4.3	

Fig. 2.11 LIFETIME PREVALENCE: SCHOOL POPULATION - 15-16 years



	cannabis	heroin	cocaine	amphet.	ecstasy	LSD	psilocybin	medic.	solvents	other
HBSC (2000) 1999 data	27.7	0.8	1.5	3.1	1.8	1.4	4.1	2.8	3.6	2
Matheis (1995) 1992 data	6	0	0.9		0.9	0.9			2.6	

LAST 12 MONTHS PREVALENCE: SCHOOL POPULATION

The HBSC survey (2000) is the only to provide last 12 months national prevalence figures in 12 to 20 years aged schoolchildren. Results mirror respective proportions of lifetime prevalence rates with particular emphasis on high cannabis (22.5%), psilocybin (3.3%) and amphetamines (2.2%) prevalence. Gender differences reflect the results of the lifetime prevalence surveys except for amphetamines use that is proportionally higher in females during the last 12 months. Medicaments use in females during last year is more prevalent than in males.

Fig. 2.12 LAST 12 MONTHS PREVALENCE: SCHOOL POPULATION - 12-20 years (HBSC 2000)

	cannabis	heroin	cocaine	amphet.	ecstasy	LSD	psilocybin	medic.	solvants	other
male	25.8	0.7	1.6	2.4	1.9	1.2	4.6	1.2	1.6	1.1
TOTAL	22.5	0.7	1.5	2.2	1.7	1	3.3	1.5	1.5	0.8
female	19	0.6	1.5	2	1.4	0.9	2	1.8	1.4	0.8

LAST 30 DAYS PREVALENCE: SCHOOL POPULATION

Fischer (1999) provides last 30 days prevalence figures for 13 to 18 year old school children. Cannabis and ecstasy prevalence figure 13.8% and 1.1%, respectively. Heroin, cocaine and LSD prevalence rates are close to last 12 months prevalence rates. Gender breakdowns are currently not available.

Fig. 2.13 LAST 30 DAYS PREVALENCE: SCHOOL POPULATION - 13-20 years
(Fischer 2000)

	cannabis	heroin	cocaine	ecstasy	LSD	psilocybin
Fischer (2000) 1999 data	13.8	0.6	1.3	1.1	1	1.8

- DRUG USE AMONG SPECIFIC GROUPS:

In 1998, the Ministry of Justice commissioned the medical department of the state prison (CPL) to perform an epidemiological study on HIV and HCV prevalence in prison population (**ref. c.2**). The research protocol included a self-administrated questionnaire on health behaviour and injecting drug use prior and during prison sentence. HIV and HCV status were determined by on site saliva tests. Data have been collected during two days on the current stock of prisoners (convicted and in custody) in all national prisons.

REFERENCE c.2	Dr. Schlink J. (1999), Etude épidémiologique des infections à l'HIV et à l'hépatite virale C dans les prisons luxembourgeoises, CPL, Luxembourg. **EN:** Epidemiological study on HIV and HCV prevalence in prisoners
Year	1998
Single/repeated study	Single
Context	HIV, HCV and injecting drug use prevalence in prison
Area covered	All national prisons
Type sample	Stock of prison population on 4 September 1998
Age range	> 17
Data coll. Procedure	ANONYMOUS SELF-ADMINISTRATED QUESTIONNAIRES
Sample size	362
Sampling frame	Exhaustive
Response rate (M, F, T)	90%

MAIN RESULTS:

- 32% of prisoners qualified themselves as injecting drug users;
- 28% reported current drug injection in prison;
- 9% have been initiated to injecting drug use in prison;
- 8% report used needle exchange with other prisoners;
- IVDUs have served more prison sentences than non drug users (control group);
- IVDUs showed lower average age than non drug users;
- a majority of imprisoned IVDUs were natives

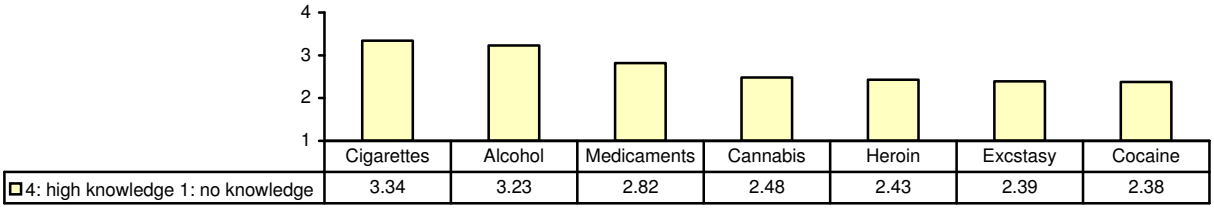
In 2003, the National EMCDDA focal point started an action research on HIV and hepatitis infections in drug users. Collected data should allow to analyse the links between drug use and referred infectious diseases. First results will be presented by the beginning of 2006.

ATTITUDES TO DRUGS AND DRUG USERS

No large-scale national public opinion survey focusing on drugs and drug addiction has been conduced thus far. Several surveys however have included items on public perceptions on legal and illegal drugs at the local or regional level.

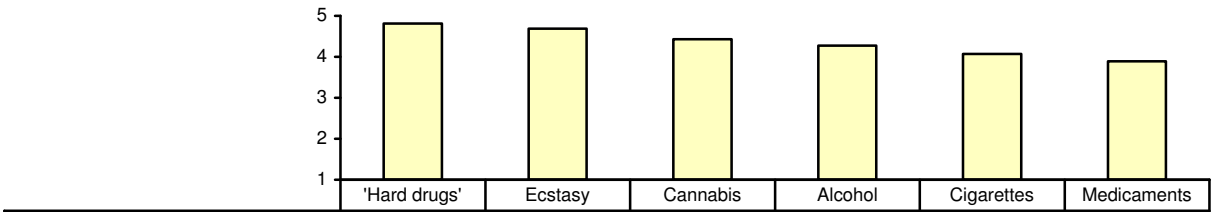
The study *' Drug prevention at the communal level'* **(Fischer and Krieger 1999)** refers to 1998 data collected in 7 representative regional districts on 667 subjects aged between 12 and 60. The following results can be stressed:

Fig. 2.14 Knowledge on effects and risks of several drugs (Fischer and Krieger 1999)



	Cigarettes	Alcohol	Medicaments	Cannabis	Heroin	Excstasy	Cocaine
4: high knowledge 1: no knowledge	3.34	3.23	2.82	2.48	2.43	2.39	2.38

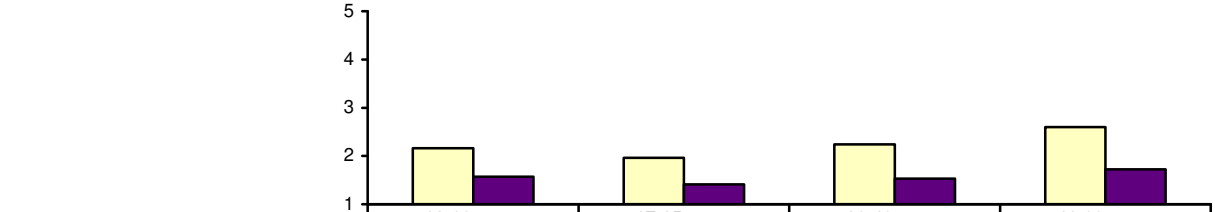
Fig. 2.15 Perceived risks associated to drug use (Fischer and Krieger 1999)



	'Hard drugs'	Ecstasy	Cannabis	Alcohol	Cigarettes	Medicaments
5: not dangerous 1: highly dangerous	4.81	4.69	4.43	4.27	4.07	3.89

One may note that the hierarchy of perceived risks associated to the above-mentioned drugs is independent of respondents' age. Respondents showing higher educational levels report higher knowledge and tend to attribute higher risks to all referred substances.

Fig. 2.16 Fear and defensive behaviour towards drug related themes (Fischer and Krieger 1999)



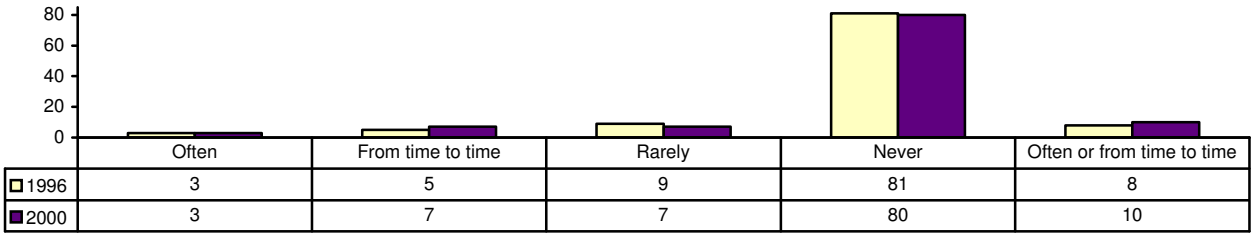
	12-16 years	17-25 years	26-40 years	41-60 years
Fear 4: absolutely 1: not at all	2.16	1.96	2.24	2.6
Defensiveattitude 4: absolutely 1: not at all	1.57	1.41	1.53	1.72

A second group of surveys worth mentioning refers to the serial surveys performed by ILRES in 1996 and 2000 in the framework of EUROBAROMETER wave surveys n°44.3 (1996) and 54.4 (2000) (EC 2001).

REFERENCE	European Commission (2001). Public opinion regarding security and victimisation in the E.U. Contact with drug related problems. Eurobarometer surveys n° 44.3 and 54.1, Brussels
Year of data collection	1996 and 2000
Single/repeated study	Repeated study
Context	Eurobarometer
Area covered	National representativity
Age range	12-60 years
Data coll. Procedure	Phone interviews
Sample size	609 valid cases

Figure 2.17 presents the distribution of answers to the question: 'Over the last 12 months, how often were you personally in contact with drug-related problems in the area where you live? (e.g. seeing people dealing in drugs, taking or using drugs, finding used syringes, etc.)'

Fig. 2.17 Contact with drug-related problems
(ILRES 1996, 2000)



	Often	From time to time	Rarely	Never	Often or from time to time
1996	3	5	9	81	8
2000	3	7	7	80	10

Although the observed percentages are low compared with most of the other EU Member States, a slight increase of the number of respondents reporting contact with drug-related problems has been observed in 2000.

3. Prevention

Overview

The present chapter provides a summary of recent universal and selective prevention measures undertaken at the national level.

More detailed information and examples of good practice can be found in the EDDRA database of the EMCDDA under: **http://eddra.emcdda.eu.int/**

The **national drugs action plan 2005-2009 comprises a specific chapter on primary prevention actions.**

The priorities of the drug prevention action plan as approved in 2005 are as follows:

- Interventions in school and youth environments, peer education and multiplicators;
- Drugs at the workplace;
- Cannabis, Alcopops and XTC use in youngsters;
- Primary prevention intervention methods and impact assessment;
- Mass media campaigns;
- Multidisciplinary training programmes;
- Documentation strategies.

The **National Prevention Centre on Drug Addiction** (CePT), which has started its activities in 1996, covers illicit drug use prevention as well as other types of addictive behaviour. Legally speaking the CePT is a foundation financed by the Ministry of Health.

A second important actor in the field of primary drug prevention is the **Division of Preventive Medicine** of the Directorate of Health. Although the latter coordinates activities in the larger field of public health promotion and prevention, it plays a major role, jointly with the CePT in the definition of the overall framework of addiction prevention.

The overall coordination of **counselling, treatment and low threshold interventions** is within the competence of the **AST** (Department of Directorate of Health, future division of Drug Addiction and Social Medicine) and the **national drug coordinator's office**. The AST has coordination and financial control missions (supervision of financial contract implementation of subsidised NGOs) in the field of drug addiction and psychiatry. Furthermore, the national drug coordinator is responsible for the conceptualisation and the implementation of activities included in **the drugs action plan 2005 – 2009** (see 1.1).

Direct drug prevention expenditures reached 672,000.- euros in 2000 and 830,000.- euros in 2005. These figures include staff and operating costs of agencies and ministerial department specialised[14] in drug prevention. In coming years the total expenditure will know a significant increase since 4 actions/programmes have been included in the 2005-2009 drugs action plan.

EDDRA has largely contributed to the promotion of a more scientific oriented evaluation approach at the national level. The Ministry of Health has implemented a modified version of the EDDRA questionnaire as a standard for funding requests for and evaluation of drug related projects.

[14] The exact estimation of prevention related costs is hazardous since multiple factors influence the development of a youngster. Education, leisure activities, sport, etc may have a positive impact on resources building; they however cannot be quantified in terms of exclusive input.

Training interventions in drug demand reduction are increasingly developed at the national level. The CePT publishes an annual training directory including training activities ranging from evaluation methodologies to demand reduction action-research strategies targeted at **drug prevention and public health actors, educators, youth animators and teachers**. The 'Recherche et Innovation Pédagogiques et Technologiques (SCRIPT) department is actively involved in the referred training activities.' The Department for Scientific and Applied Research may finance training activities following request.

As regards ad-hoc continuous training of national field actors, most of the involved structures are conventioned by the government and as such rely **on the Ministry of Health's regulation on continuous training.**

● UNIVERSAL PREVENTION

❍ **School**

Drug prevention programmes in schools are not mandatory. National drug prevention activities integrated within national school programmes have mainly resulted from **corporate actions** of different governmental and non-governmental actors: Ministry of Family and Integration – National Youth Service (SNJ), Ministry of Health - Division of Social and Preventive Medicine, Ministry of National Education – Psychological Care and Educational Orientation Department (CPOS) and since 1996, the National Addiction Prevention Centre (CePT).

The **CPOS** is permanently represented in all secondary schools by at least one trained psychologist and several ad hoc teachers. In major schools there are supplementary trained social workers. Among other tasks, they are supposed to detect, at the very early stage, problems or behaviours in relation to substance abuse.

Drug and addiction topics are included in more general courses as for instance, hygiene or ethics, which might not be mandatory. However, on the school director's demand, trained staff from the CePT or from the specialised drug department of the Police ensures information courses within secondary schools. Additionally, parent's organisation do periodically organise information evenings on drug-related topics.

In 2000, the CePT in collaboration with the pedagogical innovation department of the Ministry of Education (SCRIPT) started a pilot project called 'd'Schoul op der Sich' (**School on quest**) (see EDDRA and standard table 19) running for two years and having been evaluated in 2003. The aim of this participative project consisted in creating prevention groups among all participating secondary schools in order to initiate a process of reflection on drug related themes. Six secondary schools have participated in the pilot project. In order to involve all school partners, members of the prevention groups were teachers, students, parents, members of the SPOS, educational or technical staff. The CePT was providing training, on site interventions and documentation to the prevention groups. A first achievement of the project partners was to set up a drug related theme catalogue (by method of brain storming) and to conduct school internal surveys on drug related issues. Overall, 5,500 students have been contacted in the framework of these inquiries. Data on these surveys have not been published in order to avoid conflicts between the different schools. However, well-being in school was the most relevant theme cited and drug issues were interpreted differently by youngsters and adults. Gradually, the prevention groups organized conferences, project flyers, seminars, information sessions, round-tables, workshops etc. Meanwhile, three basic training sessions were offered to the project partners by the CePT and the judicial police, a two-years training module for teachers was offered by the SCRIPT and a further training of "multipliers in primary prevention" was organised by the CePT. In the course of 2001, two meetings from the project partners of the 6 prevention groups took place in order to share a common concept of primary prevention. In the framework of the second meeting a national prevention week was planned. This prevention week was organized in April 2002 simultaneously in all 6 partner schools. 95 different prevention activities took place of which 56 were realised by external professionals (a total number of 300 activities).

Over 4,500 students participated in at least one prevention activity and a majority participated in 2 or 3 activities. This represents a number of 8,000 participating students. As for the evaluation of the prevention week, the prevention groups had to formulate specific aims. The evaluation plan included an evaluation before, during and after the prevention week by means of questionnaires. Overall, all school partners had been satisfied with the organized prevention activities and the overall prevention week, but considered that some aims have not been reached because of too high expectations, an absence of teacher's and parent's involvement and a lack of time. It was found out that the major aims of prevention, notably an increase of resources, a close collaboration between all school partners and improvement of communication only could be reached in a view of a long-term prevention work, as prevention work needs status, time and resources. At the end of the pilot project all six partner schools expressed their motivation to continue the process of prevention work inside their respective schools. Two schools left the project however pursued the prevention process.

During 2003/2004 some of the most effective prevention activities have further been organized in the participating schools. In 2004, the CePT managed to set up a primary prevention tool adjustable to the needs of the different secondary schools.

MSF (Youth Solidarity Project) was associated to the project in terms of complementary service providing at the level of crisis intervention. The project was called "**Solution finding in case of drug abuse in school**" (see standard table 19). As school directors might see no other choice than to dismiss students showing drug consume, the MSF project is meant to act as a mediator between concerned students, parents and school direction, by proposing counselling and a series of alternative measures.

In 2004, **the SCRIPT** organized three different prevention projects in school settings. The "Extra-Tour Sucht", a mobile interactive exhibition on prevention aims to reach students aged 15 to 18 years. This project has been pursued in 2003/2004 in 3 different secondary schools. 800 students of 40 classes have participated in this interactive course composed of 5 different elements. 35 members of educational staff were trained to animate the exhibition. A prevention project called "What's up?" aims at conflict management, responsibility awareness raising and well-being by the method of interactive theatre. This project addresses to students of the 6th class of secondary schools, teachers and parents. The project" School is developing: growing strong together" aims at promoting health and especially drug prevention in the framework of primary schools. In 2004, 4 primary school participated in this project.

In the framework of the partnership ' **European Healthy School and Drugs'** (EHSD), coordinated by the Trimbos Insitut (NL), the CePT actively participates in the development of improved and innovative instruments and approaches in the field of drug prevention in schools. Specific workgroups address concepts such as multiplicators, evaluation or monitoring systems. An European manual on drug prevention in schools documents the final outcome of the EHSD project. In 2002 was published the manual "Making schools a healthier place- manual on effective school-based drug prevention".

The project '**OUT-TIME'** jointly implemented by the CePT and the SNJ links drug prevention to adventure pedagogical instruments and focus on pupils in 5th and 6th classes of primary schools. Target groups are educational staff, pupils and parents. The methodology of the project is based on the hypothesis that youngsters who are physically in a good shape, are mentally challenged and who can rely on stable orientation marks such as empathic parents show a lower probability to use (abuse) drugs. A possible way to do drug prevention could therefore consist in providing opportunities for the latter experiences in a secured framework so as to transmit the message that numerous of these emotions can be reached without using drugs. Stress and frustration management, experience of personal limits, relaxation after physical and mental efforts are some of the targeted experiences. During 2004, 13 primary school classes have participated in the project which takes place in a Youth centre in the countryside. The 'OUT-TIME project has been evaluated by the University of Koblenz.

❍ Family

Even though interventions aiming at the promotion of positive life experiences within the family and the kindergarten are not expressively addressed in the national drug prevention action plan, there are local or regional initiatives focusing on information and advice providing to teachers and the organisation of parents' evenings during which educational and health topics are discussed.

Active collaboration between the CePT and parent's association at each education level does exist. In 2001 CePT has released the so called **'prevention boxes**' (see standard table 19) including didactic material destined to potential multipliers as for instance teachers, parents and youth animators. The first prevention box, targeting 3 to 6 years old children has been released in September 2001. Due to its success, the 3-6 years prevention box will be reedited and a second one for children aged 11 to 15 years has been released in 2002. In 2004, seminars on the "prevention boxes" took place in different communities participating in the project of addiction prevention in local communities.

To date, there exists no outreach prevention programme specifically aiming at parents, pregnant women, childbirth or young parents.

❍ Community

As most of drug related interventions and strategies prevention in community settings are organised centrally and nation wide, projects are rarely initiated by the local community level without close collaboration of national authorities.

Generally speaking, local and regional communities do rarely dispose of a comprehensive drug prevention strategy. Commonly, a given national agency initiates projects, defines the general intervention framework and seeks active collaboration with community authorities in order to meet local needs. The observed situation is mainly due to geographical parameters of the Grand Duchy. At present only two agencies focus on interventions in recreational settings, namely the CePT (community project[15]) and the MSF Solidarity Youth (on site-interventions planned).

[15] In the beginning of 1995, a pilot project on **community-based drug prevention** has been launched by CePT (see EDDRA). The main idea was to focus prevention activities on the very environment and daily life experiences of young people. Various demand reduction activities have been undertaken, either developed by CePT, SNJ and several youth centres, or initiated by the respective District Councils. *13 district councils and 150 volunteers are currently involved in the project*. The funding of this community project is jointly ensured by the involved district councils, the EU (Drug Prevention Programme DG-V) and CePT.

The primary aim of the project is to improve communication skills on drugs, to increase participants' abilities in handling conflicts, stress and frustration (age range: 12 to 65 years) and to set up autonomous groups to continue implementing local prevention measures. In each participating municipality, prevention groups were composed of local volunteers who were asked to organise local drug-prevention activities related to their specific needs. Cornerstone concepts of the project are as follows:

- Multidisciplinary drug prevention
- Tailor-made community solutions
- Health promotion with regard to risk and protective factors
- Holistic and systemic approach
- Target groups oriented
- Routine evaluation

The CePT is currently developing the project "**adventure circuit**", an instrument for interactive and tangible drug prevention targeting general population. This itinerant exhibition has been prepared in 2004 by more than 40 volunteers who have fine-tuned and further developed the concept for a national prevention tour.

● SELECTIVE/INDICATED PREVENTION

❍ **Recreational settings**

Numerous programmes in recreational settings take place at the community level, church and youth organisations or sport-oriented clubs. The latter are not necessarily drug specific and as such difficult to list exhaustively.

Since its creation in 1995, the CePT, has initiated projects in the field of active leisure organisation: anti-drug discos, art performances, theatre, media supports (films, cartoons, etc.), seminars, ambulatory exhibitions, travel experiences, etc. The CePT increasingly ensures the national co-ordination of such activities.

The main national institutions involved in the youth activities or programmes are:

- The Service National de Jeunesse (SNJ)
- CePT
- The programme 'Support of initiatives of young people'
- The National Agency for the Community programme for the exchange of young people
- Centre Information Jeunes (CIJ) .
- Centre d'Animation Pédagogique et de Loisir (CAPEL)
- The Mondorf Group

A broad offer of activities for youngsters integrating the drug prevention topic as one of the various components of **Health education** is developing. The latter approach is believed to have more impact on youngsters (users and non users) than a drug-centred approach. Indeed, human interactions in daily life situations as for instance adventure or sports activities are most adequate as a conceptual framework for the progressive integration of drug-related prevention initiatives.

In this respect, the demand reduction activities organised by the "Mondorf Group" (joint initiatives of border regions of France, Germany, Belgium and Luxembourg) jointly with the CePT and SNJ combine a **non drug-centred approach** with **intercultural components** in organising corporate leisure activities for youngsters from border countries based on the concept of **'adventure pedagogy'**. The annual "**adventure weeks** [16]" do fit in a broader programme named "Adventure pedagogy and primary addiction prevention". Those activities primarily aim to provide the opportunity to youngsters to experience group dynamics, conflict management, limit and risk assessment as well as the feeling of solidarity within a group of socially and culturally different people. The program further aims at the reduction of risk factors and the enhancement of protection factors, by focussing on youngsters and their environment, rather than on drugs and addiction. Currently regional teams specialised in drug prevention meet in autonomous working and training groups and report activities to the Mondorf Group.

The CePT closely collaborates with the National School for Physical Education and Sports (ENEPS) in the framework of a project called ' Give strength to children'. Information and training sessions in presence of a top professional sportsman have been organised. A working group has

---

The community-based prevention network is an ongoing project, which is expected to develop its proper dynamic over the time. The idea was to switch from a centrally coordinated pilot project to routine and autonomous local programmes

[16] See EDDRA

been set up in order to elaborate a concept for future activities. A programme called ' **Sport and drug prevention**' started in the course of 2002.

Currently there exist no **legal framework** regulating prevention and harm reduction intervention in recreational settings such as on site information providing or pill testing. Discussions and a related parliamentary motion during the amendment process of the national drug legislation (amended in 2001) did not bring up a final decision on the matter. Prevention material and info flyers on synthetic drugs and multiple drug use are provided to bars and nightlife establishments by the initiative of CePT or on demand. There remains however an obvious lack of interventions in the referred settings. The improvement of data systems on quality of synthetic drugs to be assessed by the national early warning system is a permanent topic of the ICD meetings.

Major organisers of techno or rave events occasionally do contact the national drug coordinator's office and law enforcement agencies in order to seek advice and to inform on planed events. However, there is no legal obligation to do so. Moreover, nightlife venues are recommended to apply common **saver nightlife guidelines** by prevention agencies, but once again, there is no legally binding framework.

The **law of 29 June 1989** on taverns (inns)[17] management regulates the functioning of establishments licensed to serve alcoholic beverages in terms of control measures and security standards to meet (laid down by subsequent grand-ducal decrees). No reference is explicitly made to illegal drug use. The Ministry of Finances controls the application of the law at the national level. As far as nightlife venues are concerned, organisers have to fulfil security and hygiene standards defined and controlled by special departments of the ministry of Labour[18] and the ministry of Health.

The governmental declaration of 2004 puts emphasis on the risks of alcoholic mix-drinks (**alcopops)** and the high prevalence among youngsters. A special working group chaired by the Ministry of Health has proposed further measures to reducing the consumption of alcohol and alcopops. Measures yet to be implemented are a significant raise of taxes imposed on alcopops, 16 years minimum age for the purchase of alcoholic beverages and zero tolerance for young drivers. The very same propositions have been put forward by the national Ombuds-Committee for the right of children in 2004[19]

An exploratory study on the current situation and needs with regard of prevention in **nightlife settings** has been included in the drugs action plan 2005 – 2009.

❍ At-risk groups

In 2004, MSF in collaboration with the public prosecutor's office of youth protection, started to set up a new project called CHOICE[20] based upon a pilot project of "early intervention of first time noticed drug users" (FreD) initiated by the Federal ministry of health and social security of Germany. The target group consists of youngsters aged 12 to 17, either first-time drug law offenders or youngster having drug-related problems. The overall aim is to offer early intervention to youngsters and parents consisting in interactive conscious-raising training modules (groups of 5 to 8 participants, 6 group meetings). The project involves a cooperation network of all competent actors (school, parents, police etc.), identifying the target group, informing about the project and promoting participation by handing out a flyer including all contact details. Concerned youngsters

[17] Loi du 29 juin 1989 portant réforme du régime des cabarets. Entry in force 29/06/1989

[18] A special department of the ministry of Labour called ITM is in charge of issuing and controlling security standards for workplaces and places with public access. The ITM standard ITM-CL54.1 addresses night and festivity venues. These standards are legally binding. The ITM has to provide a formal authorisation before the opening of a given venue.

[19] Ombuds-Comité fir d'Rechter vum Kand, (2005), Rapport 2004 au gouvernement et à la chambre des députés, Luxembourg

[20] see EDDRA

have to contact MSF within 2 weeks to arrange an appointment of a first in-take talk. Only the youngsters having been referred by the police are obliged to contact MSF.

Furthermore, special attention is currently given to **Youngsters** and to the **local Portuguese community**. In the framework of the EU PIC-Equal programme, a project on ethno-specific prevention measures is about to be set-up. The latter focuses on linguistic and socio-cultural specificities of ethnic minorities and in particular Portuguese natives. Budgetary means are foreseen for 2006 to implement specific prevention and treatment options for **recent immigrants**.

Moreover, the 2004-2009 governmental programme underlines the necessity to further develop prevention programme for Youngster with regard to polydrug use and in particular the increasing use of **alcoholic mix-drinks**.

4. Problem Drug Use

Overview

At the national level 'problem drug use' (PDU) or 'harmful use' is defined according to the WHO Lexicon of Alcohol and Drug terms (Geneva, 1994):' *A pattern of psychoactive substance use that is causing damage to health, physical or mental. Harmful use commonly, but not invariably, has adverse social consequences […]*.

Data on PDUs presented in this chapter originate from the national drug monitoring system **RELIS** developed and maintained by the national EMCDDA focal point. The RELIS network includes specialised drug agencies (100% coverage), psychiatric departments of a series of general hospitals, law enforcement agencies and national prisons.

According to recent indicators **prevalence figures** applied to the national population aged 15-64 situate between 2,500 and 2,800 the number of PDUs**. Intravenous heroin use** associated to **poly-drug use** has been reported as the most common consume pattern in PDUs. More recently **low quality cocaine use** in combination with heroin has become more prevalent. **Ecstasy-like** substances and **ATS** show an increasing demand even though seizure figures do suggest an inverse and currently stable trend. The use of most 'new synthetic substances'[21] recently detected in other EU Member States have not been reported thus far (12/2004).

All indicators on **cannabis use** (problematic and recreational) have been on the increase for several years. Cannabis showing **high THC concentrations (14-19%)** is only sporadically found on the national market.

The ratio of **intravenous opiates consume** to **the inhalation mode** has stabilised at 2:1 **The provision of 'blowing paraphernalia'** (e.g. aluminium foils) by specialised drug agencies may have influenced consume patterns.

The **average age of first consume of cannabis, ecstasy and i.v. heroin** tends to decrease. Also, the **average age**, applied to the total PDU population has markedly increased over the last 6 years. The proportion of **PDUs aged 35 and more and those younger than 19 years** has constantly increased as well as the **standard deviation** of the observed age distribution meaning that the gap between youngest and oldest problem drug users tends to increase. Furthermore, increases have been noted with regard to the proportion of **minors** in the overall PDU population and to the percentage of students in problem drug users until 2003. In reference to year 2004 a stabilisation, and as far as police data is concerned, a downward trend has been observed.

[21] Substances such as MBDB, 4-MTA, Ketamin, PMMA 2C-I, 2C-T-2, 2C-T-7, 2C-D, 2C-E, TMA-2, BZP, TFMPP, 5-MeO-DIPT, 5-MeO-DMT, AMT, ALEPH 7, DXM, DPT

The average ages of native and non-native problem drug users tend to balance. The **average ages** at the moment of **first consume** of the current main drug and illicit drugs in general have shown a slow but constant downward trend for the last 5 years. In contrast to 1995 data, the **switch to intravenous drug use** occurs earlier in 2004.

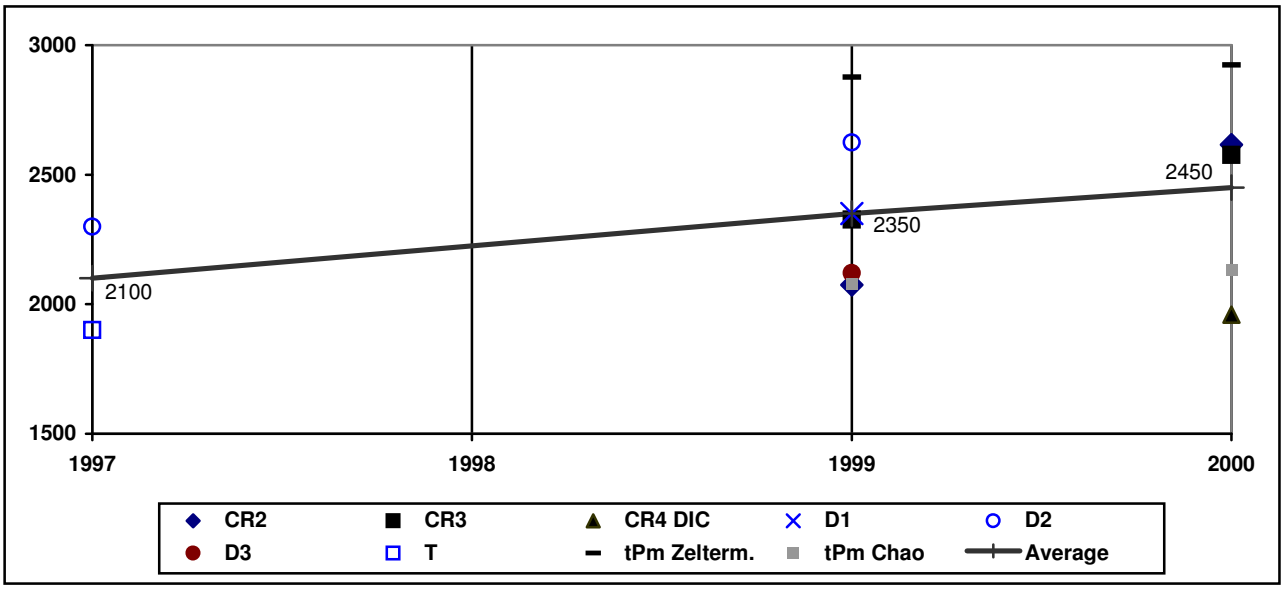
.

● PREVALENCE AND INCIDENCE ESTIMATES

Data presented in the present chapter have been provided by the latest drug prevalence study on PDUs aged between 15 and 64 years (hereinafter referred to "2001 study") conduced by the focal point between 1999 and 2001 (Origer 2001)[22] and refers to the years 1999 and 2000. Since there have been no national prevalence study since 2000, indirect indicators have been further observed and produced in order to assess the general evolution of PDU prevalence.

Data from 1999 and 2000 have been considered in comparison with first national drug prevalence figures from 1997. The following methods have been applied: Case finding (CF), capture-recapture on 2,3 and 4 sources (CR 2,3,4), truncated Poisson model associated to Zelterman's and Chao's estimators (tPm), and four different multiplier methods using data from law enforcement sources, drug mortality registers (D1, 2, 3) and treatment agencies (T).

Fig4.1. Prevalence estimation of problem HRC drug use (1997 – 2000)



Source: Origer 2001

[22] Downloadable at http://www.relis.lu

Tab. 4.1. Prevalence and prevalence rates according to selected sub-groups (1997 – 2000)

	1997	1999	2000
GENERAL POPULATION			
National population on 1st July	421,000	432,450	438,500
National population aged between 15 and 54 years on 1st July	239,818	245,308	248,440
HRC USERS IN CONTACT WITH THE NATIONAL INSTITUTIONAL NETWORK (low threshold agencies not included)			
Total number of indexed users (multiple counts excluded)	/	1,198	1,024
Number of drug treatment demanders in specialised institutions		757	637
Outpatient	/	624	557
Inpatient	/	218	178
Number of drug law offenders (ad minima consume of HRC drug(s))	/	551	510
PROBLEM USE: HRC DRUGS			
Average prevalence	2,100	2,350	2,450
Total prevalence rate	5 /1000	5.43 /1000	5.59 /1000
Total prevalence rate – age: 15-54	8.8 /1000	9.58 /1000	9.86 /1000
PROBLEM USE: MAIN DRUG – HEROIN			
Prevalence heroin	1,680	1,975	2,010
Total prevalence rate – heroin	4 /1000	4.57 /1000	4.58 /1000
Total prevalence rate – heroin – age: 15-54	7 /1000	8.05 /1000	8.09 /1000
INTRAVENOUS DRUG USE (IDU)			
Prevalence IDU	1,370	1,780	1,715
Total prevalence rate – IDU	3.25 /1000	4.12 /1000	3.91/1000
Total prevalence rate – IDU – age: 15-54	5.71 /1000	7.26 /1000	6.90/1000

Source: Origer 2001

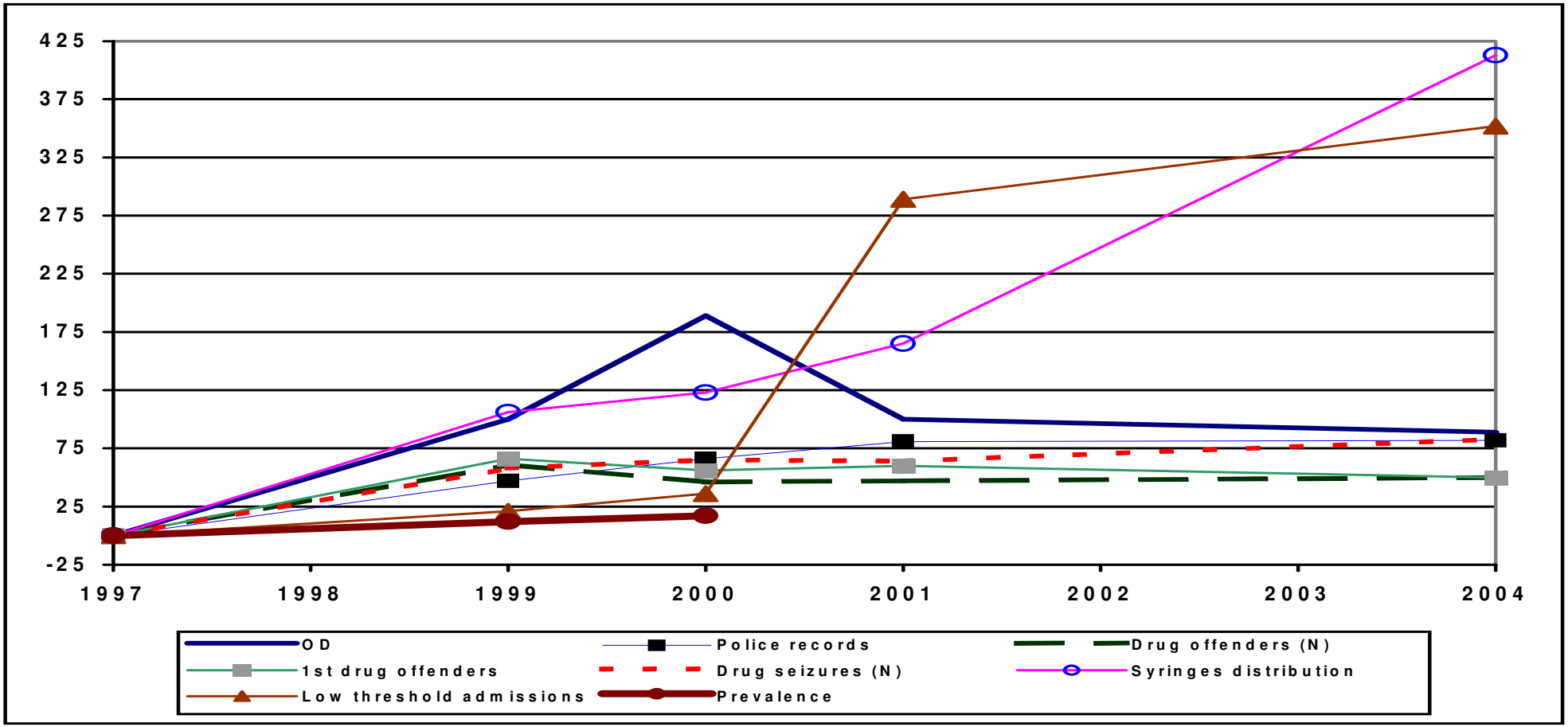
In order to validate estimated prevalence rates, data from different sources had to be considered. As can be seen in chart 4.1. prevalence estimates from 1997 to 2000 indicate a moderate upward trend in compliance with the observed evolution of **indirect drug use indicators** (1997: reference year, all values set to zero).

As can be seen in graph. 4.2 all indirect indicators, except number of low threshold contacts and number of distributed syringes, have been showing stable or deceasing trends since 2000/2001. The fact that the low threshold contact and distributed syringes indicators are on the increase has to be interpreted cautiously. Indeed during recent years new low threshold services have been implemented which may have attracted an increasing number of clients. As far as the increase of distributed syringes is concerned, one should stress that low quality cocaine has largely complemented heroin on the national drug market during recent years with the consequence that drug addicts have to inject more frequently (more syringes) than in the past, to get the desired effects.

Taking into account the previous comments, one may state that **PDU prevalence tends to stabilise** at the national level. A second national drug prevalence study, which is foreseen for year 2006, will provide more information of the current situation.

Graph 4.2 suggests another interesting hypothesis related to **the impact of harm reduction measures** on indirect prevalence indicators. The increase of the number of low threshold contacts and distributed syringes seems to be associated to the stabilisation or decrease of indicators such as overdose cases and drug related offences. Also this trend coincides with the period of the first national action plan.

Fig. 4.2. Prevalence estimates (problem use of high risk drugs) and evolution of selected indirect indicators



Source: Origer 2005

LOCAL PREVALENCE STUDIES

Due to the specificity of the national drug scene and the geographical dimension of the country, local prevalence studies are not considered as a priority.

NATIONAL 'DRUG SCENES'

Summarily five different problem drug user groups are to be distinguished at the national level:

- a sub-group of **cannabis consumers**, mainly minors, located in one of the central bus stations of Luxembourg-City. The referred group is a rather closed one showing poor contact with other drug scenes. Male and female users are represented equally. Cannabis use is also significantly associated to ecstasy consume in youngsters.
- A second group, the so-called '**disco scene'**, is often event-related and limited to rave or other dancing or party locations. This group is composed of youngsters between 15 and 20 years mainly attracted by ecstasy like substances and cannabis.
- The **'hard scene'** is characterised by a fair heterogeneity regarding age of users and consumed substances. However, composed by a majority of male users, the social-economic situation of this specific group is precarious. Female users who join this scene mostly do so for prostitution purposes and constitute a high risk group as regards overdosing (e.g. shorter drug carriers than males). Currently the main drug to be found on the drug market is low quality cocaine.
- The exclusive '**cocaine scene**' is described as a very dispersed one and difficult to access since cocaine consume mainly takes place in privacy. Typical cocaine users/abusers are middle age men of upper classes. Recently, however, cocaine use has largely spread within the street PDU population.

The '**regional scenes**' are mainly situated in the South of the country but more recently also in major cities of the Northern district.

CHARACTERISTICS OF INDEXED PDUS

Relying on a multi-sectorial data network including specialised in- and outpatient treatment centres and low threshold facilities, general hospitals as well as law enforcement agencies and national prisons, RELIS enables the assessment of new trends in the ***problem drug users*** population in general as well as in drug treatment demanders in particular. NFP has opted for a **holistic monitoring of the drug population**. The following data are provided by RELIS thus referring to all HRC drug users indexed by the national specialised treatment and law enforcement network and, as such, defined as problem drug users:

The **number of problem PDUs** indexed by national institutions in 2004 figures 3,847 (1994: 2,213) (double counting included). 873 users have been indexed by national specialised drug demand reduction agencies and 1,340 persons by supply reduction agencies in **1994.** Referred to **2004** the same agencies have indexed 1,700 and 1,897 respectively, which equals to a total **progress rate of 62%.**

38% (30%) of PDUs (of which 59 % are non-natives) reported their first institutional contact (intra-institution) in 2004. On average, a given user has 1.3 contacts/year with a specialised drug treatment agency. 5% of PDUs reported **first lifetime drug treatment** in 2004. 72% (74%) of respondents have had at least one **substitution treatment** before being indexed in 2004.

The male/female ratio of the PDU population is 4:1. Over the last 10 years the proportion of indexed non-native PDUs has been witnessing a slow but constant increase. The **population of non-natives**

drug users largely and increasingly consists of Portuguese nationals, a proportion which is consistently higher than the one observed in the general population.

The **mean age** of indexed PDUs evolved from 28 years and 4 months in 1995 to 30 years and 6 months in 2004. The gap between the youngest and the oldest PDUs continues to grow. One observes an average aging of the population of long-term drug injectors and a sensitive decrease in age referred to "new" PDUs. Also worth mentioning is the significant increase of the average age of overdose victims.

The mean age of native and non-native problem drug users tend to balance. **Average age at first use of illicit HRC drugs** has decreased approximately 3 years from 1995 to 2004. The **average ages** at the moment of **first consume** of the current main drug and illicit drugs in general have shown a slow but constant downward trend resulting in a decrease of more than 1 year from 1994 to 2004.

The **residential status** of indexed PDUs has improved over the last years. **The geographical distribution** suggests that the southern region (43%) and the centre region (34%) are the most representative. As in previous years, the northern region confirms its progression (17%).

All indicators included, the **employment status** of respondents has known no significant improvement during the last years. Also the **unemployment rate** has stabilised at a high level (46- 50%) since 1998. The decrease of financial autonomy of PDUs is associated to an **increasing social dependency**. Although a continuous decline at the level of revenues of illegal origin and a moderate decrease of the proportion of PDUs presenting **major depths** have to be underlined.

Intravenous heroin/cocaine use associated to **poly-drug use** has been reported as the most common consume pattern in PDUs. The switch to **intravenous drug use** occurs earlier compared to year 1995. More recently **low quality cocaine use** in combination with heroin seems to become more prevalent. The ratio of **intravenous opiates consume** to **the inhalation** mode has stabilised at 2:1 The recent provision of '**blowing paraphernalia'** (e.g. aluminium foils) by specialised drug agencies may have influenced consume patterns**.**

Ecstasy-like substances and **ATS** show an increasing demand even though seizure figures do suggest an inverse and currently stable trend.

All indicators on cannabis use **(problematic and recreational) have been on the increase for several years. Cannabis showing** high THC concentrations **is increasingly found on the national market.**

The **average age of first use of cannabis, ecstasy and i.v. heroin** tends to decrease. Also, the **average age**, applied to the total PDU population has markedly increased over the last 6 years. The proportion of **PDUs aged 35 and more and those younger than 19 years** has constantly increased as well as the **standard deviation** of the observed age distribution meaning that the gap between the youngest and oldest problem drug users tends to increase. Furthermore, increases have been noted with regard to the proportion of **minors** in drug offenders, in the total PDU population and to the percentage of students in problem drug users.

● PROFILE OF CLIENTS IN TREATMENT (CHARACTERISTICS, PATTERNS OF USE)

❍ **By substance used**

The main substance involved in drug treatment demands is **heroin**. Prevalence rates fluctuate around 70 and 75% (60% iv / 15% non iv). In 2004, an increase of 5% in preference for intravenous heroin use was noted compared to 2003. The increasing preference for heroin by **inhalation** registered several years ago is not observed anymore. The i.v. heroin sub-population shows the highest mean age (31Y5M) of all treatment groups. 7% of the latter are **first treatment** demanders compared to 10% of non-iv heroin users.

Cocaine use as main reason of treatment demand shows an increased prevalence (16%) that is consistent with current supply indicators. Mean age of preferential cocaine using treatment demanders is 27 years and 4 months years. With 12% of first treatment demanders, primary cocaine users show the highest lifetime first treatment rate. Cocaine prevalence as secondary drug has significantly increased from 30% in 2003 to 43% in 2004. **Crack** is newer reported as main problem drug and very rarely (1%) as secondary or occasional drug.

A recent trend has also to be seen in the increasing number of treatment demands related to **cannabis use**. The percentage of the latter has passed from 4% in 1997 to 11% in 2002 showing no increase in 2004. Treatment demands related to **ecstasy use** are rare (1-3%) and have shown a fair stability over the last years. The same comments apply to **ATS use**.

❍ **By centre types**

The present section is based on RELIS data and on in-house statistics of all specialised drug treatment agencies at the national level. The overall number of clients and **number of admissions** in specialised drug treatment agencies has constantly increased over the last decade. More recently one has observed a **stabilisation of treatment demands in outpatient drug agencies** and an increasing demand for inpatient therapies and at the opposite side for low threshold offers.

The proportion of **first treatment demanders** observed in 2004 was 5% (1998: 4%). For the sake of a comprehensive presentation of main observed trends, the following typology of treatment settings is applied:

- Outpatient, adults

After several years of stabilisation, national drug counselling and therapy centres show **decreasing admission rates and first treatment rates** in 2004. Gender distribution shows **stability following a three-year upward trend in female treatment demanders** (2004: 33% / 1997: 34%). **Age distributions** have to be analysed according to the geographical situation of treatment centres. The proportion of treatment demanders aged 30 years and beyond (56%) has sensibly increased, during recent years. The proportion of **underage treatment demanders** has been increasing in recent years but stabilised in 2004 (4.4%). **Treatment demands for problem i.v. opiate use** associated to multiple-use, is still the main demand pattern and the clear decrease observed the last years shows again an increase in 2004 (2004: 48% / 1997: 72%). **Cannabis-related demands** have shown a clear upward trend since 2000 (2003: 15% / 1997: 1%) and decreased significantly in 2004. The prevalence of **problem cocaine use** significantly increased, especially intravenous cocaine use.

- Outpatient, underage

Specialised drug care agencies for minors only exist in the centre of the country. The **rate of new treatment demanders** has constantly increased since the implementation of the referred agencies. Likewise adult outpatient agencies, gender distribution in minor treatment demanders has been showing a **rising proportion of female users** (2004: 32% / 1997: 26%), which is currently stabilised. The **mean age of clients** has been slowly decreasing since 1997. The proportion of clients aged below 15 has raised from 7% in 1997 to 17.7% in 2004. Cannabis use is increasingly the main reason of treatment demands (72.4%), followed by heroin and ecstasy.

- Inpatient, drug therapy

Likewise the situation observed in outpatient counselling centres, the proportion of **new clients** has markedly increased in inpatient therapy settings in recent years. The proportion of **female treatment demanders** has stabilised at 22-25% and the observed mean age still is on the increase (2004: 31Y11M / 1998: 27Y). The referred age distribution reflects an **overall trend** observed in most adult drug treatment demanders, that is**,** a decrease of patients under 25 and an increase of patients **older than 25**

years. An increase is observed as to the **proportion of natives** within the inpatient treatment demanders. All treatment demands are related to **opiate abuse**, mainly i.v..

- Inpatient, detoxification

Drug detoxification units throughout the country show a stable trend regarding number of admissions and patients. **First treatment demands also tend to stabilise**. **Gender distribution** has remained fairly unchanged and the mean age of clients has been on the decrease for the last six years. **Multiple drug addiction** including heroin is the main reason for detoxification demand.

- Substitution treatment

The **number of patients** admitted to the national substitution programme has been decreasing (120) for the last 6 years, which is probably due to the increasing access to low threshold substitution provided by GPs. The proportion of female substitution treatment demanders (38.3% stable) is increasingly higher than the proportion of female PDUs in the overall drug treatment population. The **mean age** of clients (35Y) has significantly increased compared with 1997 data (28Y2M) and the proportion of **native substitution treatment demanders** has stabilised in recent years (70-75%). The **socio-economical** situation of substituted patients is consistently more beneficial than the one observed in other treatment demanders, which has been confirmed by the latest external evaluation (Dellucci, 2003). The number of patients who did receive substitution treatment by prescription **from independent general practitioners** has stabilised after a constant increase in previous years. 1,553 patients (multiple counts included) have been provided substitution treatment by the national GP network in 2004.

- Low threshold services

The **number of contacts** indexed by low threshold agencies has increased dramatically over the last eight years (2004: 39,526 / 1996: 6,456), and so has the number of syringes distributed by the same agencies. The proportion of **new clients** within low threshold settings is on the increase. The number of **female clients** has been showing a weak but constant decrease. Approximately 70% of clients are aged between 18 and 35 years. On third of clients (increasing) are non-natives.

- MAIN CHARACTERISTICS AND PATTERNS OF USE FROM NON-TREATMENT SOURCES

No information available

5. Drug-Related Treatment

Overview

Drug treatment is the 'use of specific medical and/or psychosocial techniques with the goal of reducing or abstaining from illegal drug use thereby improving the general health of the client'.
(**SOURCE:** Classification of drug treatment in EU member states and Norway, Expert meeting, 8-9 February 2002)

Specialised drug treatment infrastructures are relying on state financing and on ministerial control and quality insurance mechanisms. Treatment offers are decentralised and most commonly provided by state accredited NGOs.

For the purpose of the present chapter, drug treatment is divided in the following categories:

- **Outpatient treatment**: the patient receives drug treatment without staying overnight;
- **Inpatient treatment**: the patient who receives drug treatment is staying overnight, including detoxification;

- **Substitution treatment:** a type of medical treatment provided to opiate addicts primarily based on the delivery of a similar or identical substance to the drug normally used. Substitution treatment may be accompanied by psycho-social care;

- **Low threshold measures[23]:** refer to measures aimed at reducing the harm associated with drug use without necessarily requiring a reduction in consumption.

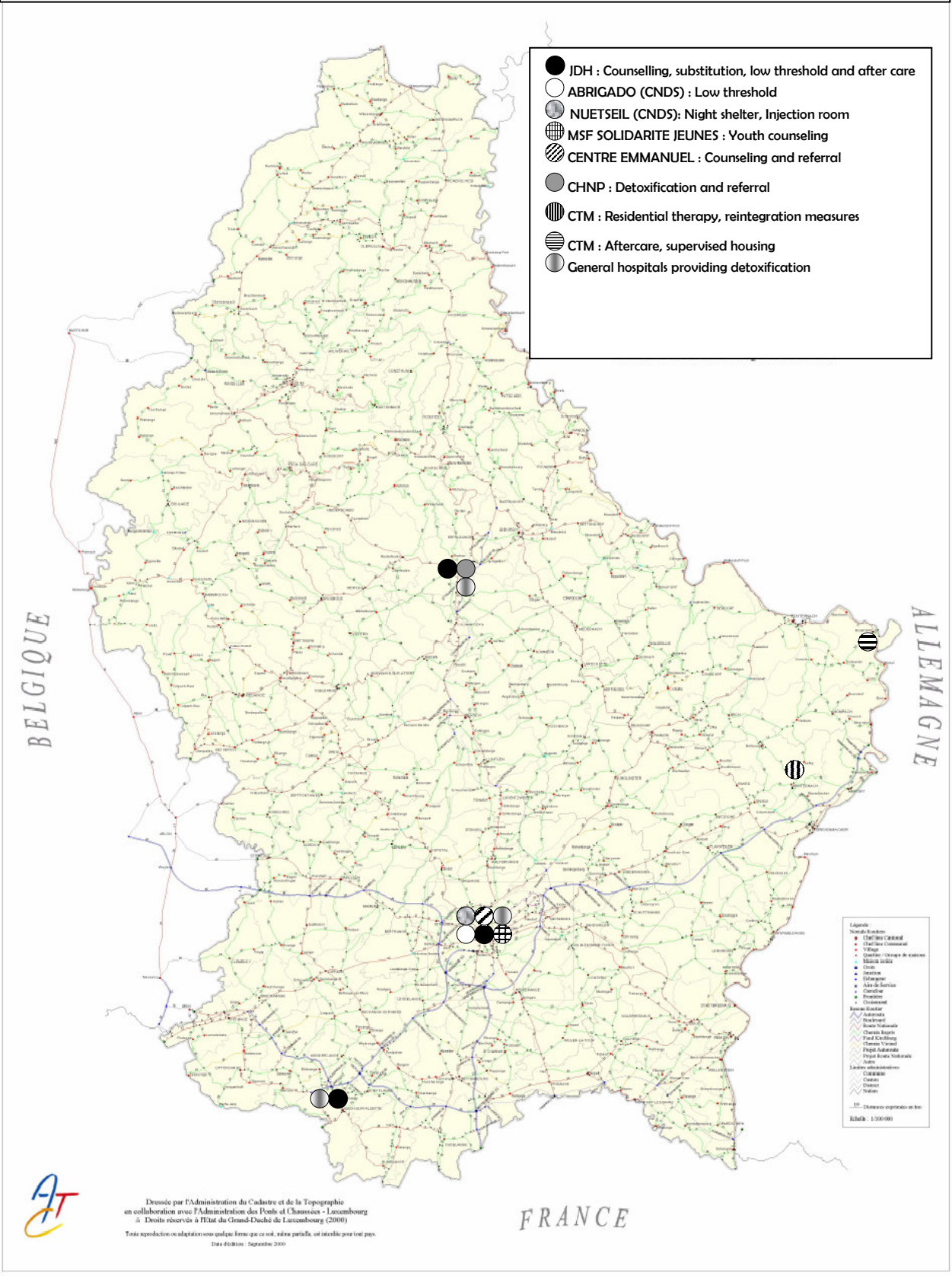
In recent years inpatient drug treatment demand has been fairly stable while outpatient treatment has been showing a weak but ongoing decrease. A clearly observable increase has been reported in substitution treatment and low threshold care demanders.

The national drugs action plan 2000 – 2004 has largely contributed to fill a series of gaps in the drug treatment network. Increased admission figures related to harm reduction offers may be linked to the implementation of new low threshold services under the former action plan. The outcome of the 2000 – 2004 action plan has been largely taken into account for the elaboration of the 2005 – 2009 drugs action plan.

[23] Although harm reduction measures are specifically addressed under chapters 6 to 9, low threshold services are to been seen as a possible alternative to treatment and thus need to be included in the analysis of treatment demand patterns.

● Treatment systems

Map 5.1 Geographical coverage of specialised drug agencies in the Grand Duchy of Luxembourg (status 2004)



As can be seen in graph. 5.1 drug treatment facilities are regionalised showing however a high concentration and diversity within the area of Luxembourg City. All listed services are specialised with the exception of regional general hospitals providing detoxification treatment. Compared with the

situation observed in 2003, a new service has been created in June 2005, namely 'The injection room for drug users' integrated in the 'Nuetseil' providing night shelter and low threshold services to drug addicts.

All drug treatment infrastructures, general hospitals excluded, are relying on governmental support and control. Most of specialised agencies have signed a **convention** with the ministry of Health, which guarantees their annual funding. NGOs involved in drug treatment fall under the obligation of the so-called **'ASFT' law** (8 /09 /98)[24] and the subsequent grand ducal decree of 10 December 1998[25], both regulating the relation (duties and rights) between State and NGOs or organisation providing psycho-medico-social and therapeutic care. The overall management of the referred agencies is ensured by a 'co-ordination platform' that includes 3 members of the concerned institution and at least one representative from the competent ministry. All major decisions have to be approved by the **co-ordination platform**.

All referred institutions work in close collaboration and have to be viewed as an **interdependent therapeutic chain** even though there are no formal agreements between them. With the exception of detoxification departments, that mainly deal with opiate users, all treatment units or agencies accept any drug using patient independently of the type of substance(s) that are involved.

The **governmental quality standard certification,** as foreseen by the **law 'ASFT' of 8 October 1998, represents** the main tool towards a standardised quality control. However, funding is not directly related to clearly defined evaluation requirements. The quality standard certification commits respective NGOs to undertake necessary evaluation measures of their activities by means, however, they deem adequate.

Drug treatment agencies have developed proper **evaluation strategies** mostly in collaboration with external evaluators. Recent examples are the evaluation of current offers in the field of socio-professional integration, which future development has been promoted by the national drugs action plan, the implementation of a computer based evaluation procedure by the national substitution programme and prevention interventions in schools by CePT.

Also, the **RELIS database** on problem drug users provides relevant data for evaluation purposes since it includes detailed data on drug consume patterns, socio-economic situation, risk behaviour and treatment or law enforcement contacts, etc. In the long run, drug 'careers' can be analysed by means of the RELIS indexing system, which allows following up treatment demands and law enforcement contacts of indexed drug users. These data can be used to assess the impact and the performance of specific treatment approaches. A practical example of the application of evaluation results is to be seen in the conceptualisation of the national drug action plan 2000-2004, which did greatly rely on RELIS data and ad hoc evaluation initiatives from field institutions.

Table 5.1 records admission and contact statistics of national drug treatment agencies according to applied typology from 1994 to 2004. **Intra-institutional multiple counts** are excluded meaning that all treatment demanders indexed by a given agency is only indexed once by the referred agency during a reporting year. **Inter-institutional multiple counts** are not excluded since a given treatment demander may have contacted several national agencies during a given year. More detailed admission data, including low threshold agencies are produced in respective sub-chapters.

[24] Loi du 8 septembre 1998 réglant les relations entre l'Etat et les organismes oeuvrant dans les domaines social, familial et thérapeutiques (entry in force: 24/09/1998)

[25] Règlement grand-ducal du 10 décembre 1998 concernant l'agrément à accorder aux gestionnaires de services dans les domaines médico-social et thérapeutique. (entry in force 18/12/1998)

Table 5.1 Clients admission statistics of drug treatment institutions (Inter-institutional multiple counting included)

INSTITUTION	NUMBER OF ADMISSIONS (A) AND/ OR CONSULTATIONS (C) AND/OR CONTACTS (CO)						NUMBER OF DRUG TREATMENT DEMANDERS (intra-institutional multiple counts excluded)					
	94	96	98	2000	2002	2004	94	96	98	2000	2002	2004
SPECIALISED OUTPATIENT TREATMENT												
SPECIALISED OUTPATIENT TREATMENT	1,664	1,093	1,104	1,444	1,936	2,692	467	618	764	867	1,052	1,136
SPECIALISED INPATIENT TREATMENT	48	58	39	43	57	53	48	55	56	56	52	70
INPATIENT - DETOXIFICATION							≈ 308	≈ 277	243	316	289	382
LOW THRESHOLD AGENCIES		6,456	9,499	13,083	29,536	39,526						
DRUG TREATMENT ABROAD							≈ 50	55	71	102	101	112
TOTAL Number of drug treatment demanders **(Multiple counts not excluded)** **(Multiple counts excluded)**							**873** n.a.	**1,005** n.a	**1,134** n.a.	**1,341** ***637***	**1,494** n.a	**1.700** n.a.

Source: RELIS 2004

Table 5.1 summarises in-treatment statistics of PDUs excluding inter- and intra-institutional multiple counts as determined for the first time by the RELIS database in the framework of the national drug prevalence study 1997 - 2000 (Origer 2001). Although, **inter-institutional multiple counting** controlled data on drug-related institutional contacts are only available since 1999, a **continuous increase of the number of drug treatment demanders** is observed.

● DRUG FREE TREATMENT

Definition: 'Drug free treatment focus on psycho-social and therapeutic techniques and is not primarily based on the routine prescription of a substance or medicament with the goal of reducing or abstaining from illegal drug use thereby improving the general health of the client'.

As far as **admission criteria** to drug free treatment are concerned, no specific standards exist. Specialised drug treatment is free of charge and detoxification treatment is reimbursed by health insurance funds. Admission and type of treatment are assessed individually with the client.

For the purpose of the present report low threshold, harm reduction services and withdrawal treatment have been excluded from the present sub-chapter. Distinction will be made between out- and inpatient treatment.

Outpatient treatment

RELEVANT TREND: Decrease of **first treatment rates.** Stable gender **distribution.** Increasing proportion of **clients over 30, non-native clients and currently stable or decreasing number of underage treatment demanders.**

The most relevant national outpatient treatment facility is the 'JDH Foundation'. Regional antennas of JDH are respectively implemented in Luxembourg City, in the South and in the North of the Grand Duchy and are entirely financed by the Ministry of Health. MSF Solidarité–Jeunes is addressing youngsters who have run into conflict with law enforcement for drug related offences. The Emmanuel Centre is primarily a referral agency of the Communita Emmanuel situated in Italy.

Further agencies provide social care or therapeutic settings that are attended by drug addicts. These agencies, however, rarely provide drug specific treatment and separate data breakdowns are not available.

Inpatient treatment

RELEVANT TREND: Increasing admission rates, stable profiles

The only therapeutic community called 'Syrdallschlass' (CTM-CHNP) is situated in the East of the G. D. of Luxembourg. The therapeutic programme of the CTM is divided into three progressive phases that have been revised during 1997. The duration of a therapeutic journey varies from 3 months to 1 year.

In addition to individual and group therapies, the centre offers the opportunity to follow training activities in several professional domains and post therapeutic accommodation facilities. The final objective is the psychological, professional and social reintegration of treated clients. The latter is highly facilitated by the quality of provided professional training to patients. The collaboration with several employers willing to employ ex-drug addicts and the active involvement of social services guarantee a fair social and professional framing to released patients.

The **national drug action plan** had foreseen the extension of CTM offers by creating a network of **modular therapeutic annexes** for specific target groups as for instance pregnant women, drug addicted couples, treatment demanders on methadone, etc. These annexes are operational since September 2002 and are situated in the vicinity of the main centre (see chart 11.1) in order to take advantage of training and social reintegration facilities offered by the CTM. The new 2005- 2009 drugs action plan foresees the further development of these annexes.

As the national inpatient therapeutic facilities are limited and not covering the whole spectrum of drug related symptoms (e.g. double diagnosis) a series of patients are referred to specialised institutions abroad. Related costs are covered by the national social security schemes.

Table 5.2 Drug treatment abroad covered by health insurance scheme (1996-2004)

AGE GROUP	1996	1997	1998	1999	2000	2002	2004	*Males (2004)*		*Females (2004)*	
	N	N	N	N	N	N	N	*N*	*%*	*N*	*%*
< 20 years					3	5	3	2	2,5	1	3
20 à 25 years					33	33	37	21	26,6	16	48,5
> 25 years					66	63	72	56	70,9	16	48,5
TOTAL	55	57	71	91	102	101	112	79	100	33	100
Mean age					27Y9M	28Y	28Y5M	30		27	

Source : Administration du Contrôle Médical : Cures de désintoxication (drogues dures et polytoxicomanie) à l'étranger - Exercices 1996-2004

A new project foreseen by the 2005-2009 national drugs action plan relates to minor PDUs. A specialised residential centre for problematic youngster will be opened in the beginning of 2006 in the North of the country under the management of CHNP. The therapeutic programme of the centre should fill the current gap in the care system for minors. Further details will be reported in the 2005 report.

● MEDICALLY ASSISTED TREATMENT

❍ Withdrawal treatment

RELEVANT TRENDS: Decreasing number of admissions, first admissions and number of clients stable - Increasing mean age – Increased proportion of clients over 30 years.

Physical drug detoxification is provided by five different hospitals via their respective psychiatric units. The most important detoxification unit is implemented within a specialised department of the CHNP (15 detoxification beds). Medical interventions and psychosocial support are provided to control and reduce

withdrawal symptoms in the framework of a 1-2 week detoxification programme. Ideally, detoxificated patients are referred to more therapeutic oriented institutions.

The other four detoxification services are provided by non specialised psychiatric units within four general hospitals:
Clinique St. Louis – Ettelbrück (North) – 15 psychiatric beds
Centre Hospitalier Emile Mayrisch - HVEA (South) – 33 psychiatric beds
Centre Hospitalier de Luxembourg – CHL (Centre) – 45 psychiatric beds
Clinique Ste. Thérèse (Centre) – 12 psychiatric beds.

❍ Substitution treatment

RELEVANT TRENDS: Decrease in number of patients in structured programme. Stabilisation of low threshold substitution demands – Increase of female clients- Increase of mean age of substitution treatment demanders - Increase in proportion of Portuguese nationals in substituted patients.

Substitution treatment is currently defined as a medical assisted treatment with opiods' agonists and with antagonists (and antagonistic agonists). The objectives of substitution and maintenance treatment are manifold. They range from no dose-digressive, out-patient low threshold maintenance to abstinence oriented (digressive doses) rehabilitation offers. The primary goal is the psychosocial and medical stabilisation of the patient by replacing 'street' drugs by quality controlled substitution drugs. The further development and outcome of the treatment is assessed individually. Both components, condition of the patient and reduction of public nuisance are considered.

Substitution treatment is provided at the national level since 1989 (JDH). Until the beginning of 2001, however, there has been no **legal framework** regulating drug substitution treatment. The law of 27 April 2001 modifying the basic drug law of 19 February 1973 introduces a legal framework for substitution and maintenance treatment. The grand ducal decree of 30 January 2002[26] regulates the practical modalities of substitution. The new law regulates drug substitution treatment in general rather than it legalises a single national substitution programme. The law does this by means of **substitution treatment licenses** granted to MDs and specialised agencies, the application of training requirements for prescribers and adequate control mechanisms of **multiple prescriptions** (i.e. centralised register of substituted patients). It should be stressed that following the application of the new legal framework, there still exists a **structured substitution treatment programme** (JDH - mainly liquid oral methadone – 120 patients in 2004) provided by specialised agencies (JDH) and **a lower threshold substitution treatment** offer provided by freelance state licensed MDs (MEPHENON ®, METHADICT ® and SUBUTEX ®).

*A **central substitution register** is about to be implemented jointly by the newly created 'Surveillance* Commission on Substitution Treatment [27]*', the national drug coordinator and involved specialised treatment centres.*

General admission criteria to substitution treatment as defined by the decree of 30 January 2002 are as follows:

- treatment demander presents symptoms of drug addiction as documented by international diagnostic criteria and toxicological evidence, and is not likely to be adequately treated by other therapeutic techniques,

[26] The decree of 30 January 2002 regulating the modalities of substitution treatment can be downloaded at: http:www.eldd.emcdda.org
[27] The decree of 30 January 2002 replaces the former 'Methadone Commission' by the 'Surveillance commission on substitution treatment' mandated to control all aspects of substitution treatment at the national level. Established in 2002, it is composed of delegates from the programme, the Directorate of Health, the AST, two pharmacists and two GPs affiliated to the programme, and is in charge of admissions, releases and exclusions of substitution treatment demanders or patients. The composition of the new commission is similar to the one of the former Methadone commission.

- treatment demander is native or is a resident of the Grand Duchy of Luxembourg. (Demanders who do not meet the latter requirement are nonetheless admitted if they follow a documented substitution treatment in another Member state of the EU).
- a written demand by the demander or his/her parental authority in case he/she is underage.

Until 2001 methadone and buprenorphine have been prescribed as part of a long-term treatment with a medium or long-term abstinence goal. There are, however, a series of cases in which substitution treatment has to be considered rather as a harm reduction or maintenance measure than abstinence oriented therapeutic action. The grand-ducal decree of 30 January 2002 lists medicaments as well as preparations containing methadone (liquid oral form in programme and pill form in lower threshold prescription) and **buprenorphine** if the notice mentions substitution treatment as a possible therapeutic indication. Furthermore**, morphine-based (salts)** medications can be prescribed if the listed substances are deemed inadequate by medical authority. Finally, the decree allows for heroin prescription in the framework of a pilot project managed by the Directorate of Health. The **list of substitution substances** can be rapidly modified by amending the referred decree. In addition to drug prescription and medical care, the grand ducal decree on drug substitution treatment (30/01/2002) defines a series of psychosocial counselling services to be provided by licensed specialised centres. Licensed MDs may refer substitution patients to licensed treatment centres for psychosocial counselling.

Diverted MEPHENON ® (methadone in pill form prescribed by accredited MDs) is largely available on the national black market. This situation is primarily due to uncontrollable **multiple prescription** of mephenon® and dealing between patients and other drug addicts. Given that no centralised substitution treatment register does currently exist, prescribing MDs have major difficulties in determining rapidly whether their patient is simultaneously be prescribed a substitution drug by one or more of his/her colleagues. In that respect, it has been decided to set up a **national substitution treatment register** within the Directorate of Health in order to reduce illicit diversion of substitution drugs. The register should become operational in the course of 2005.

The union of national sickness funds annually provides the number of patients receiving referred substitution drugs on prescription as well as the number of prescribing MDs. One observes a recent stabilisation of low threshold substitution demands and a 4-years decrease of the number of patients choosing the official substitution programme, more demanding in terms of therapeutic constraints.

Table 5.3 Ambulatory, low threshold prescription of substitution drugs by the national network of liberal MDs

YEAR	1999	2000	2001	2002	2003	2004
Number of indexed patients (double counting controlled)	745	844	849	820	913	/
Number of prescribing GPs (double counting included)	/	/	/	1,487	1,554	1,553
Number of prescribing GPs (double counting controlled)	125	145	147	157	154	158

Source : Union des Caisses de Maladie 2004

A first scientific **evaluation** of the structured JDH substitution programme occurred in 1995. In 1998, new evaluation software has been developed in collaboration with the NFP, which, in the medium term, aims at the integration of substituted patients' data directly in the RELIS database. In 2003 a third evaluation by an external expert occurred on basis of data provided by the referred evaluation software.

The **main conclusions of the evaluation exercise** (Dellucci 2003) show the following trends:

- Significant improvements of residential status, social independence of patients, occupational situation, financial situation and indebtedness status, frequency of penal and judicial contacts, health indicators and frequency of risk behaviours,

- No significant improvement of parallel consumption patterns of illicit opiates by substitution patients.

The number of **drug-related deaths** is not correlated to the increase of methadone-substituted patients. This relationship is, however, purely descriptive since no scientific analysis on the latter has been performed thus far.

The adequate tool towards the assessment of the **impact of substitution treatment** would be a cohort study. This solution has not been envisaged since, in medium term, the RELIS database, including all indexed institutional contacts of drug addicts, will allow to follow up individual careers (health and law enforcement institutions) and for instance enables the NFP to assess the impact of substitution treatment.

6. Health Correlates and Consequences

Overview

At the national level two drug-related deaths indexing routines do currently exist:

1.**The Special Drug Unit of the Judicial Police (SPJ) maintains a register on acute drug deaths (RSPJ).** The RSPJ indexes all direct overdose cases due to illicit drug use documented by forensic evidence. RSPJ applies the following definition of acute/direct drug-related death:

' Lethal intoxication, voluntary, accidental or of undetermined intent, confirmed by forensic and contextual evidence, and caused directly by the use of illicit drugs or by any other drug(s) if the victim has been known to be a regular consumer of illicit drugs'. Death has occurred due to an adverse somatic reaction to substance intake'.

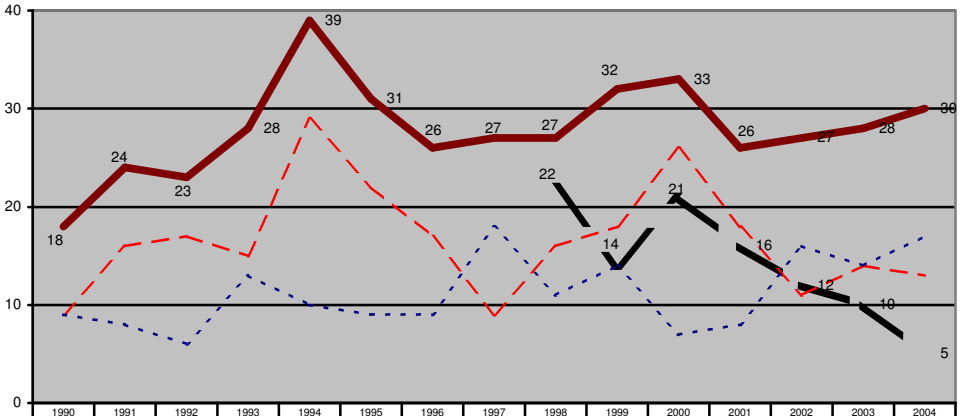
2.**The statistical department of the Directorate of Health maintains the General Mortality Register (GMR)** indexing all deaths that occurred on the national territory by means of death certificates provided by GPs. Since 1998 the GMR applies the 10th revision of the International Classification of Diseases (ICD-10). A special software jointly developed by the statistical department and the national focal point allows to extract drug-related death cases from the GMR by the application of a predefined standard (e.g. DRD).

- DRUG RELATED DEATHS AND MORTALITY OF DRUG USERS

❍ **Direct overdoses and (differentiated) indirect drug related deaths** (see ST 5 and 6)

Based on the outcome of the study: '*Epidemiological study on drug-related deaths and analysis of methodological aspects of indexing procedures applied in the Grand Duchy of Luxembourg from 1992 to 2000'* (Origer & Dellucci 2002), the NFP has decided to update annual figures by comparing SR (RSPJ) data with DRD version 3.0 data. As can be seen in figure 6.1 the DRD v. 3.0 standard (selection B) appears to be a valid instrument to estimated direct/acute drug deaths as indexed nationally by the RSPJ. Overall drug related mortality, however, should not be assessed by the same standard as far as Luxembourg is concerned.

Figure 6.1 Evolution of drug-related death cases (direct - indirect - total mortality) from 1990 to 2004 (Origer 2005)



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Drug related mortality DRD (vers.3.0 selection B)									22	14	21	16	12	10	5
Drug-related mortality: RSPJ (Special register)	18	24	23	28	39	31	26	27	27	32	33	26	27	28	30
Acute/direct drug deaths: RSPJ (Special register)	9	16	17	15	29	22	17	9	16	18	26	18	11	14	13
Indirect drug deaths: RSPJ (Special register)	9	8	6	13	10	9	9	18	11	14	7	8	16	14	17

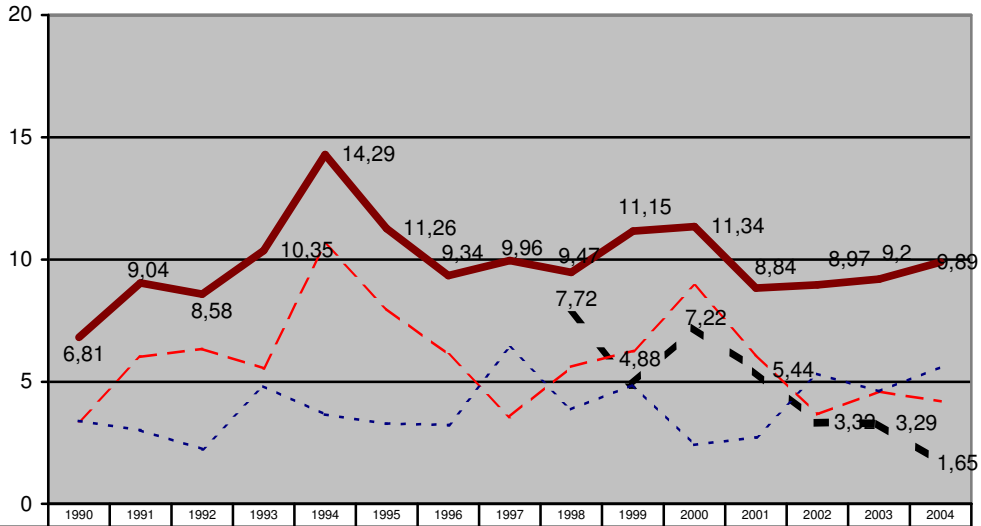
The number of **fatal acute overdoses** indexed at the national level has shown an increasing trend from 1985 to 1994 (29 cases), followed by a slow decrease until 1997 (10 cases). A similar evolution has been observed between 1997 and 2002, showing a peak in 2000 (26 cases) decreasing anew to 13 cases in 2004.

Compared with national prevalence figures on problematic drug users in 2000 (*N* = 2.450), in 1999 (*N* = 2.350) and in 1997 (*N* = 2.100) (Origer 2001), **overdose** cases represent a rate varying between 0.48% in 1997 and 1.1% in 2000 (0.77% in 99). Referred to the **total number of drug-related deaths**, indexed by national law enforcement agencies and forensic institutes, the same proportion shows weaker variations: 1.346% in 2000, 1.361% in 1999 and 1.333% in 1997. In absence of new drug prevalence estimates for 2001 and 2002, drug related death prevalence rates for those years have not been computed.

The **overdose rate in the national general population** figured 6.43 overdose deaths per 100,000 inhabitants[28] in 2000 (2.09 in 1997). An international comparison shows that the **overdose rate** of the G. D. of Luxembourg in 2000 was among the highest within EU Member states. 2001 and 2002 figures, however, show significant decreases. In 2004 overdose rates of 2.87 and 4.20 per 100.000 inhabitants and 100.000 inhabitants aged 15 to 64 years respectively have been observed.

[28] All age groups

Figure 6.2 Evolution of drug-related mortality rates (direct - indirect - total mortality) per 100,000 inhabitants aged 15 to 64 from 1990 to 2004 (Origer 2005)



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Drug related mortality rate DRD (vers.3.0 selection B)									7,72	4,88	7,22	5,44	3,32	3,29	1,65
Drug-related mortality rate: RSPJ (SR)	6,81	9,04	8,58	10,35	14,29	11,26	9,34	9,96	9,47	11,15	11,34	8,84	8,97	9,2	9,89
Acute/direct drug deaths mortality rate: RSPJ (SR))	3,4	6,02	6,34	5,54	10,62	7,99	6,11	3,56	5,61	6,27	8,93	6,12	3,66	4,6	4,2
Indirect drug deaths mortality rate: RSPJ (SR)	3,4	3,01	2,24	4,81	3,66	3,27	3,23	6,4	3,86	4,88	2,41	2,72	5,32	4,6	5,6

The steep decrease of acute overdose cases between 1994 and 1997 has been associated to the regionalisation and extension of the methadone substitution programme as well as to the further development of low threshold facilities. Whether the **upward trend in acute drug deaths from 1997** onwards was due to an increasing drug user prevalence, a changing drug market profile and use patterns, remains uncertain at present.

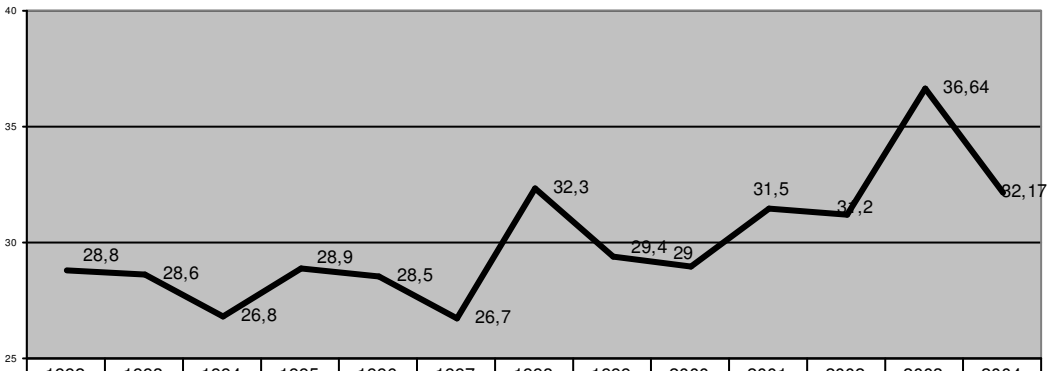
The decreasing trend from 2000 to 2002 may be a medium term consequence of the higher proportion of non-i.v. opiate users observed during that same period followed by a stabilisation around 4.5 percent. Also, availability and quality of drugs available on the national market, multiple-drug use, associate morbidity and contexts of drug-related deaths are some of the relevant topics that have been addressed by the latest study on drug-related deaths (Origer & Dellucci 2002).

In 2004, 17 **indirect drug death cases** have been indexed by the RSPJ. It is remarkable that the number of direct drug-related deaths have followed an **inversed evolution** as compared to indirect deaths from the beginning of the nineties until now.

Since 1992, results of **toxicological analysis** performed on overdose victims refer to the presence of opiate traces in almost all direct drug death cases. **Heroin** has been detected in a vast majority of acute drug deaths, (average 165 heroin cases / 222 total acute drug death cases: 75%) either exclusively or as primary drug associated to other substances. In all reported cases heroin has been administrated intravenously.

Forensic data from 2000 suggested a **decrease of heroin-related deaths** (72%), which, however, has not been confirmed by more recent data. Deaths exclusively due to **cocaine** use remain very rare. **Ecstasy**-related deaths have not been reported thus far. **Multiple substance use** has been increasingly reported during last years. In terms of associated drugs detected in blood samples of victims, cocaine and methadone are most represented. **Cocaine** traces in blood samples have increasingly been detected for the last 3 years. **Buprenorphine** (SUBUTEX ®) has been first detected in direct drug deaths in 1999.

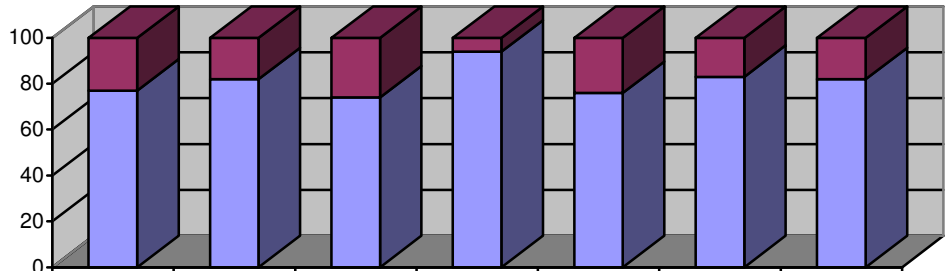
Figure 6.4 Mean age of acute drug deaths victims (1992-2004) (RELIS 2005)



	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Mean age OD cases	28,8	28,6	26,8	28,9	28,5	26,7	32,3	29,4	29	31,5	31,2	36,64	32,17

Gender distribution of direct drug death cases reflects the sex ratio observed in the total number of drug-related deaths and in the overall drug population. There appears to be no consistent evolution trend during the last 10 years.

Figure 6.3 Gender distribution of direct drug death cases (1992 - 2004) (%)



	2004	2002	2000	1998	1996	1994	1992
females	23	18	26	6	24	17	18
males	77	82	74	94	76	83	82

Source: RELIS 2004

The **mean age** of **direct drug-related death cases** shows quite important fluctuations over time (mean age from 1992: 28.4 to 2004: 32.17 years). However, over an observation period of 13 years, it appears that the mean age of acute drug deaths victims follows a long term increase. This increase has been fairly spectacular in 2003 even though it has not been confirmed by 2004 data. Age group 20 to 34 years is most represented. Overdose victims are significantly younger than **indirect drug deaths cases.**

Table 6.1. Age distribution of direct drug death cases indexed from 1992 to 2004

	2004	2003	2002	2001	2000	1999	1998	1997	1996	1995	1994	1993	1992	Total
< 20				2	1	1			1		3	3		11
20-24	1		4	2	8	3	2	2	5	6	6	6	6	53
25-29	4	2	1	5	6	6	5	5	5	10	13	2	6	72
30-34	3	4	3	2	6	3	2	2	4	5	6	3	3	45
35-39	2	3	1	5	4	3	4		1	2	1	1		27
40-44	2	3		2	1	1	3			2			1	15
45-49	1	2	2		1					1			1	7
> 50									1					1
Mean Age	32.17	36.64	31.18	31.5	29	29.35	32.3	26.7	28.5	29.85	26.8	24.6	28.4	28.15

A statistically significant **difference in age between male and female** overdose victims is observed. The same result namely a lower age of female victims applies to the overall number of drug-related death cases. Female PDUs often report relationships with older drug using partners, who have initiated them to drug use and accelerated their drug careers in terms of a rapid transition from non-i.v to i.v. use and an increased disposition towards risk behaviours such as needle sharing and prostitution. (Origer & Dellucci 2002)

A majority of drug-related deaths cases (direct & indirect) are **natives** (67% in 2004). The same applies to direct and indirect drug deaths analysed separately. The **non-native** subpopulation of victims is

primarily composed of Portuguese citizens, which proportion is much higher than the one observed in the general population. Portuguese natives are followed by Italians and citizens from border countries, whose proportion have remained fairly stable during the last five years. A confirmed majority of acute drug death victims have been in **contact with law enforcement agencies** prior to their death.

❍ **Mortality and causes of deaths among drug users**

In terms of **drug-related mortality** (direct and indirect deaths indexed by RSPJ), 30 cases have been indexed in 2004; prevalence has been showing small variations since 1996 figuring roughly 26 to 33 cases per year.

The above mentioned study (Origer & Dellucci 2002)[29], has revealed that, as far as the Grand-Duchy of Luxembourg is concerned, the mere application of the DRD standard does not allow for a valid computation of drug related death cases. Therefore, the authors did compute the total number of drug-related deaths by adding cases of the SR that were not indexed by the application of the DRD standard to the GMR. The figures resulting from corrected DRD v.3.0. data are referred to as '**national selection**' and provide the annual total number of controlled drug-related fatalities at the national level (30 in 2004 of which 13 direct/acute death cases).

In 2000, a first cohort study on the mortality in the national drug population has been performed by the NFP in the framework of a multi-methods prevalence study (Origer & Pauly 2000). The cohort included 242 opiate drug addicts followed from 1991 to 1999. Mortality data have been collected from treatment agencies, the RELIS database, the GMR and the Special Overdose Register of the SPJ. In accordance to applied methodologies, results show **mortality rates varying between 2.36 and 2.51 per cent.**

Origer & Dellucci (2002) reported 38 drug-related death cases in 2000. Applied to the estimated number of problematic drug users in 2000 (2,450) (Origer 2001), one obtains a rough **mortality rate of 1.51%**. The difference might be explained by the fact that the cohort study only included IDUs whereas the prevalence estimation, on which the present calculation is based, refers to PDUs.

Since the implementation of ICD-10 coding by the GMR (1998), a vast majority of acute drug death cases have been recorded as "accidental poisoning" (**X40 – X49**), which is consistent with the national definition of an acute overdose death. To date over 60 % overdose cases have indexed as follows: **X42.-, T40.-, T42.- T43.-** . At a more restricted level the code sequence: **X42.-, T40.-** includes around 70% of all reported overdoses. The low DRD selection B figure for 2004 is partly explained by the fact that a consistent number of acute drug death cases have been encoded X49.0 +T50.9 or X44.9 + T50.9 in the GMR. Knowingly, these selections are not retained by the DRD version 3 (selection B) standard.

Main **causes of indirect deaths between** 1996 to 2004 are, in order of importance: Suicide (30)[30] traffic accidents (23%), associated cardio-vascular or pulmonary complications (15%) undefined intoxication (12%), pharmaco-dependance (8%), liver failure (6%), HIV/AIDS (4%) and other (2%).

● DRUG RELATED INFECTIOUS DISEASES

❍ **HIV/AIDS, viral hepatitis, STD, tuberculosis, other infectious morbidity**

HIV and AIDS

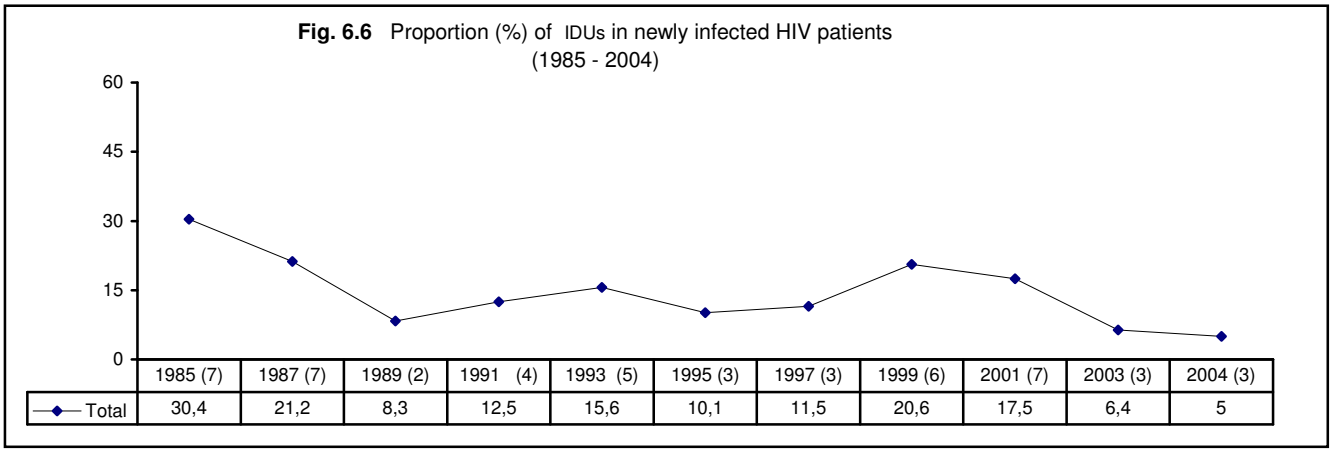
Official statistics from the national Retrovirology Laboratory of the CRP-Santé provide **the number and proportion of IDUs in HIV infected patients**. Between 1984 and 2004, 650 HIV infected persons have been registered at the national level; 94 of the former were reported IDUs, which leads to an average proportion of IDUs in the national HIV population of 14.5 per cent since the registration of the first HIV case in Luxembourg in 1984.

[29] A full text version of the study can be downloaded under: http://www.relis.lu

[30] Valid percentage

Currently intravenous drug use appears to be the third most reported transmission mode of HIV infection (new HIV infections (15.4%)) after heterosexual and homo/bisexual transmission. This sequence has remained fairly stable since 2000. The proportion of intravenous drug use transmission has noticeably decreased between 1998 (23%) and 2004 (5%), although the **number of newly indexed HIV infection has increased** from 30 to 60 cases during the same period.

Fig. 6.6 Proportion (%) of IDUs in newly infected HIV patients (1985 - 2004)



Source : Laboratoire de Retrovirologie – CRP-Santé. 2005

Since 1996, the national drug monitoring system RELIS allows for breakdowns of HIV and AIDS data by IDU and treatment status. In 2004, 78% of RELIS indexed PDUs reported a **test** during the last 5 months. Female PDUs tend to report higher testing rates than males.

In 1997, a significant decrease of **HIV rates in drug users**, mainly in IVDUs, occurred. Subsequently, **HIV rates in current IVDUs have been increasing to reach 5.10% in 2004**. **IVDUs treatment demanders** show the highest HIV prevalence rate (6.41%).

A study on **HIV and HCV prevalence in prison**, commissioned by the Ministry of Justice in 1998 (Schlink, 1998), tends to confirm RELIS figures. The study included 90% of the total national prison population and applied saliva antibody testing. Calculated HIV prevalence rates are included in table 6.2.

Table 6.2 Synopsis of national data on **HIV** infection rate in drug using populations (valid %)

YEAR	1997	1998	1999	*2000*	*2001*	*2002*	*2003*	*2004*
HIV rate in problem drug users (RELIS)	3	2.9	2.9	*4.3*	*4.07*	*4.49*	*3.88*	*3.98*
HIV rate in drug treatment demanders	3.8	2.6	3.4	*4.87*	*4.78*	*4.32*	*3.88*	*4.93*
HIV rate in current IVDUs (RELIS)	**3.6**	**3.5**	**3.3**	***3.6***	***3.41***	***4.08***	***4.17***	***5.10***
HIV rate in current IVDUs treatment demanders	4.5	3.4	3.9	*3.9*	*4.24*	*4.32*	*4.24*	*6.41*
HIV rate in current IVDUs prisoners (Schlink 1998)	/	4.4	/	/	/	/	/	/

Source: RELIS 2004

Table 6.3 Synopsis of national data on **AIDS** rate in drug using populations (valid %)

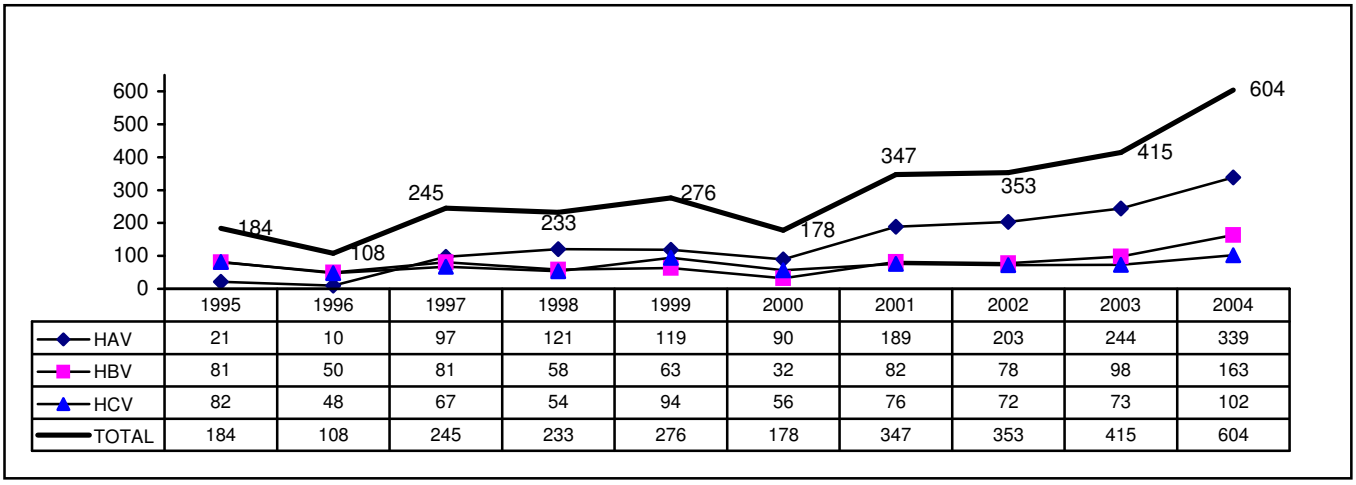
YEAR	1997	1998	1999	*2000*	*2001*	*2002*	*2003*	*2004*
AIDS rate in drug users (RELIS)	2.5	2.5	1.25	1.35	2.03	1.72	1.71	2.13
AIDS rate in drug treatment demanders	/	/	**1.66**	**1.76**	**2.43**	**1.60**	**2.04**	**2.69**

Source: RELIS 2004

b) Hepatitis B and C

The Public Health notification system on infectious diseases provides the following data concerning HAV, HBV and HCV prevalence in general population:

Fig. 6.7 Notified hepatitis cases in general population (1995-2004)



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
HAV	21	10	97	121	119	90	189	203	244	339
HBV	81	50	81	58	63	32	82	78	98	163
HCV	82	48	67	54	94	56	76	72	73	102
TOTAL	184	108	245	233	276	178	347	353	415	604

Source: Division de l'Inspection Sanitaire. Direction de la Santé. 2005

The prevalence of **HBV** infection in problem drug users has been fairly stable over the last 4 years in all PDU sub-groups. The **significant increase of the HCV infection rate** during the same period is particularly marked in IVDUs, reaching 74.14% in 2004. The above referred **prison study** (Schlink, 1999), provides a 37% HCV infection rate in IDU prisoners (saliva sample test) in 1998.

Table 6.4 Synopsis of national data on self-reported **HBV** infection rate in drug using populations (valid %)

YEAR	1997	1998	1999	*2000*	*2001*	*2002*	*2003*	*2004*
HBV rate in drug users (RELIS)	29	30	30	*28*	*25*	*22*	20.51	21.34
HBV rate in drug treatment demanders	/	27	32	27	24	20	19.79	22.69
HBV rate in IVDUs (RELIS)	/	33	35	30	30	25	22.76	23.93

Source: RELIS 2004

Table 6.5 Synopsis of national data on **HCV** infection rate in drug using populations (valid %)

YEAR	1997	1998	1999	*2000*	*2001*	*2002*	*2003*	*2004*
Self-reported HCV rate in drug users (RELIS)	26	25	32	*46*	*50*	*49*	*59.92*	*64.55*
Self-reported HCV rate in drug treatment demanders	/	29	41	***53***	***54***	***54***	***60.49***	***66.16***
HCV rate in IVDUs prisoners (saliva tests)	/	37	/	/	/	/	/	/
Self reported HVC rate in IVDUs (RELIS)		45	50	*53*	*56*	*53*	*67.97*	*74.14*

Source: RELIS 2004 (Origer 2005)

Summarily, HBV infection prevalence in PDUs and in drug treatment demanders is stable while HCV prevalence in general population and in PDUs has significantly increased during the last 4 years. HIV infection rates follow a weak but continuous increasing trend.

● PSYCHIATRIC CO-MORBIDITY (DUAL DIAGNOSIS)

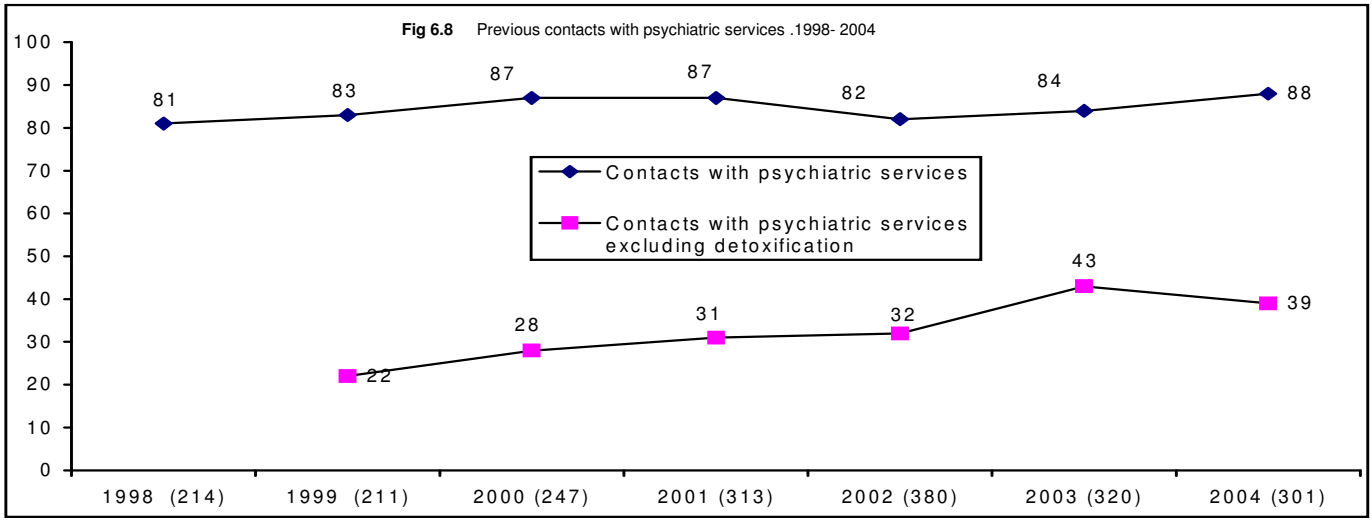
To date any genuine study on co-morbidity patterns in PDUs has been performed at the national level. Data presented in the present chapter have been provided by specialised drug agencies and the RELIS drug monitoring system and thus reflect common experiences and trends as observed during recent years.

Most common mental disorders observed in clients seeking help in specialised drug agencies or in contact with other institutions are: anxiety, depression, neurosis, psychosis and borderline behaviour. Residential drug care settings estimate that 10% of their clients show psychotic symptoms.

Furthermore, Post Traumatic Stress Disorders (PTSD) are most common and show great similarities with border-line behavioural aspects as for instance rapidly changing mood and auto-destructive tendencies.

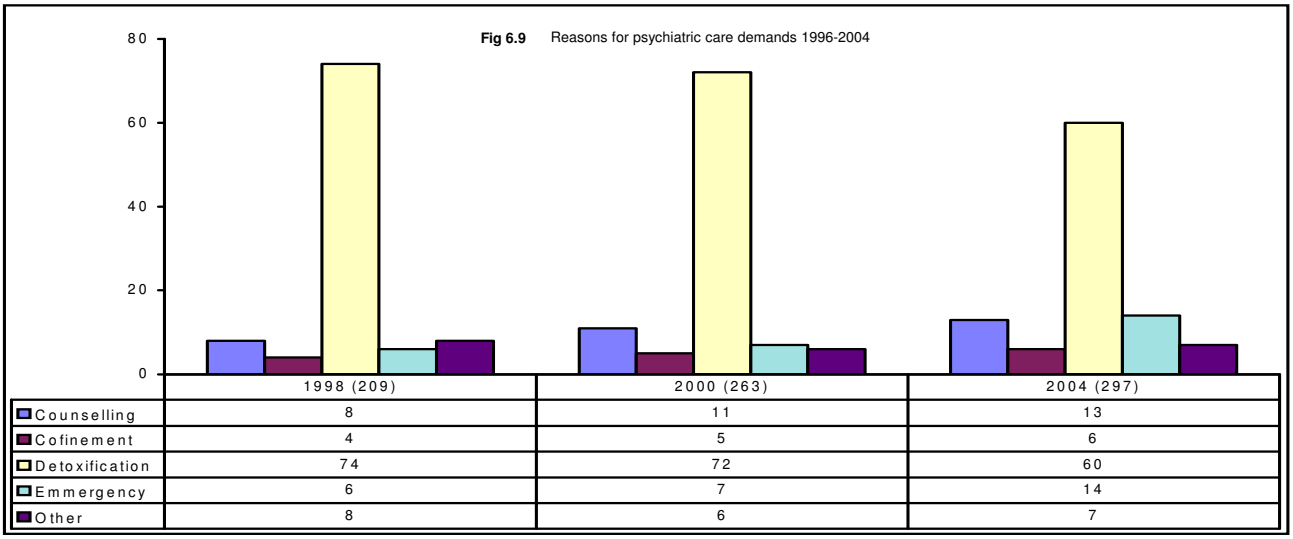
Referring to annual data provided by the national drug monitoring system RELIS one could draw the following picture:

Fig 6.8 Previous contacts with psychiatric services .1998- 2004



SOURCE: RELIS 2004

Fig 6.9 Reasons for psychiatric care demands 1996-2004



	1998 (209)	2000 (263)	2004 (297)
Counselling	8	11	13
Cofinement	4	5	6
Detoxification	74	72	60
Emmergency	6	7	14
Other	8	6	7

SOURCE: RELIS 2004

Figure 6.8 differentiates between contacts with psychiatric services and psychiatric contacts excluding detoxification. This distinction is necessary since, at the national level, most of detoxification treatments are provided by psychiatric departments of general hospitals.

Data from 1996 to 2004 reveal a quite stable proportion of PDUs showing a psychiatric history, unlike the proportion of clients reporting contacts for mental problems excluding detoxification treatment, which has been following an increasing trend in recent years.

There seem to be no significant differences of psychiatric profiles in clients according to the type of institutional settings. Consume patterns of double diagnosis (DD) patients are most frequently chaotic ranging from moments of absolute abstinence to life-threatening doses intakes. Multiple drug use is observed in almost every DD patient.

DD patients are considered as drug treatment demanders with specific and highly diversified needs that are difficult to encounter in traditional drug agencies. The concept of ‘multiple vulnerabilities’, that is, concomitant vulnerabilities to drug abuse and mental disorders, tends to be recognised by professionals. DD patients very often present a lack of behavioural structure or stability. Usually those patients are

unable to function in a regulated environment. For instance, they show great difficulties to respect time frames (e.g. appointments, length of therapeutic sessions) or any other form of commitment. Moreover, the requirement of most therapeutic settings include that the patients submit to detoxification treatment prior to admission. This latter requirement is often impossible to meet with DD clients as drug intake often represent a kind of self-managed auto-medication, dangerous to change radically at the beginning of an therapeutic process. It is therefore most difficult to integrate DD patients in traditional drug care settings also in terms of consistency of rules to be respected by all drug treatment demanders. This specificity has lead to the concept of ' dry, damp and wet house' in several countries, meaning that there should exist settings with modulated tolerance policies with regard to drug use during the treatment process. Several national treatment centres do try to implement similar concepts, although the legal situation does not facilitate such developments.

Moreover DD patients do require time and cost intensive care strategies as for instance individual case management and emergency interventions. This kind of additional service providing does often lead to conflicts in terms of human resources management and economical constraints.

The overall impression of specialised drug workers reflects a lack of qualification when it comes to the handling of DD patients. Training of drug workers did most commonly not include practice oriented intervention tools to be applied to DD patients. If required, drug agencies' staff is provided with on-the-spot training. Since there exists no care facilities specialised in drug addiction co-morbidity at the national level, the Department of Medical Control of Social Security Administration, in collaboration with drug agencies, assesses whether a given patient should be referred to specialised institutions in foreign countries. There exist agreements between the latter administration and a series of specialised care agencies abroad. If the referral demand is approved, related costs are reimbursed by Social Security.

A broad consensus exists on how treatment of co-morbidity could be improved. Summarily the following topics should be considered:

- development of care facilities with modulable concepts with respect to treatment constraints and abstinence policies. Staff of those facilities should be multidisciplinary including MDs,
- creation of specialised DD departments within psychiatric and/or general hospitals for patients who need intensive care,
- development of routine training programmes for drug workers in DD management, with special emphasis on continuous training ,
- improvement of inter-institutional and inter-professional networking,
- evaluation and documentation of treatment impact and outcome are of high importance since research in co-morbidity is still confronted to numerous unanswered questions.

Low threshold agencies do not provide psychiatric counselling. If required, clients are referred to specialised drug treatment centres or directly to psychiatric care departments.

As far as treatment of DD patients in prison are concerned a collaboration convention between the national prison administration (CPL) and the national neuro-psychiatric hospital (CHNP) has been signed in 2002. The convention sets the framework for the creation of a psycho-medical department within prison and regulates prevention, care and referral of mentally disabled as well as alcohol and drug dependent inmates. Therapeutic care, substitution treatment and counselling is provided ad hoc. In case of severe mental disorders, imprisoned patients are referred to a high security department within the CHNP.

Compulsory treatment or confinement does only occur if there is a proved offence against the law by which the offender is declared irresponsible of his/her own behaviour. This only occurs following a legal psychiatric expertise. Due to the lack of specialised infrastructures, the NFP disposes of no data on DD treatment and outcomes.

The pertinence of 'case management' has been recognised by professional during recent years. Although this method is cost and time intensive, it has proven to be most effective with double diagnosis

patients. Not only tend the DD patients to have very specific needs; they also often present extreme variations in mood and behavioural patterns.

The above quoted priority areas result from professional experience sharing. As the implementation of drug treatment and prevention strategies are traditionally planed and executed by the national drug coordinator's office in close collaboration with field agencies, emerging needs are effectively integrated in political debates and action planning. The 2005-2009 national drugs action plan foresees the creation of a specialised therapy centre for DD drug patients by 2007.

- OTHER DRUG-RELATED HEALTH CORRELATES AND CONSEQUENCES:

Health indicators retained by RELIS suggest a stabilisation of the general health state of indexed PDUs except for HCV prevalence. In 2004, 72 per cent of problem drug users reported a self-perceived satisfying general health condition against 53 per cent in 1997 (RELIS 2005).

One indexed PDU of two report single or multiple suicide attempt during lifetime. No significant changes have been observed during the last 4 years.

One should finally recall the high and increasing HCV prevalence rate among PDUs and the still low but nonetheless slowly increasing HIV rate in IVDUs.

7. Responses to Health Correlates and Consequences

Overview

Responses to Health Correlates and Consequences of drug use aim at minimising the resulting damage on the drug users him/herself and on his/her environment and at increasing individual/collective resources. The concept of risk and harm reduction are directly linked to it, whereas nuisance reduction is seen as a correlate of the latter.

- PREVENTION OF DRUG RELATED DEATHS:

In 1999 the NFP has commissioned a study on epidemiological and methodological aspects referred to drug related deaths. Results were published in 2002*: 'Epidemiological study on drug-related deaths and analysis of methodological aspects of indexing procedures applied in the Grand Duchy of Luxembourg from 1992 to 2000*' (Origer & Dellucci 2002). The epidemiological part of the study was designed to provide information on the process that leads a drug user to a drug induced fatality and to contribute to implement prevention measures.

Several risk factors or profiles have been stressed by the study:

- A statistically significant **difference in age between male and female** overdose victims has been observed (F: 25.65 years, M: 29.17 years). The same result applies to the overall number of drug-related death cases. Female PDUs often report relationships with older drug using partners, who have initiated them to drug use and accelerated their drug careers in terms of rapid transition from non-i.v to i.v. use and an increased disposition towards risk behaviours such as needle sharing and prostitution. (Origer & Dellucci 2002)

- The **release from an institutional setting** (e.g. prison, residential therapy, etc.) often creates a high-risk context for concerned persons in terms of social deprivation and substance tolerance levels. A significant number of drug-related death cases occur rapidly after institutional release (sometimes only a few hours).

- A majority of drug-related deaths cases (direct & indirect) are **natives** (64,6 to 90.9%). The same observation applies to direct and indirect drug deaths analysed separately. The **non-native** subpopulation of victims is primarily composed of Portuguese citizens, which proportion is much higher

than the one observed in the general population. Italians follow Portuguese natives and citizens from border countries which proportion has remained fairly stable during the last four years.

The following measures have been recommended:

- opening of supervised injection rooms as foreseen by the national drugs action plan
- medical controlled heroin distribution programme (foreseen by the national drugs action plan)
- first aid training courses provided to users and their relatives and partners
- gender and ethnic specific interventions
- provision of morphine receptor antagonists to users and selected persons
- creation of 'transition centres' for ex or current drug addicts leaving an institutional setting,
- development of resocialisation programs for prisoners in the framework of the recent 'Global care programme for drug addicts in prison'

The law of 27 April 2001 introduced an important modification of the basic drug law with regard to overdose prevention. Art.10-1 of the referred law exempts drug users who call for assistance in case another user is in need of medical help, from prison sentences. This change should contribute to reduce drug-related deaths occurring in consumer groups.

Finally, in the line of the recommendations of the Origer and Dellucci (2002) study, a low threshold service in collaboration with the Ministry of Health edited a documentation kit on overdose prevention and emergency intervention by peers. The information kit includes flyers on following issues:

- First aid in case of an overdose. Useless interventions (such as salt injections). Epileptic crisis. Potential added risks of substance mixtures. Vein care. Potential risk of specific injection points. Inhalation as administration mode. Risks of abscesses and endokarditis.

Provision of first aid and harm reduction training to drug users and peers takes place in low threshold agencies.

A **drug injection room** is defined as a facility allowing IVDUs who meet certain criteria to inject their own drugs in a medically supervised environment. **Drug consumption (user) rooms** meet the same definition; in terms of target population, they, however, give access to IVDUs and non IVDUs meeting the admission criteria.

Articles 2 and 3 of the law of 27 April 2001 have set the legal framework for 'user rooms and other means duly licensed by State', which also includes controlled distribution of certain narcotics (e.g. heroin). The implementation of such facilities was included in the national drugs action plan 2000-2004 of the Ministry of Health.

The implementation of a drug injection room has to be seen as a part of a broader harm and nuisance reduction oriented strategy. The national drug action plan referred to the creation of a low threshold emergency shelter facility for drug addicts to be implemented in the vicinity of the city railway station. During the planning phase of this centre it has been decided to integrate a drug user room due to obvious advantages to combine both of them (in terms of logistics staff and situation).

In July 2005, the first injection room at national level has become operational and has been integrated in the low threshold emergency centre for drug addicts. Besides the drug consumption room, as it is called officially, the emergency centre provides the whole range of harm reduction services, counselling facilities, accommodation, washing, laundering and storing facilities. It should be added that the night accommodations are not to be seen as a permanent housing facility; there are indeed daily admissions procedures.

Target population for the consumption room are primarily IVDUs. Inhalers might be admitted in a second phase. The main objective of the project is the reduction of drug-related harm and nuisances. More precisely it aims at reducing the risks of infectious diseases, overdoses and public nuisance in the neighbourhood, contact making with difficult to reach addicts, provision of special designed night shelter facilities and avoiding unnecessary prison journeys over night. The project was designed with the

support of law enforcement agencies. The public nuisance is an important factor in the public debate around the project. The site has its pro and cons although there is a general consensus that in terms of proximity to the hard drug scene and the reduction of nuisance, the site is adequate. One may add that the area in which the centre will be implemented has known major problems since a series of non-inhabited houses served drug addicts as 'self-elected' injection rooms to the distress of the immediate environment.

An expert group has been visiting similar projects in the EU in order to fine-tune the concept and implement quality control standards. All involved parties meet once a month to assess the current situation and emerging problems related to the functioning of the consumption room. 3 months after its opening no overdose has occurred and no drug scene concentration and no disturbances or nuisance in the neighbourhood has been observed.

As most relevant drug scenes concentrate in the City of Luxembourg and in the main city in the South of the country, Esch-sur-Alzette, intense discussions are currently hold with the community council of Esch/A in order to implement a similar facility. The aim is to decentralise low threshold offers in order to avoid potentially problematic migration towards and overload of one of the regional sites.

It has to be stressed that the realisation of the 2000-2004 action plan has been accompanied by a significant decrease of overdose cases in the Grand-Duchy of Luxembourg and has stabilised the last two years.

- PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES:

❍ Prevention

Interventions aiming at the prevention of drug-related infectious diseases have been initiated and developed prior to the set up of a proper legal framework. At that time, services as needle exchange and substitution programmes have been tolerated and also financed by the state. The last drug law amendment did not only allow to maintain and to further develop existing harm reduction offers but also set the first stone for the implementation of new services such as shooting galleries and medically assisted heroin distribution as foreseen by the national drugs action plan 2000 – 2004.

Objectives of these interventions are straightforward, that is an optimised management of risk factors and mental/physical damage associated to drug use. Reduction of public nuisance is a secondary objective. Traditionally harm reduction (HR) measures have been focusing on IVDUs since most exposed to a variety of health risks. Nevertheless, initiatives such as the provision of aluminium foils to heroin users and the current discussion on the future distribution of 'strawbags[31]' for sniffing purposes witness a progressive switch from IVDUs users to PDUs being considered as target groups. Furthermore infectious diseases prevention does not focus specifically on IVDUs as shows a recent action-research project on HIV and hepatitis infection among PDUs having started in August 2003.

The most relevant measure in the field of prevention of infectious diseases in drug users is the **national needle exchange programme** established in 1993 and co-ordinated by JDH. In addition to free of charge needle provision by specialised drug and AIDS agencies, automatic syringes dispensers/collectors have been placed in the most appropriate locations in five different cities of the Grand Duchy. Regarding the quantity of distributed syringes, table 7.1 shows an **increase of 470 per cent during the period 1996 to 2004**. 2004 figures witness a steady upward trend with regard to the number of distributed syringes an so do the return rates, however, reaching up to 87% in 2004. Obviously automatic dispensers show the lowest return rates.

Table 7.1 *National needle exchange programme 1996-2004*

	Distributed syringes		**Collected used syringes**

[31] A 'straw bag' contains one-way straws especially designed not to hurt the nasal cavities, thus avoiding wounds and bleeding, a special liquid to smooth tissues, a professional condom and lubricants.

	1996	1998	2000	2002	2004		1996	1998	2000	2002	2004
TOTAL	76,259	109,743	189,413	254,596	435,078↗		28,646 (38%)	58,886 (46%)	112,625 (59%)	211,621 (83%)	376,491↗ (87%)↗

Source: RELIS 2004

Condoms and syringes are provided by the **Division of Preventive Medicine** (Directorate of Health) to field actors in the framework of the national programme on prevention of infectious diseases. Vaccination for HAV and HBV is free of charge for persons under 18.

Several local outreach prevention activities have to be mentioned as for instance contact making with prostitutes within their daily work environment for HIV and hepatitis testing and subsequent health care, if needed. These specific activities are currently further developed by the **'Drop In'** centre for drug users and prostitutes (RED CROSS).

Moreover, outreach interventions targeted at (drug using) prostitutes aiming to establish contact and to prevent dissemination of infectious diseases have taken place.

According to EMCDDA's key indicators and with a view to improve quality of national data on infectious diseases, the NFP has set up an **action-research plan** (2002-2005) with the objective to estimate HCV and HIV prevalence in recent drug injectors based on medical diagnosis data (blood sample testing) and to implement required health care infrastructures.

The project is based upon a cross-sectional study design, which analyses the relationship between the prevalence of hepatitis A,B,C and of HIV in the population of drug users with other relevant factors.

A quantitative questionnaire (questions based on socio-demographic, illicitly acquired drugs consumption, consume patterns, sexual behaviour, consumption in prison, piercing/tattoo) will enable the analysis of associated factors. Serological analysis will identify the number of contaminated cases with hepatitis A, B, C and HIV. In case of medical indication a vaccination against hepatitis A and/or B will be offered. Drug users meeting the selection criteria are recruited in LTS, NSEP, Inpatient Treatment Centres, Hospitals and in the prisons of Luxembourg.

The provisional budget of the project is approximately 300.000. - EUR. The NFP has been granted a full financing of the project by the FLTS. By August 2005 almost 400 PDUs have participated in the project. The final report will be available by the beginning of 2006.

❍ Counselling and testing

AIDSBERODUNG (RED CROSS), is the main national counselling and prevention centre for HIV and AIDS. Prevention campaigns are conceptualised by the AIDSBERODUNG team in collaboration with an important network of volunteers. Facing an increasing rate of drug users within its clients, AIDSBERODUNG has joined the RELIS network in 2001. Testing is provided by the CHL and the LNS and is free of charge for drug addicts.
The above-mentioned action-research aims at increasing the testing coverage of PDUs since it includes anonymous on-site testing and diagnosis transmission facilities. Furthermore, HAV, HBV, HCV and HIV testing and vaccination for HAV and HBV is proposed to each person entering prison.

❍ Infectious disease treatment

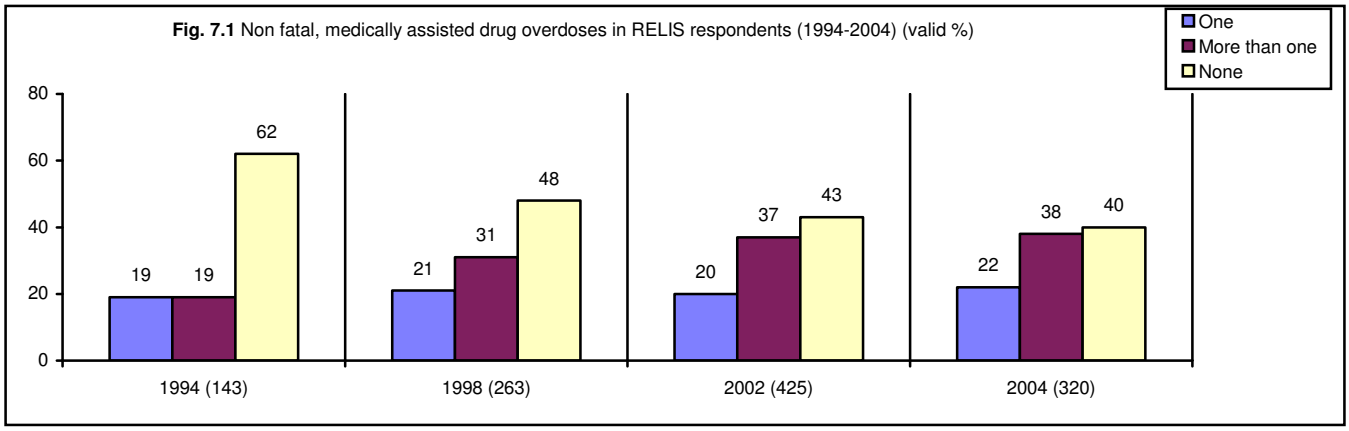
Treatment of HIV and hepatitis infections is covered by the insurance scheme. Specialised treatment is provided by a special unit in the CHL in collaboration with the counselling staff of the AIDSBERODUNG/Red Cross. In case the patient presents no valid health insurance, treatment costs can be covered by state.

❍ Somatic co-morbidity

The vast majority of specialised out- and inpatient and low threshold drug care facilities include medical or paramedical care in their service provision. If needed patients are referred to specialised treatment. Related costs are covered by health insurance schemes or by the Ministry of Health in case the patient has no valid insurance.

❍ Non-fatal emergencies and general health-related treatment

Figure 7.1 refers to RELIS data on previous non-fatal and medically assisted drug overdose self reported by respondents. The proportion of indexed drug users reporting at least one overdose (as defined) (60%) during lifetime has slowly increased during the last six years. This trend is partly due to an aging IVDU population. However the temporary stabilisation observed during the last four years might be related to an increased proportion of PDUs who prefer inhalation as administration mode of heroin.



Source: RELIS 2004

❍ Prevention and reduction of driving accidents related to drug use

In 2004, the Minister of Transport introduced a project of law (N°5366) modifying the national traffic code and introducing illicit drug testing in vehicle drivers. The homologation of respective saliva and sweat tests has already been approved by the Council. The related grand ducal decree should enter in force in 2005. The application of these tests will provide a more accurate insight as far as the relationship between illicit drugs intake and traffic accidents are concerned. Also more severe penalties in regard to offences related to driving under the influence of alcohol, illicit drugs and excessive consumption of psychoactive medicaments are foreseen. Moreover monthly prevention campaigns are organised by the Grand-Ducal Police. In January 2004, an anti-drugs campaign focussing on the consequences of driving under influence of illicit drugs was launched.

❍ Other health consequences reduction activities

The future implementation of a second drug consumption room in the South of the country and a medically controlled heroin distribution programme, as foreseen by the national drugs action plan 2005-2009 will further contribute to reduce drug related health damage.

8. Social Correlates and Consequences

Overview

Social correlates of drug use typically involve Justice, Health and Educational competences. The Ministry of Health and the Ministry of Family both intervene to reduce social consequences by measures ranging from early detection of drug use to social-professional rehabilitation measures. The reduction of drug related crime involves the Ministry of Justice, that focus on supply reduction activities and the Ministry of Health implements measures (e.g. heroin distribution) aiming at reducing daily expenses of drug addicts and thus the prevalence of acquisition crimes.

Due to obvious disparities at the European level in terms of concept definitions in the field of law enforcement data, the respective national terminology should be clarified:

- *'Interpellation' (Eng. Interpellation/peremptory questioning, to call on):*

Intervention of law enforcement agents based on reasonable suspicion. The '*interpellated' person* is heard and a police officer's record occurs. In practice the number of police records fits more or less the number of convictions (usually slightly inferior). At this level, however, there is no notification to the Public Prosecutor and no mention in the judicial record.

The term '*prévenus* ' (interpellated/indicted person) refers to persons who have been apprehended by legal enforcement agents for alleged offences against the national drug law (or against law in general).

- *'Arrestation' (Eng. Arrest) :*

Interpellation followed by a deprivation of liberty and notification to the attorney at law. The preliminary examination (instruction) refers to the subsequent judicial procedure that results in a public audience, which claims the sentence.

- *'Condamnation' (Eng. Conviction) :*

Judgement by which the accused person is found guilty.

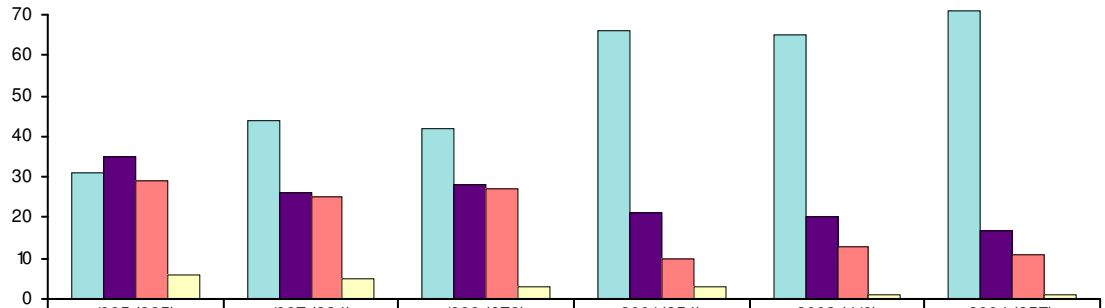
- *'Détention' (Eng. Imprisonment) :*

Deprivation of liberty. Distinction is made between protective custody (prior to the judgement) and regular detention (following conviction).

- **Social Exclusion**
  - Homelessness

Housing status of registered drug users has markedly improved during recent years and tends to stabilise. Since 1995, the proportion of persons disposing a stable accommodation has more than doubled. Currently 71 percent of PDUs report a stable housing situation. This positive evolution may be linked to an increased awareness of the housing problem and the set up of new housing networks for socially deprived people by the Ministry of Health and specialised agencies referred to under chapter 9.

Fig. 8.1 Last known housing of problem drug users. 1995 - 2004



	1995 (385)	1997 (234)	1999 (278)	2001(354)	2003 (410)	2004 (357)
stable accomodation	31	44	42	66	65	71
unstable accommodation	35	26	28	21	20	17
in institution	29	25	27	10	13	11
other	6	5	3	3	1	1

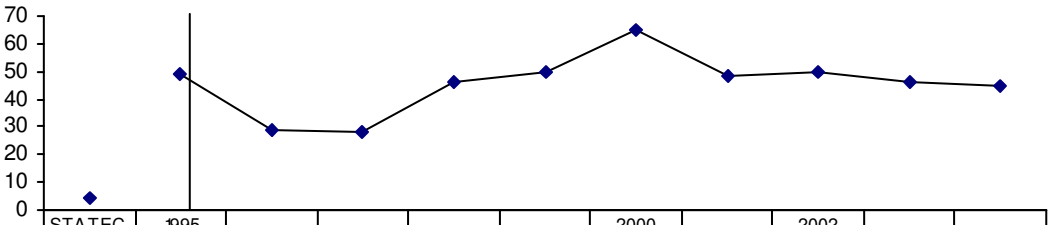
Source: RELIS 2004

- Unemployment and financial situation

All indicators included, the **employment status** of problem users has been showing a fair stabilisation over the last years. The unemployment rate in problem drug users has grown in significance since 1997 and subsequently has stabilised, varying between 45% and 50%.

Fig. 8.2 Unemployment rate in problem drug users (1995 - 2004)

SOURCE: RELIS 2004



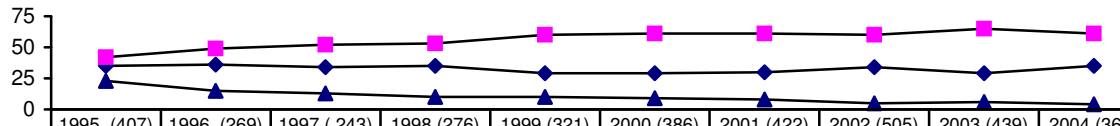
	STATEC (2004)	1995 (399)	1996 (318)	1997 (181)	1998(175)	1999(228)	2000 (287)	2001(301)	2002 (422)	2003(346)	2004(353)
unemployed	4,2	49	29	28	46	50	65	48	50	46	45

Source: RELIS 2004 (Origer 2004)
Remark: STATEC: Statistical Department of State – Unemployment rate in active general population.

Data on revenues confirm observed trends in occupational status:

- increase of social dependence associated to a stable **financial autonomy**. The Guaranteed Minimum Income constitutes the primary source of revenue of PDUs;
- illegal activities as main **revenue** have witnessed an ongoing downward trend since 1995;
- an important but decreasing proportion of respondents reporting **major depths** (≥2,500 EURO) (37%).

Fig. 8.3 Primary source of income of problem drug users (1995 - 2004)



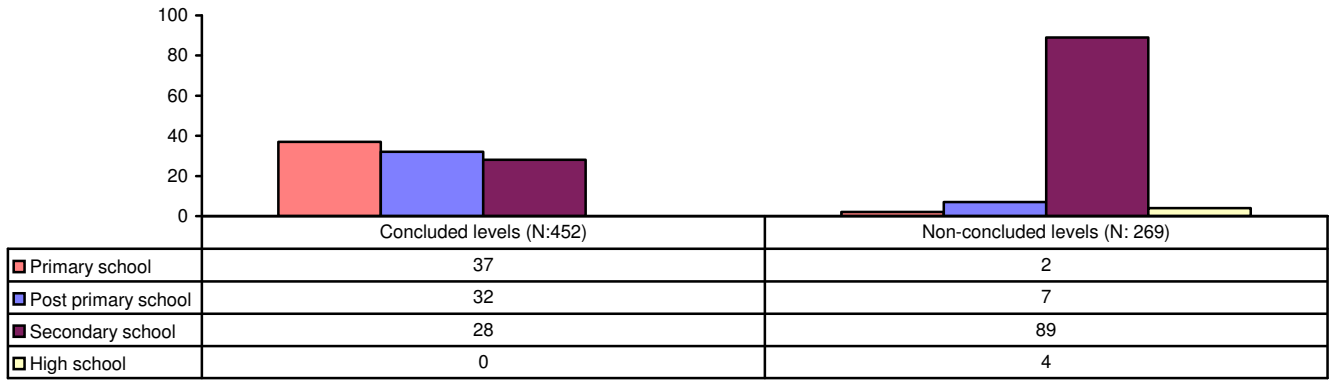
	1995 (407)	1996 (269)	1997 (243)	1998 (276)	1999 (321)	2000 (386)	2001 (422)	2002 (505)	2003 (439)	2004 (368)
Autonomy	35	36	34	35	29	29	30	34	29	35
Social welfare	42	49	52	53	60	61	61	60	65	61
Illegal income	23	15	13	10	10	9	8	5	6	4

Source: RELIS 2004

- School drop out

The **educational level** of PDUs shows a slow but constant deterioration since 1999. However an increasing proportion of respondents start secondary school without bringing their studies to term. The average age at the end of studies shows a global decreasing tendency and currently situates under 17 years. Lower levels are particularly observed as regards acquired secondary and high school diploma. Post primary school is a special educational setting for primary school pupils with learning difficulties.

Fig. 8.4 Educational level of RELIS respondents (2004)



	Concluded levels (N:452)	Non-concluded levels (N: 269)
Primary school	37	2
Post primary school	32	7
Secondary school	28	89
High school	0	4

Source: RELIS 2004

- **Drug related crime**

The NFP collects and re-formats nation-wide data on drug-related offences provided by the SPJ. A staff member of the NFP actively collaborates with the SPJ team in order to adapt law enforcement data to standards required for the editing of the national report on drugs and the EMCDDA annual report.

a. Drug related arrests data

As can be seen in tables 8.1 and 8.2, the total number of arrests (178) has increased compared to previous years. Traditionally heroin was the most frequent substance involved in drug-related arrests. In 2004 cocaine has turned to be the main substance involved in those arrests, followed by heroin and cannabis. In 2004, charges on drug traffic have known an important increase. Charges on drug use have more than doubled compared to 2003.

Table 8.1 Arrests broken down by type reporting institution (1995-2004)

	ARRESTS									
Year	**1995**		**1997**		**1999**		**2001**		**2003**	**2004**
S.P.J.	27		25		27		7		25	38
Gendarmerie	8		15		15					
Police	32		32		32		45		82	103
Customs	61		82		34		40		28	37
Total	**128**		**154**		**108**		**92**		**135**	**178**

Table 8.2 Arrests broken down by type of offence and substances involved (1995-2004)

Substance	Offence	1995		1997		1999		2001		2003		2004
	Use & Traffic	68		57		48		41		21		32

Heroin	Traffic/Deal	21		53		18		8		22		19
	Use	24		7		27		8		4		20
	Total	**113**		**117**		**93**		**57**		**47**		**71**
Cocaine	Use & Traffic	20		27		21		27		19		21
	Traffic/Deal	7		23		9		9		30		64
	Use	10		6		12		4		3		9
	Total	**37**		**56**		**42**		**40**		**52**		**94**
Cannabis	Use & Traffic	25		18		32		23		52		16
	Traffic/Deal	1		11		8		1		17		20
	Use	4		4		3		15		9		14
	Total	**30**		**33**		**43**		**39**		**79**		**50**
Amphetamines	Use & Traffic			2		1		2		2		0
	Traffic/Deal							0		0		0
	Use	2						0		0		0
	Total	**2**		**2**		**1**		**2**		**2**		**0**
Ecstasy (MDMA, etc.)	Use & Traffic	3		3		3		1		1		1
	Traffic/Deal	1		3				0		0		1
	Use	1						0		1		1
	Total	**5**		**6**		**3**		**1**		**2**		**3**
LSD	Use & Traffic			1		1		0		0		0
	Traffic/Deal							0		0		0
	Use							0		0		0
	Total			**1**		**1**		**0**		**0**		**0**
Total number of *arrest* motives independently of involved substances	**Use & Traffic**							59		**57**		**48**
	Traffic/Deal							13		**61**		**93**
	Use							20		**15**		**35**
	Total	**128**		**154**		**108**		**92**		**133**		**178**

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2004

b. Prosecution data

The number of police records for presumed offences against the modified 1973 drug law (code: DELIT-STUP), stable between 1996 and 1998, showed an important increase from 1998 to 2003 (825 to 1,660) to decrease weakly in 2004 to 1.468 police records.

The number of drug law offenders ('prévenus') has declined from 1,368 in 1996 to 1,170 in 1998 followed by a subsequent increase clearly confirmed by 2003 data (2,270). In 2004 however, the previous upward trend is followed again by a decrease (1,808). The number of arrests on the same charge has decreased from 154 in 1997 to 133 in 2003 to increase again in 2004 to 178. (see table 8.2).

Table 8.3 records the total number of law enforcement interventions and number of 'prévenus' at the national level ensured by respective law enforcement actors that are the Specialised Drug Department of the Judicial Police (SPJ), Police and Board of Customs from 1995 to 2004.

Table 8.3 Number of national law enforcement interventions (1995-2004)

	DRUG LAW ENFORCEMENT RECORDS								**PREVENUS (Offenders)**							
Year	**95**	**97**	**99**	**2000**	**2001**	**2002**	**2003**	**2004**	**95**	**97**	**99**	**2000**	**2001**	**2002**	**2003**	**2004**
S.P.J.	123	137	343	231	216	288	239	267	152	182	434	278	321	469	369	336
Gendarmerie	198	255	782						319	335	916					
Police[32]	199	177	189	965	1,126	1,261	1,326	1,072	371	280	283	1200	1272	1,605	1,753	1,268
Customs[33]	244	236	173	144	113	89	95	129	421	408	306	280	182	143	148	204

[32] The general activity report of the Government Grand-Duchy of Luxembourg can be downloaded from: http://www.gouvernement.lu/publications/informations_gouvernementales/rapports_activite/rapports_activite_2004/index.html

[33] A summary of the general activity report of the "Anti-Drugs and Sensible Products'' division of Customs can be found in annex H. The original report can be downloaded from : http://www.gouvernement.lu/gouv/fr/doss/rapact2004/index.html

Total	**764**	**805**	**1,187**	**1,340**	**1,455**	**1,632**	**1,660**	**1,468**	**1,263**	**1,205**	**1,939**	**1,758**	**1,776**	**2,217**	**2,270**	**1,808**

Source: Specialised Drug Department of the Judicial Police

The population of drug law offenders is composed of 87% **males**; a proportion that has been varying between 79% and 89% during the past decade. Since 1997, **non-natives** have been representing the majority of drug law offenders (52-68%). The spectacular increase in 2002-2003 of the proportion of **first drug law offenders** is not confirmed by 2004 data reporting a decrease from 808 in 2003 to 583 in 2004. Also the **percentage of minors** (< 18 years) among drug law offenders having increased between 1994 (4.9%) to 2003 (13.8%) shows a clear decrease in 2004 (8.7%).

Table 8.4 Socio demographic data on 'prévenus' (1986-2004) **Source**: Specialised Drug Department of the Judicial Police 2004.

YEAR	1986	1988	1990	1992	1994	1996	1998	1999	2000	2001	2002	2003	2004
AGE													
0-14	9		7	6	1	3	7	27	21	11	15	41	24
15-19	121	212	179	320	169	270	249	415	413	399	647	602	334
20-24	264	569	383	527	403	447	321	519	497	566	650	557	510
25-29	119	220	278	371	309	304	220	448	354	299	388	375	278
30-34	49	67	124	159	186	191	187	269	208	194	219	254	250
35-39	17	29	27	52	65	80	76	131	113	139	177	162	190
≥40	17	19	43	46	21	42	78	84	108	113	82	174	126
unknown	27	21	30	50	20	31	32	46	44	55	40	106	99
TOTAL	**623**	**1,137**	**1,071**	**1,531**	**1,174**	**1,368**	**1,170**	**1,939**	**1,758**	**1,776**	**2,218**	**2,271**	**1,811**
Male	503	970	851	1,248	938	1,138	958	1,658	1,415	1,546	1,905	1,935	1,581
Female	120	166	220	256	209	173	193	248	241	215	292	288	181
gender unknown	0	1	0	27	27	57	19	33	44	15	21	48	49

Table 8.5 Distribution of 'prévenus' according to first offence and underage status (1992-2004)

	1992	***1993***	***1994***	***1995***	***1996***	***1997***	***1998***	***1999***	***2000***	***2001***	***2002***	***2003***	***2004***
First offenders	*697*	*331*	*382*	*498*	*508*	*389*	*422*	*645*	*608*	*621*	*828*	*808*	*585*
Nb. of offenders underage	*96*	*48*	*57*	*92*	*102*	*84*	*79*	*155*	*154*	*100*	*145*	*189*	*103*
TOTAL ('Prévenus')	**1,531**	**890**	**1,174**	**1,263**	**1,368**	**1,205**	**1,170**	**1,939**	**1,758**	**1,776**	**2,217**	**2,271**	**1,808**

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2004.

Table 8.6 Distribution of first offenders (use and use/traffic) and substance involved ad minima (1992-2004)

	1992	***1993***	***1994***	***1995***	***1996***	***1997***	***1998***	***1999***	***2000***	***01***	***02***	***03***	***04***
High risk substance involved ad minima													
Heroin	*162*	*91*	*154*	*170*	*121*	*104*	*109*	*157*	*133*	**91**	**114**	**97**	**103**
Cocaine	*64*	*15*	*39*	*46*	*34*	*20*	*30*	*60*	*37*	*47*	*64*	*112*	*125*
Amphetamines	*5*	*0*	*15*	*11*	*11*	*12*	*18*	*14*	*9*	*14*	*12*	*10*	*2*
Type ' Ecstasy '	*1*	*3*	*9*	*47*	*20*	*26*	*26*	*6*	*11*	*16*	*34*	*23*	*8*
Illicitly acquired medicaments	*1*	*0*	*3*	*0*	*0*	*0*	*1*	*0*	*7*	*1*	*0*	*3*	*1*
Substitution substances	*0*	*0*	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*1*	*1*	*0*
TOTAL (substances HRC)	**233**	**109**	**221**	**274**	**186**	**162**	**184**	**237**	**197**	**169**	**225**	**246**	**239**

Source: Specialised Drug Department of the Judicial Police (Data formatted by NFP) 2004

c. Convictions data and court sentences for drug offences

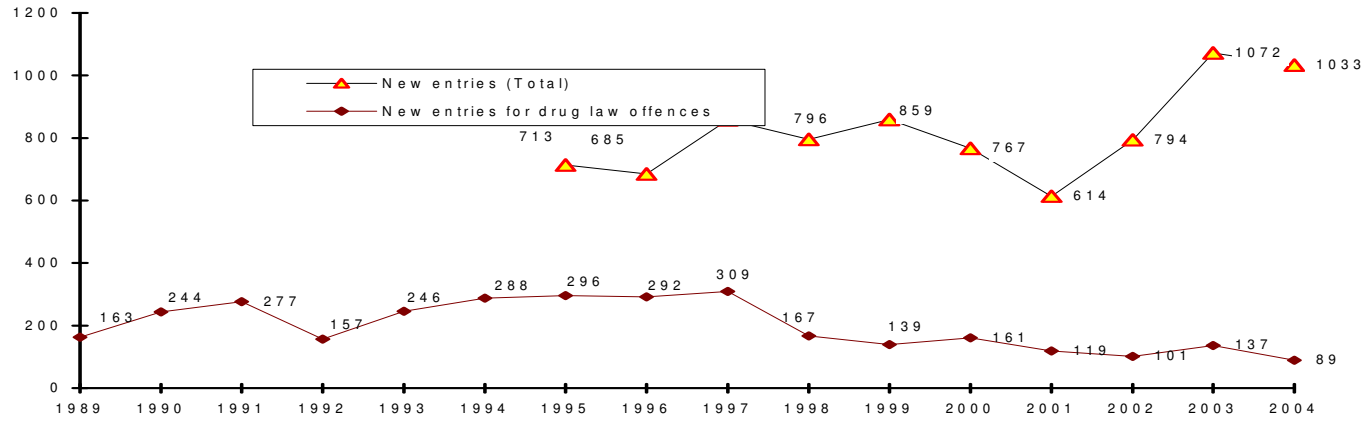
No data available.

d. Imprisonment for drug-related crime

The Grand Duchy of Luxembourg counts two state prisons; one situated in the vicinity of Luxembourg-City (CPL) and the other in the East of the country (CPG). The proportion of **prison sentences for drug law offences has been decreasing since 1998**. In 2004, 89 new entries (9%) (1997: 36%) in national

penal institutions referred to the 'DELIT- STUP ' (Drug law offence) codes have been reported. The decrease of prison sentences is however associated to an increase of arrests.

Fig.8.5 New prison entries and new drug law offenders admitted to prison (1989-2004)



Source: Central Prison Administration 2005

e. Drug-related crime

The data protocol of the national drug monitoring system (RELIS) includes a series of drug-related offences' items: The following results are worth to be retained for 2004:

- 94% of drug users indexed[34] by specialised health care institutions have already been **in conflict with law enforcement agencies** during lifetime. 79% (↗) of the total PDU population show multiple law enforcement contacts.
- The proportion of 'interpellations' for other reasons than presumed offences against the drug law (e.g. **petty crime**) has been decreasing since 1997 (38%) and has stabilised (2004:27%). The extension of substitution treatment and the intensification of socio-economic reintegration measures appear to have contributed to the currently observed situation.
- 71% of indexed PDUs have already served at least one **prison sentence** during lifetime. The proportion of PDUs having served more than one prison sentence at the time of reporting (33%) is still on the increase. Compared with previous years, a significant deterioration of the penal situation of indexed drug users must be stressed; associated, however, to a decrease of the duration of served prison sentences.

- **Drug Use in Prison**

In 1998, the Ministry of Justice commissioned the medical department of the state prison (CPL) to perform an epidemiological study on HIV and HCV prevalence in prison population (Schlink 1999). The research protocol relied on a self-administrated anonymous questionnaire on health behaviour and injecting drug use prior and during prison sentence.

MAIN RESULTS:

Drug use in prison
- 32% of prisoners qualified themselves as injecting drug users;
- 28% reported current drug injection in prison;
- 9% have been initiated to injecting drug use in prison;

Risk behaviour

- 58% of current IDU prisoners report life-time needle sharing in prison;
- 8% of current IDU prisoners report last month needle sharing in prison;

[34] Persons who have been indexed by the RELIS network during a reporting year.

- 70% of IDU prisoners only use water to clean up syringes, 22% do not clean syringes at all;
- 90% of prisoners reporting sexual intercourse in prison did not use condoms.

Miscellaneous

- IDUs have served more prison sentences than non drug users (control group);
- IDUs showed lower average age than non drug users;
- a majority of imprisoned IDUs were natives
-

Source: Schlink, 1999

No further study has been conduced thus far.

- **Social Costs:**

A recent study (Origer 2002) assessed **the direct economic costs of policies and interventions in the field of illicit drug** use referred to year 1999 (see www.relis.lu). Furthermore, the budget allocated by the Ministry of Health to drug related services and programmes, as foreseen by the national drug action plan, has known an increase rate of 354 % between 1999 and 2004. In regard to the 2005 budget, 6,195,518.- EUR have been allocated to concerned services representing a progression rate of 7.4% compared to 2004.

9. Responses to Social correlates and Consequences

- **Social Reintegration:**

Social reintegration measures and in particular improvement and diversification of housing offers for drug addicts have been one of the priorities of the 2000-2004 national drugs action plan. The 2005-2009 drugs action plan foresees the expansion of existing projects and the implementation of new decentralised reintegration measures.

In the framework of the 2000-2004 action plan, the Ministry of Health, jointly with the City of Luxembourg opened a **night shelter (called Nuetseil) for drug addicts** in December 2003.

A project called 'Les Niches' functions as a social real estate agency for drug addicts. Approximately 25 flats and apartments are rented by a drug-counselling centre and provided to drug addicts in need by means of tailor made renting contracts. One of the medium term aims of the project is to allow demanding drug addicts to take over the renting contract on basis of their own financial means and thus dispose autonomously of a stable accommodation. The project is jointly financed by the National Fund against drug trafficking and the Ministry of Health.

A network of **supervised housing facilities** for specific target groups as for instance pregnant women, drug addicted couples, treatment demanders on methadone are operational since September 2002 and are situated in the vicinity of the main centre in order to take advantage of training and social reintegration facilities offered by the CTM. The CTM also offers educational aid in several domains as well as professional training opportunities.

Aiming professional reintegration a series of residential drug care centres, clients offer oral and written **language courses** in order to provide them with basic language skills if necessary or to improve their writing skills.

Stëmm vun der Strooss association (Street voice association) primarily takes care of homeless people in providing them with low threshold facilities and in offering social and professional reintegration activities. The **editing, printing, publication and distribution of a in house magazine** addressing social matters

is supposed to help client to regain a sense of responsibility and to increase the level of acceptability in the general public. PDUs constitute a significant fraction of their clients.

The 2005-2009 national drugs action plan foresees to further develop capacities of the above mentioned services and includes new projects such as an **occupational centre for drug addicts** that provides the opportunity of a series of paid day jobs for the target population. The centre is supposed to open in 2007 and will provide approximately 30 addicts daily job opportunities adapted to their respective skills and physical and mental resources without imposing restrictive contractual requirements on them. The geographical site of the Centre has been agreed on and information sessions with residents of the concerned village have been organised.

- **Prevention of drug related crime**

  - Assistance to drug users in prisons

There exist two state prisons at the national level; the CPL situated in the vicinity of Luxembourg City and the CPG implemented in the East of the country. Figure 8.5 provides the number of general admissions and number of admissions according to drug-related convictions in both prisons from 1989 to 2004.

The law of 27 July 1997 concerning the modification of the penitentiary organisation regulates the creation of specialised medical units for drug addicts and psychiatric patients within prison.

In addition, an external expert has worked out a proposal for a pilot project (2000 – 2005) providing a global framework for specialised drug care associated to an in-house drug prevention programme on drugs and infectious diseases (hereinafter referred to as ***'global drug care programme in prison'***). The first phase of the project is currently implemented and focuses on the diversification of treatment supply, prevention and harm reduction intervention as well as quality improvement of training activities for prison staff. Joint financing by the Ministry of Justice, the FLTS and the EU (regarding evaluation) is ensured.

Currently three different types of treatments are provided to drug users in prison:
- Detoxification
- Substitution treatment
- Harm reduction measures

Detoxification treatment is either provided in-house under the responsibility of the prison medical unit, or by external detoxification units of general hospitals according to strict rules and procedures. CPL has signed a convention with a major general hospital situated in Luxembourg city ensuring out-of-prison medical care if required.

Psychosocial and therapeutic care is provided by both, in-house staff members and specialised external agents from accredited drug agencies. Therapeutic in-house resources are deemed insufficient. An example of good practice in this respect is the inclusion of clearly time on content defined service providing of external specialised drug agencies contractually foreseen by state conventions (in the framework of the global drug care programme). This mechanism also applies to external agents in the field of HIV and other infectious diseases. One should also stress the role of the Central Probation Service (SCAS), which motivates inmates to undergo treatment and enables contacts with external therapeutic agencies.
Although the psychosocial care strategy is similar in both national prisons, the CPG currently disposes of a more structured intervention programme. The CPL runs a proper psychosocial and educational department (SPSE). Jointly with the SCAS and the prison guards' association, it has set up a project called **'DEFI'** (Challenge) that aims at the development of therapeutic means, training facilities, socio-professional reinsertion measures and indebtedness management, during prison journey and during the prison release phase.

The future development of synergies with external drug care agencies aiming at a comprehensive concept of throughcare it in terms of psychosocial measures, substitution treatment or economical start-up help are some of the cornerstones of national after-prison reintegration strategies.

Regarding **substitution treatment in prison**, no formal or binding guidelines do currently exists. Three scenarios may occur:

- the most frequently encountered situation applies to new prisoners who underwent substitution treatment prior to their current incarceration. Medical prison staff inquires the accuracy of the information provided by involved inmates by contacting the prescribing GP or the national substitution programme. In case of confirmation, substitution treatment is continued and may be followed by maintenance, dose reduction or detoxification treatment,
- increasingly substitution treatment is initiated within prison. It also includes inmates who have started opiates use in prison,
- opiate using or already substituted prisoners may introduce an admission demand to the national substitution programme 6 weeks before release. Continuity of care and re-socialisation measures are ensured by the intervention of social workers from external field agencies (Substitution, HIV, hepatitis, etc.),

The main substitution opiates prescribed in prison are methadone (MEPHENON ®), and to a lesser extend buprenorphine (SUBUTEX ®) and codeine. Prescription of benzodiazepines is widespread.

A strictly structured **syringes distribution programme** has officially been started in 2005 in the framework of the global drug care programme in prison. **Condoms** are available at different discrete spots of the prison.

As far as treatment of psychiatric **co-morbid patients** in prison are concerned a collaboration convention between the national prison administration (CPL) and the national neuro-psychiatric hospital (CHNP) has been signed in 2002. The convention sets the framework for the creation of a psycho-medical department within prison and regulates prevention, care and referral of mentally disabled as well as alcohol and drug dependent inmates. Therapeutic care, substitution treatment and counselling is provided ad hoc. In case of severe mental disorders, imprisoned patients are referred to a high security department within the CHNP.

- Alternatives to prison and punishment for drug users

- Political, organisational and structural information

Alternatives to prison targeting offending drug users do exist and are anchored in national legislations. Alternative measures to prison sentences are part of the national drug policy, they are not, however, explicitly referred to in drug strategy papers.

The Ministry of Justice and Prosecution authorities are in charge of implementing referred measures at the national level.

Article 30 of the law of 19/02/1973[35] establishes the 'Multidisciplinary Committee' in charge of treatment measures provided as alternative to drug related offences' sentencing. The grand ducal decrees of 28/12/1973[36] and 31/01/1980[37] regulate the composition and the functioning of the Multidisciplinary

[35] Loi modifiée du 19 février 1973 concernant la vente de substances médicamenteuses et la lutte contre la toxicomanie. (Mém. 173, 319) (cf. ELDD)

[36] Règlement grand-ducal du 28 décembre 1973 déterminant la composition et le fonctionnement du service multidisciplinaire chargé de la lutte contre la toxicomanie et établissant les modalités de la cure de désintoxication (Mém. 1973, 1967) (cf. ELDD)

[37] Règlement grand-ducal du 31 janvier 1980 modifiant le règlement grand-ducal du 28 décembre 1973 déterminant la composition et le fonctionnement du service multidisciplinaire chargé de la lutte contre la toxicomanie et établissant les modalités de la cure de désintoxication (Mém. 1980, 81) (cf. ELDD)

Committee, hereinafter referred to as '*Committee*'. Members of the Committee are designated by the Minister of Health who does also nominate its director.

The Committee takes in charge persons who according to article 23 of the 19/02/1973 law volunteer for drug treatment, and those who accept an alternative treatment proposition of the State Prosecutor and finally those persons who have been ordered drug treatment by the prosecution authority according to articles 24 and 26. The referred articles will be addressed more in detail bellow.

Following medical and social enquiries, the Committee, composed of three MDs, a psychologist, a pharmacist, a jurist an educator or teacher and a social assistant, chooses the adequate treatment setting and follows up treatment progress to be reported to the prosecution authority having proposed or ordered drug treatment.

- Legislation

General legislation regarding alternatives to prison relies on a series of codes as the criminal instruction code[38], the penal code[39] and laws on penalties regime[40]. Legally possible alternative measures to sentencing or prison sentences rely on the nature of the offence and the type of sentence or penalties that are: criminal penalties, correctional penalties (minor offences) and police penalties. As far as legislation on alternatives to prison targeting explicitly drug using offenders is concerned the modified basic drug law of 1973 (last modified by the law of 27/04/2001) provides the national legal framework .

Alternative measures to criminal proceedings by the Prosecuting authority (art. 23/law 1973 modified by law 27/04/2001)

In case of a recorded drug use offence, the Public Prosecutor ('Parquet') may decide:
- **not to prosecute** the case if the drug use offender (under certain circumstances defined by article 7, 8c and 8h of the modified 1973 law) submitted to detoxification treatment prior to the drug use offence record,
- **to propose** to a drug user for whom a record for use of drugs defined under article 7 of the modified 1973 law has been established to undergo detoxification treatment on a voluntary basis. This also applies to drug distribution offenders if the underlying cause of the referred activity is personal drug use (as defined under art. 8a and 8b of the modified 1973 law,
- **to close** the case without proceedings (evtl. with a caution) if treatment proposed by the State Prosecutor is successfully completed (cf. Multidisciplinary Committee).

Alternatives to sentence by Court (art. 24 and 26 / law 1973)

Once criminal proceedings for illicit drug use have started, the instructing judge, may:
- **instruct detoxification** treatment for adult illicit drug users. If the treatment is successfully completed (report by the MD in charge of treatment), the case can be closed without proceedings if related to offences defined under art. 7,8c and 8h (if not completed, the offender is prosecuted). The demand for detoxification treatment (instructed by the Instruction Judge) has to be addressed by the Public Prosecutor or the offender him/herself.
- **decide to postpone the sentencing** (suspension of sentence pronunciation in case the actual sentence is not higher than 2 years imprisonment) for a determinate length of time, but the instructing judge has to decide on the culpability. When the case goes back to the court, the judge may decide not to give a sentence. There are 2 types of postponements: simple postponement, postponement accompanied by probation (which may be associated to drug therapy).

The 'suspension sentence pronunciation' may be applied once a person has been found guilty but before he/she serves a sentence. The suspension of sentence may be applied once the person is in prison. It has to be seen as a measure that fits between the legal concepts of ''prolonged leave'' and conditional liberty.

[38] Code d'instruction criminelle, art 621 ss.
[39] Code pénal, art. 22
[40] Loi du 13 juin 1994 relative au régime des peines (Mém. 1994, 59)

In case of postponement with probation a custodial sentence may be suspended (totally or partially), under the monitoring of the Prison Probation Service (SCAS). The offender is released but is subject to measures intended to monitor his/her liberty of movement and is obliged to fulfil certain judicial orders such as undergoing therapeutic treatment in the case of drug addiction.

The sentence suspension may be accompanied or the sentence itself may be replaced by a requirement to perform community work, which can also be prescribed as main penalty. The legal term for community work is **Work of General Interest** (TIG). The TIG sentence, according to article 22 of the penal code is given by the Court whereas its modalities are decided upon by the State Prosecutor and commonly apply to 2 different scenarios:

1. Main sentence;
2. If sentence is less than 6 months imprisonment

The types of applicable TIG are regulated by the grand ducal decree of 20/09/1994[41] and are managed by the Prison's Central Probation Service (SCAS). In 2003, 121 TIG sentences have been given of which 8 were related to drug offences. As far as underage offenders are concerned the so called ' educational and philanthropic activities' (EPA) apply. In 2003, 6 of 95 EPA were related to drug use offences (Ministry of Justice, 2004).

Alternatives to sentence by Youth Court (art. 25 / 1973)
Youth Court may instruct detoxification treatment or counselling sessions (MSF) for underage drug law offenders (drug use). The referred measures can be delayed or modified according to the national law on childhood protection.

- Implementation structure

As can be deduced from information provided above, the implementation of alternative measures to sentencing and prison sentences applied to drug use offenders involves a series of authorities and actors namely the Ministry of Justice, the Ministry of Health, Prosecution authorities, the Multidisciplinary Committee, specialised treatment agencies and licensed MDs. The prosecution authority plays the central role in the decision process. There are no regional or local coordination mechanisms. Both, the multidisciplinary committee and the MD responsible for the ordered or proposed drug treatment may report to the Prosecution authority.

According to article 29 of the 1973 modified drug law implementation costs of specialised treatment infrastructures for drugs users within the regime of therapeutic injunction are to be take in charge by the State. Treatment and medical surveillance costs are totally or partially taken in charge by the State if not covered by the Social Security insurance scheme of the beneficiary, and/or if the latter has no sufficient financial means. (art.8 of g. d. decree of 28/12/1973).

- Interventions

National legislation on treatment modalities for drug use offenders as an alternative to judicial measures explicitly refers to detoxification treatment. Article 30 of the 1973 modified drug law, however, allows the Multidisciplinary Committee to define adequate treatment options. According to article 29 of the same law, treatment may be provided by specialised drug treatment agencies or other therapeutic settings if medical surveillance is ensured. In practice, treatment interventions include, in- and outpatient detoxification, therapy and counselling and substitution treatment.

[41] Règlement grand-ducal du 20 septembre 1994 relatif au travail d'intérêt général (Mém. 1994, 1710)

The modified grand ducal decree of 28/12/1973 regulates treatment modalities for drug users who present voluntary for treatment to the Multidisciplinary Committee and for those who have been proposed or ordered drug treatment by the Prosecution authority.

The Committee following a medical and social enquiry chooses the adequate treatment setting. Alternative drug treatment may be provided by all state licensed/accredited national drug care facilities and if deemed necessary also by treatment institutions abroad. Most involved drug treatment facilities or non profit organisations or foundations having signed a financing convention are accredited by the Ministry of Health. These specialised agencies provide drug treatment to a broad target population since they have not been set up specifically for drug users under the therapeutic injunction regime. Treatment in state accredited drug agencies is free of charge and physical detoxification falls under the health insurance scheme.

If the medical diagnosis reveals a minor addiction problem, treatment may be provided within an out-patient setting under the responsibility of an accredited MD. For this purpose MDs have to address an accreditation demand to be granted by the Minister of Health (art. 9 of modif. G. d. decree of 28/12/1973). The Multidisciplinary Committee follows up treatment progress of the concerned person and report to the prosecution authority having proposed or ordered drug treatment.

Annual admission statistics show that between 1995 and 1999 the number of drug users referred to the Multidisciplinary Committee by the Prosecution Authority varied between 20 and 60 cases per year. From 2000 onwards it became more and more common practice to refer concerned drug users directly to specialised drug agencies, which currently ensure medico-social enquiries and treatment itself. There are no data on referral schemes from 1999 onwards. The Committee is currently to been seen as the official link between treatment providers and the competent prosecution authority more than a diagnosis and orientation setting.

- Monitoring

Article 27 of the modified 1973 drug law stipulates that the prosecution authority having proposed or ordered alternative treatment options has to be informed on the start, process and outcome of the referred treatment by the Multidisciplinary Committee in charge. In case the concerned drug use offender does not undergo or interrupt the proposed or ordered treatment, the initial sentence will be given by the prosecution authority.

Cases referred to the Youth Court are processed according to the final outcome of MSF interventions.

- Quality insurance

The procedures applying to alternative sanctions to prison for adult drug use offenders are laid down by law. Measures for underage or juvenile drug use offenders rely on a series of agreements between the prosecution authority, the Youth Court and involved NGOs.

To date, evaluation strategies as well as treatment impact assessment with regard to prison alternatives are inexistent. The global drug care programme in prison set up in accordance to the law of 27 July 1997 foresees a clearly defined evaluation strategy in terms of process and output assessment. Furthermore, the recent routine application of the RELIS protocol to new prison admissions will allow in the medium-term to assess future careers of drug law offenders under the therapeutic injunction or the TIG regime in terms of subsequent law enforcement and treatment contacts, drug-related morbidity and mortality.

Training activities will be further developed in the framework of the global drug care project.

  - Other interventions for prevention of drug related crime

- Measures for young drug law offenders

In 1996 a separate mechanism has been put in place with regard to underage and juvenile drug use offenders. The **MSF Youth Solidarity** (Doctors Without Frontiers) project is financed by the Ministry of Health and intervenes in case a minor of age has been running in conflict with law enforcement forces with respect to a drug-related offence. In this respect the MSF Youth Solidarity team may be considered as a crisis situation manager, offering their services to drug offenders referred by judicial and penal institutions. Proposed services are free of charge.

The MSF intervention team, in direct collaboration with Youth magistrates and competent law enforcement actors, offers a large variety of services with the primary aim to prevent minor aged drug offenders to enter in the criminal justice system. Interventions are based on a holistic approach of the problem, including the involved person him/herself and his/her family. MSF directly reports on intervention progress to the demanding authority. Client statistics show an increasing demand for this kind of intervention from both the criminal justice system and the social oriented institution.

Table 12.1 Clients core statistics MSF SOLIDARITE-JEUNES 1997 - 2004

		1997	1998	1999	*2000*	*2001*	*2002*	*2003*	*2004*
Number of clients		27	46	99	132	195	208	231	267↗
Referral from the criminal Justice system			26.1%	26.3%	41.4%	44.1%	44.2%	37.2%	179↗
Gender distribution	Female Male	26% 74%	28% 72%	26.3% 73.7%	34.1% 65.9%	32,3% 67,7%	34.1% 65.9%	31.6% 68.4%	31,9% 68,1%
Age distribution	< 15 15-17 ≥ 18	7% 82% 11%	11% 81% 8%	16.1% 73.8% 10.1%	12.6% 74.2% 12.9%	13,8% 80,9% 11,3%	17.8% 71.6% 10.6%	23.8% 63.6% 12.6%	17,7% 64,1% 18,6%
Main substance involved	Cannabis Heroin Solvents Ecstasy Cocaine Other	45% 33% 7% 4% 11%	49% 22% 11% 12% 3% 3%	65.7% 21.2% 5.1% 3% 1% 4%	78% 12.9% 1.5% 3.8% 3.1%	72.3% 7.2% 0.5% 3.6% 2.6% 13.8%	82.2% 2.4% 0.5% 1% 1% 12.9%	83.1% 3.5% 0.0% 0.9% 0.4%% 12.2	72,4%↘ 4,5% 0,4% 1,1% 1,1% 20,5%

Source: Solidarité Jeunes (MSF). 2005

• Prevention of public nuisances

At the national level the concept of "Public nuisance" is not approached as specifically related to drug use. PDUs are part of the population perceived as potentially nuisance generating, alongside with homeless people, asylum demanders, prostitutes, ravers, late night bar clients, etc. It is neither population specific nor substance specific if referred to PDUs.

Even though there is no officially recognised national definition, public nuisance refers to behaviours and situations that are perceived as undesirable, unpleasant, annoying, threatening or harmful by a person or a community, which consider not being involved in its generation process. Hence, there are two crucial factors to be considered: "perception" (and all the subjectivity that goes with it) and non-responsibility (or victim position).

The historical link between drug use and public nuisance is best defined if referred to the complementary and gradual influence of **public health**, public **security** and **social/economical factors**.

Drug-related harm reduction measures may be considered as the first national response to a growing concern on the alarming health condition of PDUs and the spread of infectious diseases. The set up of needle exchange programmes and the spread of substitution treatment during the end of the eighties and the beginning of the nineties have been one of the first measures that originated partly from the need to reduce drug-related harm (esp. HIV infections) and nuisance factors. The fact that in 2002 and 2003 those measures have been given a legal framework and that other measures as shooting galleries and heroin distribution programmes are retained as priorities by the government, clearly shows that health prevention and nuisance prevention/reduction continue to be strongly linked.

Public security is another crucial factor when it comes to public nuisance analysis. Basically all situations listed under the definition heading induce fear and feelings of potential insecurity. As problematic drug use became a more studied and mediatised phenomenon in the beginning of the nineties, public awareness and concern has also been increasing. Reports on increasing PDU prevalence and drug-related petty crime by officially recognised authorities have contributed to this evolution. Research, information and media have played a major role in public nuisance management.

Public nuisance phenomena are geographically spread and are often limited to certain specific areas especially in urban regions. Typically, drug-related nuisance is most felt in surroundings where drug use and drug traffic occur simultaneously, such as central railway station or isolated lots near the dealers' scenes. Understandably, a series of treatment and harm reduction facilities are to be implemented in the vicinity of those "hot spots". The implementation of new infrastructures such as drop-ins, consumption rooms or night shelters for drug addicts is often perceived as a contribution cause to public nuisance, since they are said to attract PDUs and thus degrading local live quality.

10. Drug Markets

OVERVIEW

Drug markets are of changing nature. They rely on factors such as supply mechanisms, on the economic situation and on the efficiency of law enforcement strategies. Availability and supply indicators should be interpreted with caution as they rely on the interplay of all these factors. Law enforcement authorities, the National Laboratory of Health and serial EUROBAROMETER surveys have provided data presented in the present chapter.

2004 data confirm that **cannabis, heroin and cocaine are widely and increasingly available** on the national market. New distribution networks have developed in recent years and operate in an obviously professional way and by doing so have significantly increased drug availability and in particular the supply of **low quality cocaine**. In general, most drugs show stable or decreasing quality while prices show broader ranges. More pronounced maximum prices for cocaine and heroin have been observed in 2004. Cannabis and derivates however have known certain stability during the last 4 years as far as street prices are concerned.

Overall, the **drugs market has become of a more aggressive nature** in terms of selling techniques. Dealers increasingly tend to actively approach confirmed or potential clients. West African citizens and/or asylum seekers are currently of particular concern to law enforcement authorities.

The perceived illicit drug availability in general population is high and follows a weakly increasing trend.

- AVAILABILITY AND SUPPLY

Law enforcement sources[42] indicate that currently the majority of illicit drugs consumed in the G. D. of Luxembourg originate from the Netherlands (cannabis production and transit of other drugs), followed by Belgium (ecstasy and ATS production) and Morocco (cannabis production). Till the beginning of the nineties, most of the persons involved in illicit drug distribution were consumers who supplied themselves in the Netherlands or acquired limited extra quantities of drugs in order to sell them within

[42] Non published information from the Specialised Drug Unit of the judicial Police

restricted local networks. Since the opening of EU borders, more organised distribution networks tend to develop within the national drug market.

The **expansion of more structured distribution networks** by organized criminal associations have been reported. The national market increasingly attracts "drug professionals" aiming to set up purely commercial distribution networks. The proportion of non-natives implicated in drug trafficking is increasing. Specialised law enforcement agencies report an increased proportion of asylum demanders coming from West Africa, as also from Albania and Kosovo involved in cocaine trafficking. In regard to heroin no predominant profile of nationality has been reported. A large number of traffickers have changed from heroin to cocaine traffic and currently are also implicated in cannabis traffic. Law enforcement actors estimate that approximately 300 persons are involved in drug traffic and illegal drugs distribution networks. Typically, involved dealers carry small quantities of drug hidden in their mouth ready to be swallowed in case of police controls. Initially drugs of high quality have been sold at low prices. Progressively however the quality and diversity of sold drugs have been decreasing. Currently, the national **drug market is flooded with low quality cocaine** which has induced major changes in consume patterns and behaviour of national drug users, especially in Luxembourg-City where an open drug scene has clearly established. Regardless the type of substances, selling and distribution techniques have become more aggressive in recent years.

Little, however, is known on the provision sources of the referred dealer network. It seems to rely on important stocks of cocaine. It is highly organised and has managed to significantly increase the supply and availability of drugs at the national level. It is estimated that **0.5 kg of cocaine are daily sold** to drug users within the Luxembourg City drugs scene.

In 2004 no **clandestine drug-manufacturing laboratory** has been discovered at the national level. Local cultures of cannabis and magic mushrooms remain rather insignificant in terms of quantity.

In addition to availability indicators from law enforcement sources, **perceived availability of the general public** provides a complementary insight in the current situation. Both, the 2004 Flash Eurobarometer 158 survey "Young people and Drugs" and the 2002 Eurobarometer 57.2 survey inform about the level and the evolution of illicit drugs availability in the G. D. of Luxembourg.

Tab. 10.1 Ease of acquisition of drugs in Luxembourg (2002/2004)

	QUESTION a: It is easy to get drugs?							
	Near where I live		In or near my school/college		*At parties*		*In pubs/clubs*	
	2002	**2004**	**2002**	**2004**	**2002**	**2004**	**2002**	**2004**
Luxembourg	62.2	66%	60.5	63%	74.7	74%	73.2	70%
EU	61.9	63%	54.9	57%	76.0	79%	72.3	76%

The results among the population of young people in Luxembourg lie within the scope of the European average. However the perception of ease of acquisition of drugs near schools and the immediate vicinity of the where the youngsters live is slightly more pronounced than the European average. The overall availability of illicit drugs seems to have slightly increased during recent years.

● SEIZURES (See ST 13)

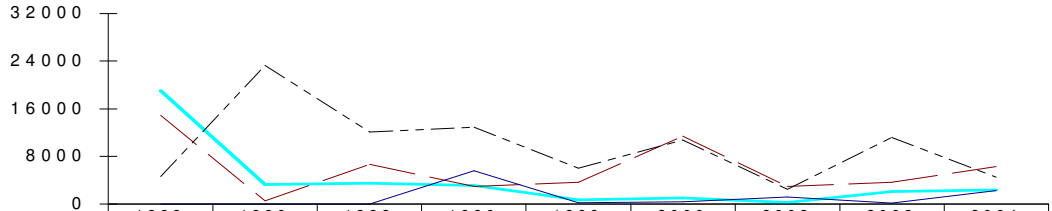
Striking variations have been observed as to the **quantity of illicit substances seized** since the beginning of the nineties. A longitudinal data analyses indicates a general decreasing tendency of heroin, cocaine and cannabis seizures until 2002[43]. Since 2002 however, one observes a significant increase in the quantity of drug seizures mainly concerning heroin and herbal cannabis. **Cocaine** seizures (quantity) are highly variable since the beginning of the nineties.

[43] Non –transit drugs destined to the nation market

Crack (cocaine-base) seizures have not been reported to date by national authorities. It has, however, appeared on the national market according to field agencies. The first national seizures of **ecstasy type substances** (MDMA, MDA, etc.) were recorded in 1994. The availability of ecstasy appeared to soar between 1994 and 1996. Most recent data indicate however a stabilization at low level.

Notwithstanding the quantities seized, the **number of seizures** has grown discontinuously since 1993. Since 2000 the number of cannabis and cocaine seizures has markedly increased and the number of heroin tends to stabilise. For instance, the number of cannabis seizures has risen from 167 to 623 between 1994 and 2004. The total **number of persons** involved in traffic has followed a constant upward trend until 2002 and seems to have stabilised since then. A confirmed majority of offenders are involved in cannabis traffic and are non-natives. For detailed information, see standard table 13.

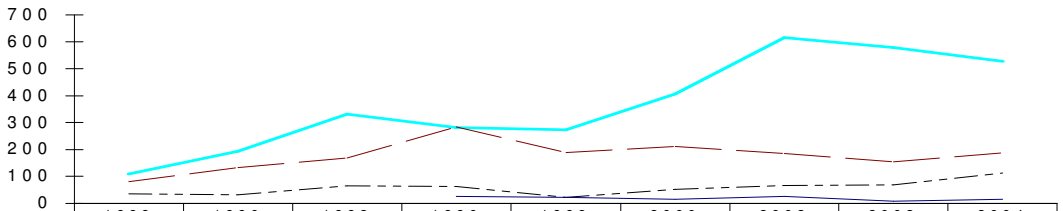
Fig. 10.1 Total quantity of seizures: heroin, cocaine, ecstasy type (1988 - 2004)



	1988	1990	1992	1996	1998	2000	2002	2003	2004
Cannabis (gr./10)	19003	3250	3448	3087	693	955	252	2093,5	2369
Heroin (gr.)	14888	527	6682	2934	3592	11358	2957	3611	6255
Cocaine (gr.)	4579	23260	12092	12891	5995	10757	2486	11153	4481
MDMA (pills)	0	0	0	5545	145	318	1139	132	2232

Source: Specialised Drug Department of the Judicial Police 2005

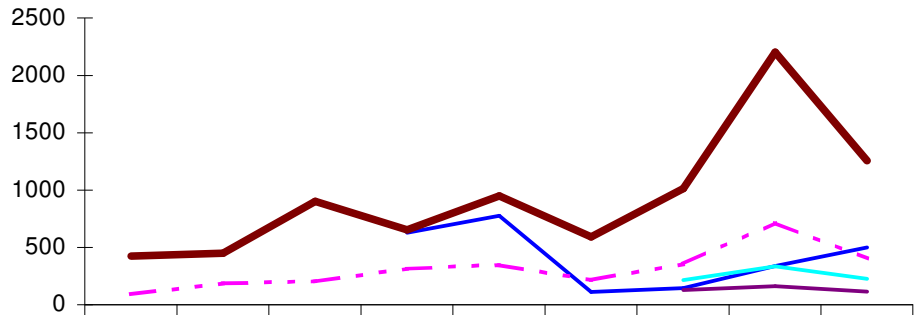
Fig. 10.2 Total number of seizures: Cannabis,Héroïne, Cocaïne, MDMA (1988 - 2004)



	1988	1990	1992	1996	1998	2000	2002	2003	2004
Cannabis	109	193	332	281	273	406	616	578	528
Heroin	81	133	169	284	189	211	185	155	187
Cocaine	35	32	65	63	22	51	66	69	113
MDMA (pills)				26	22	15	26	8	15

Source: Specialised Drug Department of the Judicial Police 2005

Fig. 10.3 Number of offenders involved in seizures according to type of offence (1988-2004)



	88	90	92	94	96	98	2000	2002	2004
Traffic				630	778	112	143	339	502
Traffic AND/OR use	424	451	901	653	949	590	1013	2202	1258
Traffic AND use							216	335	228
Traffic AND/OR use of heroin	91	186	203	312	347	215	354	715	399
Traffic AND use of heroin							129	162	116

Source: Specialised Drug Department of the Judicial Police 2005

● PRICE/PURITY (see ST 14)

Average **street retail prices** of heroin, cocaine and ecstasy like substances have been falling between 1996 and 2003 but a broadening of the price range of cocaine and heroin is currently observed. Cannabis and derivates have known a certain stability during the last years. Heroin is frequently sold as 'boulette (meat ball)' containing 0.2-0.4 grams for 12-25. - euros. Typical street retail cannabis is sold in pieces of 2.5 to 3 grams for 25. - euros.

Table 10.2 Price per unit evolution at the street level (1994-2004)

	1994	1998	2000	2002	2003	2004
CANNABIS						
Haschisch Marijuana	5-6	5 – 6 2,5 - 3	7,4 6,2	7	8.3 8.1	**7.3** **7.3**
Cocaïne	100-150	120 -170	90	50	30-85	**20-120**
Heroin (brown)	65-150	90 -150	74,4	50	40	**82**
STA		25-30	?	25	n.a.	**n.a.**
Ecstasy		9 - 13	10,7	7	10	**10**
LSD	11-13	11 -13	?	n.a.	n.a.	**10**

Source: Specialised Drug Department of the Judicial Police 2005

Price: expressed in EURO at street level.
For cannabis, cocaine, heroin and amphetamines, price per gram is indicated.
For heroin and cocaine, minimum prices refer to traffic units. Maximum and average prices refer to street retail quantities.
For ecstasy and LSD, price per pill or unit are indicated.

As far as **purity** is concerned, the maximum quality of cannabis rates (% of THC) has been increasing during recent years but the average quality has remained stable. MDMA purity in ecstasy-type drugs has decreased. Heroin tends to show higher quality and average purity of cocaine has been remaining fairly stable in recent years.

Table 10.3 Purity of drugs at street level (1994-2004)

	1996	1998	2000			2001			2002			2004		
	Pur. (%)	Pur. (%)	Pur. (%)			Pur. (%)			Pur. (%)			Pur. (%)		
	AVERAGE	AVRG.	MIN.	MAX.	AVRG.	MIN.	MAX.	AVRG.	MIN.	MAX.	AVRG.	MIN.	MAX.	AVRG .
CANNABIS (THC)			2.65	11,7	**8,03**	2,3	12,8	**7,2**	0.7	19.3	**7.96**	0.64	14	**6.94**
Cocaine	**60-90**	**60-90**	28,3	92,2	**60,25**	24,95	92,9	**56,09**	14.6	90.4	**62.99**	9.65	94.9	**62.37**
Heroin (brown)	**15-23**	**20-25**	2,8	54,9	**17,59**	24,95	92,9	**13.62**	2.0	22.9	**9.97**	5	41.55	**17.07**
STA									3.5	55.5	**15.09**	1.25	40.65	**9.44**
Ecstasy[44] (MDMA) (MDEA) (MDA)			18,7	52,3	**35,5 6,8**	35,61	109,75	**67,25**	11	120	**71.11 - 24.6**	22.35 6.25	39.50 6.25	**29.77 6.25**
Psylocine											**0.15**	0.26	0.57	**0.41**

Sources: Specialised Drug Department of the Judicial Police / Laboratoire National de Santé. Division Toxicologie. 2005.

Purity: For cocaine, heroin and amphetamines, purity is expressed in percentages of pure active substance at the street level.
For cannabis, purity refers to percentage of THC.
For ecstasy-type substances, purity refers to percentage of MDMA-HCL in relation to total mass in 2000 and to mg of active substance per pill from 2000 onwards.

[44] **Ecstasy** : dose in mg/pill

Part B – Selected Issues

11. Gender Differences

- **SITUATION**

a. Consumption in the general population and young people

A comparative analyses of two main school studies Fischer (2000)[45] and HBSC (2002)[46] in regard to gender differences suggest increased life time prevalence rates of cannabis, amphetamine and magic mushrooms consumption by young men and a more sustained use of psycho-active medicaments by young women.

Tab. 11.1 HBSC study (2002) : life time prevalence of students aged 12 to 20 - prevalence of last 12 month

	%	Male %	Female %
Cannabis	27.4	30.8 - 25.8	23.9 – 19.0
Ecstasy type	3.1	3.3 – 1.9	2.9 – 1.4
Amphetamines	3.7	4.4 – 2.4	3.3 – 2.0
Heroin	1.2	1.2 – 0.7	1.0 – 0.5
Medicaments	2.5	2.4 – 1.2	2.8 – 1.8
Cocaine	2.3	2.5 – 1.6	2.2 – 1.5
Glue sniffling	3.8	3.8 – 1.6	3.6 – 1.4
LSD	2.1	2.3 – 1.2	1.9 – 0.9
Magic mushrooms	4.8	6.3 – 4.6	3.3 – 2.0

The HBSC study (2002) is the only study to provide prevalence data of last 12 months of a school population aged between 12 and 20. The findings reflect similar gender distribution as for lifetime prevalence was with also a proportional higher medicament use in women the last 12 months.

The Luxembourgish Information System on Drugs and Drug Addiction (RELIS) provides data on gender distribution of PDUs. 2004 RELIS data on treatment demand show a gender distribution of 77% males and 23% females among PDUs (stable tendency compared to previous years), data that reflect the overall sex ratio observed among drug treatment institutions in the G. D. of Luxembourg as also, in a greater extend, in other European countries.

Since 2002, an increasing age of men and a decrease in women's age in PDUs has been observed. Male PDUs show an increasing average age (men: 30 years and 1 month; women: 28 years and 6 month). 34% of PDU's indexed by the RELIS monitoring system report having no child.

Concerning the consumption of drugs among family members (in this particular case: a regularly or sustained consumption and/or a problematic consumption of illicitly acquired psycho-active substances as also the abuse of medicaments and alcohol), PDU's report a proportion of 30% of drug abuse by brothers and sisters, 26% by fathers and in 14% of cases a drug abuse by mothers.

On average, women start smoking cigarettes earlier than men (F:13 years and 9 months; M:14 years and 10 months) and tend to get into contact with illicitly acquired drugs at an earlier age.

Since 1995 an important decrease in average age of first illicit drug consumption is observed, especially in men.

A majority of PDUs (96%) reported lifetime HIV tests (women: 99%/ men 95%) and a slightly increased proportion of women (79%) reported an HIV test the last 5 month (men:71%).

[45] Fischer U. CH. (2000). Cannabis – An analyses of the current situation, CePT, Luxembourg
[46] Well-being of youngsters (2002). Ministry of National Education, of Educational Training and Sports, Ministry of Health. Luxembourg.

Since 1995 an important decrease in average age of first illicit drug consumption is observed, especially in men. The average age of first intravenous drug currently situates around 19 years and 4 months for men and 19 years and 7 months for women. The age of first consumption of illicit drugs comes to 12 years and 5 months for men and 13 years and 11 months for women.

b. Mortality and drug related deaths

The drug unit of the Judicial Police runs a special register indexing overdose cases at the national level. In 2004, 13 acute/direct drug-related deaths were registered, 10 (77%) male and 3 female victims (23%). During the last 5 years the proportion of female direct drug deaths cases varied between 14 % and 27% showing no significant up- or downwards trend. The proportion of female victims in indirect drug deaths is lower than in od cases. However, no significant prevalence trend is observed.

c. Treatment demand data

Treatment demand data of specialized drug treatment and counselling services show a fairly stable gender distribution of 77% of men and 23% of women (RELIS).

The proportion of female substitution treatment demanders in 2004 was 38.3%, showing an increasing trend for several years. It has to be noted that pregnant women and persons infected with HIV constitute priority groups.

The sex ratio of detoxification treatment demanders typically situates at 70% males and 30% females. This proportion has been varying within narrow limits during recent years.

Outpatient drug counselling services observed a gender distribution of treatment demanders varying between 59-62% of men and 38-41% of women. Patients in residential treatment show a gender distribution of 73% of men and 27% of women (treatment demands abroad: 74.2% of male clients and 25.8% of female clients). Agencies specialized in minor's treatment show a gender distribution of 73% of male youngsters and 27% of female youngsters.

d. Infectious diseases

The 2004 annual report of the committee of HIV surveillance reported 60 new HIV infections in general population, which constitutes a dramatic increase. The gender analyses shows a distribution of 70% male and 30% female patients. A proportion of 5% of infected cases were due to contamination by intravenous drug use. Of 649 HIV diagnosed cases from 1985 to 2004 in Luxembourg 23% were of female gender. Although men are most prevalent in newly diagnosed HIV cases one observes a discontinuous increase of the proportion of female cases since the end of the 90.

d. Crimes and arrests

In 2004 national authorities reported 1,258 drug related law offenders of which 87% males and 13% females. The proportion of females involved in the possession and/or abuse of cocaine (19.2%) and heroin (17%) was significantly higher than in cannabis offences (9%).

730 offences were related to drug trafficking with a proportion of 92% of male offenders and 7% of female offenders. The proportion of females involved in heroin trafficking (12.4%) was significantly higher than in cannabis (5.6%) and cocaine traffic (5%).

- **RESPONSE**

a. Gender-specific responses on children and young people

Universal prevention programmes in kindergarten, primary and secondary schools are organized by the national centre of addiction prevention (CePT) and/ or the Department of Research Coordination and Pedagogical and Technological Innovation (SCRIPT) of the Ministry of National Education.

Training courses organised by the CePT in collaboration with the SCRIPT for adults working and living with children and youngsters, as for example teachers and socio-educational staff, parents etc., take into account gender differences in order to help multipliers transferring knowledge to youngsters and to raise awareness of social roles and perceptions.

Selective prevention programmes are organized in the framework of the Mondorf Group. The CePT and the National Service of Youth (Ministry of Family and Integration) in collaboration with specialized prevention services from the border regions of France, Germany and Belgium organize on a yearly basis "adventure weeks" for youngsters at risk. There is no selective approach according to gender of participants since heterosexual relationships and competition are potential conflict sources addressed in this programme.

Selective prevention among socially vulnerable groups: The CePT is currently developing a concept of primary prevention targeting at youth and children's homes and day admission structures taking into account gender differences.

In line with a previous national sensibilisation campaign against the misuse of psychotropic substances, training sessions on gender differences in substance abuse aiming to clarify why women are more vulnerable as man to abuse psychotropic medicaments and what are their perceptions of addiction and prevention have been organized by the CePT during 2004. The programme is provocatively called "*Do women/girls swallow more than man/boys?")*

b. Gender-specific harm reduction responses

Since 1998 a specialized harm reduction service for sex-workers and mainly used by female clients called Drop-In was set up by the Red Cross in Luxembourg city. In 2004, 4,044 clients were registered (3,149 women). In order to reduce the risk of sexual transmission of infectious diseases, preservatives are distributed to clients inside the structure and during streetwork activities. The service provides injecting paraphernalia (sterile water, filter, citric acid, bleach aluminium foils etc.), medical care, psychological counselling and a syringe exchange program. Every low-threshold service offers gender specific counselling and provides risk reduction support.

The night shelter service "Nuetseil" offers for homeless drug users a special dormitory for women as also separated sanitary equipments.

The above mentioned harm reduction service for sex workers "Drop In" certainly adopts a more female oriented approach towards their clients as they are mainly composed of female sex workers. As for low threshold services, most clients are male clients (about 80%) and staff members are mostly confronted with masculine role behaviour. However, low threshold services offer specific counselling for women.

c. Gender-specific treatment data and approaches responses

The availability of gender-specific treatment is well adjusted to the national drug situation. Specialized in- and out treatment services in the drug care system are aware of special needs of female or male clients.

From individual counselling to sanitary equipment, all service providers take care of clients' personal history and social role in offering support and organizing withdrawals and therapies.

d. Gender-specific social reintegration approaches

d.1. Family and social relationships

Since 2003, JDH Foundation has been setting up a project called “Parenthood” aiming at promoting well-being of children and developing parental competencies of drug addicted parents. The objective of this programme is to avoid a transgenerational passage of parent’s drug addiction to their children and to ensure children needs of security and development. It is of utmost importance that the family and the social worker entertain a confidential relationship and that the well-being of the child constitutes a common objective of the family. A collaboration network between services of psycho-motric rehabilitation of children, family help social services, accompanying services, day admission structures for children, children’s homes, youth protection services, homes for women, hospitals and schools has been set up. In 2004, 43 different family situations have been treated, two third being mono parental families and one-third constituted couple situations, involving 61 children. The service also supports parents, whose children have been placed in out-of-home institutions by the Youth Court. Most cases concern mother child relations. In 2004, 573 interviews have been conducted with the families. An essential part of the project constitutes the outreach work. Meetings and interviews are held within the natural environment of the family (at home).

JDH Foundation also manages in the framework of their project called “Niches” a total of 20 apartments placed at the disposal for stabilized clients in a rehabilitation process. Families or persons with children come on first place in the admission list. Half of the clients renting the apartments have at least one child.

Also the methadone substitution programme offers specialized counselling for pregnant drug addicted women and works in close collaboration with the maternity of the Hospital Centre Luxembourg that is specialized in risk pregnancies.

d.2. Work and employment

Socio-professional reinsertion constitutes a main objective of specialized drug treatment services. The national social network offers a wide range of employment services for marginalized persons aiming at a social reintegration. The Ministry of Equality of Chances implements national policies of non-discrimination between women and men at each level.

d.3. Education and training

Adult professional training Centres (CNFPC: Centre national de formation professionnelle continue) offer courses aiming at professional reinsertion. Several associations are specialized in seminars and trainings only for women re-integration.

d.4. Dept-counselling

All specialized drug care agencies provide dept-counselling aiming to improve the socio-professional status of clients regardless the gender of the latter. The social national network offers a broad range of social services also specialized debt-counselling but not specifically aiming at drug addicts. The most important are the “social service of proximity” of the Red-Cross, the ”service of information and support in the domain of dept overload” of the Medico-Social Ligue.

e. Gender-specific aspects in the criminal justice system

Drug related offences are covered by the law of 19 February 1973 modified by the law of 27 April 2001. The public prosecutor under the authority of the General Public Prosecutor decides on the appropriate legal proceedings in case of an offence against the modified 1973 law. He is obliged to order investigation in case of a crime. If a case is proceeded, firstly the seriousness of the offence is taken into account (quantity and nature of drugs involved, damage caused…), then the circumstances as well as the conviction records, age, gender, character and social situation/environment of the accused person (first-time offender, recidivist…).

12. European Drug Policies: extended beyond illicit drugs?

OFFICIAL ENDORSEMENT BY THE NATIONAL DRUG STRATEGY

In 1999 the government entrusted the Ministry of Health with the overall coordination of drug-related demand reduction issues. The first national strategy and action plan on drugs and drug addiction covered the period from 2000 to 2004. In December 2004, the Minister of Health presented the new strategy and action plan 2005-2009. The strategic framework of the action plan, set up by the national drug coordinator, constitutes the output of a multilateral concertation process in the light of priorities stated in the governmental declaration of 2004 and is further based on the evaluation output of the former action plan.

The governmental programme of August 2004 constitutes a strategic document defining political aims to be reached in the legislative period from 2004 to 2009 and states, as far as the fight against drug and drug addiction is concerned, that "[…] efforts undertaken in the drug prevention domain have to be pursued by means of prevention campaigns, especially in school. Such campaigns should address addictive behaviour regardless the legal status of involved substances (i.e. alcohol, medicaments, tobacco). Specialised services for drug dependent persons as also post-therapeutic structures will be further developed and the number of therapy places will be increased. The different initiatives in this domain are to be supported. A project of drug provision under medical control for severely addicted persons will be implemented.

The government will deposit a project of law with the objective to improve the protection of non-smokers. Specialized "anti-tobacco" counselling will be provided. To better respond particularly to the delicate situation caused by alcopops, it is intended to proceed to legal amendments […]."

The governmental programme thus follows a holistic approach by addressing licit and illicit use of drugs. Moreover it literally addresses addictive behaviour, namely non-substance related addictions.

The national anti-drug strategy 2005 – 2009 relies on two pillars: demand reduction and supply reduction and on four transversal axes: risk, nuisance and damage reduction; research and information; international relations and horizontal coordination mechanisms. Distinction should be made between the national drugs strategy on the one hand and the associated action plan on the other. The strategy situates the general context and sets priorities for the coming years. It strongly relies on a preliminary need assessment at each level of intervention. The action plan provides "flesh to the bone" meaning that it lists concrete measures and required resources necessary to fulfil the objectives stated in the strategy.

In the light of the high prevalence rate of problematic drug use at national level, the national drug strategy ostensibly gives priority to the fight against illicit use of drugs and related consequences. The target group of the national drugs action plan is primarily constituted of problematic drug users of illicitly acquired drugs and polydrug users. The concept of polydrug use renders the distinction between illicit and licit drugs artificial as far as treatment and harm reduction are concerned.

Licit drug use and non-substance related addictions are not explicitly addressed nor excluded from the strategy. A basic assumption of national drug policies is that primary prevention of addictive behaviour is of utmost importance. The very field of primary prevention has a distinctive status since addictive behaviours can develop on different grounds and eventually lead to licit or illicit substance abuse. The process behind is of such complexity and variety that only a highly flexible approach will allow to face actual needs in the light of fast changing trends, behaviours and licit and illicit substances on the market. For that very reason the national drugs strategy does not exclude non substance-related addictive behaviour or legal substance use/misuse; on the contrary it considers primary prevention of addictive behaviour of such importance that it provides for a highly adaptive intervention framework not necessarily granted by a multi-annual drugs action plan. These issues are indeed specifically addressed by the National Drug Prevention Centre jointly with the national drugs coordinator but are not included as

specific actions in the national drugs action plan unless they are directly linked to illicit use/misuse of drugs.

The national approach towards addiction prevention focuses on the individual and his environment rather than on drugs and drug addictions. According to observed needs, specific substances and behaviours may be subject of prevention activities or campaigns (e.g. campaign on misuse of psychotropic medicaments, assessment study on the national situation in regard to consumption of cocaine, alcohol and gambling) not specifically mentioned in the drugs action plan. These interventions are initiated and planned jointly by field agencies and the Ministry of Health.

GENESIS AND RATIONALE

The approach described above has resulted from successive changes of social-economical factors, of new consumption patters and emerging psychoactive substances on the market during the last 10 years. The creation of the National Drug Prevention Centre in 1996 was a clear political signal of the priority national authorities attach to the development of addictions in society. The nomination of a national drugs coordinator in 2000 and successive national action plans further witnessed the willingness of the government to tackle addictive behaviours by a complementary approach putting however emphasis on problematic drug use in the light of the high national prevalence, the prevention of health damages and deaths of PDUs and the safeguard of public security.

RESPONSIBILITY, COMPETENCES AND COORDINATION MECHANISMS

The fight against drugs and drug addiction is a competence shared by different ministerial departments (Ministry of Health, of Justice, of National Education and Vocational Training, of Family and Integration, of Social Solidarity and of Foreign Affairs and Immigration). Demand reduction underlies the Ministry of Health, supply reduction is a competence of the Ministry of Justice and the Ministry of Foreign Affairs and Immigration is responsible of international relations.

The Inter- ministerial Drug Group (GID) assures the political coordination of the different ministries competent in drug related issues. The GID is composed of delegates of the public prosecutor, heads of grand-ducal police, heads of customs' administration, representatives of the national youth service, of the National Addiction Prevention Centre, of the department of preventive and social medicine of the Directorate of Health and the national drug coordinator. The GID is chaired by a delegate of the Ministry of Health actually functions as a coordination committee. From January 2006 on the GID will be chaired by the national drugs coordinator.

Coordination and supervision of field actions related to demand reduction is a competency of the Ministry of Health and more precisely of the coordination unit under responsibility of the national drug coordinator, implemented within the department of socio-therapeutic actions (Directorate of Health). The national drugs coordinator also is the head of delegation of the national GHD delegation, the Permanent correspondent of the Pompidou Group and the Mondorf Group. The national drugs coordinator thus has a transpillar overview of drug-related issues and may influence the decision process in other fields than demand reduction, knowing, however, that the final decision of these matters lies in the competent ministries.

The department of preventive and social medicine of the Directorate of Health initiates or supervises prevention activities in fields such as licit psychoactive substances use, infectious diseases, healthy nutrition, vaccination, antibiotics misuse, etc. The CePT more specifically focus on prevention of addictive behaviour. As both actors are represented within the GID, decision can be taken at the inter-ministerial and drugs coordination level on the opportunity to implement new prevention measures at the national level. This model has proven to be most effective with regard to fast evolving consume patterns.

Associations specialized in anti-tobacco counselling and prevention are financially supported by the Ministry of Health. Therapeutic treatment of persons with alcohol dependence is available in specialized institutions. A national NGO addresses gambling addiction. Associations planning specific drug related prevention campaigns usually request the collaboration with the department of preventive and social medicine of the Directorate of Health.

As far as financial issues are concerned involved ministries are competent to define their actions and manage allocated annual state budgets. The law of 8 September 1998 regulates the relations between the State and social, familial and therapeutic organisms. As DDR is a competence of the Ministry of Health since the governmental declaration of 1999, services working in the field of drug demand reduction sign a convention defining budgetary, personnel and cooperation modalities in respect of the 1998 law. The budget control lies within the competence of the socio-therapeutic department of the Directorate of Health.

The department of preventive and social medicine of the Directorate of Health disposes of a budget line for Public Health prevention activities. The budget allocated to the CePT mainly by the Ministry of Health is entirely invested in addiction prevention activities. Supplementary financing of prevention activities is often addressed to the national fund against drug trafficking. The Fund manages assets and capital confiscated in the framework of drug law offences by virtue of the law of 19 February 1973 and coordinates, among other tasks, the allocation of financial resources to drug-related prevention, care or research projects at national and international level.

As for as other involved ministries (e.g. Ministry of Education, Youth…) are concerned budget lines are not clearly identifiable and moreover do not make a distinction between different types of addictions.

13. Developments in drug use within recreational settings

NEW FINDINGS ABOUT TRENDS IN DRUG USE, PATTERNS OF CONSUMPTION AND AVAILABILITY WITHIN RECREATIONAL SETTINGS

In the present chapter 'recreational settings' refer to non-educational and occupational environments with special emphasise on leisure activities and nightlife settings.

Research into drug use within recreational settings is fairly recent at the national level. There seems to be an obvious link between this kind of research and the increasing problems observed in urban settings in terms of city planning or public security issues.

The Flash Eurobarometer 158 survey "*Young people and drugs*" published on June 2004 by EOS Gallup Europe and conducted at the request of the European Commission gives insight in young people's attitudes towards drugs. The study's objective was to compare the evolution of the attitudes of young Europeans towards drugs two years after the Special Eurobarometer 57.2 survey of 2002. Young people from Luxembourg declared in 2004 that it is easier to get drugs near where they live and near school or college than at parties, in pubs or clubs compared to the European average. They also declared to a greater extend to know people who use cannabis and other drugs than other youngsters from the EU. In 2004, they reported having been offered and having tried cannabis more often (in 2002: slightly under European average) than the European average but to a lesser extend other drugs than cannabis.

A study called '*Aspects of leisure time activities of youngsters in Luxembourg City*' (tome 2) published in October 2004 by the CESIJE (Centre of studies on the situation of youngsters in Europe) in the framework of a "*Youth community plan*" of the City of Luxembourg aimed to get an overview of existing leisure time activities, identify individual schemes of leisure in regard of socio-demographic data and assess current problems. By means of group discussions, 12 to 25 years old youngster have been given the possibility to express their points of view in regard to different topics, as for instance the consumption of illegal drugs. With regard to the general approach towards drugs, the legalization of cannabis was

identified as a main topic. Generally speaking, youngsters were in favour of legalization of cannabis and considered that legalization could decrease cannabis related criminality and would not increase its consumption. Prohibition was seen as encouraging youngsters to experiment with cannabis. Often youngsters compared cannabis with legal substances as tobacco and alcohol. Some youngsters reported cigarette smoking of children aged 11-12, but were not in favour of that evolution. Alcohol consumption was perceived as more physically exhausting than cannabis consumption. Also some youngsters worried about missing sanctions from authorities or schoolteachers. Other themes of importance for youngsters were the different consequences of cannabis consumption as tiredness, sickness, depression and addiction.

Youngsters described that ecstasy was mostly offered in discotheques, cannabis in the central city park and cocaine in the central station area. Also schools and their immediate vicinity were often mentioned in relation to drug traffic and consumption. Some youngsters even estimated that some school classes have up to 80% of regular cannabis consumers. Parties, discos, (open air) concerts, and the sidewalks of cafes or bars have been mentioned in regard to drug traffic and consumption. Also private parties or meetings with friends at home have been described as places of drug consumption.

Three categories of drug provision patterns have been described: youngster who don't procure themselves drugs but who consume when meeting friends; regular consumers buying the drugs from friends or colleges and those who go to the Netherlands (Maastricht, Amsterdam) to buy drugs.

In the framework of the "*Youth community plan*" (YCP) of the City of Luxembourg, a quantitative telephone survey was conducted with 12-25 years old youngsters to assess their value system, preferred leisure activities and encountered problems. During leisure time, youngsters mostly experienced problems related to alcohol (47,4%) and 27,6% encountered problems related to other drugs.

These findings suggest that drugs in recreational settings play an important role for youngsters. Youngsters also pointed out that problems inherent of their generation, in order of importance, refer to drugs and alcohol, unemployment, environment, HIV and other diseases, violence, racism, poverty, loneliness and genetic engineering. Women had a more pronounced consciousness of problems than men. One of the recommendations of the study was to promote a more sustained prevention work for youngsters aged 10 to 14 in order to counteract the myths about harmless drugs. Youngsters are particularly confronted during leisure time with alcohol and illegal drug consumption. They expressed needs of more attention and interest giving from adults (parents, teacher, police). They were in favour of a more sustained control and prevention of drug traffic and consumption in schools and its surroundings.

The final report of the project "*Streetwork - Youth in urban area*" named '*Problematic behaviour of youngsters in the City*' initiated by the Ministry of Family and Youth and Luxembourg City was published in 2004. The overall objective was to identify future actions in the field of youth policy by means of interviews and group discussions. In Luxembourg City diverse youth scenes were identified. Youngsters belonging to the skater scene assessed that every tenth out of them consumes 'soft drugs', that no consumers under 14 years belong to their group and that they don't consume high-risk drugs.

Consumption patterns of young students consuming drugs have been described as follows: students who regularly consume drugs as heroin, ecstasy, medicaments and alcohol are most often expelled from school. Cannabis consumers may be able to stay the school system but in case of hard drug consumption, the concerned youngsters, after one or two years, have to leave school because they have to procure the drugs. A relatively new consumption pattern was described concerning drug consumption of children aged 12 or 13 years.

Toxicological data do not allow concluding that new psychoactive substances are widespread on the national market. Several non-confirmed cases of GHB intoxications in young women in nightclub settings were reported in 2003. No further evidence occurred to date.

AN OVERVIEW OF DEVELOPMENTS IN RESPONSES, NATIONAL POLICIES AND LEGAL ASPECTS

Objective information on drugs, consume patterns and emerging risks are increasingly provided via internet sites of specialized agencies.
The action plan on drugs and drug addiction (2005-2009) foresees a needs assessment in the techno scene in order of risk, damage and nuisance reduction as well as a study on drugs and minors.

MSF - Youth Solidarity (Doctors without frontiers) service, a specialized drug counselling and therapy service for under-aged youngsters in conflict with law, school and family, reported an increased rate of contacts the last years and a more and more younger client population. In 2004, the service counted 267 situations/ demands (231 in 2003) related to drug problems of youngsters. 35.3% of the clients were aged 15 or less. The psychoactive substances involved, in order of importance, have been cannabis (72.4%), heroin (4.5%), alcohol (2.6%), ecstasy and cocaine (1.1%).

An early intervention project called '*Choice*' has been conceptualized by the MSF-Youth Solidarity service in collaboration with the public prosecutor's office of youth protection and the judicial police. It is based upon a German pilot project FreD 'E*arly intervention of first time noticed drug users*' and aims at youngsters aged 12 to 17 in recreational and school settings. Young first drug offenders, parents or school are proposed to participate in interactive consciousness-raising groups to initiate a change in attitude and behaviour towards drugs and drug consumption.

As far as national policies and legal developments in the field of drug use within recreational settings are concerned emphasis has been put during recent years on legal substance use/misuse among youngsters. Legal amendments concerning the prohibition on the sale of tobacco and alcohol (in supermarkets) to youngsters below 16 years are foreseen. The Minister of Health will submit a proposition of law to the parliament during 2005. The Minister of Health also proclaimed to increase taxes of the so-called mix-drinks or 'alcopops', strong alcoholic designer drinks, especially targeting youngsters.

Currently there exist no **legal framework** regulating prevention and harm reduction intervention in recreational settings such as on site information providing or pill testing. Discussions and a related parliamentary motion during the amendment process of the national drug legislation (amended in 2001) did not bring up a final decision on the matter. Prevention material and info flyers on synthetic drugs and multiple drug use are provided to bars and nightlife establishments by the initiative of CePT or on demand. There remains however an obvious lack of interventions in the referred settings. The improvement of data systems on quality of synthetic drugs to be assessed by the national early warning system is a permanent topic of the ICD meetings.

✻✻✻✻ END OF REPORT ✻✻✻✻

14. Bibliography

- Alphabetic list of all bibliographic references

ABRIGADO (2005). Rapport d'activités 2004*, CNDS,* Luxembourg

AST - Point Focal O.E.D.T Luxembourg - Direction de la Santé (2000). Réseau National d'Information sur les Drogues et les Toxicomanies - RELIS - Rapport National 1999. PFN, Luxembourg.

AST - Point Focal O.E.D.T Luxembourg - Direction de la Santé (2000). Récapitulatif des lois, des règlements grand-ducaux et des conventions des Nations Unies réglementant la détention, l'usage, la production et le commerce de certaines substances et préparations psychotropes, stupéfiantes et toxiques et de certaines substances utilisées pour la fabrication illicite de stupéfiants et de substances psychotropes*. PFN,* Luxembourg**.**

Berg Ch.,et al. (2004), Problematisches Verhalten Jugendlicher in der Stadt; Kritische Reflexion über multimodale Hilfestellungen für Gefährdete; Schlussbericht des Projektes "Streetwork-Jugendliche im städtischen Raum". Cesije. Luxemburg.

Centre d'Etudes de Populations, de Pauvreté et de Politiques Socio-Economiques (1996). Atlas des communes - La population du Luxembourg, ISBN 2-87987-121-2. CEPS/ INSTEAD, Luxembourg.

Centre de Prévention des Toxicomanies (2005). Bilan d'activités 2004. CePT, Luxembourg.

Comité de surveillance du Sida, (2005). Rapport d'activités 2004 Luxembourg.

Dellucci, H. (2001). L'évolution du programme méthadone de 1993 à 2000, in Rapport d'activité de la Fondation Jugend- an Drogenhëllef, pp. 9-12. Luxembourg.

Dellucci, H. et al. (2003). L'évolution des participants au programme de substitution 2000-2001 – Etude d'évaluation, Fondation Jugend- an Drogenhëllef, Luxembourg.

Dickes, P., Houssemand, Cl., Martin, R. (1996). La consommation de drogues légales et illégales des élèves des 6èmes de l'enseignement secondaire et des 8èmes de l'enseignement professionnel et technique. CEPS/INSTEAD-Division F.E.E, Luxembourg.

European Commission (2001). Public opinion regarding security and victimisation in the E.U. Contact with drug related problems. Eurobarometer surveys n° 44.3 and 54.1, Brussels.

EDDRA. Système d'information sur les échanges en matière d'activités de réduction de la demande*,* http://eddra.emcdda.eu.int/

European Monitoring Centre for Drugs and Drug Addiction (2004). Annual report on the state of the drugs problem in the European Union 2003. Office for official publications of the European Communities, Luxembourg.

European Monitoring Centre for Drugs and Drug Addiction (2005). Annual report on the state of the drugs problem in the European Union 2004. Office for official publications of the European Communities, Luxembourg.

Fischer, U., Krieger, W. (1998). Suchtpräventioun an der Gemeng - Entwicklung, Durchführung und Evaluation eines Modells zur gemeindeorientierten Suchtprävention. *CePT, Luxembourg.*

Fischer, U. (2000). Cannabis - Eine Analyse der aktuellen Situation. CePT, Luxembourg.

Fischer, U. (2002). Beschreibung und Evaluation der Kampagne 2001 " Keen Alkohol ënner 16 Joer, mir halen eis drun!.". CePT, Luxembourg.

Fonds de Lutte contre le Trafic des Stupéfiants (2005). Rapport d'activités 2004 Ministère des Finances, Luxembourg.

Goerens, R. (1998). Alcohol and Drugs at the workplace – Attitudes, policies and programmes in Luxembourg, Ministry of Health, Luxembourg.

Groupe de Mondorf (2001). Classeur d'information. *NFP – CRP Santé, Luxembourg*.

Hartnoll R. (1994). Drug treatment systems and first treatment demand indicator - Definitive protocol. Pompidou Group, Council of Europe, Strasbourg.

ICAA (2001). Encyclopaedia on substance abuse. LH Publishing 2000.

Jugend an Drogenhëllef (1993). Zweiter Bericht zur Evaluation des Methadonprogramms, JDH, Luxemburg.

Jugend an Drogenhëllef (2005). Jahresbericht 2004. JDH, Luxemburg.

Lejealle B. (1996). Niveau de formation de la population résidante en 1994, Recueil des Etudes Sociales (PSELL n° 100), CEPS/INSTEAD, Luxembourg.

Matheis J. et al. (1995). Schüler an Drogen. IEES, Luxembourg.

Meisch, P. (1998), Les drogues de type ecstasy au Grand-Duché de Luxembourg. CePT, Luxembourg.

Ministère de la Famille, de la Solidarité Sociale et de la Jeunesse (2001). Plan d'Inclusion social – Rapport 2001 – 2003. Ministère de la Famille, de la Solidarité Sociale et de la Jeunesse. Luxembourg

Ministère de la Santé (2005). Rapport d'activités 2004. Luxembourg.

Ministère de la Santé (2002). Das Wohlbefinden der Jugend – HBSC Studie. Direction de la Santé, Luxembourg.

MSF Solidarité Jeunes (2005). Rapport d'activités 2004. Luxembourg.

O.M.S. (1997). CIM-10 / ICD-10 - Classification internationale des troubles mentaux et des troubles du comportement, ISBN: 2-225-84609-X. Masson, Paris.

Origer, A. (1995). Etude épidémiologique de la population toxicomane en milieu carcéral au Grand-Duché de Luxembourg. In rapport du Réseau National d'Information sur les Drogues et les Toxicomanies. AST - Point Focal OEDT- Ministère de la Santé, Luxembourg.

Origer, A. (1996). Procedures to avoid double counting in drug treatment reporting systems. Luxembourg. AST - Point Focal O.E.D.T Luxembourg - Ministère de la Santé, Luxembourg.

Origer, A. (1997). Etude comparative des cas de décès par overdose au Grand-Duché de Luxembourg 1993/ 1994 et 1995/1996, in rapport du Réseau National d'Information sur les Drogues et les Toxicomanies. AST - Point Focal OEDT - Ministère de la Santé, Luxembourg.

Origer, A. (1998*). Enquête auprès des médecins généralistes et des médecins psychiatres sur la prise en charge des patients toxicomanes,* in Rapport RELIS 1997. Ministry of Health, NFP, Luxembourg.

Origer ,A. (1998). Local drug prevalence estimate for Luxembourg-City, in Annual report on the state of the drugs problem in the European Union. EMCDDA, Lisbon.

Origer, A. (1999). Comparative study on the drug population of Portugal and a representative sample of Portuguese drug addicts residents of the Grand Duchy of Luxembourg. Point Focal OEDT Luxembourg - Ministère de la Santé, Luxembourg.

Origer, A. (2001). Estimation de la prévalence nationale de l'usage problématique de drogues à risque élevé et d'acquisition illicite - Etude comparative multi-méthodes 1997 – 2000, Séries de recherche n°2, Point focal OEDT Luxembourg – CRP-Santé, Luxembourg.

Origer, A., Pauly R. (2000). Mortality rate in problem drug users. Direction de la Santé NFP, Luxembourg.

Origer, A., Dellucci, H. (2002). Etude épidémiologique et méthodologique des cas de décès liés à l'usage illicite de substances psycho-actives Analyse comparative (1992-2000), Séries de recherche n°3. Point focal OEDT Luxembourg-CRP Santé, Luxembourg.

Origer, A., Cloos, J.-M. Dr. (2003). Study on socio-economic costs of drug addiction and the fight against drugs. Séries de recherche n°4. EMCDDA Focal point - CRP-Santé, Luxembourg.

Schlink, J. Dr (1999). Etude épidémiologique des infections à l'HIV et à l'hépatite virale C dans les prisons luxembourgeoises. *CPL, Luxembourg.*

Service Central de la Statistique et des Etudes Economiques (2005). Annuaire Statistique du Luxembourg 2004, STATEC, Luxembourg

- Relevant data bases and information systems

a. RELIS drug monitoring system

Relying on a multi-sectorial data network including specialised in- and outpatient treatment centres and low threshold facilities, general hospitals as well as law enforcement agencies and national prisons, the RELIS drug monitoring system, established in 1995 by the NFP in collaboration with the Ministry of Health enables the assessment of new trends in the problem drug users population in general as well as in drug treatment demanders in particular. PFN has opted for a holistic monitoring of the drug population, which by definition, is heterogeneous and not limited to drug treatment demanders. RELIS data refer to HRC drug users indexed by the national specialised treatment and law enforcement network and, as such, defined as problem drug users.

The main objectives of RELIS are the following:

- present comprehensive information on the drug phenomenon in the Grand Duchy of Luxembourg
- estimate the drug prevalence at the national level (problem drug users)
- unfold emerging trends
- track any drug-related activities, be they in policy, demand reduction or research areas
- assess the impact of offer, demand and risk reduction activities on current drug consume behaviours
- serve as a data base for research activities.

The RELIS data collection procedure is based on a ***standardised extensive data protocol*** including 23 core items and over 60 sub-items. The standard protocol, including 95 per cent of the Pompidou protocol's items, has been last modified in 2000 in order to reach compatibility with the TDI (Treatment Demand Indicator) standard. The RELIS standard protocol includes a series of internal consistency items that allow to assess quality and consistency of provided data and to operate unreliable data extraction.

A second protocol, namely the ***Actualisation Protocol*** is completed each time a previously known problem drug user is re-indexed after a period of one year following the previous indexing. Finally, a third protocol ***(Identification Protocol***) including only the identification code, the name of the contacted institution and the date and context of admission is applied if a previously known user is re-indexed in the course of the year following his previous indexing. The registration system allows for highly updated, detailed and comparable data and for a follow-up of institutional careers of problem drug users by means of a routine and cost-effective data collection procedure.

To avoid multiple counting and to allow for a follow-up of drug users' careers, RELIS is based on a 9-digit numerical code obtained by indating 3 core variables (attributers) namely: gender (i.e. 01/02), date of birth (i.e., 10051967), and country of birth into a code – calculator developed by the NFP in collaboration with the CRP-Henri Tudor. The solution found is time and cost effective because it relies on a simple HP calculator that runs an attributor-to-code transcription programme based on a multiple-step algorithm.

Each contact person from the participant field institutions disposes of such a calculator and produces the code by him/herself. The reliability in terms of data protection was approved by national data protection authorities, by German partner regions of the Mondorf Group and by the National Commission for Informatics and Liberties (CNIL) of France.

One of the main benefits of the described procedure is that no personal data can be inferred directly from the identification code. The indating and encoding procedures are carried out at the very level of the field institutions. Thus, NFP is provided with individualised data (reporting protocols) without any reference to identifying information or attributors on the indexed persons, which is undoubtedly one of the major preoccupations of field institutions.

RELIS data processing is based on ORACLE ® database software and allows for multiple variable breakdowns as well as separated data analysis for different treatment or law enforcement settings. Separate data can be provided for participation regions and institutions.

In terms of data provision, RELIS further relies on following national registers:

- Register of drug law offenders - Special Drug Department of the Judicial Police,
- National Mortality Register – Ministry of Health,
- Special Overdose Register – Special Drug Department of the Judicial Police,
- AIDS and HIV Register - Laboratory of retrovirology – CRP-SANTE.
- Early warning system on new synthetic drugs

b. Register on drug law offenders (SPJ)

The register on drug law offenders is paper-based and maintained by SPJ. Research and queries on drug law offenders are performed manually. Special authorisation has been reached by the NFP to access the referred register and to manually include non-nominative data on offenders into the RELIS database. The NPF thus has developed a standard data collection protocol relying on SPSS ® based data analysis. This procedures has enabled the NFP to dispose of detailed anonymous data on all drug law offenders indexed by SPJ and to operate breakdowns referring to use and traffic offences and to substances involved according to types of drug law offences.

c. General Mortality Register (GMR)

GMR is run by the Health Statistics Department of the Directorate of Health. The main impediment towards refined data provision on drug-related deaths and the application of the EMCDDA promoted DRD standard has been the 3-digit ICD coding applied by GMR until 1997. In 1998, ICD-10 standard was first applied by GMR. Currently, drug-related death data are extracted from GMR by means of a separate extraction routine. Efforts are currently made to implement an integrated software based on the DRD ICD-10 standard and relying on the RELIS identification code, thus allowing for cross validation of drug-related death data.

d. Special Overdose Register (SR) of SPJ

The SR is a paper-based register on acute and indirect drug-related deaths run by the SPJ. Over the past years, NFP has put major efforts in the development of a computer-based indexing procedure (SPSS ®) of drug-related deaths by means of a comprehensive data form. NFP is currently maintaining a standardised database on acute drug-related deaths from 1985 to 1999. Anonymous drug-related death data is encoded at the SPJ and transmitted to the NFP according approved standards. Data on indirect drug deaths that are still paper based is also provided to the NFP.

e. AIDS and HIV register (CRP-SANTE)

Official statistics from the national Retrovirology Laboratory of the CRP-Santé provide the number and proportion of IDUs in HIV infected patients. Breakdowns by limited core socio-demographic variables are available. Provided data has public status.

f. Early Warning System on Synthetic Drugs (NFP / SPJ)

In the framework of the Joint Action on Information Exchange, Risk Assessment and Control of New Synthetic Drugs, the NFP has developed a nation wide cross-sectional data exchange network

Decision has been made to adopt a centralised structure relying on a nation wide EWS partners' network (local contact persons) as well as centralised co-ordination of key data providers' activities. The national co-ordination unit of EWS is implemented within the NFP. The head of NFP has been appointed national EWS co-ordinator.

The new mandate of the **Inter-ministerial Group on Drugs** (November 2000), which represents the top decision level in the field of drug policies, expressively includes the follow-up of the national EWS system. Governmental delegates represented within the Inter-ministerial Group have disseminated information on EWS within their respective administration and have undertaken the required steps towards an effective inter-ministerial collaboration.

The implementation of EWS relies on a network of institutional **key-informants**. Currently all specialised drug agencies (low/high threshold) at the national are involved in the data providing process in terms of routine data transmission on new trends. Recently two new agencies have joined the EWS network, namely a counselling centre for drug users underage and a low threshold project. The first does provide relevant data on new consume patterns and trends within youngster population and the second focuses on opiate users. One has to stress that the key-informants network does mainly provide data on trends in drug use but not on toxicological characteristics of substances since the referred agencies do not propose substance related services.

Currently, drug seizures are still one of the most important and the most reliable data source as to substance profiling and detection of new drugs. Samples seized by Customs or Police are either analysed (rapid tests) by the SPJ, or sent, via the Prosecutors office, to the National Laboratory of the Department of Health (LNS) for toxicological profiling. Respective results are not systematically transmitted to the department of Health or the NFP. However, effective bilateral co-operation between the NFP and the **national Europol unit** (SPJ) allow for rapid data transmission in case a new trend or substances should be detected by the latter. The active involvement of law enforcement agencies in the national monitoring system highly facilitates the implementation of Joint Action-related activities.

Agreements have been made between the *National Fund Against Drug Trafficking,* the *NFP* and the ***National Health Laboratory*** *(LNS)* on the funding of new technical equipment allocated the toxicology unit of the latter. This achievement has largely contributed to the improvement of the quality of toxicological analysis provided by LNS.

General practitioners have recently been involved in the EWS in terms of data provision on new substances and new consume patterns. All GPs and psychiatrists registered in the Grand-Duchy of Luxembourg have received a standardised data form allowing them to provide relevant information to the NFP in case they were confronted with an unknown psychotropic substance or unusual consume patterns. The NFP, as a counter part, committed to provide GPs and psychiatrists with information on the detected trends or substances, as far as there is any information available.

Drug-related deaths have to be reported by **emergency services** to the Police and the SPJ. Non-fatal drug-related emergencies requiring medical intervention have not to be reported systematically. Moreover, emergency services do not index drug-related interventions separately, which means that no monitoring of those cases can be performed. The referred situation is not likely to change and thus, the inclusion of emergency services in the EWS appears to be unfeasible at the present stage.

National drug legislation does not foresee a legal framework for **testing or profiling illicit drugs** in nightclubs, public events or rave parties. No such activities have been planned or carried out under the authority of public administrations. Taking into account that the first official seizure of 'ecstasy' has only been recorded in 1994, harm reduction and close monitoring activities in this particular field were previously not viewed as a priority.

In October 1995, a **new drug help line** was created, under the responsibility of the CePT. Given its easy access and the anonymity it guarantees, phone help lines often represent the first step with regard to further orientation or treatment demand proceedings and as such are able to provide high quality data on recent trends in drug use. The national Drug Help Line has been included in the EWS system in the course of 1999.

The drug issue is largely covered by various **media supports**. Press, Music, fashion and leisure industries are often the mirror of life styles and current trends in substance use. Information could be collected by screening the media targeted at young people and sub cultural groups. Radio, television, newspaper, magazines, fanzines, books, comics, announcement of events, opening of new clubs, etc., are to be viewed as complementary indicators towards the global monitoring of new drug trends. Since the resources of the NFP do not allow for an overall monitoring of media supports, decision has been made to compile, in collaboration with the information and press department of the State's Ministry, a monthly national and international press review on drugs.

g. Documentation Centres (NFP / CePT)

The **Centre Logistique de Documentation sur les Drogues et les Toxicomanies (CLDDT)** is a logistic documentation service run by the NFP since 1995. CLDDT runs the only computer-based national documentation management base specifically focusing on licit and illicit drugs. The CLDDT indexes about 2,900 documents mainly in French, German and English language. Users of information services provided by the

CDTL are mainly researchers, journalists, policy makers, drug treatment and prevention specialists, and general public. The majority of indexed documents are paper-based and abstracts are provided.

The following topics are covered by CLDDT:

chemistry, pharmacology, etc.
medical pathology & psycho pathology
treatment
prevention
harm-reduction
AIDS & HIV
epidemiology
drug trafficking & drug markets
legislation & legal studies
international co-operation
training activities
inventories of professionals, researchers etc.

In addition to its function of documentation base, CLDDT also ensure the conceptualisation and execution of drug documentation dissemination strategies as required by the NFP. Topic-specific mailing lists have been developed and maintained by active contact making and demand response.

CLDDT is linked to the **Centre de Documentation du Centre de Prévention des Toxicomanies** run by CePT since 1996. The CePT documentation centre mainly focuses on primary prevention, training and evaluation in the fields of licit and illicit drugs. The current stock approaches 1,000 documents or media supports. Queries are handled manually and no computer-based consultation facilities are provided.

- Alphabetic list of relevant Internet addresses

http://www.ceps.lu/

http://www.cept.lu/

http://www.crp-sante.lu/

http://eldd.emcdda.eu.int/

http://www.emcdda.eu.int/

http://www.etat.lu/

http://www.etat.lu/MS/

http://www.gouvernement.lu/

http://www.ilres.com/

http://www.jdh.lu/

http://www.legilux.public.lu/

http://www.msf.lu/

http://www.police.public.lu/PoliceGrandDucale

http://eddra.eu.int/

http://www.relis.lu/

http://www.statec.lu/

http://www.unodc.org/

http://www.who.int/

15. Annexes

- List of Graphs

- List of Tables

- List of Maps

- List of Abbreviations

AST	Service d'Action Socio-Thérapeutique
CNDS	Comité National de Défense Sociale
CePT	Centre de Prévention des Toxicomanies
CPOS	Centre de Psychologie et d'Orientation Scolaire
CRP-HT	Centre de Recherche Public - Henri Tudor
CRP-Santé	Centre de Recherche Public - Santé
CTM	Centre Thérapeutique de Manternach
CHNP	Centre Hospitalier Neuro-Psychiatrique
CPG	Centre Pénitentiaire de Givenich
CPL	Centre Pénitentiaire de Luxembourg
GHD	Groupe Horizontal « Drogues »
GID	Groupe Interministériel « Drogues »
EMCDDA/OEDT	European Monitoring Centre for Drugs and Drug Addiction
EMEA	Agence Européenne pour l'Evaluation des Médicaments
EUROPOL	Office Européen de Police
FLTS	Fonds de Lutte contre le Trafic des Stupéfiants
JDH	Fondation Jugend- an Drogenhëllef
LNS	Laboratoire National de Santé
MSF	Médecins Sans Frontières
OEDT/EMCDDA	Observatoire Européen des Drogues et des Toxicomanies

OGD	Observatoire Géopolitique des Drogues
PFN	Point Focal National de l'OEDT
PNUCID	Programme des Nations Unis pour le Contrôle des Drogues
RELIS	Réseau Luxembourgeois d'Information sur les Stupéfiants
SEPT	Semaine Européenne de Prévention des Toxicomanies
SNJ	Service National de la Jeunesse
SPJ	Service des Stupéfiants de la Police Judiciaire
TRANSRELIS	Réseau transfrontalier d'Information sur les Stupéfiants
ZePF	Zentrum für Empirische Pädagogische Forschung – Universität Landau

- List of Standard tables and Structures questionnaires used in text

1 – STANDARD TABLE 01: BASIC RESULTS AND METHODOLOGY OF POPULATION SURVEYS ON DRUG USE
2 - STANDARD TABLE 02: METHODOLOGY AND RESULTS OF SCHOOL SURVEYS ON DRUG USE
4 - STANDARD TABLE 04: EVOLUTION OF TREATMENT DEMANDS
5 - STANDARD TABLE 05: ACUTE/DIRECT DRUG-RELATED DEATHS
6 - STANDARD TABLE 06: EVOLUTION OF ACUTE/DIRECT DRUG-RELATED DEATHS FIGURES
7 - STANDARD TABLE 07: NATIONAL PREVALENCE ESTIMATES OF PROBLEM DRUG USE
9 - STANDARD TABLE 09: PREVALENCE OF HEPATITIS B/C AND HIV INFECTION AMONG INJECTING DRUG USERS
10 - STANDARD TABLE 10: SYRINGE EXCHANGE, DISTRIBUTION AND SALE
11 - STANDARD TABLE 11: ARRESTS/REPORTS FOR DRUG LAW OFFENCES
12 - STANDARD TABLE 12: DRUG USE AMONG PRISONERS
13 - STANDARD TABLE 13: QUANTITY AND NUMBER OF SEIZURES OF ILLICIT DRUGS
14 - STANDARD TABLE 14: PURITY AT STREET LEVEL OF ILLICIT DRUGS
15 - STANDARD TABLE 15: COMPOSITION OF TABLET SOLD AS ILLICIT DRUGS
16 - STANDARD TABLE 16: PRICE IN EUROS AT STREET LEVEL OF ILLICIT DRUGS
21 – STANDARD TABLE 21: DRUG RELATED TREATMENT AVAILABILITY
22 – STRUCTURED QUESTIONNAIRE 22: UNIVERSAL SCHOOL-BASED PREVENTION
23 – STRUCTURED QUESTIONNAIRE 23: HARM REDUCTION MEASURES TO PREVENT INFECTIOUS DISEASES IN INJECTING DRUG USERS
34 –TDI DATA